Perceptions of Suicide by Cop and Mental Health

Jessica Roos

A Dissertation Submitted to the Faculty of

The Chicago School of Professional Psychology

In Partial Fulfillment of the Requirements

For the Degree of Doctor of Psychology

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Abstract

Suicide by cop is an event that takes place frequently in the United States and in other countries. Suicide by cop is the act of an individual provoking law enforcement officers to use deadly force with either verbalizing their desire to be killed by law enforcement officers or making gestures such as pointing a weapon. The lack of clarity in definitions and reporting of this incident leaves uncertainty about how to detect who participates in this act and early prevention of suicide by cop. In an effort to examine clinical subtypes of individuals who participate in the act of suicide by cop, this dissertation explored the perceptions of suicide by cop by individuals in the professional fields who might encounter these individuals. The main goal of this dissertation was to get a better understanding of the clinical subtype of the individual who decides to commit suicide in this manner in order to further the literature. Furthermore, it is the intention of this dissertation to provide clinical information that can be used to proactively inform professionals in the fields of psychology, legal, and law enforcement to better recognize and prevent the event of suicide by cop.

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Chapter 1: Nature of the Study

Background

Studies have shown that in more than 700 officer-involved shootings between March 2006 and January 2007, 41% of those shootings showed evidence of suicidality in the alleged perpetration, hereinafter the individual whom the officer shot (Mohandie, Meloy, & Collins, 2009). According to Mohandie and colleagues (2009) suicidality is defined as the likelihood of an individual completing suicide. Therefore, evidence of suicidality can be defined as signs of life threatening self-harm in that individual's life. In 256 of those 291 cases, the individual was either killed or injured by the police officers rather than by his or her own hand. Furthermore, 51% (131 cases of the 256 cases) of the individuals were killed during the encounter by the police, 40% (101 cases of the 256 cases) were injured, 7% (17 cases of the 256 cases) committed suicide themselves, and 3% (7 cases of the 256 cases) the individuals were unharmed (Mohandie, Meloy, & Collins, 2009). Based on these statistics, Mohandie and colleagues (2009) stated that there was a 97% chance of injury or death to the individual who participated in incidents with the police that have evidence of suicidality. Even though Mohandie and colleagues (2009) have supporting evidence that there is connection of suicidality in an individual among cases involving officer shootings, little is known about the large prevalence of these types of suicides. Due to this minimal knowledge about these types of suicides, Geberth (1993) has coined the term "suicide by cop" (SbC).

SbC can be defined as an incidence when a suicidal individual purposely provokes the police officers to shoot and kill him or her (Dewey, Allwood, Fava, Arias, Pinizzotto & Schlesinger, 2013). The individual engages in threatening behavior to provoke the desired outcome that the individual wishes, which is death (Dewey et al., 2013).

Police officers and law enforcement as a whole lack an understanding of SbC, such as not recognizing a SbC incident before it escalates or recognizing the warning signs of an SbC incident. Furthermore, a lack of a unified definition and lack of reporting procedures on SbC cause these incidents to go unreported on a national level. Per Pinizzotto, Davis, and Miller, (2005) the lack of understanding starts with the crime reporting practices. The Uniform Crime Report (UCR) Program was developed in 1927 by the International Association of Chiefs of Police (IACP) (Pinizzotto et al., 2005). The goal of this program was to enable the law enforcement community to aide in understanding and to quantify the nature and extent of crime in the United States (Pinizzotto et al., 2005). Additionally, this program developed standardized definitions of offenses for law enforcement agencies to use when reporting crime statistics to avoid recording offenses based off different definitions and tarnishing the statistics (Pinizzotto, et al., 2005).

The UCR program functions under the administration of the FBI with support from the IACP (Pinizzotto et al., 2005). The dilemma with SbC reporting is that the UCR program does not record information on suicides. Suicides are usually reported at a local level of law enforcement (Pinizzotto et al., 2005). According to Pinizzotto and colleagues (2005) SbC is grouped under a form of suicide; therefore, the UCR does not record this information, making it extremely difficult to gather national data on this reoccurring problem. According to Dewey and colleagues (2013), even when the intent of suicide is present in the individual and SbC is confirmed by evidence such as a suicide note or law enforcement witnesses, the medical examiner records the death of the individual as a justifiable homicide.

According to Pinizzotto and colleagues (2005) justifiable homicide can be defined as "the killing of a felon in the line of duty" (p. 10). UCR does record justifiable homicides, and in 2002

law enforcement officers justifiably killed 339 individuals (Pinizzotto et al., 2005). With the knowledge of the act of SbC, of these 339 justifiable homicides, some of these individuals may have had the intention of using the law enforcement officers as a means of committing suicide. Therefore, the lack of reporting in the UCR and by the medical examiner makes it difficult for awareness and prevention of the occurrence of SbC.

Statement of the Problem

Examining SbC information from a mental health viewpoint may lead to an increase in awareness of this type of suicide and its risk factors (Dewey et al., 2013). Moreover, researching SbC could increase early detection of individuals who are at risk to partake in SbC (Dewey et al., 2013). In general, suicide risk is often determined by clinical risks from a mental health viewpoint including previous suicide attempts, psychiatric illness, substance abuse, and traumatic life events (Karch, Crosby & Simon, 2006). According to Dewey and colleagues (2013), of the individuals who successfully completed SbC, 16-47% had a prior suicide attempt. Secondly, a large majority of the individuals who completed SbC communicated verbal suicidal intent, either prior to or during the event (Dewey et al., 2013). Additionally, Mohandie and colleagues (2009) stated that of the 256 cases that were deemed SbC, 55% of these individuals in those cases gave some sort of verbal indication of suicide. Furthermore, 38% of those individuals specifically referred to the method of SbC. However, only 14% of those SbC individuals left suicide notes; of that 14%, four of those notes referenced SbC specifically (Dewey et al., 2013).

Huston and colleagues (1998) found that 98% of the cases in which they examined the individuals who engaged in SbC were male. Moreover, Homant and Kennedy (2000) also reported that 92% of their subjects who were involved in SbC were male. Lastly, Mohandie and colleagues' (2009) sample of SbC individuals were 95% male.

The Present Study

The research of SbC has focused on the clinical subtype of the individual who partakes in this act. Additionally, research has focused on the risk factors that surround the incidence of SbC. However, there is a lack of research in the reporting and perception of SbC in terms of the individuals who handle these occurrences, such as law enforcement agencies.

The current research aims to examine professionals in law enforcement, current or past professionals in the legal field, and the perceptions of SbC among current and past professionals in the psychology field. Additionally, this research aimed to examine those same professionals' perceptions of the clinical subtype of the perpetrator who partakes in SbC. In particular, this research will focus on gender (male/female) and race (African American and Caucasian) and the clinical subtypes of mental illness, life factors, criminal factors, and situational factors from the participant's perspective. This research hypothesized that there is a significant difference between gender (male/female) and race (African American and Caucasian) on the professional's perception of who commits SbC based on mental illness factors, life factors, criminal factors, and situational factors. This research also hypothesized that there is a significant difference between gender (male/female) on the professional's perception of who commits SbC based on mental illness factors, life factors, criminal factors, and situational factors. Lastly, this research hypothesized that there is a significant difference between race (Caucasian/ African American) on the professional's perception of who commits SbC based on mental illness factors, life factors, criminal factors, and situational factors.

Chapter 2: Review of the Literature

Overview

This literature review establishes the prevalence and impact of suicidal behavior and the act of SbC to help understand the prevalence and the clinical subtypes of the individuals who engage in this act of suicide. In addition, the review will recognize the research on risk factors for these behaviors, methods in which level of risk for these behaviors are currently assessed throughout the United States, as well as the limitations of the existing research in terms of suicide and the act of suicide by cop. Finally, the literature review provides support for developing future research to aide in recognition of clinical subtypes of individuals who engage in suicide by cop to aid in developing better law enforcement training and protocol to better handle these high-risk situations.

Suicide

Suicide Terminology

Suicide exists in all cultures and societies. Suicide carries both a social and religious meaning and society's perception of the concept of suicide can influence the rates of suicide (Goldsmith, Pellmar, Kleinman, & Bunney, 2002). Suicide remains a significant public health subject worldwide despite the lack of understanding of the various behaviors and inconsistent terminology. O'Carroll and colleagues (1996) recognized that even though suicide research has been conducted for numerous decades, there is no generally accepted "nomenclature" or system for referring to suicide-related behaviors (O'Carroll et al., 1996, p. 238). Meaning, that from clinician to clinician suicidal terms such as suicide itself, attempt, or ideation do not have a consistent definition. There is no reference for clinicians to refer back to in order to define a term such as suicide. Therefore, O'Carroll and colleagues (1996) had the goal of developing a system

for referring to suicidal terms that clinicians and/or researchers could utilize to be consistent with terminology on this subject. Before examining O'Carroll and colleagues' (1996) proposed standard it is important to note that 20 years after O'Carroll and colleagues (1996) proposed a standard nomenclature for suicide-related behavior, it appears that while the situation has improved, many concerns still remain regarding the topic of suicide terminology.

O'Carroll and colleagues (1996) used compelling examples to back up their revelation that there is no set of terms to help define suicidal behaviors. For example, researchers have been called to testify before a subcommittee of the United States Senate in which the researchers showed interest in the problem of suicide (O'Carroll et al., 1996). When the researchers were asked to provide the prevalence of suicide rates in the United States from year to year, they responded with a series of questions, "What do you mean by 'attempted suicide'? Do you mean how many came to the hospital? Or how many were injured? Or how many were injured who were serious about ending their lives? Or how many made some effort to kill themselves, even if they did not mean it, or even if they were not injured?" (O'Carroll et al., 1996, p. 238). By these responses, it is clear that there is no uniform approach to gathering this information and it is not recorded in any uniform manner. Therefore, O'Carroll and colleagues (1996) proposed a standard nomenclature or set of terms for suicide-related behavior, clearly defining terms such as suicide, suicide attempt, suicidal act, suicide threat, and suicide ideation.

Silverman and De Leo (2016) stated there is still a lack of agreed upon nomenclature which incorporates the full range of what are often clinically defined as suicidal-related behaviors. Furthermore, assessment tools used to assess suicide tend to not adhere to the definitions that do exist, nor do these assessments sufficiently differentiate among suicidal behaviors such as attempts, act, threat, and ideation (Silverman & De Leo, 2016).

Additionally, terminology used in the suicide literature is often varied, inconsistent and confusing at times. Silverman and De Leo (2016) stated that not only does the terminology need to be clearly operationalized and consistent, but the terms must be easily understood, applied, and relate to each other in a way that has effectiveness, meaning, and relevance to the reality of the real world of at risk individuals. Terms such as suicide attempt, self-injury, self-harm, and parasuicide are often used interchangeably. Parasuicide is another term used for an apparent suicide attempt (Silverman & De Leo, 2016). Therefore, the purpose of this section is to clarify the definitions of these terms and to establish how these terms will be used in the current study.

Suicidal Ideation. O'Carroll and colleagues (1996) defined suicidal ideation as "any self-reported thoughts of engaging in suicide related behavior" (p. 247). The majority of suicidal ideation and behavior occurs on a scale of severity which ranges from events that are less severe and more prevalent (Crosby, Cheltenham, & Stacks, 1999). Studies have shown that the frequency rate of suicidal ideation varies between 2.3% and 14.1%, depending on how suicidal ideation is defined, as well as the population studied. (ten Have et al., 2009). According to ten Have and colleagues (2009), suicidal ideation is associated with younger aged individuals, not being in a stable and/or healthy relationship, unemployment, low levels of social support, and hopelessness. Much research focuses on suicide attempts and completed suicides rather than suicidal ideation. However, Crosby and colleagues (1999) conducted a study examining the occurrence of suicidal ideation and behavior among adults in the United States. There were 5,238 completed adult interviews, 3,630 refusals, and 474 incomplete interviews with a response rate of 56.1% (Crosby et al, 1999). Out of the 5,238 participants, 310 participants reported suicidal ideation in the 12 months prior to the survey (Crosby et al, 1999). Of those 310 participants, 148 were male and 162 were female, with majority of these participants in the age range of 25 to 34

years of age (Crosby et al, 1999). Thus, Crosby and colleagues (1999) concluded that a widespread strategy for the prevention of suicidal ideation relies on several key factors such as the causation of suicidal behavior and the efficacy of intervention and prevention strategies. Furthermore, early detection such as identifying the risks associated with suicidality requires an immediate focus on diminishing self-harming cognitions to ensure safety before attending to the primary etiology of the behavior (Cohen, Mannarino, & Deblinger, 2006). Therefore, a measure that could lead to delineation of suicidal ideation in the community can be valuable, especially if the measure was brief and excluded leading or confronting questions (Chamberlain et al., 2009).

A measure that fits the above criterion and has potential is the K10 Psychological Distress scale, which was developed by Kessler and Mroczek (1994). This scale quickly screens and assesses the common symptoms of depression and anxiety and assesses for suicidal ideation in medical settings (Kessler & Mroczek, 1994). Therefore, Chamberlain and colleagues (2009) used this scale in their study, using four of the 10 questions to measure and screen for suicidal ideation. The results of the study concluded that just over 5% of the 11, 456 participants indicated having suicidal ideation in the two weeks prior to taking the K10 survey (Chamberlain et al., 2009). Correspondingly, the study concluded that males were more likely to have suicidal ideation than females when they were experiencing high levels of psychological distress such as symptoms of depression (Chamberlain et al., 2009). Overall, this study shows that having a screener for suicidal ideation can help maximize the individual's safety and prevention of suicidal attempts by being able to refer these individuals to the appropriate mental health resources. Lastly, it is important to understand the predictors of suicidal ideation. A study conducted by ten Have and colleagues (2009) addressed the frequency of suicidal ideation and the predictors. The participants of this study (2009) study were from the Netherlands. The data

was collected by the Netherlands Mental Health Survey. The Netherlands sample was a representative sample of the Dutch adult general population (ten Have et al., 2009). The study concluded that the suicidal ideation in the Netherlands was 2.7% over a three-year period. Additionally, the study concluded that among individuals who had suicidal ideation in the first year, 31.3% still had these ideations in year three, and 7.4% of the 31. 3% reported attempting suicide during the next two years (ten Have et al. 2009). In regard to the predicators of suicidal ideation, ten Have et al. (2009) found that interpersonal relationship conflicts and becoming unemployed were the two main predictors of the onset of suicidal ideation. Even though this study was conducted on a population from a different country than the United States, it sheds light that ideation of suicide has common risk factors in a variety of countries and general populations. It is also important to note that in the United States, relationship conflicts and/or loss of a job may be a risk factor for suicide ideation. However, those factors may not be the top two risk factors for the United States.

