POLICE SUICIDE:

DETECTION, PREVENTION, AND INTERVENTION

Written by Toby Snelgrove, Ph.D.

July, 2005

Published by

710 Horton Bay Road
Maye Island, BC
250 222 8747

www.easton-snelgrove.com

Preface

In July of 1993 I noticed a shift in my clients behaviour. Something had shifted and I was concerned. I called her doctor and left a message about her change in behaviour and wanted him to re-assess her medication. I did not hear back from him till the following Monday when, during a call, he said to me: ”Toby, didn’t you hear? She committed suicide on the weekend!”

I was stunned. I couldn’t believe it. This didn’t happen to me…her counselor. I experienced a mix of emotions including profound sadness, guilt, and anger. I attempted to maintain a professional composure as, in a rather detached manor, he informed me of the details of her death. I listened to him through a fog of despair. The details were irrelevant. She was dead and I felt that I could have made a difference.

I franticly reviewed my files: Was there something I missed? Did any thing stand out indicating that my concerns for her would be indicators of suicide? Despite finding nothing, I still felt that I should have known. In retrospect, it was obvious that I did miss something. But would have I known that ‘that something’ was a harbinger of what was to follow. In hind site, if it did, I would have had her institutionalized not just called her MD.

As it turned out, her suicide was well planned. Her meeting with me was really a “good-bye” session. The note found on her pillow indicated she dreaded the affliction that tormented her mother up to her death - an affliction to which she was genetically pre-disposed - an affliction to which she was experiencing devastating symptoms - an affliction she did not want to battle any longer. She had given up. She had chosen death.

Could I have made a difference? Who knows? Her death stole those options from me. That is what was so difficult: I had no options left. She was a victim of her despair; I was a victim of her choice to commit suicide.

Fearful that her family would be angry with me, I was hesitant to go to the funeral, but I did. I must. I had to say goodbye. I had to face whatever I had to face. To my relief and surprise, the family was grateful of my presence and together we mourned her leaving.

Suicide is like no other death. It is a death that leave many victims. I is a death that can possibly be prevented. This book is dedicated to making a difference where a difference can be made. It is a book written for the policing service – a service where there are too many suicides and too many who are not sure how to respond to those that may be at risk.

1. INTRODUCTION

Suicide is intentionally ending one's life. It is the ultimate act of desperation for some people overwhelmed with personal problems. The consequence of suicide is profound and far-reaching. Due to the nature of the act, it leaves many victims. What is even more tragic is its finality: Retrospective insight is common but no insight can make a difference in this case.

How can this happen? For many the idea of suicide is inconceivable. From a rational point of view it is hard to understand the thinking pattern of a suicidal person. But unlike those who find solutions to their problems, the suicidal person gets stuck in a tunnel of despair. Here is how it can happen.

1. Despair and nowhere to turn.	For the suicidal person, they feel they have walked down a long and narrow road with nowhere to turn. Despair with no way out.
2. Restricted thinking.	As they make their way down this road, their thinking becomes as narrow as their path. Their thinking becomes more and more focused on what they perceive to be unsolvable problems.
3. Pain Avoidance.	As the proceed down this road they see fewer and fewer options and get to a point where they just want a way out from the pain.
4. Suicide becomes an option.	Stuck in their angst, consumed by their pain, with no perceivable options, suicide looks like the best way out.

If you have had a suicide in your family, friendship, or occupational circle, you know the pain left behind. You also know that you don't "get over" the tragedy…they actually change us in some way.

One of these changes is the shock that the event could actually occur along with the resulting emotions of sadness, emptiness, disbelief, and even anger. As time passes, we have a choice: what we do with the impact of the tragic event? I believe our challenge is to turn that shock and despair into proactivity – to learn something from this act and to make a difference to us, to our profession, or to life.

For example, if we discover something about the sources of stress associated with the death, we may choose to focus altering the source of that stress. If we realize that part of the problem is how to reach out to distress colleagues, we may choose to get training enhancing our interventions skills. The point is, if we can have something good coming from this tragic event, it aids un in our healing.

