WHY SUICIDE HAS BECOME AN EPIDEMIC

The Daily Beast-Tony Dokukil May 23, 2013

When Thomas Joiner was 25 years old, his father—whose name was also Thomas Joiner and who could do anything—disappeared from the family's home. At the time, Joiner was a graduate student at the University of Texas, studying clinical psychology. His focus was depression, and it was obvious to him that his father was depressed. Six weeks earlier, on a family trip to the Georgia coast, the gregarious 56-year-old—the kind of guy who was forever talking and laughing and bending people his way—was sullen and withdrawn, spending days in bed, not sick or hungover, not really sleeping.

Joiner knew enough not to worry. He knew that the desire for death—the easy way out, the only relief—was a symptom of depression, and although at least 2 percent of those diagnosed make suicide their final chart line, his father didn't match the suicidal types he had learned about in school. He wasn't weak or impulsive. He wasn't a brittle person with bad genes and big problems. Suicide was understood to be for losers, basically, the exact opposite of men like Thomas Joiner Sr.—a successful businessman, a former Marine, tough even by Southern standards.

What makes some people, such as Vincent van Gogh, desire death in the first place?

But Dad had left an unmade bed in a spare room, and an empty spot where his van usually went. By nightfall he hadn't been heard from, and the following morning Joiner's mother called him at school. The police had found the van. It was parked in an office lot about a mile from the house, the engine cold. Inside, in the back, the police found Joiner's father dead, covered in blood. He had been stabbed through the heart.

The investigators found slash marks on his father's wrists and a note on a yellow sticky pad by the driver's seat. "Is this the answer?" it read, in his father's shaky scrawl. They ruled it a suicide, death by "puncture wound," an impossibly grisly way to go, which made it all the more difficult for Joiner to understand. This didn't seem like the easy way out.

Back home for the funeral, Joiner's pain and confusion were compounded by ancient taboos. For centuries suicide was considered an act against God, a violation of law, and a stain on the community. He overheard one relative advise another to call it a heart attack. His girlfriend fretted about his tainted DNA. Even some of his peers and professors—highly trained, doctoral-level clinicians—failed to offer a simple "my condolences." It was as though the Joiner family had failed dear old Dad, killed him somehow, just as surely as if they had stabbed him themselves. To Joiner, however, the only real failing was from his field, which clearly had a shaky understanding of suicide.

Survivors of a suicide are haunted by the same whys and hows, the what-ifs that can never be answered. Joiner was no different. He wanted to know why people die at their own hands: What makes them desire death in the first place? When exactly do they decide to end their lives? How do they build up the nerve to do it? But unlike most other survivors of suicide, for the last two decades he has been developing answers.

Joiner is 47 now, and a chaired professor at Florida State University, in Tallahassee. Physically, he is an imposing figure, 6-foot-3 with a lantern jaw and a head shaved clean with a razor. He wears an off-and-on beard, which grows in as heavy as iron filings. The look fits his work, which is dedicated to interrogating suicide as hard as anyone ever has, to finally understand it as a matter of public good and personal duty. He hopes to honor his father, by combating what killed him and by making his death a stepping stone to better treatment. "Because," as he says, "no one should have to die alone in a mess in a hotel bathroom, in the back of a van, or on a park bench, thinking incorrectly that the world will be better off."

He is the author of the first comprehensive theory of suicide, an explanation, as he told me, "for all suicides at all times in all cultures across all conditions." He also has much more than a theory: he has a moment. This spring, suicide news paraded down America's front pages and social-media feeds, led by a report from the Centers for Disease Control and Prevention, which called self-harm "an increasing public health concern." Although the CDC revealed grabby figures—like the fact that there are more deaths by suicide than by road accident—the effort prompted only a tired spasm of talk about aging baby boomers and life in a recession. The CDC itself, in an editorial note, suggested that the party would rock on once the economy rebounded and our Dennis Hopper–cohort rode its hog into the sunset.

But suicide is not an economic problem or a generational tic. It's not a secondary concern, a sideline that will solve itself with new jobs, less access to guns, or a more tolerant society, although all would be welcome. It's a problem with a broad base and terrible momentum, a result of seismic changes in the way we live and a corresponding shift in the way we die—not only in America but around the world.