Suicide attempt. As noted earlier, the problem of unclear definitions for suicidal terminology extends to suicide attempts. There has been a lack of clarity and consistency in the terms used to define suicide attempts according to Nock and Kessler (2006). Nock and Kessler (2006) stated that clarifying and defining suicide attempts can be broken down into three separate perspectives. The first perspective defines suicide attempts as all self-injurious behaviors without any regards to whether or not that individual had intent to die (Nock & Kessler, 2006). The second perspective, theorizes that intent to die is an important factor, and, therefore, individuals should be put into groups based on their level of intent (Nock & Kessler, 2006). The third perspective theorizes that it is impossible to distinguish between self-injurious individuals who have the intent to die and from those who do not have the intent to die (Nock &

Kessler, 2006). Therefore, terms such as parasuicide and deliberate self-harm are often used to describe nonfatal self-injury (Nock & Kessler, 2006). It is important to differentiate between an individual who had intent to die and an individual who did not have the intent to die. An explanation provided by Nock and Kessler (2006) was "individuals with intent to die have been shown to engage in more lethal self-injury and are more likely to subsequently die by suicide" (p. 616). Therefore, consistent with this example and the evidence on intent an expert panel defined suicide attempt (Nock & Kessler, 2006). Suicide attempt can be defined as "potentially self-injurious behavior with a nonfatal outcome, for which there is evidence that the person intended at some level to kill himself/herself" (O'Carroll et al., 1996, p. 247). Furthermore, O'Carroll and colleagues (1996) stated that a suicide attempt may or may not result in injuries; what is key in a suicide attempt is the intent to kill oneself, which can only be determined by clinically interviewing an individual who has made a suicide attempt. A study conducted by Nock and Kessler (2006) examined the prevalence of suicide attempts and took suicidal intent into consideration. Furthermore, this study attempted to decipher if individuals with suicide attempts with intent to die differ significantly with those individuals without such intent but with the intent of communicating with others or what are known as suicide gestures (Nock & Kessler, 2006). The results concluded that 4.6% of the sample in Nock and Kessler's (2006) study reported a previous suicide attempt. However, when adding in the intent to die, the suicide attempt reduced to 2.7% of the sample. On the other hand, 69.8% of the sample reported making a suicide gesture (no intent to die but intent to communicate with others as in a cry for help) (Nock & Kessler, 2006). Therefore, given the definition that there must be intent to die, only 2.7% actually made a suicide attempt.

Suicide prevalence. Suicide is the 10th leading cause of death in the United States according to the American Foundation for Suicide Prevention (2017). Crosby and colleagues provided suicide prevalence in the United States during the year 1984. Crosby and colleagues (1999) reported that there were 4, 506,892 individuals who thought about suicide which translates to 2.6% of the United States adults. Approximately 520,026 adults made suicide attempts or 0.3% of adults in the United States. Lastly, 28,257 adults completed suicides in 1984 (1.4% of adult United States population). Crosby and colleagues (1999) stated that studies during the 1980s and 1990s estimate that 0.3% to 0.8% of the United States adult population attempt suicide each year. Moving forward in time, an article by Nock and colleagues (2008) also investigated suicide prevalence in the United States. Nock and colleagues (2008) collected their data by the National Vital Statistics System of the Centers for Disease Control and Prevention (National Center for Injury Protection and Control, 2008). Nock and colleagues (2008) examined the rates of completed suicides in the United States from the year 1990 to the year 2005. The results of this data indicated that in the year 2005, 10.8 per 100,000 individuals committed suicide, which is 1.4% of all deaths in that year (Nock et al., 2008). There were no gender differences in the prevalence of suicide rates until the ages of 15 to 19 years old. Then the rate of suicide among males increased substantially relative to females (Nock et al., 2008). Nock and colleagues (2008) contributed this increase in male suicides due to the amount of self-injurious behaviors males partake in, which increased their suicide attempts compared to females. Nock and colleagues (2008) stated that females are more likely to make suicide gestures, where males make more suicide attempts. Nock and colleagues (2008) also found an increase in completed suicides among Native American/Alaskan Natives, Non-Hispanic, and Caucasian males in their early 20s and among those over the age of 65 (Nock et al., 2008). Lastly, according to the

Centers for Disease Control and Prevention (2016) in the year 2014 more than 42,000 individuals committed suicide or 12.93 per 100,000 individuals, which is a 24% increase since the year 1999.

Along with the average suicide rate increasing steadily since the year 1999, suicide in young adolescents and middle-aged adults is also drastically rising (Centers for Disease Control and Prevention, 2016). In terms of prevalence of suicide in gender, men commit suicide 3.5 times more often than women, and white males accounted for seven out of ten suicides in the year 2016 (American Foundation for Suicide Prevention, 2017). Lastly, in 2016, firearms were the most commonly used method in terms of committing suicide, accounting for 51% of all suicide deaths; the statistics were not broken down into which gender has the preferred method of using a firearm to commit suicide (American Foundation for Suicide Prevention, 2017). Suffocation (including hangings) was the next most common method (25.9%), followed by poisoning (14.9%), and other (8.2%) (American Foundation for Suicide Prevention, 2017). It is important to note that no complete count is kept of suicide attempts in the United States, however the Centers for Disease Control and Prevention gather data from hospitals on non-fatal injuries from self-harm to get a better understanding of suicidal behavior (American Foundation for Suicide Prevention, 2016). According to the Centers for Disease Control and Prevention (2015) there were 505, 507 self- / non-fatal injuries in the year of 2015 across the United States.

To summarize, the studies discussed above have consistently shown that suicide is a significant problem in the United States. However, the literature on suicide is less clear on the significance of suicidal cognitions such as suicidal ideation and planning. Research continues to show the need for assessing and early detection of suicidal ideation to help prevent the number of individuals committing suicide worldwide each year.

Suicide Risk Factors

There is an abundant amount of research that focuses on the risk factors of suicidal behavior. Researchers have defined broad categories in which risk factors have been identified including prior self-harm, childhood maltreatment, stressful life events, biological factors, and a range of psychiatric factors. The support for the mentioned risk factors is reviewed below. Research has tended to focus on risk factors for completed suicides, as opposed to other suicidal behavior such as ideation and attempts. Furthermore, research has grouped other suicidal behavior as mentioned before under one umbrella that is distinct from suicide completion. Therefore, it is possible that a suicide attempt that was unsuccessful was intended to be lethal. Furthermore, self-injurious behavior with no intent to die would be grouped under the same category as an attempt, yet the review of the literature determines that this would be defined as a suicide gesture, not an attempt. Understanding these limitations outlined in the literature will help clarify and separate what types of suicide behavior is being investigated in relation to identifying risk factors.

Childhood maltreatment. A variety of research has demonstrated relationships between childhood abuse and suicidality (Read et al., 2001). According to Read and colleagues (2001) suicidality has been linked to related child abuse, even after controlling for mediating variables such as childhood disadvantages and family dysfunction. Santa Mina and Gallop (1998) conducted a meta-analysis investigating the relationship between victims of child abuse and suicidality in adolescence and adulthood between the years 1988 and 1998. The results showed that all 21 studies found a significant relationship between being a victim of child abuse and suicide attempts, suicide ideation, or both (Santa Mina & Gallop, 1998). Briere and colleagues

(1997) found in their study that childhood sexual abuse was significantly related to suicide attempts and suicidal ideation after controlling for demographic variables. Additionally, Briere and colleagues (1997) found that childhood physical abuse also yielded similar results as victims of childhood sexual abuse. Read and colleagues (2001) reviewed files of 200 clients who were being treated at a New Zealand Community Health Centre. The results yielded that individuals who reported at least one form of child abuse (sexual or physical) were more likely to have attempted suicide than those who reported neither form of abuse (Read et al., 2001). Individuals who reported childhood sexual abuse were more likely to have attempted suicide than those who did not report childhood sexual abuse, while those individuals who reported both types of abuse were more likely to have attempted suicide than those reporting only one form of abuse or neither (Read et al., 2001).

Brodsky and colleagues (2001) conducted a study to look at the relationship between childhood trauma and suicidal behavior in depressed adults. The results of this study concluded that 38% of the subjects reported a history of physical or sexual abuse before the age of 15, while 62% reported no childhood abuse. The subjects who reported abuse were more likely to have made a suicide attempt and were more likely to be female (Brodsky et al., 2001). Additionally, those subjects who reported abuse and a suicide attempt made their first attempt before the age of 18 (Brodsky et al., 2001). Most childhood maltreatment focuses on childhood sexual abuse and physical abuse, however Brown and colleagues (1999) found that childhood neglect was also strongly related to suicidal behavior. This study consisted of 776 randomly selected children who were studied from age five to adulthood during a 17-year period in New York (Brown et al., 1999). However, the final number of participants fell to 639 due to attrition. Furthermore, Brown and colleagues (1999) conducted assessments of the child, family, environmental risks

and psychiatric disorders. They determined a history of abuse by official records and self-reported abuse (Brown et al., 1999). The results of this study indicated that 39 participants were considered to be neglected (Brown et al., 1999). Of those 39 participants, 15% (six participants) had made suicide attempts and 5% of that 15% had made repeated suicide attempts (Brown et al., (1999). Brown and colleagues discussed that while neglect in childhood is related to suicidal behavior, a combination of different types of abuse such as neglect, and sexual abuse have a higher risk of suicidal behavior.

Sfoggia and colleagues (2008) investigated whether history of childhood neglect at the time of admission of psychiatric patients was associated with suicide attempts or ideations. The results of this study concluded that at the time of admissions 51.6% of the inpatients presented with suicidal ideations. From that 51.6%, 10.24% reported having childhood neglect (Sfoggia et al., 2008).

Attempts have been made to summarize suicide literature to guide professionals when assessing level of risk in an individual. However, even though the literature shows a powerful relationship between suicidality and childhood maltreatment, child abuse is rarely mentioned in suicide assessment guidelines (Read et al., 2001). It is acknowledged that child abuse plays an important role in developing suicidal ideation and behavior, however none of the 21 studies in the meta-analysis by Santa Mina and Gallop (1998) cited child abuse and suicidality, indicating that abuse history is not considered an important factor in suicide assessments with adult populations (Read et al., 2001). A survey asked 256 United States psychologists to rank 48 risk factors from one (unimportant) to nine (critical) when assessing suicidality in a depressed client (Peruzzi & Bongar, 1999). The four factors that were rated at eight or above were medical seriousness of previous attempts, history of attempts, acute suicidal ideation, and severe

hopelessness, supporting the idea that childhood abuse in suicide assessments is nonexistent (Peruzzi & Bongar, 1999). The pool of items that was drawn from previous reviews of the literature had no reference to abuse or violence in the past or present, indicating that clinicians may benefit from paying more attention to the clients' abuse histories when conducting suicide assessments (Read et al., 2001). Thus, all of the above research studies support that there is a relationship between a victim of child abuse and suicidality in adulthood. Additionally, it can be understood that early negative life events such as abuse form enduing cognitive styles such as hopelessness or attributions such as self-blame for the abuse which can lead to suicidal behavior (Barker-Collo et al., 2000).

Prior self-harm. Previous acts of self-harm are strong indicators of a suicide attempt or multiple attempts. Joiner (2005) states three factors that mark those who are at most risk of death by suicide: first, the feeling of being a burden on loved ones followed by the sense of isolation and, lastly, the learned ability to hurt oneself (Joiner, 2005). Cooper and colleagues (2005) conducted a study investigating self-harm cases to estimate suicide rates during a follow-up period of up to four years after a self-harm episode. The study consisted of 7,968 individuals who indicated deliberate self-harm from September 1, 1997 to August 31, 2001 (Cooper et al., 2005). The results showed that 15.5% of the individuals repeated self-harm before the end of the study period and 13 of the 60 individuals died by suicide (22%) before the end of the study period. Of the 22%, 18.3% of the individuals had repeated self-harm before their actual suicides (Cooper et al., 2005). Cooper and colleagues (2005) also reported that the number of suicides in the self-harm subjects was 34 times higher than expected. This rate was calculated by using standardized mortality ratios to adjust for age and gender differences between the study population and that of the general population (Cooper et al., 2005). Additionally, the results

showed that the risk of suicide in the first year of follow-up was 0.5% and that within the first six months was the highest suicide rate for the individuals (Cooper et al., 2005). As the follow-up length increased, the suicide rate tended to decrease (Cooper et al., 2005). The results of this study confirm that there is a high risk of subsequent suicide among individuals who have previous deliberate self-harm (Cooper et al., 2005).

A more recent study that looked at previous self-harm was a study conducted by Hawton, Haw, Casey, Bale, Brand, and Rutherford (2015) who analyzed data on self-harm individuals in Oxford, England between the years 1996 and 2010 using the Oxford Monitoring Systems for self-harm. Hawton and colleagues (2015) investigated trends in prevalence, methods, and repetition of self-harm. The results of the study yielded that rates of self-harm rose in both genders between the years 1996 and 2002/2003 and after that they slowly declined (Hawton et al., 2015). Over the 15-year span of the study, a total of 5,107 males and 7,111 female individuals aged 15 years and older presented to the general hospital in Oxford following 8,935 and 14,127 occurrences of self-harm (Hawton et al., 2015). Additionally, during the study period, the ratio of self-harm episodes to each person remained constant for males, and in females the ratio increased to 1.33 for the years 1996-1998 and to 1.45 for the years 2008-2010 (Hawton et al., 2015). Overall, the results that Hawton and colleagues gathered (2015) are consistent with other research indicating that after an initial self-harm episode, other self-harm episodes are to follow, and the intent for suicide remains relatively the same within these individuals.

It is important to note that self-harm can also be non-suicidal. According to Klonsky (2009) non-suicidal self-injury can be defined as "intentional, direct damage to one's body tissue without suicidal intent" (p. 1). Common forms of this type of self-injury include: skin-cutting,

scratching, burning, self-banging, or hitting (Klonsky, 2009). Non-suicidal self-injury is common in clinical settings with individuals diagnosed with mood disorders, anxiety disorders, substance abuse, eating disorders, and personality disorders, especially borderline personality disorder (Herpertz, Sass, & Favazza, 1997; Stanley, Gameroff, Michalsen, & Mann, 2001). Non-suicidal self-injury can also be found in non-clinical settings and approximately 4% of individuals from large community samples of report a history of this type of self-injury (Klonsky, 2009).

Klonsky (2009) conducted a study to address the consequences, affect-states, and reasons associated with non-suicidal self-injury. There were 39 participants with histories of repeated self-injury who were administered a structured interview addressing the concerns listed above (Klonsky, 2009). In Klonsky's (2009) study, 77% of the participants were female, 95% were Caucasian, and the mean age of the participants was 19.4 years old. The study revealed that participants cut themselves a mean of 17.2 times (Klonsky, 2009). Participants disclosed ways of self-injuring such as, banging body parts against something (51%), severe scratching (46%), burning (38%), sticking sharp object into skin (28%), interfering with wound healing (26%), severe skin picking or pinching (23%), biting (21%), hitting (13%), and rubbing skin against rough surfaces (3%) (Klonsky, 2009). Participants also disclosed the most common reason for partaking in this self-injurious behavior and the most common answers included: to release emotional pressure that builds up inside of me; to control feelings; and to get rid of intolerable emotions (Klonsky, 2009). Other participants disclosed their main reason for this behavior was to feel exhilarated (21%), to feel real (18%), and to avoid impulse to attempt suicide (5%) (Klonsky, 2009). Lastly, participants were asked to disclose how they felt before the injurious behavior and after the behavior. The most common affect states before were overwhelmed, sad, hurt emotionally, frustrated, and anxious, while the most common affect states after were

relieved, angry at self, and calm (Klonsky, 2009). Overall, it can be concluded that self-harm is not always with suicidal intent. Klonsky's (2009) study indicated that individuals have a variety of reasons for partaking in this type of behavior other than wanting to commit suicide. Therefore, it is important to understand the difference between self-harm with suicidal intent and self-harm with no suicidal intent in regard to suicide risk factors.

