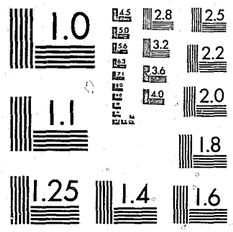

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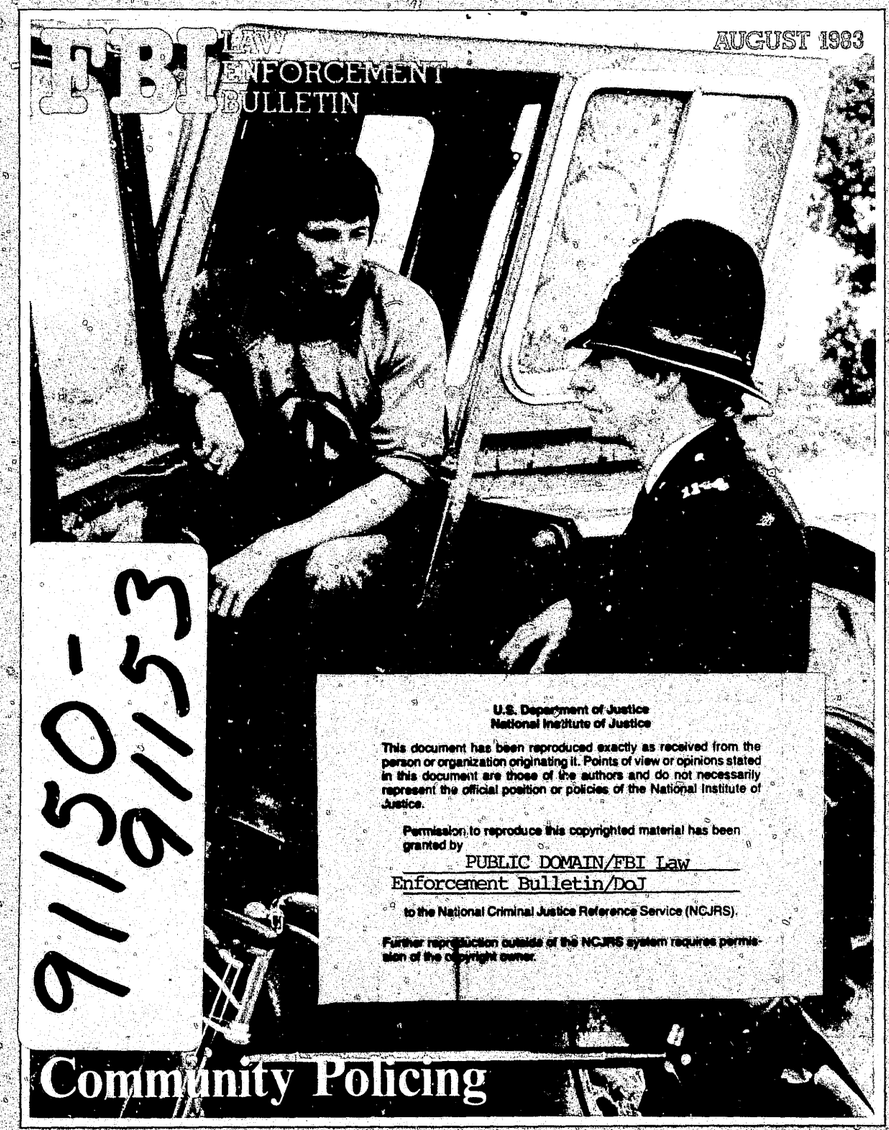

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William H. Webster, Director

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Personnel

Alcoholism and Suicide: A Fatal Connection

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When a police suicide occurs, the impact reaches far beyond the victim. The event shakes the very core of law enforcement—to preserve life, not destroy it, in carrying out one's duties. As Dr. Maurice Farber, a well-known psychiatrist, has said, "Suicide is an action that takes place in sadness and desperation . . . . It inflicts grief and remorse upon survivors." [1]

In this country, suicide has become the focus of scientific study only within recent years. During a symposium on the subject in 1969, Dr. Karl Menninger said:

> ". . . the incidence of suicide will be reduced only when the public recognizes it as a social problem, as a psychological problem, and as a medical problem, rather than as a moral problem and a disgrace to be covered up, regretted, and forgotten." [2]

Concerned about the problem, a study conducted by the Chicago Police Department in 1980 identified and described the suicide deaths of all Chicago police officers during a 3-year period (1977–1979).[3] The data indicate that there is a strong correlation between alcoholism and suicide.

