PoliceOne.com News

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Practical Police Psychology
with Dr. Laurence Miller

Police intervention and the suicidal subject: Suicide facts and fictions

How can police officers effectively intervene against citizens' attempted suicide?

Of all the mental health crises that law enforcement officers encounter in their work, the threatened suicide of a civilian evokes some of the most mixed emotions. Unlike a hostage crisis, there are no "innocent third parties" at stake (although many hostage situations do evolve out of suicidal crises tinged with rage), so the sense of heroic urgency may not be as compelling. At the same time, many people, including law enforcement officers and mental health professionals, feel a twinge of creepy revulsion when faced with someone who can't "suck it up" and appears to be taking the "easy way out."

Expert Analysis

Warning signs of suicide

By Dr. Laurence Miller

Coworkers, family members, and friends can all be valuable resources in identifying people in distress who may be at risk for suicide. Clues may be few or many, verbal or behavioral, direct or indirect, with any combination possible.

Threatening self. Verbal self-threats can be direct: "I'd be better off with a bullet in my brain." or indirect: "Enjoy the good times while you can — they never last."

Threatening others. Often, self-loathing is transmuted into hostility toward others, especially toward those believed to be responsible for the subject's plight. Verbal threats against others can be direct: "I oughta cap that damn supervisor for writing me up." or indirect: "People with that kind of attitude deserve whatever's coming to them."

Continue reading Warning signs of suicide
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Whether you're the first officer on the scene or a member of a specialized crisis response team, this two-part PoliceOne series (part two appears one week from today) will give you some basic background and insight into the suicidal process, and will make some recommendations for intervention.

Suicide Facts and Fictions

Many citizens, law enforcement professionals, and even some mental health clinicians, are misinformed about the nature of suicide. The following represent some of the more frequently misunderstood issues.

Those who threaten suicide don't really do it.

The number of suicidal threats is far greater than the number of suicidal acts and most such threats are not followed by an actual suicide. But attempted or completed suicides are often preceded by one or more suicidal threats, so each threat has to be taken seriously. Most psychologists think of suicidal threats or gestures in clinically depressed subjects in much the same way as physicians consider chest pains in patients at risk for heart attack: most may be false alarms but, in both cases, if you miss the real one, the patient is dead. It is also true that many disturbed people use suicidal threats as an attention-seeking or manipulative ploy.

But responding in a forthright way demonstrates both concern for the subject and the fact that there are real consequences (temporary involuntary commitment, a permanent mental health record, for example) for "playing games." Therefore, all suicidal threats should be taken seriously.

Discussing suicide will impel the person to do it. Well-meaning friends, family members, first responders, and even some clinicians may avoid asking a subject about suicidal ideation for fear of "putting ideas in her head." In fact, just the opposite is usually true. Most depressed persons have already thought of suicide, indeed, may be currently ruminating about it but reluctant to bring it up for fear of being seen as crazy or of having restrictive action taken. Yet most are actually relieved to have another person

question them about their suicidal thoughts because it gives them the opportunity to discuss their fears and concerns. Many people express suicidal intentions or make suicidal gestures because they're really hoping to be rescued.

If someone has actually not been considering suicide, usually the only consequence of your raising the issue will the person's disavowing it. But it is highly unlikely that an otherwise non-suicidal person is going to abruptly decide to kill themselves just because you brought up the subject. Better to have as much information as possible, rather than too little.

Suicide is always an irrational act. Sometimes it is and sometimes it isn't. It is difficult for most people to relate to the excruciating mental pain that would drive a person to end his or her life, especially if, to our eyes, the situation "isn't all that bad," or the person seems to "have everything to live for." But a clinically depressed person who is overwhelmed by despair and hopelessness may not possess the rational perspective we might have when confronted with a similar challenge. In the depressed state, negatives are magnified and positives are discounted.
In many such cases, a crushing accumulation of adverse life events squeezes any hope for the future out of the person's life, making the rationale for suicide seem crystal clear: if everything in life is pain and nothing is pleasure, and it's never going to end, then what's the point of going on? Always remember that psychological pain cannot be measured by a standard barometer — everybody's pain is real to them.