Stressful life events. Suicidal behavior often occurs adjacent to stressful life events such as family and interpersonal conflicts or legal/disciplinary conflicts. Stressful life events usually occur in the year preceding the onset of mental disorders such as substance-use disorders, depression, bipolar, and posttraumatic stress disorder and, in turn, these disorders are linked to suicide attempts (Wang et al., 2012). In the literature regarding stressful life events and suicide, there are some limitations regarding a clear understanding of this relationship (Wang et al., 2012). Current research on this relationship has concentrated on restricted populations, such as youth or suicidal individuals seeking treatment in a hospital, making it difficult to generalize it to the overall population (Wang et al., 2012). However, some studies have shown that suicide attempts among individuals who have experienced stressful life events in the past year were approximately five times higher than those who reported no such experiences (Fergusson et al., 2000). The primary goal of Wang and colleagues' (2012) study was to examine whether being exposed to a stressful life event in the past year is related to a past year suicide attempt in a nationally representative sample. Results of this national sample indicated that shocking or traumatic events, relationship, interpersonal conflicts, or changes were the most prevalent stressful life event categories (Wang et al., 2012). Additionally, death of a family member or close friend and changes in employment were the most prevalent individual stressful life events according to Wang and colleagues (2012). Wang and colleagues (2012) adjusted for

sociodemographic factors (race/ethnicity, education, marital status, age, sex, and income) and after doing so concluded that stressful life events and suicide attempts were still significantly related. Thus, there does seem to be a relationship between stressful life events and suicide attempts even after adjusting for different variables. The study shows that the strain of the stressful life event is often too much to bear for some individuals. These individuals see no other solution but to make a suicide attempt.

Yen, Pagano, Shea, Grilo, Gunderson, Skodol, and Zanarini (2005) used data collected through the Collaborative Personality Disorder Study, which was conducted by Gunderson, Shea, Skodol, McGlashan, Morey, Stout, and others (2000) and to investigate whether individuals with a personality disorder who attempted suicide had experienced a stressful life event in the month prior to the suicide. The total number of participants was 668; each participant was interviewed at six months, one year, two years and three years following the baseline assessment which examined both Axis I and Axis II disorders as shown in the DSM-IV-TR (APA, 2000; Yen et al., 2005). During the three-year follow-up time, 65 participants made suicide attempts. Yen and colleagues (2005) found that negative life events such as broken engagement, divorce, spouse infidelity, or crime-legal matters (physical assault attack, accused of crime, went to jail), were significant predictors of a suicide attempt. Furthermore, in regard to personality disorders, borderline personality disorder had a more significant predictor of suicide attempts compared to schizotypal, avoidant, and obsessive-compulsive personality disorders (Yen et al., 2005). Overall, the study concluded that specific events carry intermittent risk for a suicide attempt in the month of or the month following the onset of such an event (Yen et al., 2005).

Conducting psychological autopsies is a technique that utilizes a combination of interviews of those closest to the deceased individual and examination of supporting evidence from collateral sources such as hospital, general practice case notes, social work reports, and criminal records (Cavanagh et el. 2003). The goal of psychological autopsies is to produce a full and accurate picture of the deceased individual with a view to understand why these individuals complete the act of suicide. A review conducted by Foster (2011) focused on life events proximal to adult suicide from at least 75 psychological autopsy studies worldwide. In regard to North America, in a psychological autopsy study of 134 suicides in St. Louis in the years 1956-1957, only four of those suicides were considered to not have a stressful life event prior to the completed suicide (Foster, 2011). Events such as loss of affectional relationships within one year occurred in 25% of suicides; 13% of the 25% occurred within six weeks of the stressful life event (Foster, 2011). Foster (2011) found in North America over 27% of the suicides had suffered loss of a family member within one year. The San Diego Suicide study conducted by Young and Flower (1986) found that 93% of 283 suicides during the years 1981-1983 experienced at least one stressful life event (Foster, 2011). Other stressful life events that occurred in North American suicides reported by Foster (2011) included economic problems, which are more likely in males than females (49%). Younger individuals who committed suicide experienced more interpersonal loss or conflict within one year (32%). Lastly, Duberstein and colleagues (2004) conducted a psychological autopsy study in New York during the years 1996-2001 and found that family discord and employment change increased suicide risk after adjusting for other mitigating variables that occurred within a year of the suicide.

The supporting literature has shown that nearly all adults who commit suicide have experienced at least one or more stressful life event within one year of the suicide. The above

research indicates that interpersonal conflict poses the greatest risk followed by unemployment, financial problems, criminal/legal conflicts, and physically illness (Foster, 2011).

Psychiatric risk factors. Presence of a psychiatric disorder according to Kessler and colleagues (1999) is a consistently reported risk factor for suicidal behavior. A psychological autopsy conducted by Cavanagh and colleagues (2003) examined all articles that used a psychological autopsy to examine risk factors for successful suicides. This systematic review concluded that 90 to 95% of individuals across a wide range of age groups who completed suicide had a diagnosable psychiatric disorder at the time of the suicide (Cavanagh et al., 2003).

Personality disorders such as borderline personality disorder have been recognized risk factors for suicidal behaviors (Yen et al.,2003). Numerous studies have looked at risk factors for completed suicides among high-risk populations such as individuals with psychiatric disorders. McGlashan (1986) examined individuals with borderline personality disorder and monitored them for 15 years. McGlashan (1986) found higher rates of suicide among these individuals with co-occurring major depression. However, one 15-year follow up study failed to find any difference in prevalence rates of mood disorders between borderline personality disorder who committed suicide and non-suicidal borderline personality disorder individuals (Paris, Nowlis, & Brown, 1989). On the contrary, studies have found that individuals with co-occurring major depressive disorder and borderline personality disorder are more likely to have a history of suicide attempts than those with major depressive disorder only or co-occurring with a different personality disorder (Kelly et al., 2000). Yen and colleagues (2003) examined longitudinal data in which suicidal behaviors, Axis I symptomology, and personality disorder features were assessed at certain follow-up intervals. Axis I disorders are all clinical disorders except personality disorders, which are labeled under Axis II (APA,2000). In regard to Axis I

symptomology, participants were eligible to participate if they met diagnostic criteria as assessed by the Diagnostic Interview for DSM-IV personality disorders and Axis I disorders (APA, 2000) (Yen et al., 2003). Yen and colleagues' (2003) main goal was to examine whether the diagnoses of individuals are frequently associated with suicidal behavior. Moreover, Yen and colleagues (2003) investigated if there was an increase in the risk for suicide attempts with disorders that were exacerbated. The researchers collected their data from the Collaborative Longitudinal Personality Disorder Study, which is a prospective study of four personality disorders (schizotypal, borderline, avoidant, obsessive-compulsive, and comparison group of major depressive disorder without personality disorder). The sample for the Yen and colleagues' (2003) study included 668 participants who were interviewed at six months, one year, and two years following the baseline assessments. Results of this study concluded that of the confirmed 621 participants who had at least one year of follow-up data, 15.5% reported suicidal behavior (Yen et al., 2003). Of those individuals, 9.3% reported behaviors that met criteria for a suicide attempt. Forty percent of the sample had more than one of the four study personality disorders, and 31% of the sample were diagnosed with more than one disorder (Yen et al., 2003). Of the 15.5% that reported suicidal behavior, 10.3% has schizotypal personality disorder, 77.6% has borderline personality disorder, 53.4% has avoidant personality disorder, and 24.1% has obsessive-compulsive personality disorder (Yen et al., 2003). Furthermore, 48.3% of the 621 participants has major depressive disorder, 19% has alcohol dependence/abuse, and 29.3% has drug dependence/abuse (Yen et al., 2003). According to Yen and colleagues (2003), 20.5% of the individuals who had borderline personality disorder had made a suicide attempt during the two-year interval. Yen and colleagues (2003) also found that 10.2% of individuals with avoidant personality disorder, 6.5% of individuals with schizotypal personality disorder, 5.6% of

individuals with obsessive-compulsive personality disorder attempted suicide during the follow-up interval. Lastly, the results yielded that risk ratios indicating worsening of symptoms of major depressive disorder, alcohol use, and drug use were significant predictors of suicide attempts (Yen et al., 2003). Overall, Yen and colleagues' (2003) study concluded that baseline diagnoses of borderline personality disorder were predictive of suicide attempts during the follow-up intervals and worsening of depression and substance use was predictive of suicide attempts.

Along with mood disorders, suicide is associated with substance use disorders, in particular alcohol use disorders (Bertolote & Fleischmann, 2002). Cohort studies have shown strong association between substance use disorders and suicide (Wilcox, Conner, & Caine, 2004). An article written by Schneider (2009) gave an overview of cohort studies and psychological autopsy studies regarding substance use disorders and suicide. Schneider's (2009) search concluded that in general, women have lower rates of substance consumption than men and about one third of all male and about 15% of all female suicides had substance use disorders. Suicide rates with substance use disorders were higher in younger individuals than in elderly individuals (Schneider, 2009). Within Schneider's (2009) review, Bukstein and colleagues (1993) found that risk factors for suicide among adolescent substance abusers included major depression, current substance use, alcohol abuse, family history of substance use, affective disorder, and conflicts with the law. In regard to alcohol dependence, lifetime suicide risk is 8% and remains elevated throughout the disorder unlike some other psychiatric disorders (Inskip, Harris, & Barraclough, 1998). According to Inskip and colleagues (1998), the lifetime suicide risk for schizophrenia is 6% while mood disorders are at 4%.

Harris and Barraclough (1997) conducted a meta-analysis with a follow-up at 30 years, which included a population of 45,000 people in 32 studies and in 11 countries. Harris and

Barraclough (1997) found a six-fold increase for suicide risk in alcohol abuse and dependence compared to the general population. In regard to alcoholism and suicide, the risk factors for this disorder are limited in terms of research. Schneider and colleagues (2006) identified risk factors for suicide in alcoholism as recent heavy drinking, talk/threat of suicide, being unemployed, living alone, little social support, interpersonal life events, major depressive disorder, and substance dependence. Lastly, the overview of cohort studies conducted by Schneider (2009) concluded that 89% of all suicides with alcohol dependence had co-morbidity with other Axis I disorders, such as major depression.

Clarke, Davies, Hollin and Duggan (2011) examined the rate of completed suicide within a forensic psychiatric facility in England. Clarke and colleagues (2011) obtained death certificates of all patients who had died in the facility since it opened in July 1983. Out of a total of 595 patients, as of the June 2003 census, 18 patients (3.0%) had committed suicide (Clarke et al., 2011). In contrast, there were deaths that were categorized as "open" verdicts or instances where the coroner was unable to classify the cause of death (Clarke et al., 2011, p. 20). When Clarke and colleagues (2011) added these open deaths, the number of suicides rose to 26 or 4.4%.

Biological risk factors. Literature has indicated that there is a possibility of heritable risk of suicidal behavior. A variety of studies provide significant evidence for the risk that family history of suicide conveys for future suicidal behavior (Joiner, Brown, & Wingate, 2005). Initial studies attempting to clarify if there was a genetic contribution to suicidal behavior were conducted with twin samples. Roy (1992) reviewed four early twin studies and found that 13.2% of the monozygotic (identical) twin pairs were concordant for death by suicide as compared to only 0.7% for the dizygotic (fraternal) twin pairs.

Further evidence of genetics in suicide has been conducted through family studies. An early study conducted by Egeland and Sussex (1985) examined Old Order Amish over a 100-year span. During this 100-year span, 26 people died by suicide and the majority of these individuals came from four families (Egeland & Sussex, 1985). These four families had a high genetic risk for affective disorders such as depression and bipolar disorder; other families had the same risk level for affective disorders but no suicides (Egeland & Sussex, 1985). Thus, evidence shows that an independent genetic component to suicide does exist.

There has been a great deal of research in regard to genes and suicidality. The serotonin transporter gene has received substantial attention. The serotonin transporter (5-HTT), which maintains control over the availability of serotonin in the "synaptic cleft," has two alleles: long alleles and short alleles (Joiner, Brown, & Wingate, 2005, p. 290). A synaptic cleft is the area between two neurons at a synapse (Joiner, Brown, & Wingate, 2005). Synapses are junctions between neurons in which information is passed by neurotransmitters (Joiner, Brown, & Wingate, 2005). A study that followed 103 suicide attempts over the course of a year found that the short allele increased the risk for subsequent suicide attempt and that the frequency of the short genotype rose as the number of suicide attempts increased (Courtet et al., 2004). In research, the short allele is known as the risk allele because this allele is associated with psychological sensitivity to stress (Glenn, 2011). Another study looking at short alleles found that short alleles were more common among individuals who committed suicide than among non-suicide individuals (Mann et al., 2000).

The most common gene that has been studied in relation to suicidal behavior is the tryptophan hydroxylase or TPH gene (Joiner, Brown, & Wingate, 2005). This gene is the rate-limiting enzyme in the synthesis of serotonin (Joiner, Brown, & Wingate, 2005). Two

polymorphisms in particular have been studied in regard to this gene (A218C and A779C) (Joiner, Brown, & Wingate, 2005). Rujescu and colleagues (2003) conducted a meta-analysis of the relationship between the A218C polymorphism and suicidal behavior and found that the presence of this allele was significantly related to increased risk for suicide.

Lastly, the hypothalamic-pituitary-adrenal (HPA) axis may also be a risk factor in suicidal behavior (Joiner, Brown, & Wingate, 2005). A way to measure HPA activity is to administer the dexamethasone suppression test (DST) (Joiner, Brown, & Wingate, 2005). The DST is utilized to assess adrenal gland function by measuring how cortisol levels change in response to an injection of dexamethasone, which is a type of corticosteroid medication (Longo et al., 2012). A meta-analysis yielded that non-suppression of cortisol in response to the DST can be predictive of later death by suicide (Lester, 1992).

Mann (2003) reviewed the neurobiological literature on suicidal behavior and found evidence that supports the twin studies noted earlier and familial transmission of suicidal behavior indicating that biological factors such as genes do play a role in suicidal behavior. Mann (2003) also reported that biological parents of individuals who have completed suicide have higher rates of suicidal behavior. Lastly, Mann (2003) stated that heritability of suicide and suicide attempts can be compared to the heritability of other psychiatric disorders, such as bipolar and schizophrenia.