We know, thanks to a growing body of research on suicide and the conditions that accompany it, that more and more of us are living through a time of seamless black: a period of mounting clinical depression, blossoming thoughts of oblivion and an abiding wish to get there by the nonscenic route. Every year since 1999, more Americans have killed themselves than the year before, making suicide the nation's greatest untamed cause of death. In much of the world, it's among the only major threats to get significantly worse in this century than in the last.

The result is an accelerating paradox. Over the last five decades, millions of lives have been remade for the better. Yet within this brighter tomorrow, we suffer unprecedented despair. In a time defined by ever more social progress and astounding innovations, we have never been more burdened by sadness or more consumed by self-harm. And this may be only the beginning. If Joiner and others are right—and a landmark collection of studies suggests they are—we've reached the end of one order of human history and are at the beginning of a new order entirely, one beset by a whole lot of self-inflicted bloodshed, and a whole lot more to come.

THE RISE of suicide in the U.S. has been slow enough to sneak up on people. I realized this just the other day, on the phone with Catherine Barber, who directs the Means Matter Campaign, a suicide-prevention program at Harvard. A decade ago, she led the team that designed the National Violent Death Reporting System, a key source of federal data on premature exits. Because she's now focused on education and prevention, not data mining, it had been a few years since she looked at national numbers, so we logged on together.

time. Around the world, in 2010 self-harm took more lives than war, murder, and natural disasters combined, stealing more than 36 million years of healthy life across all ages. In more advanced countries, only three diseases on the planet do more harm.

And this assumes we can even rely on the official data. Many researchers believe it's a dramatic undercount, a function of fewer autopsies and more deaths by poison and pills, where intention is hard to detect. Ian Rockett of West Virginia University thinks the true rate is at least 30 percent higher, which would make suicide three times more common than murder. Last fall the World Health Organization estimated that "global rates" of suicide are up 60 percent since World War II. And none of this includes the pestilence of suicidal behavior, the thoughts and plans that slowly eat away at people, the corrosive social cost of 25 attempts for every one official death.

But perhaps the most concerning part of these developments, according to Harvey Whiteford, head of the GBD's mental and behavioral health group, is that the changes behind them are likely to intensify amid the galloping progress of developing nations. Where people lack basic services, they live unsanitary, impoverished lives, and death comes to visit long before it's invited. Where conditions improve, life expectancy does too, and somewhere in this transition there is a tipping point, a Rubicon beyond which death is no longer a bone-fingered stranger but the man in the mirror.

That's scary in a world of constant (and welcome) improvement, but there's an even bigger reason to fear the burden of suicide in the new millennium: it's a charge being led by people in middle age. In America in the last decade, the suicide rate has declined among teens and people in their early 20s, and it's also down or stable for the elderly. Almost the entire rise—as both the new CDC and GBD numbers show—is driven by changes in a single band of people, a demographic once living a happy life atop the human ziggurat: men and women 45 to 64, essentially baby boomers and their international peers in the developed world.

The suicide rate for Americans 45 to 64 has jumped more than 30 percent in the last decade, according to the new CDC report, and it's possible to slice the data even more finely than they did. Among white, middle-aged men, the rate has jumped by more than 50 percent, according to a *Newsweek* analysis of the public data. If these guys were to create a breakaway territory, it would have the highest suicide rate in the world. In wealthy countries, suicide is the leading cause of death for men in their 40s, a top-five killer of men in their 50s, and the burden of suicide has increased by double digits in both groups since 1990.

The situation is even more dramatic for white, middle-aged women, who experienced a 60 percent rise in suicide in that same period, a shift accompanied by a comparable increase in emergency-room visits for drug-related (usually prescription-drug-related) attempts to die. In a sad twist, they often make a bid for death using the same medicine that was supposed to turn them back toward life. And the picture is equally grim for women in high-income countries, where self-harm trails only breast cancer as a killer of women in their early 40s—and has become the leading killer of women in their 30s. "In the middle of the journey of our life / I found myself in a dark wood," begins Dante's epic tour of hell. He wouldn't have to change the line today.

Baby boomers have the highest suicide rate right now, but everyone born after 1945 shows a higher rate than expected.

