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The Forensic Forum® Series

The Dynamics of Suicide

Ron Martinelli, Ph.D., BCFT, CFA, CLS

In the aftermath of San Diego Charger icon Junior Seau's tragic suicide his family and fans mourn the loss of this football giant here in SoCal. The classic news reports portray Seau accurately as a friendly, fun and outgoing man who appeared to them to always be in good spirits. However, a "psychological autopsy" might actually reveal a different side of Junior that few if any ever got to spend time with. Evidence might in fact eventually show that Junior Seau may have been the victim of a silent killer that has historically affected other famous football players – severe, clinical depression.

A number of football greats like former NFL 49er and Cincinnati Bengals Terrell Owens, Chicago Bears Brandon Marshall and Tampa Bay Buccaneers former defensive running back Stephen White have "come out" and candidly discussed their battle with severe depression. It is more than a little interesting to note that eight of Junior Seau's Superbowl teammates have all died prior to their forty-fifth birthdays.

Junior's parents are presently wrestling with their decision as to whether or not to donate his brain to science so that scientists might probe for a causal link between severe depression and traumatic brain injury (TBI) acquired as a result of years of headshots on the gridiron. I hope they decide to do this. While it would be interesting to speculate as to such a connection; today's article deals with forensic facts on "suicidology" or the study of suicide. There are millions of people out there who suffer from various psychosis and wage a daily battle against suicidal ideations. I thought it might be helpful to provide you with some insight into the dynamics of suicide along with some warning signs and a quick assessment check-off list. Perhaps by doing so I might assist you in identifying the Junior Seau's out there in time to intervene and prevent future tragedies.

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Mental Illness Factoids

Mental Illness

Part of our society's failure to properly address and care for people with mental illness are ineffective treatment laws that require someone to be a danger to themselves or others before they can be treated over their objection. As of the most recent documentation of 2005, eight states still had no mechanism to mandate treatment for the mentally ill in a community setting.

Suicide Dynamics and Risk Assessment

To best respond to a potentially suicidal person you must first understand forensically the basic psychological dynamics of suicide, suicidal ideation and suicidal behavior. Remember that because you are not a doctor or a certified psychologist, you do not make diagnosis. Rather, you are "assessing" suicidal risk based upon a preponderance of evidence and a "totality of circumstances" presented, observed and experienced at the time your observations are made.

As a parent, relative, significant other, friend, or colleague, learning how to intervene in suicidal situations is as important as learning CPR or basic first aid techniques since both may deal with life and death situations. While CPR is "physical" first aid, suicide intervention can be seen as "psychological" first aid.

Although you might not be formerly trained as a psychologist, think of yourself as a "First Responder." First Responders should at least be knowledgeable in some basic psychology and cues of suicidal behavior sufficient to quickly assess a subject's current state of suicidality and potential lethality. The assessment of verbal communication and behavioral indicators and stressors that might be impacting the stability of the suicidal subject encountered is referred to as a "Suicide Risk Assessment" or 'SRA'. The objectives of an SRA are: (1) to see the warning signs when they are being communicated; and (2) to judge how close the person is at risk of suicide. Suicidal ideations and behaviors are alarms that sound out to you as a First Responder, *"Notice me!" "I'm in trouble!" "I need help!"* [1]

It is important to remember that the method of suicide is determined by both availability to a means and the personality of the individual.

There are many distinct types of suicide. They include: teenage suicide; euthanasia; murder-suicide; suicide bombing; ritual suicide; suicide pacts; internet suicide; copycat suicide; forced suicide and "Suicide by Cop."

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People view the act of suicide differently. The most common views of the act of suicide are based on cultural, religious, medical, legal, philosophical differences including, for example, "Right to Die" advocates.