Personality risk factors. Research has shown that impulsivity and aggression are linked to suicide attempts with regard to stress being a trigger for the individual to act (Brodsky et al., 2001). Impulsivity can be defined as a trait that influences the individual to engage in self-destructive behavior in response to suicidal thoughts (Brodsky et al., 2001). According to Brodsky and colleagues (2001), the term impulsivity has been used in regard to a variety of

loosely defined constructs such as a personality trait, a tendency to act quickly on urges, and a class of psychiatric disorders characterized by "behavioral dyscontrol" (p. 1871). Herpetz and Favazza (1997) found that measures of trait impulsivity were higher in individuals with a history of self-harm than those individuals without such history.

Conner and colleagues (2003) explained no matter how a researcher defines aggression, aggression presents as a risk for suicidal behavior. According to Joiner, Brown, and Wingate (2005), reactive aggression, which is defined as propensity to reflexive anger due to aversive events, particularly interpersonal threats, has been proposed as a "diathesis for suicide risk" (p. 303). Overall, personality traits such as impulsivity and aggression have been shown by the research stated above to be risk factors for completed suicides and suicide attempts.

Suicide by Cop

Suicide by cop (SbC) has become a common event in the law enforcement community, yet the literature is sparse and lacks empirical rigor (McKenzie, 2006). The majority of literature regarding this topic is just a brief overview and leaves a great deal of open ended questions.

History

This phenomenon has been described in news accounts since 1981 (Van Zandt, 1993). The following is a true account of the first coined SbC incident (Van Zandt, 1993):

> At 11:30 AM, June 17, 1981, 38-year old William Griffin walked down the stairs leading from his second-floor bedroom in his parents' Rochester, New York residence to their living room. Without a word of warning, he shot and killed his mother and the blasts from the shotgun, critically wounded his stepfather. He then walked two blocks to a neighborhood bank where he took nine bank employees hostage. A three-and-a-half-hour standoff with police and Federal Bureau of Investigations (FBI) agents took place.

> During which he shot and wounded the first two police officers who responded to the bank and shot six different citizens who happened to be walking near the bank. He made demands to the teller stating, "If they do not come into the bank and execute me in one-half hour (3:00 PM), I will start throwing out bodies." At exactly 3:00 PM, Griffin fired his shotgun, killing the bank teller. Griffin turned and walked across the bank and stood in front of the large window, where he knew police snipers had occupied the second floor of a church. The sniper given the proverbial green light to shoot this man shot Griffin, he fell to the floor, dead (p. 2).

When police officers and FBI agents searched Griffin's room, they found a diary, which revealed an insightful entry dated 13 months prior (Van Zandt, 1993). This diary entry consisted of a rambling account, which suggested to FBI agents that Griffin had a history of psychosis (Van Zandt, 1993). In this entry he indicated his plan of entering the bank and demanding law enforcement to take his life for not "allowing me the position of liberty here in the dominion of earth" (p. 3). Griffin did everything necessary to ensure that law enforcement would, in fact, take his own life and to ensure that his plan was successful (Van Zandt, 1993). Van Zandt (1993) stated that this was not a conventional crime; it was not a robbery that had gone bad, but the pre-mediated, carefully planned suicide of a man who wanted to be killed by law enforcement. According to Van Zandt (1993), this was one of the first clear examples of a "form of manipulative behavior known as victim precipitated homicide, or Suicide by Cop" (p. 4).

Too often an individual who is armed with a weapon has challenged law enforcement in such a manner to prompt a violent, self-defense action by these law enforcement officers (Van Zandt, 1993). Law enforcement, frustrated after being forced to shoot these individuals, question whether the individual intended to be shot or why they were made to kill (Van Zandt, 1993). Van

Zandt (1993) posed the question: "But why are police often forced to participate in such incidents?" (p. 9). Van Zandt's (1993) response was that law enforcement looks past the SbC incident, they have guns, they have the training to react to a theoretically life-threatening situation with lethal force, and they are readily available.

Some of the first research on the topic of SbC was conducted by Parent (1996), who was a sergeant of the Delta Police Department, which is located in British Columbia. Parent (1996) investigated the rate of SbC in officer involved shootings. Parent's (1996) research will be discussed in subsections below.

Suicide by Cop Defined

Current definitions for SbC are perplex and unclear. Police officer and psychologist Karl Harris reportedly began the conversation about the term SbC in 1983, even though the first real incident of SbC occured in 1981. Prior to the use of the term SbC, these incidents were described as officer-assisted suicide (Homant, Kennedy, & Hupp, 2000), law enforcement-assisted suicide (Lord, 2000), and suicide by victim-precipitated homicide (Hillbrand, 2001).

According to Geberth (1993), SbC can be defined as incidents in which individuals "bent on self-destruction" engage in life-threatening and criminal behavior in order to force the police to kill them (p. 105). Parent (1996) defined SbC by stating that killings in which the victim is a direct, positive precipitator of the incident can be considered an act of suicide. Additionally, Parent (1996) stated that incidents where the individual contributes in a premeditated life-threatening criminal incident in forcing a law enforcement officer or another individual to kill him or herself can be classified as SbC. Lord (2004) defined this concept as individuals, when confronted by law enforcement either verbalizing their desire to be killed and/or making gestures at law enforcement, for example pointing weapons and taking hostages, to portray their desire to

be killed. These definitions lack clarity, and some definitions assume the end result is the individual being dead, while other definitions do not make it clear what the end result of these incidents is. However, there is a consensus across definitions that the suicidal individual plays a direct and conscious role in these incidents (Sarno & Hasselt, 2014).

Prevalence

The exact prevalence of SbC cannot be accurately reported due to variability in the definitions. However, estimations of this incident have been suggested. Van Zandt (1993) indicated that FBI statistics show during the years 1981 through 1991, there was a total of 3,776,105 reported assaults on law enforcement officers. Furthermore, Van Zandt (1993) reported that during a larger period from 1979 through 1991, 1,044 law enforcement officers were killed by an estimated number of 1,434 identifiable perpetrators. Of those identifiable perpetrators, 162 were justifiably killed by law enforcement officers and 60 of those perpetrators committed suicide by their own hands (Van Zandt, 1993).

Hutson and colleagues (1998) examined officer-involved shootings in Los Angeles County from 1987 to 1997. Hutson and colleagues (1998) found that SbC accounted for 46 (11%) of the 437 officer-involved shootings and 25 (13%) of the 200-officer involved justifiable homicides. As discussed in the background of the problem, the medical examiner or the coroner often labels incidents of SbC as officer involved justifiable homicides. These results indicate that approximately 4.2% of cases are SbC or attempted SbC and take place in Los Angeles County annually (Hutson et al., 1998). On the other hand, Miller (2006) stated that roughly 10% of the estimated 600 police shootings that occur every year in the United States are provoked SbC incidents. Miller (2006) further stated that these occurrences frequently ensue in the context of a law enforcement response to an armed robbery or a domestic disturbance call.

A more recent study about the prevalence of SbC was conducted by Mohandie and colleagues (2009); this study examined 707 cases from over 90 police departments in the United States between the years 1998 and 2006. A total of 256 (36%) of the 707 cases was categorized as attempted or completed SbC (Mohandie et al., 2009). The results of this study further support the theory that SbC occurs at a higher rate than expected among officer-involved shootings.

Cues Signs of Suicide by Cop

While the prediction and prevention of SbC are still being researched, Sarno and Hasselt (2014) stated that there are early warning signs of an individual who partakes in SbC. According to Sarno and Hasselt (2014) some early warning signs that an individual is planning SbC include making arrangements for their possessions, setting a deadline or timeline for their death, naming people who are dead and stating they will be with them soon, creating confrontation with police, stating an intent to die, and making biblical references. Sarno and Hasselt (2014) further discussed additional warning signs, such as refusing to negotiate with authorities or law enforcement, demanding to be killed, killing a significant other prior to the incident, indicating a plan for death, avoiding requests for escape or freedom, and providing a verbal will. Honig (2001) stated that awareness of SbC indicators may help efforts in predicting and preventing the acceleration of the individual's behavior to partake in SbC. Honig (2001) stated other warning signs such as dramatic mood swings and prior suicidal ideation are strong indicators of SbC.

According to Sarno and Hasselt (2014) warning signs can fall under two categories: verbal and behavioral. Verbal indicators include looking for a grandiose way out of the situation (e.g. going out in a big way such as appearing on national television), offering to surrender to the person in charge, and expressing feelings of hopelessness and helplessness. Furthermore, Kingshott (2009) stated that verbalizations could also be interpreted as overt challenges such as

threat to others (move away or hostage dies), giving up (there is no other way), explicit demands (I want my wife here now), or a countdown (I'm going to count to three; then I will do it). Kingshott (2009) stated these verbalizations should be taken into consideration as reflections of suicidal motivation. Other verbalizations that should be taken into consideration are religious references (My pastor and I have an understanding; The final judgment will be in heaven; I am right with God) or a verbal will and/or final plans (Tell my son I am sorry for everything; the keys to my safety deposit box are in the dresser; tell everyone I just tried to do right in this world) (Miller, 2006).

According to Miller (2006), an individual may indicate his or her desire to die by the hands of law enforcement without saying anything. The individual may phone in to 911 to report the crime he or she committed to make sure law enforcement will be present at the scene (Miller, 2006). According to Sarno and Hasselt (2014) behavioral indicators include uncoordinated movements, finger pointing to accentuate statements, head banging, and pacing. These behavioral indicators are important in also mirroring the individual's current mental status, especially abrupt behavioral changes, as well as signs of emotional distress (Sarno & Hasselt, 2014). Pointing a weapon, shooting at law enforcement, reaching for a weapon when law enforcement officers are on scene, and advancing towards the law enforcement officers are also behavioral indicators according to Kingshott (2009). Kingshott (2009) described these behavioral indicators as actions carried out to confirm the law enforcement officer's awareness of lethality in the incident in hopes of forcing law enforcement to use deadly force. However, Kingshott (2009) does mention that law enforcement officers should never assume logical explanations for these behaviors when involved in these incidents because there may not be any logical

explanations. Behaviors of SbC are often unpredictable and irrational; the indicators should be looked at as guidelines to improve detection of possible SbC (Kingshott, 2009).

Miller (2006) also discussed contextual cues to take into consideration. Miller (2006) stated that law enforcement should work to obtain any available information about the individual such as demographics, situational information, historical details about this individual that may be useful for law enforcement to use in assessing risk.

Factors of Suicide by Cop

A study by Dewey and colleagues (2013) examined if clinical classification schemes from general suicide cases are applicable to SbC cases and questioned whether there were indicators as to why law enforcement may be engaged in the suicide attempt. The study conducted by Dewey and colleagues (2013) is the first known attempt to statistically classify cases of SbC using clinical information. Dewey and colleagues (2013) used data from 85 closed state and local cases of officer involved shootings in the United States. The data that were used were compiled by law enforcement agencies and included incidents of SbC that took place between the years 1979 and 2005 (Dewey et al., 2013). The data expanded over 55 jurisdictions and 26 states in the United States (Dewey et al., 2013). These files contained police reports, photographs, audio/video tapes, autopsy reports with toxicology information, 911 call transcripts, suicide notes, mental health notes, and statements from collateral sources (family, friends, and witnesses) (Dewey et al., 2013). Of the 85 cases, the researchers labeled 58 cases as SbC and 10 as attempted SbC; they excluded 17 due to lack of evidence of suicidal intent or missing too much information across several categories.

Potential cases of SbC were determined by a multidisciplinary team consisting of two employees of the FBI (one agent, one clinical psychologist), a clinical forensic psychologist, and

three trained clinical forensic graduate students (Dewey et al., 2013). This study included 19 clinical and psychosocial variables based on previous research; of those 19 variables, four describe demographic information and outcome (attempted or completed SbC), 13 are binary variables that characterize the individual's clinical risk factors (e.g. prior suicidal ideation, previous suicide attempts, history of depression, substance use, previous arrests, history of domestic violence) and two are descriptive variables (psychiatric diagnosis and criminal history) (Dewey et al, 2013). The results of this study are broken down into the appropriate subsections of the individual of SbC.

Demographic Characteristics. Referring back to the results of Dewey and colleagues' (2013) study there were 62 males and six females in the sample, and the majority was identified as Caucasian (64.7%). In another study that looked at SbC samples, the individuals were identified as older, single Caucasian males (Lord & Sloop, 2010). In Lord and Sloop's (2010) sample, 91.5% were males and only 8.5% were females in regard to SbC cases. Research from the CDC shows that women are three times more likely to attempt suicide, however men are more likely to complete suicide (CDC, 2010). In regard to SbC incidents, males both attempt and are successful at completing SbC at higher rates than females (Hutson et al.,1998). Furthermore, the results of Dewey and colleagues (2013) indicated that the individuals ranged in age from 15 years old to 84 years old with an average age of 35. Meanwhile, Lord and Sloop (2010) reported in their study that 47.7% of the SbC cases they examined fell in the age range of 25 years old to 39 years old.

Suicidal Intent. Something to consider within the definition of SbC is the intent of the individual (Lord & Sloop, 2010). Hutson and colleagues (1998) expanded the definition of SbC to incorporate more apparent details, but also put an emphasis on the individual's intent:

> "…intentionally engage in life threatening and criminal behavior with a lethal weapon or what appears to be a lethal weapon to gain attention of law enforcement officers…These suicidal individuals then intentionally escalate the potential for a lethal encounter by threatening officers or members of the civilian population. This forces officers to use deadly force by shooting the suicidal individual… "(p. 666).

SbC intent can be portrayed as situations where either by word, gestures, or confrontation with the police and with a weapon despite having no way to flee, an individual forces the officer to shoot (Kennedy, Homant, & Hupp, 1998). Furthermore, the gestures that shed light on the intent can be things such as pointing the weapon at the law enforcement officers, hostages, or civilians, running at or towards the law enforcement officers with the weapon directed at them, or throwing weapons or objects at law enforcement officers (Lord, 2000).

As mentioned, intent plays a vital role in defining the suicidal feature of SbC, however it is complex and needs to be fragmented into its own concepts and categories. Best, Quigley, and Bailey (2004) described the chains of behavior, which is a set of nine observable risk factors for suicide. These chains of behaviors can be broken down into four categories to aide in assessing the intention of suicide in regard to SbC (Best et al., 2004). The first category explained by Best and colleagues (2004) is primary evidence of suicidal intent (verbal or nonverbal communication) to be killed by law enforcement officers. The second category is secondary indicators of suicidal intent, which includes previous attempts and/or use of unloaded or a fake weapon (Best et al., 2004). The third category is state-based indicators of irrationality such as intoxication, mental illness, or domestic dispute-related occurrences (Best et al., 2004). Lastly, the fourth category is minimal evidence of suicidal ideations such as refusal to give up the weapon or if the individual has a history with law enforcement officers (Best et al., 2004).