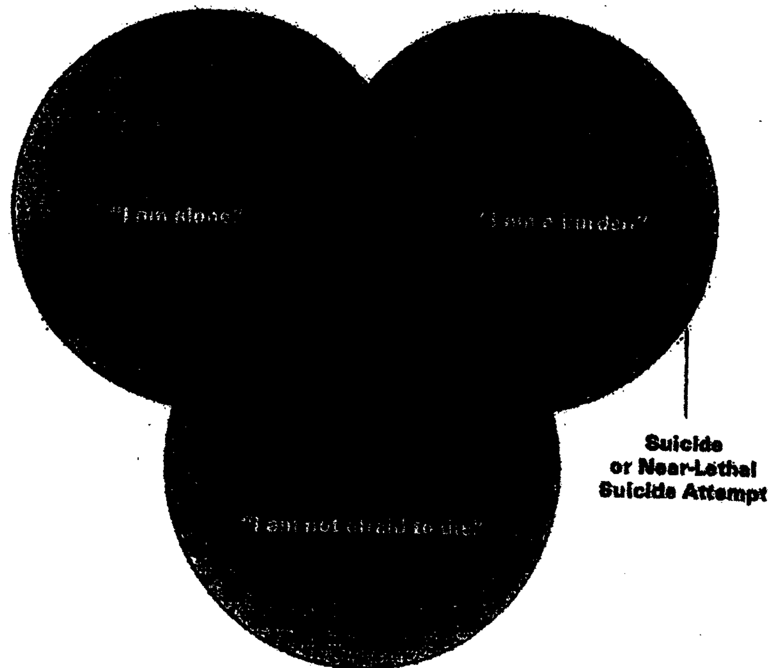
In the United States, Julie Phillips, a sociologist at Rutgers University, was among the first researchers to frisk these middle-age suicides for deeper meaning. In 2010 she and a colleague declared the age range a new danger zone for self-harm. Many commentators took this as another fun fact about the boomers, not a cause for general alarm. But earlier this month, Phillips presented the results of a second paper, an attempt to settle the question of whether the boomers were especially suicidal. She sifted through eight decades of U.S. suicide data, wrenching it to separate the influence of absolute age, peer effects, and the events of the moment, and she found something shocking: the boomers have the highest suicide rate right now, but everyone born after 1945 shows a higher suicide risk than expected—and everyone is on pace for a higher rate than the boomers.

That means that the last decade isn't just a statistical blip, a function of a bad recession, unlocked gun cases, or an aging counterculture. It's much darker, and deeper than all that. This is the "new epidemiology of suicide," as Phillips puts it, one where the tectonic changes of the last decade—socially, culturally, economically—have created a heavy burden of suicide, growing heavier by the year. "The baby-boomer generation," Phillips writes in her new paper on boomers, "may be the tip of the iceberg."

When teen suicide was on the rise in the 1970s and 1980s, society was stung by the conclusion that something must be wrong with the way we live, because our children don't want to join us. The question today is different, but just as unsettling. With people relinquishing life at its supposed peak, what does that say about the prize itself? What's gone so rotten in the modern world? In her next bundle of research, Phillips hopes to pinpoint the massive, steam-rolling social change that matters most for self-harm. She has a good list of suspects: the astounding rise in people living alone, or else feeling alone; the rise in the number of people living in sickness and pain; the fact that church involvement no longer increases with age, while bankruptcy rates, health-care costs, and long-term unemployment certainly do.

Sociologists in general believe that when society robs people of self-control, individual dignity, or a connection to something larger than themselves, suicide rates rise. They are all descendants of Emile Durkheim, who helped found the field in the late-19th century, choosing to study suicide so he could prove that "social facts" explain even this "most personal act." But when someone's son dies by suicide and the family cries out for an answer, "social facts" don't begin to assuage the pain or solve the mystery. When a government health official considers how he might slow down the suicide problem, "society" is a phantom he can't fight without another kind of theory entirely.

JOINER'S THEORY OF SUICIDE



Kimberly A. Van Orden et al., "The Interpersonal Theory of Suicide," Psychol Rev. 117(2) (2010): 575

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It's a "clearly delineated danger zone," a set of three overlapping conditions that combine to create a dark alley of the soul. The conditions are tightly defined, and they overlap rarely enough to explain the relatively rare act of suicide. But what's alarming is that each condition itself isn't extreme or unusual, and the combined suicidal state of mind is not unfathomably psychotic. On the contrary, suicide's Venn diagram is composed of circles we all routinely step in, or near, never realizing we are in the deadly center until it's too late. Joiner's conditions of suicide are the conditions of everyday life.

