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Training Police Officers to Handle Suicidal Persons

The Center for the Administration of Justice at Temple University in Philadelphia conducts training for persons attending the police academy. Part of the crisis intervention training includes dealing with a suicidal person. Didactic material is presented on depression and suicide. Class members are then taught the technique of reflection and practice briefly with each other. The technique is demonstrated by the instructor with an actor posing as a suicidal person. Finally, some members of the class get an opportunity to use the techniques with the actor. Feedback and suggestions are given by other class members and the instructor.

What follows is a portion of the material presented in the crisis intervention training. It is hoped that this will be of use to others interested in providing such training.

The police officer is frequently called on to deal with persons who are suffering from mental illness. According to Bittner [*1*], officers make apprehensions of mentally ill persons "about as often as they arrest persons for murder, all types of manslaughter, rape, robbery, aggravated assault and grand theft *taken together* and more than one-fifth of all referrals to the receiving psychiatric service of the public hospital come from this source" [italics added]. Thus, the handling of a mentally ill person is not a rare exception for the police officer but a frequent occurrence. To deal effectively and safely with the mentally ill, the officer needs to have an understanding of the illness and a knowledge of practical techniques. The purpose of this report is to provide the understanding and techniques relevant to depression and suicide. Not all individuals who are suicidal appear outwardly to be depressed and in such cases the person's suicidal intent is more difficult to detect and the suicidal act is more difficult to prevent. But people whose suicidal feelings are the result of or associated with depression usually give warning signs that allow time for intervention. It is often at this point that the police officer is called and his action may be able to prevent a fatal outcome.

Depressed persons show characteristic behaviors, statements, and physical symptoms. Table 1 presents a list of the features of depressed individuals [*2,3*]. While few patients manifest all these symptoms, a majority of symptoms are found in most depressed individuals. Some symptoms, such as feeings of worthlessness, are found very frequently; others such as suicidal wishes and interference with personal grooming vary according to the depth of the depression. As noted in Table 1, some depressed individuals show a pattern of agitation and restlessness rather than one of retardation in speech and movement, but the other behaviors, statements, and physical symptoms listed in the chart apply to "agitated" as well as "retarded" depressions.

Statistics on the frequency of suicide are difficult to collect for a number of reasons and underestimate the true figure. Even with many suicides excluded, the statistics on suicide are staggering. The figures indicate that each year one in 10 000 Americans commit suicide, a total of almost 23 000. In addition, there are approximately 1 500 000 attempts each year. The relative frequency of suicide as the cause of death in the United States varies somewhat

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TABLE 1—*Characteristics of depression.*

Behaviors	Content of Statements	Physical Symptoms
Sad face	worthlessness	loss of appetite
Stooped posture	guilt	constipation
Crying	suicidal wishes	insomnia
Slowed speech	anxiety	easy fatigability
Slow responses	pessimism	headaches
Slow motor activity	hopelessness	dry skin and hair
Poor personal grooming	helplessness	bad breath
Apathy	failure	coated tongue
Withdrawal	sadness	loss of sexual interest
Complaints	badness	loss of weight
Agitation[a]	sense of loss	
Trembling[a]	feeling of being unworthy of love	
Restlessness[a]	loneliness	
Anger	martyrdom	
Demanding	envy	
	deservedness of illness	
	indecisiveness	
	inadequacy	
	loss of interest	
	loss of motivation	

[a]Most depressions are "retarded" and are characterized by behaviors such as slow speech and withdrawal. However, some depressions are "agitated" and show these symptoms.

year to year, but it is always among the ten most frequent causes of death. For some groups, such as male teenagers, it has at times been the leading or second most frequent cause of death (alternating with automobile accidents).