Statistics

The gathering of meaningful data on suicide is controversial and presents many problems. Experts believe that the statistics concerning suicides are unreliable because suicide is underreported. In addition, scientists and statisticians disagree about the definition of suicide. If the definition takes into account the individual's intention about death, the problem is clear immediately. The person who is to be classified is dead and unable to state his conscious intention.

Suicide is the 10th most prevalent cause of death among adults and the 3d highest cause of death among adolescents 15 to 19 years old. For every "successful" suicide there are perhaps 10 nonfatal attempts.[4]

No single theory accounts for all suicides; experts do not even agree about the suicide rates. While one author says that the variation in suicide rates among cultures is extreme,[5] another argues the statistics reveal an overall stability in suicide rates, stating that his study of nearly all cultures reveals a suicide rate of 20 to 30 per 100,000 regardless of urbanization and industrial growth.[6] It is important to note that data in the Chicago study, using figures from The National Center on Health Statistics and the Chicago Department of Health, indicate that the local rate is 10 suicides per 100,000 people.

About police suicides, Drs. Dash and Reiser summarize the statistics:

> "To date, only five published studies have offered specific data on police suicides. Friedman reported an annual suicide rate of eight per 100,000 for New York City police officers during the six-year period from 1934 to 1940. Nelson and Smith had reported that for the state of Wyoming, the 1960 to 1968 rate for police was 203 per 100,000. Heiman has reviewed Friedman's study and added comparative data for London Bobbies and New York City police officers during the period 1960 to 1973. The 13-year rates average out to 5.8 per 100,000 in London and 19.1 per 100,000 in New York. In a subsequent paper, Heiman reported that for 1934 through 1939, the average Chicago Police Department rate was 48 per 100,000. The average for the San Francisco Police Department (was) 0 per 100,000 and the St. Louis Police Department rate was 17.9 per 100,000. Danto reported 12 suicides among Detroit police officers between 1968 and January 1976. These figures were not, however, reported in population statistics terms." [7]

Ms. Wagner

Mr. Brzeczek

Definitions

Various definitions of suicide appear in the literature, particularly where there is an attempt to present a theory of suicide. These definitions reflect the sociology and psychology of suicide. Regardless of the theoretical framework, though, all experts find suicide to be an extremely complex process. Lawrence Kubie states it is very difficult to research suicide when one cannot tell when this act of self-injury has self-extinction as a goal and when it does not. "A healthy, energetic youngster faces a serious illness. He cannot tolerate the idea of living without the high, active energy level. He skips his medicine, pretending he is not sick. He may be dead. Is this suicide?" [8]

At one time it was thought that suicide was related to hostile feelings that were turned inward on the self—murder in the 180th degree. Now it is clear that other emotions are important, too. They include shame, guilt, dependency, and the affective states of hopelessness and helplessness. Most suicides are characterized by an ambivalent feeling—hostility vs. affection, wanting to die vs. wanting to be rescued.[9]

At first, suicide seemed to be clearly identifiable—that is, a person was "suicidal" when he talked about suicide, attempted it, or succeeded in killing himself. Later studies of suicide, however, revealed it to be more complicated. Did the individual simply talk about suicide, or did he intend to take action? What period of time was involved in self-destructive action? Did the victim intend to die, intend to gamble with death, or intend not to die but simply hurt himself? Did the person passively accept death or actively inflict it upon himself? [10]

Direct self-destruction may take many forms, but it clearly results in self-inflicted pain, injury, or death. The behavior is visible and the effect is immediate. Indirect self-destructive behavior differs from this in two ways—the time and awareness involved. The effect is long-range; the behavior may span years. The person is usually unaware of or doesn't care about the effects of his behavior, nor does he consider himself a suicide.[11]

Emile Durkheim defined suicide as "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." [12] This definition eliminates the cases where a person commits suicide by dying at the hand of another. It implies that suicide is entirely rational.

"Suicide may result from external social factors, internal psychological factors, and internal biological factors."

Jean Baechler's definition carries Durkheim's theory even further: "Suicide denotes all behavior that seeks and finds the solution to an existential problem by making an attempt on the life of the subject."[13] Suicide, Baechler adds, is a behavior rather than an act because only rarely is it circumscribed by the precise moment when it is accomplished. The behavior is a response to a problem. Whether real or imaginary, the problem is real to the individual considering suicide. Baechler does not believe in a distinction between normal and pathological suicide. He says that one can kill oneself because one had contracted an incurable disease, or can kill oneself because one thinks he has contracted an incurable disease.