Male Australian redbacks sacrifice their lives for sex. The females often devour the males after they mate. But there's an evolutionary upside: a greater chance the male passes along his genes.

He calls the first "low belonging," and it's the most intuitive idea in his formula. Joiner argues that "the desire to die" begins with loneliness, a thwarted need for inclusion and connection. That explains why suicide rates rise by a third on the continuum from married to never been married. It also accords with the fact that divorced people suffer the greatest suicide risk, while twins have reduced risk and mothers of small children have close to the lowest risk. A mother of six has six times the protection of her childless counterpart, according to one study. She may die of work and worry, but not of self-harm.

The need to belong is so strong, Joiner says, that it sometimes expresses itself even in death. "I'm walking to the bridge," begins a Golden Gate Bridge suicide note he cites. "If one person smiles at me on the way, I will not jump." The writer jumped. He was alone, and so are more of the rest of us. Unattached is the new fancy-free, a strategy for success that translates to later marriages, easier divorces, fewer kids, and a tendency to keep running toward the next horizon, skipping family dinner in the process.

Twelve years and a tech revolution after Robert Putnam wrote *Bowling Alone*, his treatise on the decline in American community, the institutions that used to bind America together have, if anything, crumbled even further. People tell surveyors that the world has become less helpful, trustworthy, and fair. It's a place where you work longer at more deadening jobs for less pay, your life pulsing away with each new email, or worse, each additional hour on your feet. What's deadly about all this is the loss of what Joiner calls "reciprocal care." When people have no shoulder to lean on, they feel more isolated, and that isolation can be lethal.

Maybe Facebook is not "making us lonely," as Stephen Marche argued in an Atlantic cover story last spring. But Facebook doesn't help. "The greater the proportion of online interactions, the lonelier you are," John Cacioppo, a professor at the University of Chicago and the world's foremost expert on loneliness, told Marche. The opposite is also true: more face time, less loneliness. But as you might expect, the trend lines in our relationships are all in one direction.

the leading cause of disability in the world, vexing developing countries in particular, and the United States most of all. In the land that commercialized positive thinking and put pill bottles in every drawer, depression has emerged as the most debilitating condition we face.

Joiner calls his final condition for suicide "fearlessness," and all that really means is "the ability to die," an ability he says people have to develop over time. That's because it's hard to kill yourself. This should be obvious. The human body is built to endure, the mind rigged to flee from death, which is why so many people flinch. They apply the brakes, pull up at the railing, beg someone to pump their stomach, lever themselves off the tracks, or just pass out before they can inflict the damage they intend.

Athletes, doctors, prostitutes, and bulimics all share a heightened risk of suicide. All have a history of tamping down the instinct to scream.

In this way, suicide isn't about cowardice. It's not painless or easy, like pulling the fire alarm to get out of math class. It takes "a kind of courage," says Joiner, "a fearless endurance" that's not laudable, but certainly not weak or impulsive. On the contrary, he says, suicide takes a slow habituation to pain, a numbness to violence. He points to that heightened suicide risk shared by athletes, doctors, prostitutes, and bulimics, among others—anybody with a history of tamping down the body's instinct to scream, which goes a long way to unlocking the riddle of military suicides.

For the population at large, it might seem mildly reassuring at first. After all, most of us don't fall into these categories. But Joiner believes there may be a side door to fearlessness: exposure to violence in media. Remember this debate? Well, it's basically over. "The strength of the association between media violence and aggressive behavior," the American Academy of Pediatrics concluded in 2009, "is greater than the association between calcium intake and bone mass, lead ingestion and lower IQ, and condom nonuse and sexually acquired HIV infection, and is nearly as strong as the association between cigarette smoking and lung cancer." In one of the studies reviewed, a social psychologist showed students pictures of a man shoving a gun down another man's throat, among other images. The people who had been exposed to more violent media didn't respond. They were numb.