Understanding Suicide

In recent years, extensive studies on suicidal behaviors have been conducted. Among the most informative has been a book entitled *The Cry for Help* [*4*]. The title of the book was chosen to emphasize the point that a suicidal statement, or attempt, and even in some cases an actual suicide, is often a means of interpersonal communication that occurs when the individual feels that other methods of crying for help are unacceptable or have failed. Clinicians find that the individual who becomes involved in suicidal behaviors is often a dependent individual. That is, he has a poor image of himself and needs emotional and sometimes concrete support from others to maintain his functioning. Such an individual often experiences feelings of anger and resentment toward those on whom he is dependent because his needs are so great that he is fearful of and sensitive to cues of rejection from those on whom he is dependent. But the person with a tendency toward suicide usually has difficulty appropriately expressing anger, at least in part because he fears that to do so would lead to the rejection he fears. Simultaneously, he has a tendency to feel guilt that stems from his poor self-image. The hostile thoughts further increase the guilt, anxiety, and fear of rejection. The suicidal behavior is often an attempt to reestablish a dependent relationship that the individual fears he is losing. The emotions and behaviors involved form a complex network leading to a vicious circle of dependency, anger, guilt, and increased needs for dependency.

Scales for assessing suicidal risk can be compiled by evaluating demographic and clinical information. Table 2 presents the most important indicators of risk. A review of this table

TABLE 2—*Indicators of suicidal risk.* [a]

1. Age: generally, the older the person, the greater the risk.
2. Sex: males have a higher risk.
3. Unusual stress or loss: loss of loved one or job, serious physical illness.
4. Recent intensification of symptoms as opposed to a chronic level of functioning.
5. Suicidal plans; risk is greater if (a) he has chosen a specific method and more so if the method is a more lethal one (such as gunshot or hanging) and if familiarity with and access to the method are present; (b) he has chosen a particular time and place; and (c) he has made out a will or otherwise arranged to dispose of his personal property.
6. Statements of suicidal intent: (a) direct: 70% of those who commit suicide have made a direct statement within the preceding three months and (b) indirect: examples include general references to death and burial such as "I'd be better off dead" and "You wouldn't care if I were dead."
7. Symptoms of depression: insomnia, loss of appetite, feelings of hopelessness.
8. History of alcoholism or homosexuality.
9. Prior suicidal behavior: The risk is greater if there is a history of threats or attempts; 75% of completed suicides have made a prior attempt or threat.
10. Lack of resources: risk is greater if there are no friends or family who are willing to help or who could detect a suicide attempt and intervene.
11. Presence and reaction of significant others: Risk is greater if communication has been broken off or if the other is rejecting, punishing, or unwilling to recognize that the individual needs help.

[a] Adapted from studies by researchers at the Los Angeles Suicide Prevention Center.

shows that many myths about suicide are untrue and that acting on those myths may increase the possibility of suicide. Table 3 presents common myths about suicide and the facts.

Preventing Suicide

The police officer may be the first person with authority to arrive on the scene when a person is threatening suicide. When possible, the officer should call to the scene a crisis intervention team if such a program exists in his area, but often the police officer will have to handle the situation himself. The individual who is threatening may be on a bridge or building threatening to jump or in a car or house with a gun threatening to shoot himself. The very fact that enough time has elapsed for the police officer to arrive on the scene indicates that the person is undecided about killing himself. To elaborate on this point, anyone who is fully intent on dying can kill himself quickly and with a minimum of attention. The fact that the individual is delaying indicates his ambivalence, and this ambivalence is one of the police officer's strongest allies in convincing the individual not to commit suicide. The following are some concrete steps to take in dealing with the suicidal person:

1. Keep him talking. The dynamics of depression and suicide have been described above. The suicidal person needs evidence of the caring and attention of others. One of the best and easiest ways to communicate this is to be a good talker, and even more importantly, a good listener.

2. Use the technique of reflection to communicate empathy. The reflective technique was developed by Carl Rogers for use in psychotherapy and has also proved to be an effective crisis intervention technique. Reflection is simply a restatement of what the person says and may be done on three levels. The first of these is to reflect the content of what is said. For example, if the suicidal person says, "My wife and I just can't get along," the officer can respond, "You've been having trouble getting along with your wife." This sounds as if the officer is parroting what the suicidal person is saying, but it has been shown that this is not the way the person sees it. Rather he feels that someone is listening carefully and is trying to understand. The second level of reflection involves the reflection of the feeling, and this is thought to be more effective than reflection of content. Often these statements begin with