Learning from suicide is extremely important in policing. First, the nature of the job exposes a police officer to life's tragedies including suicide. Attending to these incidents can be challenging and potentially emotionally exhausting. If one's personal life-stress increases and if the officer has no outlet for this stress, it can lead to job burnout and despair.

Secondly, because of access to weapons, in a lonely moment of desperation, their gun can almost be viewed as a facilitator of a suicide attempt. Simply, it is easy for a police officer to kill him or herself.

Thirdly, the police culture is tight and closed. It can be hard to reach out for help for fear of being seen as weak. Consequently, an officer may continue to suffer in isolation using drugs and or alcohol to cope.

In many cases, it is the proactive caring of a colleague that can often encourages a suicidal person to take the extra step and receive professional help. You ***can*** make a difference.

Though you can't prevent what has already occurred, this publication may assist you in determining what, if any, differences you could make in the future if faced with someone at-risk. The publication will teach you about the nature of suicide, its warning signs, and intervention options. It was written to be a part of a one-day workshop for police or other emergency service personnel. However, information in this publication should be a valuable resource in and of itself.

2. MYTHS AND FACTS ABOUT SUICIDE

Suicide is a "taboo" topic. People do not like to think about it, talk about it, or be with people who are considering it. Consequently, there are a lot of myths and misconceptions about suicide. Check out your responses to these comments.

QUESTION	True or False	Explanation
1. People who talk about suicide don't commit suicide.	False	• This myth is persistent and considered one of the most dangerous. • Talking about committing suicide is one of the strongest clues a person offers before attempting or completing the act. • Seventy to eighty percent of people committing suicide have offered prior warnings, and about forty percent of those warnings were verbal in nature. • Listen carefully and sincerely when this is a topic of discussion.
2. If a person says he wants to kill himself, talking can make a major difference.	True	• Suicidal persons are often undecided about living or dying. • At times they gamble with death, leaving others to save them. • Talking about suicide is an indication that they are undecided. • Talking helps.
3. Raising the topic of suicide to a suicidal person will make things worse.	False	• Being willing to address the issue squarely is a very helpful action. Avoiding it is not. • Often it is the fear of the unknown that stops people from bringing up the topic. • If you think suicide is on their minds, check it out - ***ASK!***
4. Suicidal people are primarily mentally ill or crazy	False	• While some indeed are, and while suicide rates are higher in psychologically disturbed populations, most people who commit or attempt suicide do so when their conditions improve. • Suicidal people do not tend to have hallucinations or delusions. • However, suicidal people, while not insane, can be confused and their logic may appear convoluted. • People not contemplating suicide can rationally choose, weigh, and analyze most of the factors pertinent to a given situation. Suicidal persons might omit some key considerations and their logic reflects this.

		• Often the middle ground is ignored and the person tends to think in extremes ("If my life doesn't turn around today, it never will!"). • Relate to them as normal folks with their life out of whack.
5. Suicide risk is higher following a failed attempt.	True	• Approximately eighty percent of individuals who kill themselves have made at least one previous attempt. • If you learn that there has been a previous attempt, increase your.
6. The suicidal act is a well planned, well thought out expression of an attempt to cope with serious life problems.	False	• Most – not all - suicidal persons are irrational during the time of their suicidal crisis. They often have ambivalent feelings. The angst of the moment is often the precipitating stimulus. • Find a reason for life not reasons for death – e.g., kids, mate, parents, help, anything.
7. Only a psychiatrist or other trained professional can prevent a suicide.	False	• These professionals can certainly help, but often lay or para-professionals and other persons in the community have successfully prevented suicides. • Peers are most helpful – people who walk the same walk. • Para-professionals are the one's often found in suicide prevention centers, religious establishments or similar agencies. • Family members, colleagues, and friends can be extremely helpful in preventing a suicide since it is they who interact with the person most frequently and would be most likely to note changes in behaviour. • Peers have "face validity" – their presence is familiar and safe to the colleague • Professionals seldom wander about searching for suicidal clients in the community and therefore must rely on referrals from persons who are concerned about the welfare of the suicidal person. • Don't minimize your role as a helper.

