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Suicide Risk in Adult Offenders: The Interpersonal Theory of Suicide

PA Association on Probation, Parole and Corrections

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MCES
Building Better Tomorrows

Objectives:

1. Review explanatory power of prevailing theories in accounting for suicide in criminal justice settings.
2. Describe the interpersonal theory of suicide and its value in understanding suicide risk in adult offenders.
3. Describe the utility of the interpersonal theory in achieving further gains in suicide prevention in criminal justice settings.

Quiz:

1. Where do most prison suicides occur?
   [ ] General Pop. [ ] Med Unit [ ] Isolation

2. When do most jail suicides occur?
   [ ] 0-72 Hrs. [ ] >72 Hrs. [ ] No Difference

3. Any criminal justice contact raises suicide risk.
   [ ] True [ ] False

4. Which causes the most post-prison deaths?
   [ ] Suicide [ ] Homicide [ ] CV Disease

Site of Most Prison Suicides:

- Studies have consistently shown that most prison suicides occur when inmates are in isolation.

(Bonner, 2001; Hayes, 2003; Winter, 2003)

- Inmates in segregation are significantly more likely to report higher levels of depression and suicidal ideation

(Bonner, 2006)

Jail Suicides Timeframe:

- In 2005 and 2006 only 12% of suicides in US jails occurred during “holding” (i.e., <72 hours) while almost 88% took place during “detention” (i.e., >72 hours)

National Institute of Corrections and National Center on Institutions and Alternatives, National Study of Jail Suicides, 2006.

- “The data indicate that inmate suicide no longer occurs mostly during the first 24 hours of confinement and can occur at any time during an inmate’s confinement.”

(Hayes, 2010)

Criminal Justice Contact & Risk:

- A study of >27000 Danish suicides (Webb et al., 2011) indicated that the odds of completing suicide rose for both men and women after any criminal justice contact.
- The link between higher risk and criminal justice contact applied even with probation and not-guilty verdicts.
- It was not clear if pre-existing suicide risk or interaction with the criminal justice system was the cause.

Causes of Death After Prison:

Five leading CODs in former Washington state inmates:

Overdose (Cocaine)	29.3%
Cardiovascular disease	16.2%
Homicide	15.6%
Suicide	11.4%
Cancer (Lung)	9.9%

Binswanger et al., 2007

Suicidality in PA:

- In 2008, 1512 suicides (.012%) in a population of 12.4M, an average of 4.1 suicides every day
- In 2006, 10,357 suicide attempts in PA that resulted in hospitalization *(SPRC)*
- There were an average of 28.4 medically serious attempts every day statewide *(SPRC)*
- It may be estimated that in PA every year:
  - 500,000 experience serious suicidal ideation
  - 285,000 make a doable suicide plan

Questions:

- Why is non-fatal suicidality (i.e., thoughts, plans, and attempts) *comparatively common*?
- Why is fatal suicidal behavior (i.e., completed suicides) *comparatively uncommon*?
- Why do so few of those who become suicidal complete suicide?

Possible Answers:

1. Effective suicide prevention efforts deter high-risk individuals from suicide
2. Those who complete suicide and those who become suicidal but do not complete suicide represent two distinct populations
3. It is difficult to take one's life because of a deep-seated instinct for self-preservation

Prison Suicide Trend?

- 85% of prisoners who completed suicide had histories of psychiatric care (*Cox, 2003*)
- Rates of suicide in jails and prisons have stabilized since 2000 *(Bureau of Justice Statistics, 2007)*
- Of the inmates who completed suicide in the TX Prison System in 2006-2007, 51% had a psychiatric disorder, and 49% did not (*Baillargeon et al., 2009)*
- Voluntary and mandated institutional suicide prevention may have reduced suicide mortality among inmates with mental illness *(Hanson, 2010)*

Theory of Suicide:

- Provides testable explanations of behavior
- Provides a system for organizing what is known
- Provides clarity among types of suicidal behavior
- Provides assessment tools
- Provides a pathway to predictability
- Provides a paradigm – a widely accepted explanatory context shaping research, training, and policy*

**Thomas Kuhn*
The Structure of Scientific Revolutions (1962)

Suicide Research:

- Focuses on the variations between suicidal and non-suicidal individuals.
- Differences are seen as risk factors and, very often, their absence is been interpreted as protective factors.
- Such research has not reduced suicidal behavior or increased predictive efficacy.