Suicide is a religious issue because it involves an orientation toward life and death and the forces that control both. Philosophers from Plato to Camus have been concerned with suicide. Some have opposed it, some have held a permissive attitude toward it, and still others have praised it. It is also an issue for psychology. Dr. Karl Menninger reasons that three elements are required by the victims of suicide. The first is the wish to kill—aggression; the second is the wish to be killed—punishment; the third is the wish to die—the death instinct.[14]

Suicide may result from external social factors, internal psychological factors, and internal biological factors. Since these three categories are always interacting, the causes of suicide are likely to be a combination of these factors.[15] For example, an individual suffering from a manic depressive psychosis in a deep depression may commit suicide although little is occurring in the outside world to cause it. A psychologically healthy person faced with the certainty of being torched to death might commit suicide. "Suicides in the main are committed by psychologically damaged personalities confronted by a deprivational situation. It is the nature of the vulnerability, the kind of deprivation, and their interactions that must be analyzed."[16]

Hope also is considered to be crucial to one's decision to choose suicide; the act of suicide has been described as an act of hopelessness, despair, and desperation. Suicide occurs when there appears to be no available path that could make for a tolerable existence. "Not everyone is an equal candidate for suicide. There are those who become the more readily hopeless in the face of difficulties of life. These suffer basically from an impaired sense of competence . . . that predisposes (them) . . . to suicide."[17]

The Chicago Police Department Study of Suicide, 1977–1979

This study was conducted to determine whether the incidence of suicide is higher among sworn members of the police department than among the general public. Knowing that there has been speculation that suicide is a problem to police, the ultimate aim was to produce a profile or guide for supervisors and command personnel so they could identify officers who display suicidal tendencies.

The study began by examining the Personnel Division's listing of department members who died 1977 through 1979. These lists were compared to the master files at the office of the medical examiner. Each officer's death that was listed as a medical examiner's case was thoroughly investigated.

The medical examiner's files contained death investigation reports submitted by detectives who visited the scenes of the fatalities. They also contained autopsy and toxicologic reports and miscellaneous reports. Most cases of suicide were clearly apparent. Where there was a question about whether a fatal injury was intentionally self-inflicted, the researcher consulted professionally trained people rather than make an arbitrary decision or rule out a possible suicide, which included the chief surgeon in the Medical Division and members of the police department's Research and Development staff.

Twenty police officers were the victims of suicide during the period studied:

1977	6
1978	7
1979	7

If one looks only at the numbers, a Chicago police officer was five times as likely during this period to take his life as a citizen of the city, based on a department strength of 13,000 and a general city population of 3 million.

The officers who committed suicide ranged in age from 25 to 60 years.

Age group	Number of victims
25 to 29	2
30 to 34	4
35 to 39	6
40 to 44	2
45 to 49	1
50 to 54	3
55 to 60	2

The average amount of time each officer served was 13.4 years, although this figure varied from year to year, the average ranging from 11.7 years to 16 years.

Of the 20 individuals studied, 13 officers were married and living with their spouse, 3 were single, 3 were separated from their wives, and 1 police officer was widowed. None of the victims was divorced at the time of his death. All of the victims were male. Suicide notes were available in only two cases.

All available department records on these 20 individuals were carefully analyzed for data that described what was known about them. Judging by their medical records, a majority could be classified as medical roll abusers. Twelve had extensive medical roll records, six had average medical roll records, and two had limited medical roll records. The overwhelming majority of the medical complaints of the deceased members was stomach flu. Others complained of such ailments as nervous problems, high blood pressure, heart trouble, back trouble, kidney disease, bursitis, and alcoholism.

Of the 20 victims, 17 held the rank of police officer, 1 was a youth officer, and 2 were lieutenants. Evidence of family problems was discovered in 13 cases. Four of the officer's disciplinary records showed complaints registered by a spouse or girlfriend concerning off-duty personal problems. Serious health problems were noted in six cases, and financial problems were noted in two cases.