Suicide is always an impulsive act. Sometimes it is — in which case there is hardly sufficient time to intervene because the person completes the act with little or no warning. In many other cases, however, the individual will express his or her suicidal ideation to someone: family member, friend, clergy, clinician, or 911 call taker. In such cases, the person is at least somewhat ambivalent about taking his or her own life and this leaves room for intervention.

Individuals who commit suicide are mentally ill. In most cases, suicide does not just occur in an emotional vacuum, but takes place in the context of a history of mood disturbances and erratic behavior. Indeed, a high proportion of suicide attempters have had at least some prior contact with the mental health and/or legal systems. While there need not be a psychiatric diagnosis per se, most suicidal individuals are clinically depressed or struggling with some form of persecutory delusion, perhaps a combination of the two. Knowing the subject's history of mental illness is important mainly for predicting what kind of post-crisis life that person will be going back to, and thereby formulating an intervention strategy that realistically takes this variable into account.

Suicide runs in families. Mood disorders like depression and bipolar disorder usually have a genetic-familial component and suicide is an additional risk factor in these syndromes so, in that sense, suicide can be said to run in families. This does not mean, however, that someone with a family history of depression and suicide is predestined to take their own life — only that the risk is somewhat greater than in others without such a background. Again, as with other family medical risks, proper treatment can help many individuals "beat the odds" of their family history. Of course, during an actual suicidal crisis, the primary priority is to keep the individual alive right now so that he or she can be provided access to appropriate therapeutic services later.

Once suicidal, always suicidal. Again, partly true. As a general rule, a person who has attempted suicide once is at greater risk of attempting it again under conditions of stress that precipitate a depressive episode. Therefore, one important goal of any effective treatment is to give the person the coping skills necessary to reduce the frequency and intensity of these crises, and thereby make suicidality less of an automatic, reflexive choice for that individual.

Once the suicidal crisis has passed or the person's mood has improved, the danger is over. It may be over for that moment, but without follow-up treatment, there is increased risk of future crises, as noted above. This highlights the need for follow-up treatment after the immediate crisis has been resolved.
Next week, we will look closely at a hypothetical example in order to better understand the type of interaction one might encounter between the police intervener and the suicidal subject. Meanwhile, if you haven't already done so, check out the sidebar item above and left. It contains a helpful list of potential warning signs of suicide.

About the author

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Threatening others. Often, self-loathing is transmuted into hostility toward others, especially toward those believed to be responsible for the subject's plight. Verbal threats against others can be direct: "I oughta cap that damn supervisor for writing me up." or indirect: "People with that kind of attitude deserve whatever's coming to them."

Nothing to lose. The subject behaves insubordinately or obnoxiously, without regard to career or family repercussions: "I'll come in to work whenever I damn please. What are they gonna do — fire me?" "Yeah, I called her a bitch — she's gonna divorce me anyway and take the house and kids, so what do I care what she thinks?"

Surrender of weapons or other lethal means. The subject may fear his/her own impulses, but be reluctant to admit it: "I'm cleaning out my basement this week. Why don't you hold on to these guns for me?" or "I've been a little forgetful lately, so I'm letting my husband hand me out my pills."
Cry for help. "I've been feeling exhausted lately. Maybe I ought to check in to the hospital to see if there's something wrong with me."

Brotherhood of the damned. "You know that news story about the guy in Ohio who got fired and divorced and killed his boss, his family, and himself? I know how that poor bastard felt."

Overwhelmed. "My girlfriend just left me, my kids won't talk to me, my checks are bouncing, I'm drinking again, and the cops want to talk to me about some bullshit stolen car. I just can't take all this."

No way out. "If I go down for that stolen car thing, that's my last strike. I could go to jail when I didn't do nothing? No friggin' way that's happening."

Final plans. Without necessarily saying anything, the subject may be observed making or changing a will, paying off debts, showing an increased interest in religion, giving away possessions, making excessive donations to charities, and so on.

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