Joiner first sketched his theory about a decade ago, which isn't all that different from yesterday in the science world, a place where evolution is still just a theory. But his ideas have already survived direct challenges, and he has defended them before ballrooms of academics and long tables lined with government officials. The Guggenheim and Rockefeller foundations have forked over cash, as have the National Institutes of Health and the Pentagon, which recently tapped him to co-direct its Military Suicide Research Consortium. In two books—*Why People Die by Suicide* (2005) and *Myths About Suicide* (2010), both published by Harvard University Press—and hundreds of articles, he has built a testable model. It's "elegant" in the words of Aaron Beck, a University of Pennsylvania psychiatrist, known as the father of cognitive therapy. It's "insightful" and "effective," added the American Psychological Association, which published a $60 volume of Joiner's work to help guide clinicians suffering their own Galveston crossroads.

As we discussed suicide in his office, the Florida sun blazing through a picture window, Joiner gently bounced side to side in a swivel chair. He wore blue jeans and a short-sleeve button-down in the buff color of a cartoon desert. He spoke in careful, complete sentences. But it was hard to concentrate once I noticed the trophy-size silver fish and coiled snake mounted near his computer. "That's a piranha," he explained, "and that's a rattlesnake." He keeps both as reminders of this principle that killing your own kind, let alone yourself, is hard to do. "The piranha won't do it. They'll kill us, but they won't kill each other," he says. "Same with rattlesnakes. They have venom and fangs and everything, but they don't use those. They wrestle. It's a rule of nature, not a hard fact, but a rule of thumb: you don't kill your own."

And yet his father did. He grew lonely, letting old friendships die as he built his career. He formed an identity through work, one that left him rudderless when he entered semi-retirement. Here was his sense of not belonging, a feeling so acute he tried to join an African-American church, apparently lured by the community and the possibility of connection. The sense of burdensomeness came later, as his dark moods prevented him from being the pillar he had been within his family. That gave rise to the desire to die, according to Joiner's theory.

But the *ability* to die took root earlier and grew much more slowly. Joiner's father had a lifetime of painful physical experiences—freak accidents, sporting injuries. He was also a fisherman, a man who knew how to use a knife and was comfortable with blood on his hands. Joiner recalls one fishing trip in particular, father and son unzipping the sea in a boat that felt like a 25-foot piece of driftwood in the heaving Atlantic. When a sudden storm developed, Joiner watched his father wrestle the waves, trying to keep the tiny yacht from capsizing. He gripped the wheel until it snapped off, at which point he steered using all that remained, a shattered column, his hands slashed and bleeding.

This, in the end, is what killed him, Joiner says: the fact that his father was strong enough, in a perverted way, to fall on his own knife. This, and the fact that he found himself in the center of the three circles of risk. After decades of walking in and out of them, much as we all do, he walked into the middle.

These days, Joiner's thoughts have shifted toward prevention. If he's right about suicide, the ability to foil one of the three variables is the ability to save a life. Smart clinicians can do it, but it's not easy to get people into treatment. There's the cost, for one thing, but more than that, there's the shame and the stigma. Suicide is the rare killer that fails to inspire celebrity PSAs, 5K fun runs, and shiny new university centers for study and treatment. That has to change, says Joiner. "We need to get it in our heads that suicide is not easy, painless, cowardly, selfish, vengeful, self-masterful, or rash," he says. "And once we get all that in our heads at last, we need to let it lead our hearts."

Suicide by Cop – The ultimate "trap"

Louise C. Pyers, M.S., B.C.E.T.S.

(Article published in the July/August, 2001 issue of the FBI National Academy Associates Magazine, Volume 3, No. 4)

"She drove by in the hospital parking lot as I was getting into my patrol car. After parking her car she approached me. The polite and attractive young woman told me she wanted to talk to me and then was silent. I then began to feel that something was bothering her.

"I asked, 'Is there something I can do for you?' She then pulled a revolver out of her purse and aimed it at my chest. We were standing about 6 feet apart.. I thought, 'Is this some kind of a joke?' But the look in her eyes told me it wasn't. I drew my weapon, aimed and fired. She fell to the pavement. I rushed to her - trying to stem the bleeding.