TABLE 3—*Myths and facts about suicide.*

Myth	Fact
1. People who talk about suicide won't do it.	1. Most people (70 to 80%) who commit suicide do talk about it first.
2. An unsuccessful suicide attempt means the individual was not really serious and was just doing it for attention.	2. This attempt may be an early cry for help and may be unsuccessful for many reasons; 12% of those who make attempts do commit suicide within two years.
3. Talking about suicide with a depressed person makes it more likely.	3. Talking about it provides the attention that may help to overcome it. Avoiding the question when all the signs are there may be fatal.
4. Improvement after a serious depression or suicidal crisis means the danger is past.	4. Severely depressed persons often do not have the energy to commit suicide; as they improve the energy returns and they are able to act. Half the suicides occur within 90 days after the beginning of improvement.
5. All persons who attempt suicide are mentally ill.	5. He is almost always depressed or agitated, not necessarily mentally ill.
6. Suicide happens without warning.	6. Most people give definite direct or indirect warning.
7. Suicidal people are fully intent on dying.	7. Most suicidal people are undecided and the action of others may be the critical factor.
8. Once suicidal always suicidal.	8. Though many suicidal persons do eventually kill themselves, the majority pass through a suicidal crisis and are no longer actively suicidal.
9. Suicidal tendencies are inherited.	9. While individuals may learn from family that suicide is an alternative, it is not inherited and factors specific to the individual are important. (Some forms of mental illness do involve hereditary factors, but suicide per se does not).

phrases such as "I guess," "It seems," or "Perhaps." An example of this could be that when the suicidal person makes the same statement about the difficulty in getting along with his wife, the officer responds, "I guess you're worried that she might not care about you anymore." Although this sounds as if it might encourage suicidal thoughts, such statements generally do not. The person is already feeling this and by reflecting it you demonstrate again that you are listening and trying to understand. In addition, it is designed to have him start exploring these feelings and, as he works these feelings through, the need to carry out the suicidal act tends to be decreased. The third level of reflection has to do with interpersonal communication and is also very effective. Here to the same statement the officer might focus on communication to the wife: "Perhaps this is a way of showing her how you feel about it," or to the officer, "You seem to be telling me that you're not sure anybody cares about you."

3. If his suicidal feelings are related to specific problems, for example finances or relationships, help him identify and clarify the problems. Discuss the reality of these problems and possible solutions.

4. Ask questions about him only when reflection is not eliciting sufficient information. Questions often make a person feel pressured. Use an occasional question only to elicit information and feelings and then return to reflection.

5. Always actively take the side of life. As noted above, most suicidal persons are undecided, and thus the officer may be able to sway him by taking the side of life. Also, many suicidal individuals have had prior depressive or suicidal episodes and have had the experience of those feelings lifting for a period of time. This experience can be built upon. For example, the officer can say, after getting this information, "You've felt this way before and

then the feelings have gone away and you were glad you were alive. If you stop now, you'll be glad tomorrow." This approach is often effective because while depressed the individual cannot see an end to his depression and discussion of past recoveries may provide him with perspective.

6. Establish a relationship and use it. All the above techniques will probably lead to some feeling of a relationship between the person and the officer. Once the officer senses this he can, often with sincere feelings, express personal emotions such as "I care whether you live or die," or "I can see from talking to you that you're a caring person (husband, wife, father)." Such statements as these can be made, however, only after a relationship has been developed or they will be viewed as insincere.

7. Acknowledge that his suicidal threat is a cry for help. Communicate that it is a way of telling others that he needs love, attention, and help. Make the point clearly that his threat and the present situation have already made that point and there is no need to complete the act.

8. *Do not* ever use hostility, sarcasm, daring, or indifference as a method. All police officers have heard the story, or similar ones, of the officer who after hours of talking without result finally said to the man, "Go ahead and jump so we can all go home," with the effect that the man gave up his suicidal threat. This case is the rare exception. Frequently, when such a statement is made, the person does kill himself. Of course, officers do not hear about these cases as often because the officer responsible is not likely to brag about it. Years of studying suicidal persons have conclusively found that such approaches increase the chance of suicide. Also, in a number of states someone can be found criminally and civilly liable for abetting a suicide if he uses such a technique.

These techniques may be helpful in preventing individuals from killing themselves. However, the officer should also remember that human behavior is difficult to predict and that no technique can be guaranteed to be perfect. The officer may do all the "right" things and the person may still commit suicide.