Suicide Factoids [2]

- Suicide is the 8th leading cause of death in the U.S.;
- The U.S. suicide rate is approximately 10.6 per 100,000;
- On an annual basis, there are more suicides (31,484) than homicides (17,732) in the U.S.;
- Firearms are used in 58% of all suicides in the U.S.;
- Women attempt suicide more frequently than men, but men are 4X more likely to be successful than women;
- Suicide is the 3rd leading cause of death in persons between the ages of 15 – 24 years;
- 90% of suicide completers had either a diagnosable mental illness, or substance abuse disorder;
- 69% of suicide completers expressed suicidal communication prior to their suicide; between 33% - 55% did so within one month of their suicide.[3]

Suicide Risk Factors

The risk factors associated with suicide intent behavior include, but are not limited to:

- Age (adolescents/elderly)
- Alcohol/drug dependence
- Depression
- Social isolation
- Impulsivity
- Psychosis – Mental Illness
- A precipitating event
- Feelings of hopelessness
- Poor coping skills
- Family history of suicide
- Recent loss of an intimate relationship
- Suicidal ideations
- Presence of a lethal means
- Presence of an organized plan

Several recent studies identified characteristics that should be evaluated in the psychiatric assessment of people suspected of suicide intent behavior. [4] Among these are:

- Suicidal or self-harming thoughts, plans, behavior and intent;
- Specific methods considered for suicide, including their lethality and their expectation of success;
- Evidence of hopelessness, impulsiveness, panic attacks, or anxiety;
- Absence for reasons for living, or plans for their future.

- Thoughts, plans, or intentions of violence towards others

Suicidal Behavior – The Psychiatric/Mental Illness Nexus

The psychiatric or public safety professional, or you as a First Responder conducting an SRA of a suspected suicide intent subject should pay attention to the subject's presentation of signs and symptoms of psychiatric disorders with particular attention to mood disorders such as: primary major depressive disorders; mixed episodes; schizophrenia; severe anxiety with panic and agitation; and personality disorders.

Proactive questioning of the suspected suicide intent subject or post-incident forensic analysis of the suicide completer's mental health background should include evidence of the following:

- Previous psychiatric diagnosis and treatments;
- Voluntary and involuntary mental health hospitalizations;
- Treatments for substance abuse disorders;
- Severe psychic anxiety, agitation, or panic episodes;
- Current and past history of episodes of psychotic behavior.

A recent study of suicide completers indicated that 79% of suicide completers presented evidence of severe anxiety or agitation and 41% presented positive evidence of psychosis within one week of suicide. [5]

Suicide "attempters" vs. "completers" – Motivation for Suicide

In a 1922 study on suicidal behavior, R.W. Maris compared the motivations behind suicidal ideation, attempts and completion' finding that the reasons that "completers" killed themselves were the loss of a spouse, children, or a job. The motivations behind non-fatal suicide attempts were identified as mental illness, alcohol/drug abuse and interpersonal problems. [6]

Suicide Completion – The Intentional Loss of Control

Important in forensically analyzing the dynamic of suicide is the understanding that the suicide completer accomplishes his/her ultimate goal by using/selecting an instrument or method of lethality that removes all aspects of personal control from the "death act" at the ultimate moment. This explains why the suicide completer will jump from extreme elevations (high building/bridge); will suddenly jump in front of a speeding train; or will orchestrate a circumstance where they force multiple armed police officers to deploy deadly force

upon them. Once the subject feels that lethality is assured and initiates their final action, they have no control to change their minds or "take it back."

"Cues" Indicate Potential for Suicide

Communication Cues

Risk assessors observing the suspected suicide intent person should pay particular attention to any communication "cues" presented by the subject. Studies of suicide completers indicate that 69% of completers expressed verbal or written suicidal communication sometime prior to their suicide. The same study documented that within one month of suicide, 33% made direct threats of suicide and when less direct communications were considered, this figure rose to 55%. [7]

Mental State Cues

As previously discussed, suicide intent subjects present with a variety of psychological cues which indicate psychiatric/mental illness, and/or severe emotional/psychological distress. Along with those symptoms mentioned earlier, risk assessors should be alert to observations and evidence of the subject presenting with:

- Poor focus
- Rage
- Insomnia
- Acute depression
- Loss of rational thinking
- A lack of concentration and being easily distracted
- Self-hatred
- Humiliation
- Feelings of abandonment
- Hopelessness
- Indifference (at final stage)

Remember the "SAD PERSON" Pneumonic in your SRA Evaluations [8]

While certified mental health professionals conduct Suicide Risk Assessments on a regular basis, the task for public safety personnel and "First Responders" like you is a less frequent occurrence that is often made more difficult by circumstances that are frequently time compressed, rapidly evolving, dynamic and which rarely take place within a controlled environment.