Don't let society's fear and misconceptions about suicide prevent you from being proactive to someone in need. ***YOU CAN MAKE A DIFFERENCE.***

3. POLICING AND THE REASONS FOR SUICIDE[1]

Suicide is an increasing cause of death in the police force. One study of 2,662 police officers from1959 to 1979 found that, on average, there was a suicide every 2.5 years. The rate increased to 1.25 years from 1980 to 1990.[2]

Studies have indicated that there are several contributing factors related to police suicide. Understanding these factors may assist you in recognizing people at risk and direct you as to what action or focus you should take.

1. Stress	Police work is stressful, more stressful than the average profession. While most police officers like the challenge, however, it has its price. There is a constant barrage of stressors associated with the dangers inherent to police work.
2. Frustration and Helplessness	Most P.O. enter the profession with high ideals and a noble desire to help others. Their task is to regulate a public that doesn't want to be regulated. There is tremendous frustration and potential isolation, which can lead to cynicism and despair.
3. Access to firearms	Few professions have access to fire arms. A study that compared the New York police force to that of London, England's found that New York's suicide rate was double that of the England's force. The latter's suicide rate was similar to the city's civilian population.
4. Alcohol abuse	Alcohol is frequently use to numb emotions. It also alters one's judgment. A study of the Chicago police force found that alcohol was related to sixty percent of the suicides in the police force.
5. Fear of separation from the police subculture	The police subculture is very important for social support. The potential loss of this support as well as factors associated with the end of one's career, can be a very alienating and frightening. A recent study found a 10-fold risk of suicide among police retirees.
6. The "loner" syndrome	Policing is isolating in itself. When one is also a "loner" the isolation is compounded, especially if one is in distress. People are less proactive with loners than they are with others.
7. Critical incidents	Policing consists of periods of routine work interspersed with intense acts of violence, deceit, and human misery. Stress can be cumulative, especially if there is not mechanism for "talking it out." Workplace shocking events (critical incidents)

[1] Adapted from John M. Violanti, The Mystery Within: Understanding Police Suicide. FBI Law Enforcement Bulletin, Feb., 1995, p. 19-23.
[2] J.M Violanti and J.E. Vena, "Epidemiology of Police Suicide", cited in Violanti, 1995.

		such as a gruesome child death can push an officer over the top.
8.	Humour as a stress relief.	The police culture effectively uses gallows humour to defuse emotions; however, in some cases humor doesn't work. Cumulative stress can become very debilitating. An accumulation of critical incidents - events that hold negative emotional punch - can lead to powerful negative symptoms. In these instances, the use of humour can actually exacerbate the level of stress. If there is not an alternative for humour, there may be nothing left to do but implode.
9.	Emotional invincibility myth	Society, as well as the police culture, often views the helping professions as emotionally invincible. Within the work culture, expressions of vulnerability are often treated with cutting humour: the tougher the occupation, the harsher the comments. In policing, one can take a great risk in asking for help. One "smart-ass" comment from a colleague may result in an officer not reaching out for help. Peer-support programs help greatly in breaking down this myth. Tragically for some, suicide is the only way to end the pain.

If you know someone that fits any of the above descriptions, talk to a friend, Employee Assistance Program referral agent, or any other ***trusting person*** and consider an action plan. A minimal action plan might be to hang out with this person from time to time and see how they are doing. A more aggressive action plan may be for you or another person to proactively connect with them. This will be discussed later in this document. Whatever you do, don't ignore the situation. The next section will assist you in actually identifying warning signs and other risk factors associated with possible suicidal behaviour.

4. WARNING SIGNS AND RISK FACTORS[3]

Warning signs are simply that – indicators that there ***may be a risk*** that this person ***may*** turn to suicide as an option. But remember: Warning signs are not written in stone. Some are very subtle in nature; in some cases they are not noticeable at all.