Rogers and Lester
Understanding Suicide: Why We Don't and How We Might (2010)

What we Know:

- A great deal about underlying conditions
- Who completes suicide
- The *hows, wheres,* and *whens*
- The methods, places, and seasons
- But not *why:* "What we do not know kills."

Kay Redfield Jamison

Night Falls Fast: Understanding Suicide (1999)

Offender Suicide Profiles (WHO):

- “Pre-trial” – Male 20-25, unmarried, first-time offender arrested for minor, usually substance related, offense; typically intoxicated at the time of arrest; completes suicide at an early stage of their confinement.
- “Sentenced” – Male 30-35, violent offender who completes suicide after considerable time in custody (often 4-5 years); suicide may be precipitated by a conflict with other inmates or the administration, family conflict, or loss of an appeal or denial of parole.

Problems with Profiles:

- Insufficient for Screening - Do not permit staff to distinguish between suicidal and non-suicidal inmates.
- Insufficient for Risk Assessment – Produce many “false positives” (i.e., individuals who fit the profile but do not show signs of suicidality).
- Insufficient for Prevention Programming

Prevailing Theories:

Hopelessness	***Psychache***	***Emotional Dysregulation***
Suicide results from diminished self-worth caused by an extreme state of hopeless-ness.	Suicide results from intolerable psychological pain caused by frus-trated emotional needs.	Suicide results from an effort to regulate emotions because normal controls failed.
Aaron Beck	***Edwin Shneidman***	***Marsha Linehan***

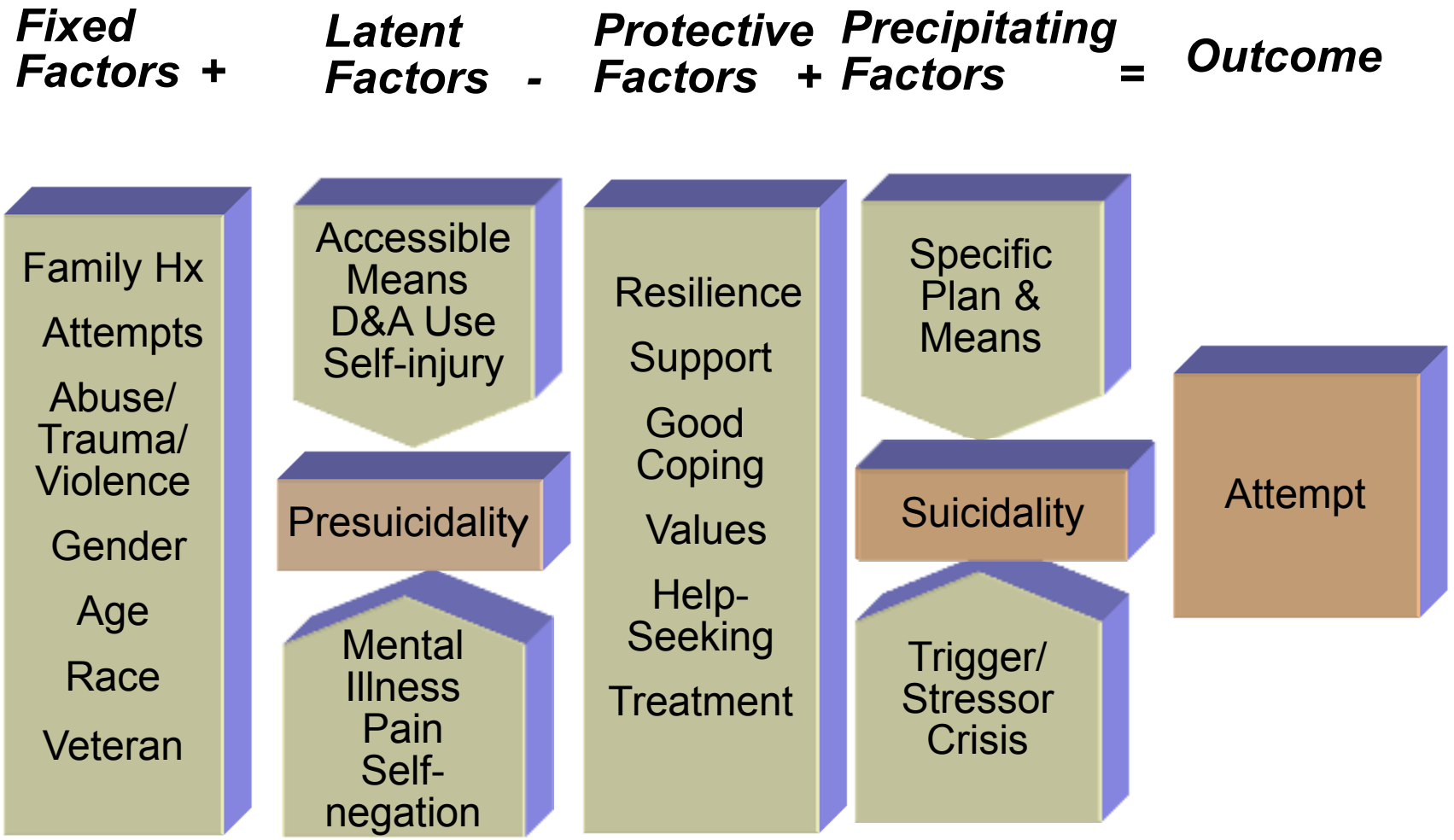
Theory Validity:

- A valid theory of suicide must account for:
  - How people come to complete suicide
  - Why so few people complete suicide
- The prevailing theories do not
  - Explain how people are led to suicide as a result of hopelessness, psychache, or emotional dysregulation
  - Explain why the indicated emotional states (which are all much more pervasive than suicide) produce so few completed suicides

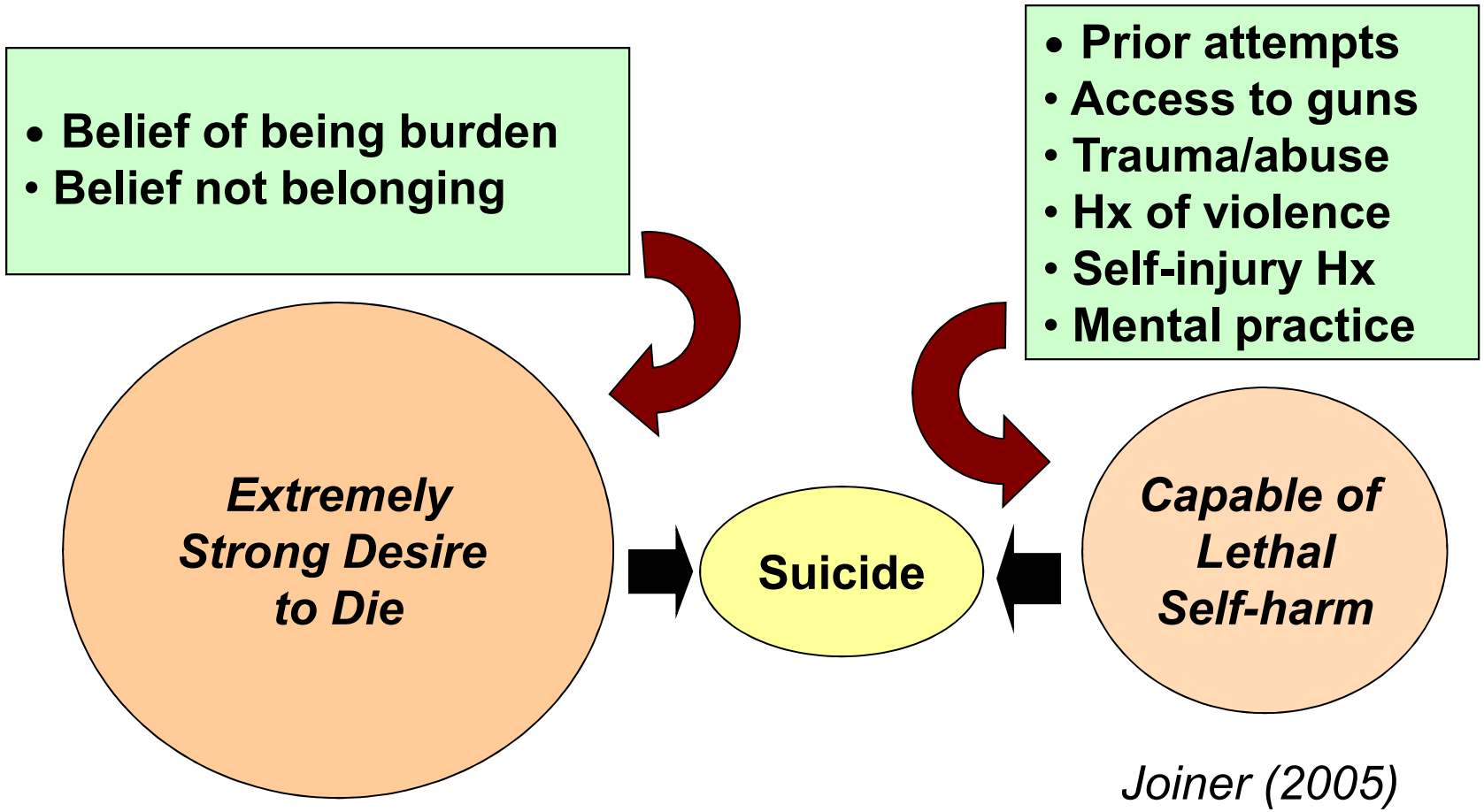
Prevailing Paradigm:

- Suicide is a voluntary decision (i.e., it is “committed”)
- Suicide is almost always an impulsive act
- Suicide is driven by depression and mental illness
- Suicide is a complex biopsychosocial phenomena
- Suicide is not predictable
- Suicide is nominally preventable

Suicidality as Process:



Interpersonal Psychological Theory:



Joiner (2005)

Perceived Burdensomeness:

- The belief or feeling of being a unbearable burden on family, friends, or society
  - Sense of being a burden on those one cares about
  - Belief that one is a liability to these others
  - Belief of failing to contribute as expected
  - Belief that one's death would be worth more than one's life
  - Reversible

Failed Belongingness:

- A sense of failure regarding maintaining social relationships and connections
  - An strong unmet need to belong
  - Involves a lack of frequent, positive social interaction
  - Sense of not being cared about by others
  - Perceived inability to connect with others
  - Reversible

Acquired Capability:

- The acquired ability to engage in or to withstand violence or painful behavior
  - The degree to which one overcomes fear of death and the instinct for self-preservation
  - The degree to which this capacity is developed overtime by exposure to fearful, provocative, and/or hurtful experiences
  - Irreversible

Capability ≠ Suicidal Intent:

- Capability for lethal self-harm can be present without desire to complete suicide
- Capability may be acquired through medical, military, or law enforcement training or other activities
- Capability may be acquired through role-based exposure to the pain and trauma of others
- Police/correctional officers, veterans, active duty military, MDs/DOs, DDSs, RNs, EMTs acquire capability on job

Suicidal Ideation:

- 34% of ideators plan an attempt, most within year
- Suicidal thoughts may be source of relief, control *(Hendin)*
- As distress arises thoughts may be drawn on *(Beck)*
- Habituates client to the idea of suicide overtime *(Joiner)*

“Mental Practice”

- May occur after a specific suicide plan has been formulated
- Involves repeatedly running through the plan in one’s mind
- Has effect of lessening resistance to carrying out plan and making an attempt
- Represents extremely high risk because it raises suicide competence

“Aborted Attempt”