"We were in the parking lot of the emergency room. I knew she would get immediate care. I watched as the doctors worked on her. An hour and a half later, she was dead. In her car was a note: *'Please forgive me. My intention was never to hurt anyone. This was just a sad and sick ruse to get someone to shoot me. I'm so very sorry for pulling innocent people into this. I just didn't have the nerve to pull the trigger myself.'* She left her name and address and the names of her parents adding, *'I am very sorry for this.'"*

This is the story of Los Angeles County Sheriff's Deputy Glenn Vincent, who, on his 29th birthday, shot a 30-year-old woman who, family members said, suffered from debilitating headaches and depression. She had made a number of suicide attempts in the past.

"Every year after on my birthday, I would be reminded of the shooting from the pain I had inside. I didn't feel like John Wayne or Dirty Harry. This was not a movie. I continued to hurt inside. I am no RoboCop, " states the deputy.

Introduction

Suicidal individuals, in their desperation to escape their emotional pain, will use a variety of instruments such as guns, ropes, pills, knives, etc... to fulfill their suicidal wish. In some cases, the "instrument" is an unsuspecting law enforcement officer.

According to recent studies, police-assisted suicide or "suicide by cop" occurs in 10-15% of officer-involved shootings. Studies by Dr. Karl Harris, former Deputy Medical Examiner of Los Angeles County, Richard Brian Parent of Simon Fraser University and Dr. H. Range Huston of Harvard University School of Medicine show similar results.

- Dr. Harris' 1983 study of 99 shootings by police in Los Angeles County revealed that approximately 10% of officer-involved shootings involved suicide attempts. The method of suicide was to entice a police officer, in a self-defensive action, to shoot the decedent. *It was later discovered that often the weapon used by the subject was unloaded or non-functioning.* Dr. Harris believes that another 5% of the subjects he studied may have used the same method, but not enough evidence could be gathered to be conclusive in those cases.
- Constable Rick Parent, M.A. of the Delta, British Columbia Police Department, a Doctoral Student at Simon Fraser University, showed similar results in his 1996 research of municipal police and Royal Canadian Mounted Police. In roughly half the cases, the police reacted with deadly force to despondent individuals suffering from suicidal

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tendencies, mental illness or extreme substance abuse acting in a manner to elicit such force. He found that 10-15% of these cases could be considered pre-meditated suicides. [1]

- The most recent study to date, published in 1998 in the "Annals of Emergency Medicine" [2] covered officer-involved shootings investigated by the Los Angeles County Sheriff's Department between 1987 and 1997. Out of the 437 shootings studied, 46 events (11%) were classified as "suicide by cop."

In 1997, the last year of the Los Angeles County study, the percentage of shootings identified as "suicide by cop" jumped to 25%. No one knows if this rise in identified incidents represents a bona fide increase in this form of death as a means of suicide or improved investigative techniques and documentation by the law enforcement agencies involved.

Profile

The results of the above study, further extrapolated by Dr. Barry Perrou, forensic psychologist and former commander of the LA County Sheriff's Hostage Negotiations Unit, showed:

- 96% of the perpetrators were male
- Ages ranged from 18-54
- Weapons ranged from firearms (46%), stabbing instruments (46%) and firearm replicas (8%)
- 58% asked to be killed by police
- 58% had a psychiatric history

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- 38% had previously attempted suicide
- 50% were intoxicated
- 42% had a history of domestic violence
- 38% had a criminal history .[3]

Another study performed in 1998 analyzed 15 shooting deaths of suicidal persons by law enforcement personnel in Oregon (Marion County) and Florida (Dade County).[4]

- All but one of the victims were male
- All possessed an apparent handgun or other weapon and threatened to kill the officers with these weapons. 60% of the suspects USED their weapons
- 40% were intoxicated
- 50% had made previous suicide attempts
- 40% had a history of mental illness with 60% showing compelling evidence of depression.

Dr. Vivian Lord of the University of North Carolina - Charlotte conducted a study of 54 cases in which people attempted "suicide by cop" in North Carolina between 1992 and 1997.[5]

- 94% were male
- 63% were armed with guns, 24% had knives, 3 had other objects ; 3 were unarmed
- More than 50% were under the influence of alcohol
- 45% were experiencing family problems or the end of a relationship
- Almost 40% talked about homicide and suicide with officers involved
- In 46% of the cases, the incidents began as a domestic argument
- Two-thirds appeared unplanned.