Also, these indicators do not mean this person is a suicide risk. Over sixty percent of the general population have thought of suicide and not acted on it. Whether one is at risk for suicide or just depressed, these behaviours should get your attention and proactive curiosity.

Simple Assessment Methods

Pretzel (1972) claims that a commitment towards some action on the part of the person to take his or her life is the clearest signal of intent to commit suicide. This means that a plan has usually been constructed, and Pretzel suggests every plan has three important aspects that should be considered.

1. Does the person have specific ideas about how to go about committing suicide? Perhaps a weapon or a particular drug has been considered as the means to complete the act. Perhaps a date, hour, or place has been chosen.

2. How lethal is the means? A gunshot to the head is more lethal than the intent to drink alcohol until death results. While it is possible either could result in a successful suicide, there is more chance for discovery, recovery and a change of mind if alcohol is the chosen method.

3. Are the means available to the person? A gun in the hand is more lethal than one that has to be purchased or borrowed.

For a police officer, point two and three are particularly petinent given that they have easy accsss to guns. whether one is suicidal or not. This means that once a PO has decided to go down this road, they are at higher risk than the general population.

There are other indicators of a potential suicide. If a police officer is showing any of the following signs, assume that this person ***may*** be close to the edge. Find a way for you or another to reach out to this individual.

Indicator	Reason	(√)
1. Distressing loss accompanied with depression	Experiencing a recent loss, such as death, divorce, separation health, job, money status, freedom, self-confidence, self-esteem, faith, or any other thing one has become emotionally attached to and is experiencing distress over. Depression is often an indication of helplessness. Intense or extended depression is most likely an indictor of a more serious problem.	

[3] Adapted from Borough Based Training Program, Suicide Awareness, New York Police Department, 1991.

2. Using drugs or alcohol to cope	There is nothing wrong with moderate drinking. However, when drinking or drugs are used to alter one's mood in order to cope, either chronically or on a binge basis, trouble is on the horizon.	
3. Marked change in behaviour	A marked change in this person's personality or actions such as from happy to sad, or inappropriate use of humor, inability to concentrate, over or under reacting, significant change in routine, etc. Essentially, this person is not who they were.	
4. Changes in sleep patterns	Always tired or complaining of lack of sleep.	
5. Hopelessness	We all get discouraged, but rarely hopeless. Indications of hopelessness are saying things like: "It will never get better." "What's the point?" "I will always feel this way."	
6. Drastic changes in eating habits	Over- or under-eating. Significant loss or increase in weight.	
7. Overwhelming feelings.	The person is overwhelmed by feelings of guilt, shame, or self-hatred. They seem trapped in their own minds.	
8. Profound sadness	Uncharacteristic unresolved sadness often expressed through crying. This could be sporadic or continuous.	
9. Fear of losing control.	Statements that indicate this person is fearful of "losing it," "going crazy," harming self or others.	
10. Expressing suicidal or hopeless thoughts.	Hopelessness has turned into "terminal" statements such as the following: "I might as well hang it up." "What's the use?" "You'll be better off without me." "Life has lost all its meaning." "I won't be around here much longer." "Please take care of my wife/husband/children/pet." "I won't be here. I'm going on a long trip." "I have nothing to live for." "I'll be away for a long time." "There won't be a next week." "I'm just no good to anyone." "This is the last straw." "This is the last shot you'll ever take at me." "This is the last time I'll ever be here."	

11. Giving things away	Uncharacteristic giving up of personal possessions or making a point of returning things they have never returned may be a powerful indicator that a decision has been made.	
12. Previous attempts	Learning that a previous suicide attempt has been made. Past behaviour is a good indication of future behaviour.	
13. Talking about suicide	Positive or negative talk about suicide.	
14. Taking unnecessary risks	Unnecessary risks of any kind – carelessly going into dangerous situations, reckless driving, not using protective gloves in risk situation, etc.	