Whether I am discussing often complex psychological issues with public safety professionals or the general public I always go for the *Keep It Simple, Stupid (KISS)* principle of learning. Again, you do not need to be a trained psychologist, but as a parent, relative, significant other, friend, co-worker, or professional networking with the potentially suicidal person, you need an easy learning tip that can assist you in conducting a simple SRA.

The following pneumonic provided by G.E. Juhnke, will serve this purpose.

- **S**ex
- **A**ge (adolescent/elderly)
- **D**epressed
- **P**revious suicide attempt
- **E**thanol (alcohol/drug abuse)
- **R**ational think loss (psychotic/mental illness)
- **S**ocial support lacking (isolation)
- **O**rganized suicide plan
- **N**o spouse (single, estranged, divorced, widowed)

I hope that I have been able to open a few eyes and minds to this growing problem in our country. Remember that as I previous discussed in my article *"Ticking Time Bombs,"* with all of the economic, employment, family, social and personal stresses effecting those who surround us everyday; it only takes one bad day, one bad incident, or even one bad moment to light the fuse of a suicidal "bomber." Maybe as a "First Responder" you can be there in time to intervene and douse that fuse.

End Notes

1. Wiley – Blackwell, "Suicide by Cop" Phenomenon Occurring in Over a Third of North American Shootings," Science Daily, 04-19-09

2. Treatment Advocacy Center (www.psychlaws.org) Briefing Paper, "Law Enforcement and People with Severe Mental Illness, Feb., 2005

3. Ibid.,

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4. Frye, James, J., "Policing the Mentally Disturbed," Journal of the American Academy of Psychiatry, 28:345 (2000)

5. U.S. Center for Disease Control Statistics, Suicide Statistics – United States, 2004

6. Bush, Katie A., M.D., Fawcett, Jan, M.D., Jacobs, Douglas, G., M.D., "Clinical Correlations of Inpatient Suicide," Journal of Clinical Psychiatry, 125: pp. 355-373, 1974

7. Ibid.

8. Morris, R.W., Methods of Suicide: Assessment and Prediction of Suicide, pp. 362-380, Guilford Press, N.Y., 1992

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10. Juhnke, G.E., "The Adapted SAD PERSONS: An assessment scale designed for use with children," Elementary School Guidance & Counseling, 1996, pp. 252-258

About the Author

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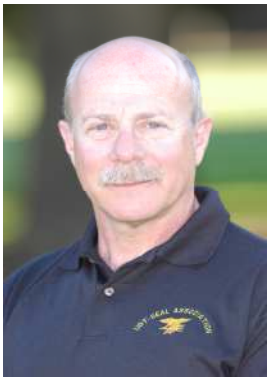

Ron Martinelli, Ph.D., BCFT, CFA, CLS, is a forensic criminologist in private practice specializing in police practices and death cases. Dr. Martinelli is a retired San Jose (CA) police officer and a 32 year law enforcement training and forensic consultant who is qualified in Federal/State Courts as a law enforcement practices forensic expert. Dr. Martinelli specializes in Use of Force, in-custody death and Officer-Involved Shootings. He is a Fellow at the American College of Forensic Examiner's Institute, a Certified Force Analyst from Minnesota State University's Force Science Institute®, an AELE Certified Litigation Specialist and an ACEFT Diplomate who is Board Certified Expert in Forensic Traumatology. He can be reached at: (951) 719-1450 and at: www.martinelliandassoc.com and www.policepracticesexpert.net

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