Treatment Following Prevention

Police officers who have been successful in preventing a suicide often have little contact after the individual has been taken to the hospital. Often the officer experiences frustration and anger when he finds out that an individual for whom he risked his life or spent many hours to dissuade from suicide has been released from the hospital after only a short period of time. The following information is designed to provide the officer with an understanding of how the mental health system deals with suicidal individuals and to give the officer some guidelines for influencing the future treatment of the patient.

The laws concerning commitment of individuals vary from state to state; however, there is a national trend toward allowing the individual greater choice in his treatment and, if he disagrees with hospitalization, due process in the courts to uphold his civil rights. The discussion here involves commitment law in Pennsylvania, which is representative of this national trend. Once the suicidal person is brought to the hospital he may be committed as either a voluntary or involuntary patient. Because the law promotes the "least restrictive alternative" as preferable, many hospitals will attempt to have the patient sign a voluntary commitment. If this is done, the patient may leave the hospital at his own request if he gives a period of notice. The period of notice required depends on the type of voluntary commitment signed but it is usually 24 to 72 h. If the voluntary patient requests to leave, the hospital staff has the option of obtaining an involuntary commitment, that is, a commitment that keeps the patient against his will, within that period of time.

Whether an involuntary commitment is obtained on admission or after a voluntary patient indicates his desire to leave, the procedure is essentially the same. The hospital staff and any other appropriate witnesses must go before a judge or a mental health review officer and

prove to his satisfaction that not only is the patient suffering from mental illness but also that by virtue of this illness the patient represents a danger to himself or others. Further, in Pennsylvania the law explicitly states that proof of such danger is needed in the form of an overt dangerous act within the last 30 days. That is, under the law, it is no longer possible to confine a person to a mental hospital against his will because he is mentally ill; it can only be done if, because of his mental illness, he is dangerous to himself or others. Also, again specifically stated in the law, it is not enough for the doctor to have an opinion that the person is dangerous; the doctor must prove it by documenting a specific act within the last 30 days.

It would seem that when the police bring an individual to the hospital because they have been called to a suicide attempt that this would be documentation of an overt act, and this is usually the case. However, to ensure this documentation, the police officer should, when possible, provide information to the admissions personnel at the hospital in as great detail as possible with specific description of the dangerous acts and, where possible, quotes or paraphrases of what the individual said to indicate his suicidal intent. For example, if all the police officer reports was that "the individual tried to commit suicide by jumping from a bridge" and that officer is not present at the commitment hearing, it is possible that if the person presents a different version he will not be involuntarily committed. On the other hand, the police officer's report may be specific: "The individual was standing on a six-inch ledge outside the bridge railing and he repeatedly stated that he had nothing to live for and that if anyone came within 20 feet of him he would jump, and on two occasions he actually made a beginning move to jump. He was talked out of killing himself only after an hour and a half of talking to him." Such a report not only provides the basis for commitment but also provides information which may be helpful in the patient's treatment.

After 20 days have elapsed, if the patient has not made another overt dangerous act, he cannot under the law be kept in the hospital against his will. The frustration the police officer feels when hearing that the person he tried so hard to save was released after 20 days often is expressed as anger toward the doctors or hospital. However, often the officer's frustration is shared by the doctor, who also feels that the patient needs further inpatient treatment. This frustration is especially intense because the doctor is aware that suicide risk often increases as the patient improves and the critical period is approximately 90 days.

Danger to Police Officers in Suicide Cases

Police officers are well aware of the dangers of intervention into domestic arguments, but they are less aware that dealing with a suicidal individual can be dangerous. Statistically, the homicide rate is higher among persons with a history of suicide attempts, and the converse is also true: the rate of suicide attempts is higher among persons with assaultive histories. From a dynamic point of view, these statistics are not really surprising; both suicide and assault represent an inability to deal effectively with anger and a tendency toward inadequate interpersonal relationships. The police officer should be particularly wary in cases where an individual has locked himself in his house or car and is threatening to kill himself with a gun. It only takes a moment of turning his resentment over feeling unloved outward, instead of inward, for him to begin firing at the officer. The talking in this situation is best done from a protected position.

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