5. INTERVENTION STRATEGIES

When imagining intervening with a suicidal person we often fear the worst – "If I don't do it right, they will kill themselves!" The good news is that most people are not on the verge of suicide. Crisis hot-line operators report that fewer than seven percent of their clients are in the midst of a suicide attempt when they call. It is unlikely that it will be necessary to deal with such a person.

Detecting a potential suicide early and acting to prevent the behavior should again decrease the chances of a more dramatic intervention later. A suicidal person is likely to proceed through a series of crises before reaching the crisis of the act of suicide itself. Intervening at these earlier stages is encouraged.

An interesting aspect of a crisis is the fact that those who are having the crisis are more likely to be influenced by an intervention. They are open to change. From this perspective, a crisis is an opportunity. You can build on this opportunity by encouraging positive changes in their life such as seeking outside help.

1. Relax	Take a deep breath. Say, "All I can be is myself. All I can do is my best." The person you are helping needs to see calm not anxiety.
2. Use open probing	Find out what the problem is for this person – what is troubling them. Ask questions that require descriptive answers or **open-ended questions**. E.g.; "What is troubling you?" "Tell me more about that." "Describe the situation to me." What is the hardest part of the situation?" "What would it take to have things different for you?" How could you make that happen?" Where could you go or who could you get to help you with this?"
3. Honest empathy	Don't pity them. Imagine the world through their eyes. Empathize. You may not agree with them, but if you saw the world the way they do, could you imagine what that would feel like? If so, show it.
4. Look for ambivalence.	Listen for their doubt or ambivalence. Be curious about it. Bring it out. The more they talk, the more they hear their own ambivalence and begin to think in more rational ways.
5. Communicate acceptance	Without agreeing with what they are doing, communicate your pleasure in their letting you into their life. Empathetic listening is healing in itself.
6. Show interest in their story	Have them describe their story, and describe it accurately. Though they may be confused - as are most people in crisis - with your listening assistance, they will be able to reconstruct their troubled journey. Your task is to be curious, caring, and structured. E.g., "Tell me more." "How did this relate to that?" Summarize their story from time to time.
7. Probe negative feelings	Ask about the "worst part" or the "hardest part." Go for the negative feelings. With you staying calm and asking questions, things don't get worse, you actually get on with dealing with the reality of the situation. It also shows them that you are in for the duration. Ask questions about

	the bad feelings. State that sometimes generating bad feelings is our minds way of forcing us to change something, or look at something in our life. If that is true, what do you think it might be?“ Again, focus on any indecisiveness and ambivalence. You are not manipulating. You are simply providing them with an opportunity to look at the proverbial half full versus the half empty glass of water.
8. Clarify the suicide intention	If you are not sure if they are having suicidal thoughts, ask them directly. “When you get feeling that bad, have you ever considered taking your life?” This does not make things worse.
9. Community resources – know and probe	Be familiar with what might be available for them in the community – work or home. Ask them if they are aware of such resources. Often people are unaware of the local crisis line or of policing support services. Help them get connected.
10. High risk for suicide? Act!	If it becomes clear that suicide is a distinct possibility, ask questions about the specificity of their plans. Find out if they have lethal drugs or weapons and plan an intervention for their removal.
11. Social and family connections	Make sure that their significant other, whether it be family, mate or good friend, is aware of the danger. Obviously, get permission to make this contact and ensure the result will help the situation not create more stress. If you can’t get permission, negotiate something with which you could live. Remember, it is better to be hated for erring on the side of caring, than pained by their loss.
12. Commitment to act	Extract a promise from the at-risk officer for action. Ensure that s/he have agreed to call you if they feeling vulneralbe. Many have not committed suicide due to the rationalizing influence of talking to someone.
13. Get professional help	If the risk is of sufficient threat, obtain help from professionals. This may mean you take them to the hospital emergency or to their physician. Sit with them if they request it. If they are reluctant to go, offer to stay with them.
14. Push the point when necessary	If necessary, help them use excuses such as migraine headaches or depression to get them the physician. If necessary, tell the doctor the truth. If you feel you would be betraying your friend, tell him or her why you are doing, this then tell the physician. When you are dealing with life and death, friendship could require “tough love.”
15. Suicide Call	If you receive a suicide call, you have probably had an ongoing relationship with that person. Build on this. Thank them for calling you. Find out what state they are in. Determine their location. Use another phone to call in help. Keep them on the line till help arrives.