Aftermath

Police officers reacting to the aftermath of "suicide by cop" will often display symptoms of post-traumatic stress which can potentially affect their ability to perform their duties. Police officers are also victims in these cases. Among the many symptoms reported are hypervigilance, fear, anger, sleeplessness, recurrent nightmares and depression.

In many instances, the timing, speed at which the encounter escalated and officer's perception of immediate danger to self or others left him or her with no choice but to use deadly force. Yet, second-guessing on the part of the officer is common. One officer wrote:

> *"I hope you find some solution to this problem. As a police officer with 30 years experience, I had never heard the phrase, until it happened to me. Left me with mixed emotions. It was a family feud that had been going on for months...I only went there this time to remove small children. I was met at the front door by subject with a semi-automatic SKS rifle... When told to put the gun down numerous times, he refused and pointed the weapon at my partner and me. We both fired our weapons at the same time from less that three feet.*
>
> *An investigation by an outside agency turned up the fact the suspect wanted to commit suicide...I think if I had been aware of this situation, I could have handled it different[ly] as senior officer on scene. I am not trying to second-guess this situation. I just feel that with some type of preparation or schooling, I might have handled the situation differently.*
>
> *"I am glad that someone is trying to address this situation, as I feel it will get to be a larger problem as time goes on. Thanks again for seeing this need, and bringing it out in the open."*

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Suicide-by-cop or decedent-precipitated-homicide?

The Los Angeles County Sheriff's Department study used all of the following criteria as a means of identifying "suicide by cop" incidents.

1. Evidence of suicidal intent
   - written note stating a wish to die,
   - recent verbal communication of a desire to die to friends or family and at times to officers
   - Suicidal characteristics or behavior indicating suicidal intent (i.e. holding a firearm to one's head.)
2. Evidence that suicidal individuals specifically wanted officers to shoot them
   - Outright statements by the precipitators indicating they wanted officers to shoot them
   - Written or verbal communication to family or friends stating they wanted officers to shoot them
   - Refusal to drop their weapon when advised by officers to do so and then aiming their weapon at officers or civilians.
3. Evidence the precipitator possessed a lethal weapon or what appeared to be a lethal weapon
4. Evidence the precipitator intentionally escalated the encounter and provoked officers to shoot them in self-defense or to protect civilians.

In the Oregon/Florida study, cases identified as law enforcement assisted suicide or suicide by cop must demonstrate, with reasonable probability, that the victim provoked a police officer to shoot at the victim and that the victim had suicidal intent. Decedents were

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excluded if acute cocaine intoxication was a precipitating factor because the possibility of cocaine psychosis or delirium may complicate the ability to evaluate suicidal intent. Amphetamine-related incidents were not excluded because psychosis and delirium are not typically associated with amphetamine use. Toxicological testing was performed on all decedents.

Richard Parent states that "victim-precipitated homicide" is not necessarily "suicide by cop." They are similar in that the decedent's behavior did cause the use of deadly force by law enforcement in a defensive action. And while one might describe the subject's actions as "suicidal," the intent of the decedent may remain unclear.

For example, someone's judgement might be so impaired by alcohol or mental illness that he or she fails to understand that an officer will use deadly force if the officer perceives he or she or those in the vicinity are in mortal danger.

Officer Gary Bush writes, "I take us back to a cold December night when Christmas was on our minds and our lives were happy and warm. A call comes at 10:25 PM and my colleague who was supposed to take the call was still doing paperwork. I take the call so she can finish up in time for the Christmas party at 11 PM.

"It amazes me how fate comes in and knocks the breath out of you. Robbie and I take the call and remark on the way that we are going to have to arrest this guy and we will be late for the party. When we arrive, a white male in his thirties exits the house and says that his uncle has been pointing a gun at him and his family all night and threatening to kill the whole family and himself. He states that he is drunk and has gone to the garage apartment in the back.

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Suicide by Cop: The Ultimate Trap

"Rob and I walk down the alley towards the garage and a man comes up behind us and says that the guy in the apartment is his cousin and maybe he can talk to him. I stated that he had a gun and as soon as we secured the scene he could talk to him. We go to the door and I stand on the left side while Rob stands on the right. We take our guns out and I knock on the door with my left hand. At this time, I notice that the door has a latch, not a door knob. The door is pushed but not fully closed. I knock again with my left hand and again get no answer. I push the door open and step inside.