Lord and Sloop (2010) replicated Best and colleagues' (2004) nine observable risk factors and four categories for suicidal intentions of SbC with a few modifications. The categories remained the same as in the Lord and Sloop (2010) study, however the factors within those categories were expanded. For example, Lord and Sloop (2010) expanded on verbal and nonverbal communication in regard to category one of primary evidence of suicidal intent. Lord and Sloop (2010) stated that their primary indicators of intent involve explicit communication of suicidal intention during or before the incident, showed intent that was described as criminal behavior with a lethal weapon, and required that the individual purposefully engaged in contact with law enforcement either by telephone or through use of an outrageous act. In regard to the second category of secondary indicators, Lord and Sloop (2010) added "the individual is confronted by officers immediately after committing an offense, or the subject is served a warrant. The individual threatens the officers with a weapon or threat of a weapon stating he (she) would rather die than go back to jail" (p. 891). The last two categories in the Lord and Sloop (2010) study remained the same as Best and colleagues (2004) described them. Lord and Sloop's (2010) reasoning for altering the original factors was due to previous research studies on SbC, which indicated that these should be factors to consider in intent of SbC.

To determine in the study if the individual who participated in SbC had high suicidal intent, Lord and Sloop (2010) stated that if one or more of the primary indicators were present, then the intent was highly likely. If one or more of the secondary indicators along with a primary indicator were present, this increased the likelihood of intent (Lord & Sloop, 2010). Furthermore, the presence of one or more of the indicators of irrational thought without the co-occurrence of primary indicators would be moderate or questionable intent (Lord & Sloop, 2010). Lastly, intent

would be insignificant if that individual only had minimal evidence of suicidal intentions (Lord & Sloop, 2010).

The goal of Lord and Sloop's (2010) study was to examine if there was a significant difference between self-inflicted suicides, suicide attempts, and SbC subjects based on the indicators proposed by Best and colleagues (2004). Lord and Sloop (2010) compared cases classified as self-inflicted suicide or suicide attempts with classifications of SbC in the Hostage Barricade Data System (HOBAS). Lord and Sloop (2010) focused on the individual's intent and the series of events involved in the situation. In regard to the sample size, there were 356 cases that were identified; of those cases, 18 or 7.1% were classified as SbC (Lord & Sloop, 2010). The findings of the main research question did not yield any significant results. However overtly the individuals communicated, showed, and/or planned their intentions to provoke law enforcement officers to kill them, the more likely the case was labeled as a SbC (Lord & Sloop, 2010). McKenzie (2006) argued that a few individuals or cases that are classified as SbC may not have intended to provoke law enforcement officers to kill them, but instead were in a state of confusion and an irrational thought process. However, the results of the Lord and Sloop (2010) study found that self-inflicted suicides did not significantly differ from SbC in regard to irrational thinking, which conflicts with what McKenzie (2006) argued. Due to the results not showing an increase in intent between SbC and self-inflicted suicides, future research needs to distinguish these factors to have a better understanding of factors that are involved in SbC.

Suicide Attempt. While the clinical risk factors of an individual who decides to participate in SbC are unclear, research has narrowed down some potential clinical subtypes of these individuals. The first clinical factor that research has shown to be an indicator of SbC is a previous suicide attempt. Mohandie and colleagues (2009), as stated earlier, looked at officer

involved shootings and the prevalence of SbC. Within this study of the 256 individuals who committed SbC, 55% gave verbal indication of suicide, and 38% specifically referenced the method of SbC (Mohandie et al., 2009). Additionally, the results of Dewey and colleagues' (2013) study, indicated that 66.2% of the individuals in the SbC cases had suicidal ideation and 23.5% had at least one previous suicide attempt. Lastly, Lord and Sloop (2010) found in their study of SbC that SbC individuals were more likely to have attempted suicides multiple times compared to self-inflicted suicides.

Mental Illness Factors. An additional clinical risk factor is the presence of a mental illness. According to Mohandie and colleagues (2009), 40-63% of individuals in SbC incidents met criteria for at least one mental illness. The most common diagnoses for SbC individuals are bipolar disorder, depression, and schizophrenia according to Mohandie and colleagues (2009). However, Bresler, Scalora, Ebogen and Moore (2003) also stated that a traumatic brain injury has been reported to be linked to a few SbC incidents and increases the likelihood of a mental illness. Additionally, Mohandie and colleagues (2009) found in their study that 29% of those who committed SbC were prescribed psychotropic medications, 21% were under the care of a mental health professional, and 21% had a prior psychiatric hospitalization at the time of the SbC. In Dewey and colleagues' (2013) study, the results yielded that 16.2% of the individuals had previous psychiatric hospitalizations. Moreover, there is a superior link between suicidal intent and lethality with diminished decision making that is prevalent in various psychiatric disorders (Jollant et al., 2005). These disorders involve the orbitofrontal cortex or serotonergic dysfunctions such as substance abuse and affective disorders (Jollant et al., 2005). Lastly, Lord and Sloop (2010) discovered in their sample of SbC cases, that 25.5% of the individuals had

been previously committed to a psychiatric hospital, while 21.3% were either in counseling for a mental illness or have had prior counseling due to their mental illness.

Furthermore, Dewey and colleagues (2013) broke down SbC into three classifications. The first being mental illness, which included five mental health related risks. This classification accounted for 25.93% of variance in their study, indicating that almost all of the cases in this classification (sample size of 25) had a history of depression, were diagnosed with a mental illness, experienced prior suicidal ideation, or were prescribed psychiatric medication.

Criminal Factors. Miller (2006) stated that individuals who partake in SbC, usually have prior contact with law enforcement but for minor offenses or misdemeanors. Miller (2006) further stated even though the contact with law enforcement may be minimal prior to the SbC incident, it may give the individual awareness of how law enforcement functions in regard to their responses to critical incidents.

As noted earlier, Dewey and colleagues (2013) developed classifications of SbC. The second classification was criminality, which consisted of four criminal risk variables. These four-criminal risk variables accounted for 19.8% of variance in the study (Dewey et al., 2013). The four risk variables included facing incarceration, previous arrests, criminal activity as a precipitating factor in the SbC incident, and substance use at the time of the SbC incident (Dewey et al., 2013). Dewey and colleagues (2013) found that 38.2% of the individuals were facing potential incarceration for a crime (prior crime or the crime that initiated law enforcement's attention). The number of cases in this classification were 25, and all 25 cases had a history of arrests; 83.3% were facing jail time at the start of the incident, and 75% experienced recent legal stressors such as commission of a crime, questioned by police, or a warrant was issued (Dewey et al., 2013). In regard to the last variable of being under the influence, 87.5% of

the individuals in this classification were under the influence of some substance at the time of the SbC incident (Dewey et al., 2013).

Furthermore, Lord and Sloop (2010) found that of the individuals who participated in SbC in their study, 63.8% had a criminal history, and 47.7% committed a criminal act to engage law enforcement into a SbC incident. Based on the criminal classification that Dewey and colleagues (2013) created for SbC regarding intoxication at the time of the incident, Lord and Sloop (2010) indicated that 83.8% of the individuals were on drugs in their sample.

Life Factors. Another factor of why SbC might occur are certain factors in the individual's life. Per Miller (2006), the start of a SbC incident may be due to a conflict or estrangement in an important relationship in correlation with this individual's self-esteem or social support, such as a family crisis or job crisis. Other research has indicated that interpersonal loss and conflicts are common precipitators for an incident of SbC to occur (Foster, 2011; Pompili, Innamorati, Szanto et al., 2011). More than 70% of individuals who partake in SbC have experienced recent interpersonal problems, while the other 20-30% of these individuals have had a recent romantic falling out (Homant, Kennedy, & Hupp, 2000). According to Lord (2000) domestic violence was an event that could trigger a SbC incident. In the SbC incidents Lord (2000) examined, 31.3% of the incidents were triggered by a domestic disturbance compliant to law enforcement officers. Another life factor that was a precipitating factor in a SbC incident was involvement in legal situations. A study conducted by Cooper, Appleby, and Amos (2002) found that individuals who committed SbC were five times more likely to have experienced a recent forensic encounter, for example, being arrested, charged, or sentenced. Furthermore, other legal situations, such as divorce or child custody, have played a role as precipitating factors for SbC (Dewey et al., 2013).

Law Enforcement Response to Suicide by Cop Call

Although not really research, Miller (2006) provided literature on effective methods and guidelines for law enforcement officers to follow during a SbC incident. Miller (2006) indicated that mental health clinicians can play a vital role in developing response protocols, conducting training for these protocols, and providing on scene support during crises or active SbC incidents.

Assess the Situation. Even if the incident was not SbC, law enforcement should always assess the potential danger in a situation (Miller, 2006). Law enforcement should take every emergency call seriously, even if it is the same caller with the same emergency, because law enforcement does not know which call is going to be a serious crisis or a fatal one (Miller, 2006). Miller (2006) suggested that the first step in all crisis situations, but particularly SbC incidents, is to secure the scene and assess the threat to safety of the individual and any civilians in the surrounding area. Next, law enforcement should make a great effort to obtain background information on the individual (Miller, 2006). Miller (2006) stated if the individual is known in the community and has frequent contact with law enforcement, sending in an officer who is familiar and trusted to the individual is an asset and should be utilized in this situation.

Evaluate Suicide Risk. If it is not noticeable right away that this is a SbC incident, the general risk of suicide should be evaluated in terms of three essential factors according to Miller (2006). The first factor is suicidal intent, which can be either remote, such as general statements of "Times like these, you get to feeling life just ain't worth living," or immediate such as "I cannot take another minute of this-I am checking out" (Miller, 2006, p. 169). The second factor is a suicidal plan, which can be vague or specific (Miller, 2006). An example of a vague plan would be the individual stating he or she thinks there is medication at home that he or she can

use or stating maybe he or she will just turn on the car exhaust in their garage. While a specific plan would be, "I am going to put this gun to my head and shoot." The third factor Miller (2006) stated to assess suicide is suicidal means. This factor should be evaluated in terms of availability (low or high). Low availability would be the individual indicating he or she knows someone who could get drugs to overdose, while high availability again goes back to an example of the individuals having the gun in hand ready to kill themselves. Additionally, the third factor should also be examined by level of lethality (low or high) (Miller, 2006). Low lethality, would be the weapon the individual has is a butter knife versus high lethality where the individual is a trained military personnel with a handgun. Miller (2006) makes a point to state that whether the apparent immediate threat level of these various contexts may seem low, law enforcement officers should never let their guard down because a low-risk situation can turn high-risk and deadly in an instant.

Establish Contact. The next guideline Miller (2006) provided that law enforcement officers should follow in regard to a SbC incident is to establish communication with the individual. Law enforcement should begin this communication as soon as they secure the scene; the officers should introduce themselves, their organization by name and title (Miller, 2006). Miller (2006) stated that establishing this rapport can help reduce the risk in regard to having a completed SbC incident. Miller (2006) discussed how some law enforcement officers may see SbC situations as less urgent due to majority of the time there being no hostages in these incidents. Therefore, the officers may feel it is waste of time to establish rapport and spend hours trying to talk down an individual who only wants to hurt him or herself (Miller, 2006). Thus, Miller (2006) suggested that law enforcement officers who are responding to this SbC call should remember that a life saved is a life saved, and that it can be just as rewarding to save a

man from himself as it is to talk down a hostage situation and keep him from harming innocent civilians. Secondly, Miller (2006) stated that there have been reports of officers letting their guard down due to a "useless" call and then it turns lethal and officers loses their life due to the other officers not taking the call seriously (p. 169). Lastly, Miller (2006) stated that that the same skills used in a hostage negotiation can be useful in a SbC call, therefore establishing that communication is vital no matter how low-risk the call may seem to law enforcement.

Determine the Problem. Sometimes in SbC calls, there is not a glaring problem, or a specific problem. The individual may be making statements that are vague as to why he or she is in this situation such as "politicians are all the same" (Miller, 2006, p. 169). This is why the step before this, establishing communication, is so vital. Being able to gather information and talk to the individual can lead the law enforcement officers to understanding what the main problem is in the SbC call.

Talking the Individual Down. Once the problem is determined, the law enforcement officers can use their crisis intervention skills plus their judgment and experience to bring the occurrence to a nonviolent resolution (Miller, 2006). Miller (2006) suggested seven strategies they may be used individually or combined in order to come to that nonviolent resolution. The first, and simplest strategy, is to provide the individual reassurance. Empathize with the individual and normalize his or her feelings; let that individual know that law enforcement is there to help (Miller, 2006). Second, comply with reasonable requests, inquire from the individual about immediate needs, offer the individual things to make him or her feel more comfortable, and therefore, more likely to comply with law enforcement demands (Miller, 2006). Third, offer alternative, realistic optimism such as providing resources for their problems instead of open ended promises (Miller, 2006). Fourth, avoid being baited. If an individual is set on

committing SbC, he or she may use the law enforcement officer's rapport-building process against him or her (Miller, 2006). As rapport builds between the officer and the individual, the officer may become more at ease and approach the individual, where the individual may then attack, leaving the officer no choice but to use lethal force; therefore, the individual accomplished the goal (Miller, 2006). Fifth, consider non-lethal containment; lethal force should be a last option for law enforcement officers. Sprays, gels, tasers, nets, and flash bang grenades should be utilized first before lethal force is utilized (Miller, 2006). Sixth, consider limited walk away containment; this involves a situation where there are no hostages, no imminent danger, and is a response that lessens the risk of the surround community (Miller, 2006). This approach is where the law enforcement officers on scene pull away, leaving a few officers surrounding nearby exits of the building or the area in which the individual is while still maintaining communication with the individual (Miller, 2006). This approach lets exhaustion do the work for the law enforcement officers; the individual will eventually get tired of the law enforcement officers not threatening the individual to use lethal force which may force the individual to surrender (Miller, 2006). Lastly, employ appropriate follow up; after a successful prevention of a SbC incident, spend a few minutes with that individual (Miller, 2006). Furthermore, applaud that individual for his or her courage to do the right thing and surrender, and follow through on any offers the law enforcement officers may have made during negotiation to build trust with the individual or future reference (Miller, 2006).

Summary and Transition

Existing research on both suicide and SbC focuses on the factors that may contribute to an individual's taking their own life or partaking in having law enforcement use lethal force to kill them. Debates surrounding this topic include correct meaning of SbC incidents, motivations

of these occurrences, who is more likely to engage in this act, surrounding triggers to these events, and the outcome of these incidents. Furthermore, there is a lack of research on how to deescalate SbC incidents, and there is also an absence of research on proper protocol for SbC incidents.

The findings of the literature on SbC are consistent with general suicide literature which was reviewed above and stated that some risk factors are overlapping. However, subtypes of SbC are still unclear, and there is minimal research on this topic There is only one study by Dewey and colleagues (2013) that examined the clinical subtype and other variables to gather a better overall picture of an individual who partakes in SbC, hence the reason for the current study.