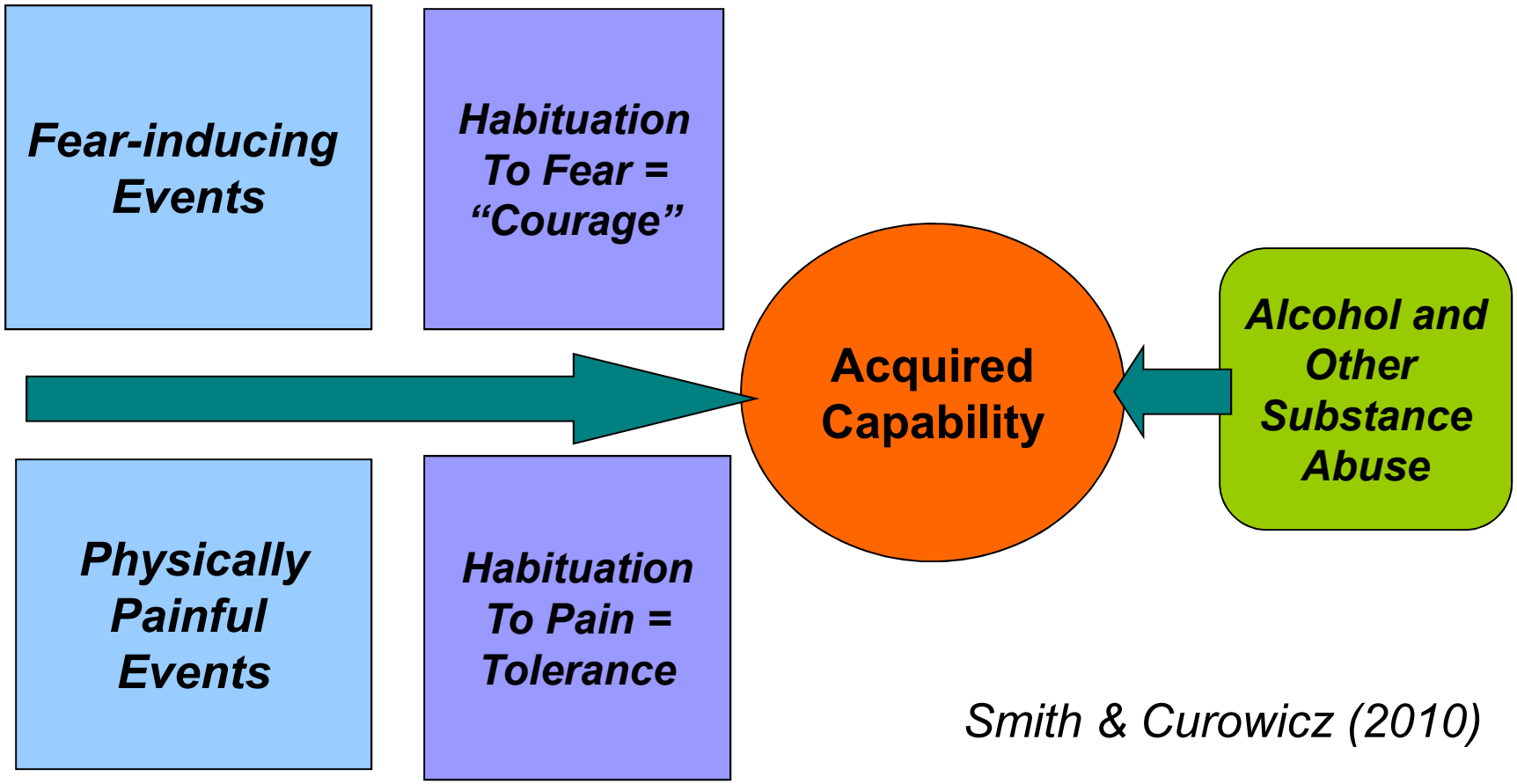
- Intent to die, plan, and means are present
- Change of mind immediately before attempt
- No act or physical injury (but still traumatizing)
- Strongly associated with actual suicide attempts

Barber et al. (1998)

“Suicide Rehearsal”

- May occur after a specific suicide plan has been formulated
- Involves practicing the plan one or more times (i.e., holding gun or pills, visiting bridge or RR tracks)
- Has effect of lessening resistance to making an attempt
- Represents extremely high risk because it raises suicide competence

Acquired Capability Emergence:



Smith & Curowicz (2010)

Non-belongingness Signs:

- Living alone with little apparent social interaction
- Divorce or separation (“traumatic betrayal”)
- Recent relationship loss
- Recent deaths, especially to suicide (also family Hx)
- No social network at the facility
- Isolation or segregation in correctional settings
- Anxiety over transfer or release

Burdensomeness Signs:

- Recent loss of job, financial autonomy, foreclosure
- Feels unable to help family; belief that caused problems for others or fell short of expectations
- Pending litigation, sentencing, new legal problems
- Onset of disability, exacerbation of chronic illness
- Initial diagnosis, early stage of serious mental illness (e.g., schizophrenia)
- Shame of offense, incarceration, failed rehabilitation
- Extended sentence; parole violation
- Inmates with frequent family visits

Signs of Acquired Capability:

- Past suicide attempt(s), especially if requiring medical care and hospitalization
- Frequent exposure to violence
- Past/current non-suicidal self-injury (e.g., cutting)
- Abuse/bullying victim or perpetrator
- Intravenous drug use
- Exposure to severe trauma, chronic pain
- Violent offender; crimes against persons

Suicide in Violent Offenders:

- Violent offenders in both local jails (92/100,000) and State prisons (19/100,000) had suicide rates over twice as high as those of nonviolent offenders (31 and 9 per 100,000 respectively).
- Kidnappers had the highest suicide rate, followed by those held for rape or homicide.

Mumola, Suicide and Homicide in State Prisons and Local Jails (2005)

Belongingness Questions:

- Do you feel close to people that you care about?
- Do you often feel that you are isolated and not part of anything?
- Do you feel that nobody cares about you?
- Do you have a sense that you can't connect with other people the way that you'd like to?
- Did you lose a social relationship that was very important to you?