"The room is well lit and rectangular in size. There is a bed at the end of the room perpendicular to the rectangle. The uncle is laying down with his head towards the left side of the room. As I step further into the room, he sits up on the bed with his feet on the floor. He stares at me for a couple of seconds and I am about to speak when he reaches to his right. As he reaches, I notice on the left side of the bed there is a rifle. He picks up the rifle and I remember thinking *I can't believe he's doing this*. He grabs the rifle and I bring my gun up and start to back out of the room. He starts to swing the rifle towards me and I tell him to drop the gun, drop the gun, drop the gun. He swings the rifle almost to his shoulder and I fire one shot.

"I didn't hear anything but I recall the shock I felt as the gun went off. I backed out of the doorway and stood to the left. Rob was on my right. I did a quick peek into the room and remember feeling that the last thing I wanted to do was go back into that room. I re-entered the room with my gun trained on Mr. Smith (name changed). He was still on the bed leaning to the right on his right elbow. The rifle was still in his right hand with his finger still on the trigger. As I approached him I again told him to drop the gun, drop the gun. I soon got close enough to grab the rifle, I handed it to Rob and told him to clear it.

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"I handcuffed Mr. Smith and flipped him back over so he was facing me. I wondered if I actually had hit him and looked at Rob and asked him if I had hit him. Rob said he didn't know. I stared at his chest and stomach and could not see any wound. I remember feeling relieved that I had shot at this man and had missed him. The threat was over and nobody got hurt. I started flipping through his layers of clothing and still could not see anything. I got down to his T-shirt and saw a small hole just below his chest. I turned to Rob and told him to holler at headquarters that shots have been fired, suspect down, we need back up, first responders and paramedics.

"At this time, the man in the alley started yelling to let him come into the room 'to pray with Frankie.' I knew from training that when you are in charge of a crime scene, you are not to let anyone into the area. I also knew that Mr. Smith was hit in a bad spot and there was a good chance that he would die. I told Rob to search him. He did and stated that he was clear. I told Rob to let him in. I took the handcuffs off Mr. Smith and held his left hand while the cousin held his right hand. We prayed. After we said 'amen,' I told his cousin to leave. Mr. Smith then looked at me and said 'why did you shoot me?' I said, 'I told you to drop the gun.' He answered, 'I wouldn't have shot you!'

"How was I supposed to know that? The man I killed that night pointed an *unloaded* 30.06 at my partner and I.

"Why?

"Who knows?

"I do know that there is hell on earth and I have been there."

Mr. Smith's actions that night clearly looked suicidal (especially when he brandished an unloaded weapon at officers). However, his question to the officer "Why did you shoot

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me?" brings the question of suicidal intent, at that time, into question. Was it a clear suicidal act or the actions of an individual who was so impaired by alcohol that he failed to anticipate the consequences of his actions? While he did express suicidal tendencies earlier with family members, he took the answer to the question to his grave. He leaves a police officer in anguish.

Conclusion

Studies on law enforcement assisted suicide continue around the U.S. Police departments are beginning to take notice of the long-range detrimental effects these dangerous incidents have on the police officers involved. In some cases, officers are placed in a no-win situation. The key to help unlock the secrets behind this phenomenon is in the sharing of information, training and raising awareness among police agencies.

Recent changes in state laws regarding treatment of mentally ill individuals have increased the likelihood that law enforcement officers will encounter more of these incidents in the future. The dearth of adequate community-based services for this population leaves both the mentally ill and law enforcement vulnerable.

To complicate matters further, no universal standard is currently used within law enforcement to define or officially record these incidents. There are many serious implications to this lack of knowledge, not the least of which can be how a case will be litigated. A death classified as homicide is very different than one classified as suicide. Proper recording, the sharing of information and training using varied scenarios can go a long way toward assisting law enforcement and the mental health community in assessment and prevention as well as helping police officers cope with the aftermath of the "suicide by cop" trap.

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For more information on ***training*** *please contact Dr. Barry Perrou of the Public Safety Research Institute at (818) 952-9800*

You may also download the results of Richard Parent's study at www3bc.sympatico.ca/parent

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