Chapter 3: Research Design and Method

Chapter Overview

The purpose of this study was to gather in-depth perceptions of individuals who are professionals in the legal field, professionals in the law enforcement field, and professionals in the psychology field toward clinical subtypes of SbC in order to analyze the perceptions of what type(s) of individuals are more likely to engage in the act of SbC based on different factors: mental health, criminal, life factors, and situational factors. Therefore, this study was designed in an effort to provide a deeper understanding of how individuals in the professional field who may encounter perpetrators of SbC perceive them, while simultaneously offering a clinical subtype of these perpetrators. Moreover, it was the intention of this research to provide clinical information that can be used to proactively inform professionals in these fields to better recognize and prevent the event of SbC.

This chapter describes the methodology of the present study. First, the research questions and hypotheses are presented. Second, the research design of the current study and characteristics of the sample populations are described. Third, the study procedures are explained. Fourth, the validity of the study is presented. Fifth, instruments used in the current study and data processing are portrayed. Finally, the assumptions of the study and known limitations are presented.

Research Questions and Hypotheses

Research Question 1: Do various professionals (legal professionals, psychology practitioners, law enforcement) differently perceive the reasons for whom partakes in SbC based on race: Caucasian/ African American?

Research Question 2: Do various professionals (legal professionals, psychology practitioners, law enforcement) differently perceive the reasons for whom partakes in SbC based on gender: male/female?

Mohandie and colleagues (2009) found when examining SbC, most of these incidents are instigated by Caucasian males. However, understanding how professionals who may be involved in these incidents perceive the clinical subtype of the SbC perpetrator is imperative. Understanding the clinical subtype of who partakes in SbC can help aid in prevention strategies and earlier warning signs for SbC incidents. Therefore, this study focused on variables of race and gender.

Research Question 3: Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have a mental illness?

Research Question 4: Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have a criminal background?

Research Question 5: Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have life stressors?

Research Question 6: Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have threatened the law enforcement officers (i.e. situational factors)?

Research questions 3 through 6 are the primary focus of this investigation. Understanding the factors that are perceived to contribute to a perpetrator who involves him or herself in an incident of SbC will help professionals develop a clinical subtype.

Based on the extensive data and research reviewed above, this study proposes the following hypotheses:

Hypothesis 1: There is a significant difference between perpetrator's demographic characteristics (race/gender) and the profession of an evaluator upon the evaluator's perception of mental illness factors, life factors, criminal factors, and situational factors as leading towards committing SbC in a constructed scenario.

Hypothesis 2: There is a significant difference in the interplay of the race (Caucasian/ African American) and gender (Male/Female) towards a professional's perception of mental illness factors, life factors, criminal factors, and situational factors as leading towards committing SbC in a constructed scenario.

Hypothesis 3: There is a significant difference between various professionals (legal professionals, psychology practitioners, law enforcement) in their perception of mental illness factors, life factors, criminal factors, and situational factors as leading towards committing SbC in a constructed scenario.

Research Design

This study was conducted using a descriptive quantitative experimental independent measures design. This means this research design measured the participants' opinions to establish an association between the independent variables and the dependent variables by using multiple experimental groups. Each participant was only in one condition of the combined independent variables during the experiment. Recruitment was the only point of contact with

participants, via LinkedIn or Facebook. The study was hosted by Survey Monkey online survey platform and data was downloaded directly into Statistical Package for the Social Sciences (SPSSS) version 23 software.

For this study there were two independent variables with multiple levels; first, the demographic background of the perpetrator is broken down into race: Caucasian and African American and gender: male and female. Therefore, there were four possible perpetrators; Caucasian female, African American female, Caucasian male, and African American male. The second independent variable is profession, which has three levels, psychologist, legal, and law enforcement. Professionals considered for the psychology realm included licensed or non-licensed psychologists, LCSW, MFT, MFC, and other psychology professionals including graduate students. Professionals considered for the legal realm included attorneys, paralegals, other legal professionals including graduate students which could be law students or master's in legal studies. Lastly, law enforcement professionals included local, state, city, federal, and other law enforcement professionals. The professionals could be current professionals or past professionals in the field. There were four dependent variables, perception of mental illness factors, perception of life factors, perception of criminal factors, and perception of situational factors.

Population and Sample

The population for this research study consisted primarily of professionals and graduate students currently or previously in the field of psychology, legal, and law enforcement. Recruitment flyers were posted on Facebook and LinkedIn social networks (see Appendix A).

All potential participants were screened in order to have only professionals within the three professional domains the study was looking for. Specifically, all prospective participants

were asked "Are you 25 years of age or older?" "Are you currently or previously a professional in the field of psychology, the legal field, or law enforcement field?" and "Are you currently a graduate student in the field of psychology, the legal field, or law enforcement field?" If the potential participants met the criteria, they would be eligible to participate in the research study.

Procedures

After receiving approval from the Institutional Review Board (IRB), the online survey resource Survey Monkey was utilized to administer the study's surveys. First, participants received an informed consent containing information about procedures, benefits and risks of participating, a brief description of the purpose of the study, an explanation how to acquire the results of the research, availability of counseling services, voluntary participation, and contact information of the researchers (See Appendix B). Consent for this study was provided via electronic signature. Next, a demographic questionnaire was given to each participant which asked for age, gender, ethnicity, profession, years in the profession, level of education and two questions regarding whether they ever heard of SbC and whether they have ever been involved with a SbC incident (See Appendix C).

After completing the demographic questionnaire, the participants were randomly assigned to one of the four conditions, SbC perpetrator who is male/Caucasian, SbC perpetrator who is male/African American, SbC perpetrator who is female/Caucasian, or SbC perpetrator who is female/African American (See Appendix D). Each condition received the same vignette except the gender and race of the perpetrator was altered depending on which condition the participant was placed into.

Once the participants read the vignette provided to them, they were asked a series of questions regarding the perception of the dependent variables (mental illness factors, life factors,

criminal factors, and situational factors). These questions were derived from a checklist developed by Lindsay and Lester (2008) composed of criteria for SbC incidents. The questions were on a nine-point Likert scale, 9 being strongly agree and 1 being strongly disagree (See Appendix E).

At the end of the survey, participants were given the option to provide their e-mail address to enter into a contest to win one of the four $20 Amazon gift cards as a thank you for their research participation.

Validity

Internal, external, and quantitative validity were three types of threats to validity in this study. A power analysis was not performed to assess a sufficient sample size, which is a quantitative limitation to this study. The sample size may not have been sufficiently large enough to reveal statistically significant differences of interest. Threats of internal validity also existed such as experimental mortality, which is the loss of participants across groups. In the study, 13.8% of participants did not complete the study, which could have affected the results of the study.

There were indications of threats to external validity as well. The sample consisted primarily of individuals from specific professions (psychology, legal, and law enforcement), therefore the sample may not represent the whole population of these professional fields in the United States. Results of the study may not be entirely representative of how the general field of psychology, legal, and law enforcement professionals perceive SbC.

Data Processing

The tests were all conducted at the 95% confidence level (α=.05). SPSS version 23 was utilized to analyze the data. In order to analyze the hypotheses of this study, the following were

executed: A description of the study sample was computed, and descriptive statistics of the study variables were than calculated. Assumptions of the statistical tests used in this study were verified and statistical tests were executed. Finally, the hypotheses of the study were analyzed using the results of the statistical tests.

The research questions were addressed using a 4 x 3 multivariate analysis of variance (MANOVA) to determine if there was a significant difference between the perpetrators' demographics (gender and race) on the professional's perception of who commits SbC based on mental illness factors, life factors, criminal factors, and situational factors. Furthermore, it is necessary to determine if there was a significant difference between the various professionals' perceptions of the perpetrator who engaged in SbC. Specifically if this perpetrator had a mental illness, criminal background, situational factors such as threatening law enforcement officers, or life stressors.

Assumptions

There are several assumptions made about the participants in this study. It was assumed that those individuals who filled out the informed consent were willingly participating. Second, it was assumed that the participants answered honestly on the demographic questionnaire. Also, it was assumed that participants took the time to read the vignette and responded to the questionnaire honestly. Lastly, it is assumed that a MANOVA is the most appropriate method for the investigation of the multiple levels of independent variables of demographic background of the perpetrator and the perceptions of professionals on the dependent variables: mental illness, criminal factors, life factors, and situational factors.

Limitations

There were numerous limitations to this study. First, there was limited access to participants, who were representative of the professional populations this study was seeking, and it was also difficult to recruit a sample of suitable size. Secondly, it was challenging to control for the diverse range of participants' attitudes, which could lead to bias. Finally, the questionnaire utilized in the study is not validated through research, but the questions on the survey were derived from current research of indicators of SbC.

Ethical Assurances

The study presents minimal risk to participants and was approved by The Chicago School of Professional Psychology Institutional Review Board. Furthermore, the vignette and survey questions contained content that may make the participants experience slight discomfort due to reading a vignette about an individual committing SbC. All the participants in the study were considered voluntary, confidential, and anonymous.

The potential breach of confidentiality would be a risk to participants. The only record linking the participant to the research study is a participant number assigned by the survey resource at the beginning of the study, or an e-mail address given voluntarily by the participants after they completed the study for the purpose of being entered into the gift card giveaway. The e-mail addresses that participants voluntarily provided were stored digitally in a password protected file. After the four participants were selected for the gift card giveaway, all e-mail addresses were destroyed. There was no other identifying information collected or stored for this study. Furthermore, all of the e-mail addresses have been removed from the data set, therefore, no identifying information can be associated with survey responses. According to the Office for Human Research Protections (OHRP), research records must be retained for at least three years after the completion of the research (45 C.F.R. § 46, 2009). Therefore, to adhere to this

requirement, all data related to this study will be stored for at least three years in a password protected file.

Chapter 4: Results

Chapter Overview

The research of SbC primarily has focused on the clinical subtype of the individuals involved in this type of act. Moreover, current research on this topic has focused on risk factors for SbC. However, there is a lack of research in the reporting and perception of SbC in terms of the individuals who handle these occurrences such as law enforcement agencies. The purpose of the current study was to examine how professionals in law enforcement, legal professionals, and psychology professionals perceive SbC. Additionally, this research aimed to examine law enforcement professionals, legal professionals, and psychology professionals' perceptions of the clinical subtype of the perpetrators who partake in SbC. The current study focused on gender: male/female and race: African American and Caucasian and the clinical subtypes of mental illness, life factors, criminal factors, and situational factors from the participant's perspective.

Population and Demographics

For this study, there was a total of 94 participants, but only 81 were used, because 13 participants did not complete the survey. There were 57 (70%) female participants and 24 (20%) male participants (see Figure 1). There were 40 (49.4%) participants in the age range of 25-34, 13 (16%) in the age range of 35-44, 16 (19.8%) in the age range of 45-54, 10 (12.4%) in the age range 55-64, and two (2.5%) in the age range of 65 or above. In regard to ethnicity, 57 (70.4%) participants reported Caucasian, 14 (17.3%) participants reported Hispanic or Latino, 3 (3.7%) reported African American, one (1.2%) participant reported Asian/Pacific Islander, and six (7.4%) participants who reported their ethnicity as other.

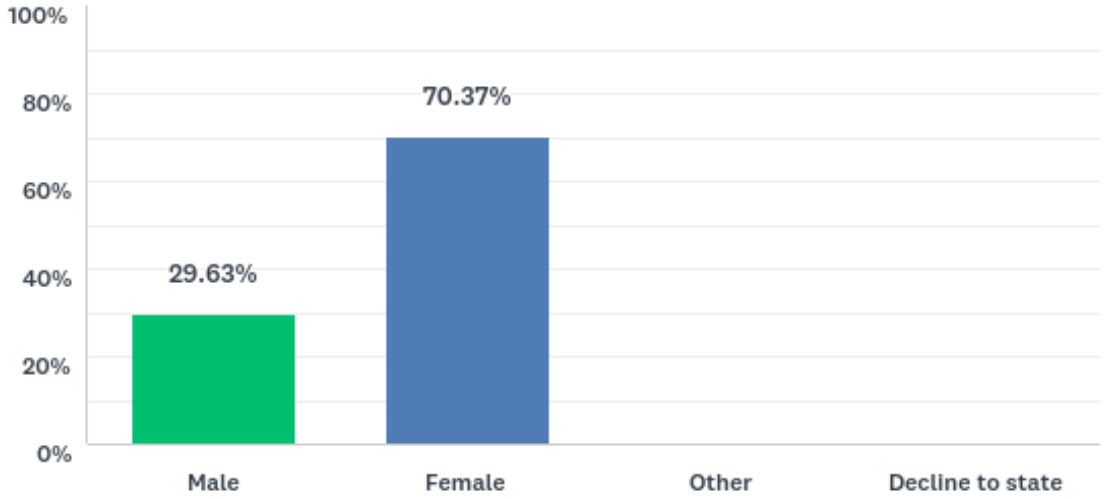

Figure 1. Descriptive Statistics Gender

In addition, when examining the participants' current profession, 22 (27.2%) participants reported they were in the psychology profession (licensed, non-licensed, LCSW, MFT, MFC, and other psychology professions), 26 (32.1%) participants reported they were in the legal profession (attorney or other legal professional), and 33 (40.7%) participants who reported they were in the law enforcement profession (local, state, city, federal, other law enforcement professional) (see Figure 2). From the participants who responded to the psychology profession, six (12.5%) reported they have worked with or for law enforcement, while 11 (22.9%) reported they have not worked with or for law enforcement. From the participants who responded to the legal profession, 19 (39.6%) reported they have worked with or for law enforcement while, 12 (25%) reported they have not worked with or for law enforcement.