Burdensomeness Questions:

- Do you feel that those who care about you would be better off if you were dead?
- Do you think that you are a burden to your family and others?
- Do you feel that you have let people down?
- Would people in your life like to be rid of you?
- Do you feel that you would be worth more dead than alive?

Capability Questions:

- Have you ever attempted suicide?
- Have you ever had a plan for suicide?
- Did you rehearse or try out your plan?
- Have you ever experienced persistent suicidal ideation?
- Have you served in the military?
- Have you experienced abuse, violence, or trauma?
- Do you feel that you can handle pain better than others?

Suicide Risk Levels:

Low	Moderate	Severe	Extreme
No capability /Capability & Feels connected and not a burden No Hx	No capability /Capability& Feels disconnected or a burden No Hx	Capability Feels disconnected or a burden Hx suicidality No plan	Capability Feels disconnected & a burden Hx suicidality Specific plan

The New York Times

Suicide Bigger Threat for Police Than Criminals

Alison Cowan April 8, 2008

NORWALK, Conn. — When Matthew Morelli, a 38-year-old police officer, was found slumped in a secluded parking lot with an AK-47 rifle on March 21, state and local authorities spent two days looking for a suspect, with helicopters and police dogs scouring the neighborhood, where witnesses reported hearing multiple shots. The culprit turned out to be a stealthy if surprisingly familiar cop killer: suicide.

Back Story:

- Officer Morelli became a Marine after high school and was decorated for his service in Operation Desert Storm
- Officer Morelli was locked in an international battle with his ex-wife over their 6-year old daughter
- Officer Morelli sought sole custody of the child, but the divorce settlement allowed his ex to remain in Australia
- Officer Morelli accused his ex-wife of running up $11,000 on credit cards he was not aware she had

Morelli Case IPT Assessment:

Belongingness	Burdensomeness	Capability
- Divorce - Custody loss - Lost social ties	- Financial loss - Control loss - Powerlessness - Self-esteem hit	- Marine - Combat - Police Officer - Scuba Unit - Firearms

Three Risk Groups:

1. Inmates who deal with a problem by with threats and/or self-harm until they get an acceptable solution.
2. Inmates who make threats and/or self-harm to relieve overwhelming emotions (and who may show symptoms of borderline personality disorder).
3. Inmates who are severely depressed and hopeless and manifest strong intent to die.

Bonner 2001

Forms of Suicidality:

Chronic Suicidality

- Frequent suicide threats
- Contingent threats
- Low intent to die
- Low/growing self-harm ability
- Low/growing risk

Acute Suicidality

- Episodic suicide threats
- Noncontingent threats
- Higher intent to die
- Higher self-harm capability
- High/imminent risk

Suicide Threats:

Contingent

- Dramatic, demanding
- Secondary gain
- Self-investment
- Legal involvement
- Refuge seeking
- Substance use
- Personality Disorder

Non-contingent

- Silent, passive
- Escape from pain
- Hopelessness
- Social withdrawal
- Few demands
- Major Depression

Lambert (2002, 2003)

Sorting Out Suiciders:

IPT Risk Variable/ Suicidal Group	*Problem-solving Threateners*	*Emotional Relief Threateners*	*Depressed/ Hopeless Threateners*
Belief of being a Burden	May be Present	Often Present	Always Present
Belief of Not belonging	May be Present	Often Present	Always Present
Capability for Lethal Self-harm	Very Rarely Present	Rarely Present	Always Present

Emerging Paradigm:

- Suicide is a planned act and the outcome of a process
- Suicide is predominantly a psychosocial phenomena
- Suicide is not primarily driven by mental illness
- Suicidality has a lethal and a non-lethal form
- Suicide is predictable
- Suicide is increasingly preventable

Risk Along the Continuum:

Intercept	*Risk Potential*	*Prevention?*
Police Contact/Arrest	Low ↑	
Detention/Hearing	Moderate ↑	
Pre-trial/Jail/Trial	Severe	
County/State Prison	Extreme	
Pre-Release/Release	Severe	
Community Supervision	Moderate	

Contact Info/Sources:

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- Joiner, T. (2005) *Why People Die by Suicide* Cambridge, MA: Harvard University Press.
- Joiner, T. et al. (2009) *The Interpersonal Theory of Suicide* Washington, DC: American Psychological Association.