6. CONTACT GUIDE

A. You initiate the contact

TASK	EXAMPLE
1. Introduce yourself.	Hi, ___. (Whatever)
2. Explain why you are here. Unless they appear imminently suicidal, get permission to talk. Own it as "your problem."	*"Joe, I've got a problem.* *I have known you for a long time and I truly care about you.* *I can't help but notice that things have been very different with you. (Offer some description if appropriate.)* *I have been thinking about it for some time and I have gotten to the point where I have decided to just check things out with you.* *Is that OK?"*
3. If "Not OK"	Decide what this is all about. Perhaps you are the wrong person, it is the wrong time, the wrong place, or whatever. *"Well, OK. Sorry for intruding into your world. For the record, I am concerned with how you are doing and would be more than willing to help out in anyway I can if things aren't working out for you. Sorry to intrude."* Leave knowing that they know you are open and available to their reaching out to you.
4. If "OK"	*"Now again, I realize that I am an outsider. All I can tell you is what I see that concerns me. I apologize if I am off base.* *Here is what I am noticing…"* Offer a behaviour description then your inference. *E.G.: "You used to be a fun guy – cracking jokes all the time. I know because your humor helped me cope with some tough times. But for the last month things have changed. You don't crack jokes. You don't even laugh at others jokes. In fact, you seem to be pulling away. To me you are becoming a recluse. I get the impression that something is eating at you. (If appropriate "I kind of miss the ol' buddy and I am very concerned for your well-being.)* *Well, what's up? Am I off base or what?"*
5. If they minimize their behaviour.	Probe for an explanation – without being an intrusive jerk. *E.g. "So what happened to the ol' joker?"* *"Why are you not hanging out?"* *"Do you not notice a difference?"*
6. If they continue to minimize their problem and you feel there is one.	They may not be aware of their change in behaviour. Your honesty may be the first time they realize it or the first time they realize it is conspicuous. Leave the door open and get out of their face. *"Well, OK. But as a friend, I am concerned. I care for you very much. If you find that there are some things that you want to check out with me, I am available. Now, you take care of yourself."*

7. If they open up	• Relax – calm yourself as it calms them • Use open probing • Honest empathy • Look for ambivalence • Communicate acceptance • Show interest in their story • Probe negative feelings • Clarify the suicide intention • Community resources – know and probe • High risk for suicide? Act! • Inquire about social and family connections • Get a commitment from them to act • Make the bridge to professional help • Push the point when necessary • If imminently suicidal, call for help
8. Closure	End with an action plan as indicated in the previous material
9. Defuse yourself	Without breaking confidentiality, touch base with someone in the field of peer-support and talk it out.

B. They initiate the contact

TASK	EXAMPLE
1. They make contact.	Determine from their initial story the severity of the problem. If it is high, make sure your goal is to get them connected with professional help.
2. Affirm the OK-ness of their reaching out to you.	*"I am really glad you have connected with me. I am sorry that things are so tough."* Self disclose if appropriate. *"I have been through a few tough times myself. It can be a lonely place. I have learned…(whatever)."* Depending on your comfort level as a helper, decide to refer or invite a deeper discussion. If possible, have them tell their story knowing that your goal at the end will be to direct them, not become their therapist.
3. If you decide to talk.	• Relax • Use open probing • Honest empathy • Look for ambivalence • Communicate acceptance • Show interest in their story • Probe negative feelings • Clarify the suicide intention • Community resources – know and probe • High risk for suicide? Act! • Social and family connections • Get a commitment from them to act • Make the bridge to professional help • Push the point when necessary • If imminently suicidal, call for help
10. Closure	End with an action plan as indicated in the previous material.
11. Defuse yourself.	Without breaking confidentiality, touch base with someone in the field of peer-support and talk it out.