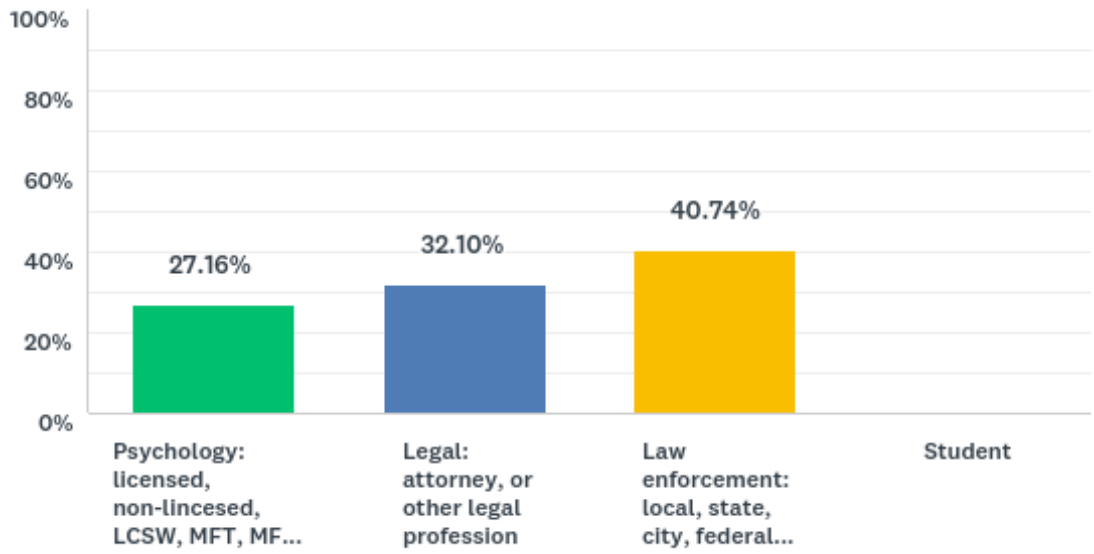

Figure 2. Descriptive Statistics Profession

Lastly, participants were asked if they have ever heard of the term SbC and then what their experience with SbC was. In regard to ever hearing about the term SbC, 67 (82.7%) participants reported yes, they have heard of this term, while, 14 (17.3%) participants reported they have not heard of this term. There were 34 (50.8%) participants who reported their experience with SbC was hearing about it on the news, 8 (11.9%) participants reported they have been involved in SbC, 20 (29.9%) participants reported they have received training on SbC, and 5 (7.5%) reported "other" and were asked to explain. In the explanations, two participants stated they heard about it in fictional television shows, one participant stated he or she was interested in true crime and has read articles about SbC. Another participant stated he or she learned about SbC in law school, and the last participant stated he or she has heard about SbC at work, and it seems that instances of SbC are on the rise (see Figure 3).

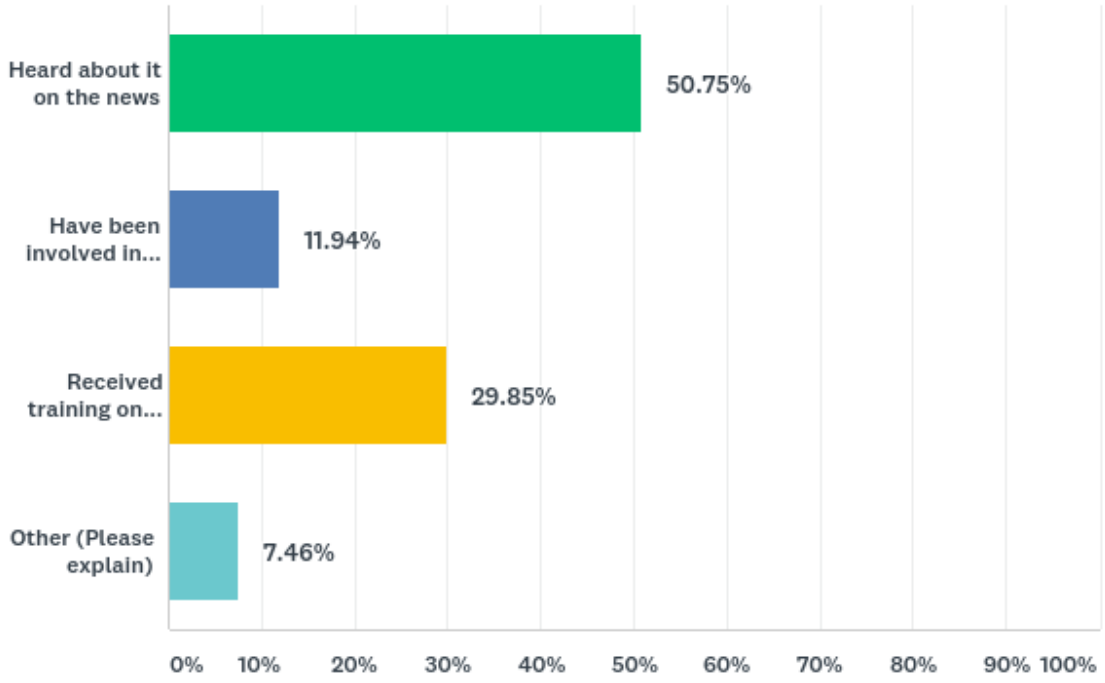

Figure 3. Descriptive Statistics Experience with SbC

Results

As mentioned, there were 94 participants, but only 81 participants were used for this study. Data were cleaned up to gather the necessary information needed for this study. The data were organized to reflect the participants who fully completed reading the vignette assigned to them and completing the SbC questionnaire. In addition, 13 participants were excluded from the study because they did not fully complete either the demographic questionnaire, or the SbC questionnaire.

Interaction Hypothesis

A multivariate analysis of variance (MANOVA) was conducted to determine if there was a significant difference between the perpetrators' demographic characteristics (gender and race) and the profession of an evaluator upon the evaluator's perception of mental illness factors, life factors, criminal factors, and situational factors as leading towards committing SbC in a

constructed scenario. According to Meyeres, Gamst, and Guaino (2006), a MANOVA must have the assumption of homogeneity of variances/ covariances. Therefore, prior to conducting the MANOVA, SPSS was utilized in order to test these assumptions.

Box's M test was utilized in order to test for homogeneity of variances/ covariances among the dependent variables. The results of the Box's M test indicated that variances and covariances for the dependent variables were heterogeneous as evidenced by a significant result ($p=0.013$, $p<.05$). As a result of this significant finding, Pillai's trace was employed as the MANOVA test statistic.

The results of the two-way MANOVA did not reveal a significant multivariate effect between the perpetrator's demographic characteristics (gender and race) and the profession (psychology practitioners, legal representatives, and law enforcement) of an evaluator upon the evaluator's perception of mental illness, life, factors, criminal factors, and situational factors, leading towards committing suicide by cop in a constructed scenario: Pillai's Trace= .388, $F(24,276) = 1.236$, $p>.05$.

Main Effect Demographic Characteristics Hypothesis

Research question 1 was "Do various professionals (legal professionals, psychology practitioners, law enforcement) differently perceive the reasons for whom partakes in SbC based on race (Caucasian/African American)"? Research question 2 was: "Do various professionals (legal professionals, psychology practitioners, law enforcement) differently perceive the reasons for whom partakes in SbC based on gender (male/female)"? The corresponding hypothesis was that there is a significant difference in the interplay between race (Caucasian/African American) and gender (male/female) and a professional's perception of mental illness factors, life factors, criminal factors, and situational factors that contribute to an individual committing SbC in a

constructed scenario. There was no main effect between the demographic characteristics (race and gender) towards the professional's perceptions as leading towards committing SbC in a constructed scenario, Pillai's Trace=.141, F (12, 204) = .837, p>.05.

Main Effect Profession

Research question 3 was "Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have a mental illness?" Research question 4 was "Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have a criminal background?" Research question 5 was "Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have life stressors?" Lastly, research question 6 was "Do various professionals (legal professionals, psychology practitioners, law enforcement) perceive the perpetrators who partake in SbC to have threatened the law enforcement officers (i.e. situational factors)?" The corresponding hypothesis was that there is a significant difference between various professionals (legal professionals, psychology practitioners, law enforcement) on their perception of mental illness factors, life factors, criminal factors, and situational factors as leading towards committing SbC in a constructed scenario. There was a significant main effect between professionals and their perception on factors leading towards committing SbC in a constructed scenario; Pillai's Trace=.453, F (8, 134) =4.912, p <0.001.

Based on the post-hoc analysis using Tukey HSD, there was a statistically significant difference between law enforcement professional's (M=8.18, SD=2.26) perception and psychology professional's (M=10.8, SD=2.95), p<0.001, perception of situational factors. Psychology professionals perceived situational factors to be a stronger indicator of a SbC

incident than law enforcement professionals. There was also a statistically significant difference between law enforcement professional's (M=8.18, SD=2.26) and legal professional's (M=10.73, SD=1.85), $p<0.001$, perception of situational factors. Legal professionals perceived situational factors to be a stronger indicator of a SbC incident than law enforcement. In contrast, there was no difference between psychology professional's perception of situational factors (M=10.8, SD=2.95) and legal professional's perception of situational factors (M=10.73, SD=1.85), $p=.892$. Furthermore, law enforcement professional's perception differed significantly on situational factors between the perpetrator's demographic characteristics (gender/race) than the perception of psychology professionals and legal professionals. For example, law enforcement perceived situational factors less of an indicator of SbC for Caucasian females (M=6.4, SD=1.27) while psychology professionals (M=12.25, SD=1.7) and legal professionals (M=9.6, SD=1.95) perceived situational factors for Caucasian females stronger in regard to an indicator of a SbC incident. Law enforcement also perceived situational factors less of an indicator of SbC for African American female's (M=8, SD=2.2) than legal professionals perceived African American female's (M=11.3, SD=1.11). Lastly, law enforcement perceived situational factors less of an indicator of SbC for African American male's (M=8.86, SD=1.86) compared to psychology professional's perceptions of situational factors for African American male's (M=12.7, SD=4.03). Professional's perception of situational factors based on race and gender are presented in Figure 4.

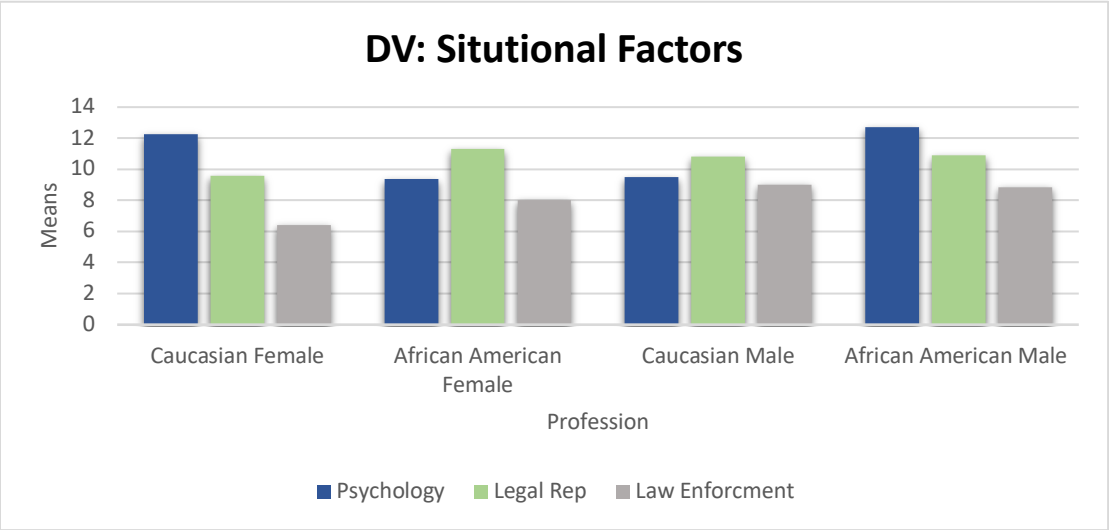

Figure 4. Independent variable means on situational factors by profession type.

Conclusion

The following chapter will provide further analysis and discussion about the implications of the research results with respect to both existing literature and the current research questions. Additionally, the final chapter will examine limitations of the study and opportunities for future research on the topic that would provide additional depth to the current body of knowledge on the subject of SbC and perception of clinical subtypes. Recommendations for practice and future research will also be discussed in Chapter 5.

Chapter 5: Findings, Conclusions and Implications

Introduction

Attempts at SbC in any scenario is a dangerous and an unstable situation for all individuals involved. Nevertheless, the situation, the SbC subject, or the environment surrounding the SbC incident, the scenario is potentially dangerous and can affect the lives of the individuals involved. Due to the lack of research and training involving incidents of SbC, it is critical to bring to light the true perceptions of clinician subtypes of individuals who commit SbC. This research was designed with the purpose of examining the perspectives of professionals (law enforcement, psychology, legal) and how they perceive individuals who would partake in SbC. Furthermore, the research investigated race and gender in regard to the perpetrator who is likely to engage in SbC and different factors such as mental illness, criminal, situational, and life factors. This research project was undertaken with the intent to gather more information on a clinical subtype of SbC to advance training, to improve detection of these incidents, and to improve de-escalation tactics of incidents of SbC. More specifically, the following questions were addressed in this study: Do various professionals differentially perceive the reasons of those who partake in SbC based on race? Do various professionals differentially perceive the reasons of those who partake in SbC based on gender? Do various professionals perceive that the perpetrators who partake in SbC have a mental illness? Do various professionals perceive that the perpetrators who partake in SbC have a criminal background? Do various professionals perceive that the perpetrators who partake in SbC have life stressors? Finally, do various professionals perceive that the perpetrators who partake in SbC have threatened the law enforcement officers (i.e. situational factors)?

Interpretation of Findings

Participants in this study read a vignette of an individual committing SbC. The vignettes differed in regard to the race of the individual partaking in the SbC incident and the gender of the individual. Therefore, there were four possible conditions for this study: male/Caucasian, male/African American, female/Caucasian and female/ African-American. The participants then took a survey that examined their perception of the SbC individual. The questions contained four domains: mental illness, life factors, criminal factors, and situational factors. There were several findings. First, the data revealed that there was no significant difference between demographic characteristics (gender and race) of the perpetrator who participated in the SbC incident. This indicates that the professionals (legal, psychology, law enforcement) in this study do not perceive one gender and/or race as to more likely to commit a SbC incident. The results of this data contradict the prior research regarding demographics of a perpetrator who commits SbC. The research states that Caucasian males are the majority of the perpetrators who commit or partake in SbC incidents (Mohandie et al., 2009). However, in the current study, professionals who interact with these perpetrators who may partake in SbC conclude that they do not perceive one gender or race over the other as to whom is more likely to partake in this type of suicide.

Second, the data revealed that there was a significant difference between professionals (legal, psychology, law enforcement) and their perception of factors leading towards committing SbC in a constructed scenario. Additionally, the data revealed that law enforcement professionals had significantly different perceptions for situational factors such as pointing a weapon at law enforcement than psychology and legal professionals had of situational factors. This was an enticing finding because the data are stating that law enforcement does not perceive situational

factors such as pointing a weapon as pertinent in a SbC incident compared to psychology and legal professionals. Again, this data does not correlate with the previous research on SbC, which state that when the individual points a weapon at law enforcement, law enforcement feels threatened and that this act is a gesture of the individual wanting a SbC incident to occur.

Third, the data also revealed that law enforcement professionals' perception differed significantly on situational factors between the perpetrator's demographic characteristics of gender and race than that of psychology and legal professionals. Law enforcement perceived situational factors (pointing a gun at officers) as weaker for Caucasian females while psychology and legal professionals perceived situational factors (pointing a gun at officers) as stronger for Caucasian females. This indicates that law enforcement professionals do not observe Caucasian females' situational factors such as pointing a gun to be a perceived lethal threat that will be carried out, while psychology and legal professionals feel this is a perceived lethal threat by Caucasian females. Moreover, law enforcement professionals also perceived situational factors for African American females and males to not be a strong factor in a SbC incident compared to psychology and legal professionals. Therefore, in regard to situational factors law enforcement perceived Caucasian males to have the highest lethal threat. These findings are noteworthy. The media and situations that have occurred across the United States in the last couple years, have shown that young African American males are being shot by police unarmed. Even though this data has a slightly different context the threat and lethality are the same; law enforcement professionals view African American males at a lower threshold in terms of lethality of pointing a weapon than Caucasian males.

Lastly, the data demonstrated that there was no significant relationship among the professionals' (psychology, legal, law enforcement) perception of the perpetrator who was

partaking in SbC to have current life stressors, a mental illness, or criminal factors. However, it is important to note that this finding does not mean the perpetrator seeking to commit SbC does not have these factors that may contribute to the escalation of a SbC incident but rather that these professionals do not find these factors to be more significant than the other overall in this situation. According to Dewey and colleagues (2013), all of these factors surrounding the individual who partakes in a SbC incident plays a vital role in that individual's determination and will to carry out this act. It is the combination of these factors that aid the individual to commit this type of suicide.

Implications

Although the media and news programs have reported on SbC incidents since the 1980s, minimal research exists on investigating the clinical subtype of the individual who involves him or herself in these incidents. Furthermore, minimal research exists on prevention strategies, or early warning signs of a SbC incident. Lastly, minimal research exists on the training or crisis intervention programs available to law enforcement officers who may respond to such incidents. Currently, no definitive model has been established that can aid law enforcement, mental health professionals, legal professionals, and community public health professionals in identifying potential individuals who may perpetrate SbC. Moreover, mental health professionals may not have access to individuals who want to commit SbC before they carry out this act. This is in part because a trigger for SbC is a loss in an interpersonal relationship, job loss, or legal troubles, where the individual most likely has not sought out mental health help for his or her difficulties (Dewey et al., 2013; Foster, 2011).

The results of this study have implications for potential positive community changes on the individual and organizational levels. At the individual level, the results of this study may

inform lay people in society of warning signs in their friends and/or family members that may become a factor for SbC. Furthermore, at the individual level, the results may inform individual law enforcement officers of how they react to a crisis call or a potential SbC call. Law enforcement officers can take the information from this study and the past literature and apply it to their professional work. Lastly, psychology professionals can have a better understanding of SbC and who is most likely to make up this subtype. Therefore, psychology professionals can see the potential warning and behavioral signs in their clients and/or train current law enforcement agencies on this topic to help them understand the potential perpetrator of SbC.

At the organizational level, the results of this study have implications for positive change for improving crisis intervention plans and models across the United States in regard to SbC. For example, protocols can be set in place, and training can be conducted for law enforcement agencies on signs and gestures of an individual who may attempt to cause a SbC incident. Furthermore, SbC units can be developed and employed just like there are for hostage situations. These units can help negotiate and talk the individual down if the incident has escalated to a SbC incident and help resolve the incident without any fatalities.

Limitations

There are several limitations involved in this study. First, there were a total of 94 responders but only 81 of those were able to be utilized as participants due to the lack of completion of the survey. Therefore, the study may have lacked significant power which could have had an impact on the outcome of the study. Second, in connection to the first limitation a power analysis was not performed, which can potentially limit the detection of statistically significant relationships examined by the research questions. Therefore, it is recommended that this study be replicated and improved using a sample of adequate size after a power analysis is

performed. Third, only a small sample of psychology, legal, and law enforcement professionals were utilized as participants in the study, so the results may not be generalizable to these professions as whole. Future studies should obtain samples more representative of these specific professionals in the United States. Fourth, a limitation of this study was the methodology used to obtain participants. A limitation of using an online survey as a method to obtain data is the potential for the participants to lie while taking the survey. In addition to utilizing the survey, the survey used in this study is not psychometrically sound. The survey questions were derived from previous research of SbC, therefore the instrument was not standardized may not have been valid. Lastly, the material used in this study was a vignette to gauge perceptions of a real-life scenario of SbC. However, vignettes do not always capture the real-life experience of a situation to gauge real perceptions of a subject. Future studies should try to obtain video material of a SbC incident in addition to a vignette to see if the perceptions may differ based off the video material capturing real-life experience.

Recommendations for Future Research

Due to the results of this study, future research should be conducted. There are various recommendations that could be implemented in future research to alter the outcome of this study. One recommendation is that archival data of SbC incidents can be utilized to further explore the research question of what type of clinical subtype partakes in SbC. In addition, examining the motivation behind the individual partaking in SbC is a recommendation for future research. It is clear that the individual wants law enforcement to take his or her life but examining why this route is taken and not self-harm as a means of suicide is something future research can examine. Furthermore, as stated previously, adding in video material either in place of or alongside the vignette to gather a better in-depth perception of factors of SbC could lead to new results.

Observing a video clip, the participant can witness how the individual is acting in the situation in order to have a better overall perception of the factors studied in this current study (mental illness, situational, criminal, and life). Future studies should also continue to examine cues and warning signs of these incidents. Finally, future studies should investigate models and tactics to reduce the fatalities in SbC incidents. A replication of this study could be conducted with some changes, such as not using graduate students as part of the participant pool because they have not been in the professional realm as long as current or past professionals utilized in this study. Secondly, adding in a demographic question about geographic location of where the professional is located. This supplementary question could add substance to the data in regards to whether the results differ based on the geographic location of the professionals.

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Appendix A: Recruitment Flyer

Research Participation Needed!

Be part of a mental health research study

- Are you 25 years of age or older?
- Are you currently or previously a professional in the legal field, law enforcement field, or psychology field?
- Are you currently a graduate student in the legal field, law enforcement field, or psychology field?

If you answered YES to these questions, you are eligible to participate in a mental health research study, please click the following link to participate in the online study: https://www.surveymonkey.com/r/KTVVT2B

The purpose of this research study is to gather in-depth perceptions of individuals who are professionals in the legal field, professionals in the law enforcement field, and professionals in the psychology field toward clinical subtypes of "suicide by cop". "Suicide by cop" occurs when an individual provokes law enforcement to use deadly force.

Eligible participants will be asked to fill out a survey taking approximately 15-20 minutes. Participation is voluntary, and participants can opt out at any time during the study.

Participants will be able to submit their e-mail address for a chance to win a $20 Amazon Gift Card.

Please contact Jessica Roos if you have any questions regarding this study at (631) 513-3036 or Jlr4849@ego.thechicaghoschool.edu for more information

Dissertation Chair: Linda Gomberg, J.D., Ph.D.

lgomberg@thechicagoschool.edu

This study fulfils the dissertation requirement for my Doctor of Psychology Degree from The Chicago School of Professional Psychology. Thank you for your time and participation.

Appendix B: Informed Consent

Investigators: Jessica Roos

Study Title: Perceptions of Suicide by Cop and Mental Health

I am a student at The Chicago School of Professional Psychology. This study is being conducted as my dissertation requirement in partial fulfillment of the Doctor of Psychology (Psy.D) degree in Clinical Forensic Psychology.

I am asking you to participate in a research study. Please take your time to read the information below and feel free to contact me with the information below to ask any questions before signing this document.

Purpose: The purpose of this study is to gather in-depth perceptions of individuals who are professionals in the legal field, professionals in the law enforcement field, and professionals in the psychology field toward clinical subtypes of suicide by cop in order to analyze the perceptions of what type of individuals are more likely to engage in the act of suicide by cop. The research will be helpful to understand what the specific clinical subtype of these individuals are.

Procedures: If you choose to participate in the study you will first be asked to read a vignette and fill out two separate questionnaires, providing information about perceptions of suicide by cop. The first survey will ask basic demographic questions while the second survey will obtain perceptions of suicide by cop based on the vignette provided. You will be asked to fill out the survey forms as completely and truthfully as possible. If you agree to participate, the study will take about 15-20 minutes of your time. A total of about 120 participants will be involved in the study.

Compensation: You will not be compensated for their participation but will instead be entered into a drawing to win one of four $20 Amazon gift cards. If you would like to be entered into the drawing you will be prompted to submit your email address at the end of the study. When you enter your email address, there will be no way to link your email address to your survey answers. Winners will be notified by email shortly after all questionnaire responses have been collected.

Risks to Participation: There are no foreseeable risks involved in participating in this study other than those encountered in day-to-day life such as emotional discomfort due to the sensitivity of some questions.

Benefits to Participants: You will not directly benefit from this study. However, it is hoped the information learned from this study may benefit society in our understanding what type of individuals partake in the act of suicide by cop. More importantly, promoting awareness of suicide by cop can help to achieve information that can be used to proactively inform professionals in these fields to better understand the event of suicide by cop.

Alternatives to Participation: Participation in this study is voluntary. You may withdraw from study participation at any time without any penalty.

Confidentiality: During this study, information will be collected about you for the purpose of this research. This includes non-identifying demographic information such as race, age, gender, education level, etc. All information/data collected during the study will be stored on a password protected computer and database for a minimum of 5 years, as required by the American Psychological Association (APA). The information collected will be safely deleted from the password protected computer after 5 years. For the purposes of entering the raffle, email addresses will be collected (also on a password protected computer and database) to be in contact with the winning participants but will not be used to identify the participants in any way.

You have a right to privacy, and all information identifying you will remain anonymous and confidential. Your answers on all questionnaires will be coded with numbers and only the primary researcher will have access to participant information. No identifying information will appear on any material. Any information obtained in connection with this research that can be identified with you will remain confidential and will not be disclosed without your permission or as required by law. However, it is possible that under certain rare circumstances, data could be subpoenaed by court order if requested by lawful authorities.

Research records may be reviewed by federal agencies whose responsibility is to protect human subjects participating in research, including the Office of Human Research Protections (OHRP)

and by representatives from The Chicago School of Professional Psychology Institutional Review Board, a committee that oversees research.

Questions/Concerns: If you have questions related to the procedures described in this document please contact Jessica Roos, B. A. at (631) 513-3036 or at Jlr4849@ego.thechicagoschool.edu. The faculty member who is supervising the research is Linda Gomberg, J.D., Ph.D. who can be contacted at (949) 769-7727 or at lgomberg@thechicagoschool.edu

If you have questions concerning your rights in this research study you may contact the Institutional Review Board (IRB), which is concerned with the protection of subjects in research project. You may reach the IRB office Monday-Friday by calling 312.467.2343 or writing: Institutional Review Board, The Chicago School of Professional Psychology, 325 N. Wells, Chicago, Illinois, 60654.

Consent to Participate in Research

By clicking the button below the participant has consented to take part in the research.

Appendix C: Demographic Questionnaire

Please indicate your gender.

- Male
- Female
- Other
- Decline to state

Please select the category that includes your age.

- 25-34
- 35-44
- 45-54
- 55-64
- 65 or Above

Please indicate your ethnicity.

- Caucasian
- Hispanic or Latino
- African American
- Native American or American Indian
- Asian / Pacific Islander
- Other

What is the highest level of school you have completed or the highest degree you have received?

- High school degree or equivalent (e.g. GED)
- Some college but no degree

- Associate degree
- Bachelor's Degree
- Graduate Degree

Please indicate if you are a current graduate student?

- Yes
- No

If yes, which field of study are you enrolled in?

- Psychology
- Law enforcement
- Legal field

Please indicate your current profession.

- Psychology (licensed, non-licensed, LCSW, MFT, MFC, other psychology professional)
- Legal: attorney, or other legal profession
- Law enforcement: local, state, city, federal, other law enforcement professional

If psychology or legal profession was indicated, they received this next question

Have you ever worked for law enforcement or with law enforcement?

- Yes (psychology profession)
- No (psychology profession)
- Yes (legal profession)
- No (legal profession)

Please indicate how many years you have been in your current profession.

- Less than 1 year
- 1-5 years

- 6-10 years
- 11-15 years
- 16-20 years
- 20+ years

Please indicate if you have ever heard of the term "suicide by cop"?

- Yes
- No

If yes, what is your experience with suicide by cop?

- Heard about it on the news
- Have been involved in suicide by cop
- Received training on suicide by cop
- Other (Please explain):

Appendix D: Vignettes

Condition 1:

Female Caucasian Vignette

A Caucasian female called 911 stating that she was going to "kill anyone who comes near me". Before hanging up on the dispatcher, the Caucasian female stated: "I'm going to kill somebody. I have a gun. Send a cop here." While operators attempted to call her back, officers were dispatched. Two Deputies and a Sergeant arrived on scene and found the Caucasian female subject walking down the street with what appeared to be a small handgun. The officers repeatedly demanded that she drop the weapon. All three Deputies opened fire. The subject was later pronounced dead at a local hospital.

Condition 2:

Female African-American Vignette

An African-American female called 911 stating that she was going to "kill anyone who comes near me". Before hanging up on the dispatcher, the African-American female stated: "I'm going to kill somebody. I have a gun. Send a cop here." While operators attempted to call her back, officers were dispatched. Two Deputies and a Sergeant arrived on scene and found the African-American female subject walking down the street with what appeared to be a small handgun. The officers repeatedly demanded that she drop the weapon. All three Deputies opened fire. The subject was later pronounced dead at a local hospital.

Condition 3:

Male Caucasian Vignette

A Caucasian male called 911 stating that he was going to "kill anyone who comes near me". Before hanging up on the dispatcher, the Caucasian male stated: "I'm going to kill somebody. I have a gun. Send a cop here." While operators attempted to call him back, officers were dispatched. Two Deputies and a Sergeant arrived on scene and found the Caucasian male subject walking down the street with what appeared to be a small handgun. The officers repeatedly demanded that he drop the weapon. All three Deputies opened fire. The subject was later pronounced dead at a local hospital.

Condition 4:

Male African-American Vignette

An African-American male called 911 stating that he was going to "kill anyone who comes near me". Before hanging up on the dispatcher, the African-American male stated: "I'm going to kill somebody. I have a gun. Send a cop here." While operators attempted to call him back, officers were dispatched. Two Deputies and a Sergeant arrived on scene and found the African-American male subject walking down the street with what appeared to be a small handgun. The officers repeatedly demanded that he drop the weapon. All three Deputies opened fire. The subject was later pronounced dead at a local hospital.

Appendix E: Questionnaire

Please select the number below which best represents your perception of the individual based on the vignette you just read.

1. The individual had a mental illness such as schizophrenia, bipolar, or depression.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

2. The individual has or had a substance abuse problem.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

3. The individual has had prior suicide attempts.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

4. The individual was hallucinating or having delusions during this event.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

5. The individual was from a low socioeconomic status.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

6. The individual was having financial hardship.

Strongly Agree	**Agree**	**Moderately**	**Disagree**	**Strongly Disagree**
1	2	3	4	5

7. The individual was having relationship problems.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

8. The individual lost their job.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

9. The individual has had a prior arrest record.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

10. The individual is on probation/parole.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

11. The individual was in a domestic violence situation.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

12. Law enforcement officers' actions were justified.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

13. The individual refused to drop their weapon.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

14. The individual threatened law enforcement officers with their weapon.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

15. The individual was under the influence of drugs and/or alcohol at the time.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5

16. The individual wanted to cause an event where the police would have to respond.

Strongly Agree	Agree	Moderately	Disagree	Strongly Disagree
1	2	3	4	5