Alcoholism was documented in 12 cases in the study. Six officers had undergone treatment for alcoholism. One officer had been hospitalized four times for treatment of alcoholism, while another had been treated on two occasions. Because inpatient alcoholism treatment often requires 3 to 4 weeks of hospitalization, it is usually documented on department medical records. Nine of the victims had substantial quantities of alcohol in their systems at the time they died. This fact was verified by toxicologic reports maintained by the medical examiner. Evidence of narcotics use was found in only one case—that of an officer whose body contained an intoxicating amount of morphine believed to have been caused by heroin injection. Based upon these findings and the data from disciplinary and medical records, we believe that heavy use of alcohol and alcoholism played a significant role in the lives of these police officers.

Thirteen of the officers were white; seven were black. This is significant because during this period only 20 percent of the Chicago police force was black, while black officers composed 35 percent of the suicide victims. The ethnic backgrounds of the officers are as follows:

	Percent
Black	35
German	20
Irish	20
Polish	17.5
Italian	5
Swedish	2.5

Of the 20 officers, 10 were members of the Catholic faith, 2 were Baptist, and 1 professed to have no religious ties. Church affiliations of the other victims could not be determined. The suicide victims had the following number of years of education:

Some high school	5
High school graduate	3
Some college	8
College graduate	4

Eighty percent of the subjects took their lives by gun—revolvers were used in all cases. Fourteen of these men died of head wounds, while two of the victims (both black officers) shot themselves in the left breast. Three of the subjects died as a result of carbon monoxide poisoning, and one was burned to death after setting his apartment on fire. Fifteen of the subjects committed suicide at home or on their own property.

". . . medical and discipline histories at work reflect the progression of illness among employees who suffer from alcoholism and other substance abuse problems."

Five were away from their homes. Six were discovered in their bedrooms, while another six died in personal automobiles.

Seventeen of the subjects were born and raised in the city of Chicago. One was born in Wisconsin, another in South Carolina, and a third in Arkansas.

Disciplinary records disclosed that seven of the victims had serious disciplinary problems. Seven others had normal or average disciplinary records, and the remaining six had a virtual lack of job-related problems. What follows is a list of the types of disciplinary troubles encountered by the subjects of the study. The incidents are shown in order of frequency:

1) Inattention to duty,
2) Negligent operation of department vehicles (charges resulting from an accident in which the officer was at fault),
3) Unauthorized absence from duty,
4) Intoxication on duty,
5) Failure to purchase a city vehicle license, and
6) Issuing bad checks.

Two of the officers in the study had made known suicide attempts before their deaths. Three of the victims had taken a leave of absence from the department but had returned to duty before their deaths. Three others had been placed on disability pensions during their police careers. Three were on limited duty status at the time they committed suicide. Fourteen of the officers had been injured on duty at least once during their employment.

The average performance rating of the subjects at the grading period just prior to their deaths was 85.2. In almost every case, there was a notable drop in the victims' performance ratings within a period of 6 months to 2 years before the suicide.

These data are summaries of the information available in the records of the 20 officers. No personal interviews with close family members of the victims were conducted, partly because the study occurred 1 to 3 years after the suicides. Such interviews might be useful to an ongoing study of suicide, if family data could be collected at the time of the occurrence. A high percentage of this small sample had a problem with alcohol. The following vignettes from the study will highlight this issue.

Subject 1: He was 56 years old and had been diagnosed as an alcoholic. During the last year of his life, he was treated for alcoholism, cirrhosis of the liver, and organic brain syndrome. He had been reported as depressed over his ill health and a family problem.

Subject 2: He was 51 years old. He had been treated for alcoholism twice in the 4 months before his death. There was evidence of depression.

Subject 3: He was 44 years old. There are no clues in the existing records that would allow a hypothesis. However, before his appointment he was arrested for drunk driving and had serious marital problems. He was intoxicated at the time of death. The records suggest that the problem was related to alcoholism.

Subject 4: He was 33 years old and had 4 years on the job. The night of the suicide, he was involved in a sexual deviation that was being investigated. There were no narcotics found in his system at the time of his death. He appeared to have had a psychiatric problem.

Subject 5: He was 36 years old and had been on the job for 12 years. He was documented repeatedly for minor offenses that made him an unsatisfactory worker. He was known to be unhappy with his job and experiencing personal problems. He was a heavy user of the medical roll. At the time of his death, he was "slightly intoxicated."

Subject 6: He was 42 years old. There is evidence of a drinking problem in this officer's entire history. A "large quantity" of alcohol was found in his body at the time of death. He had a history of drunk driving, a disorderly conduct arrest, and a heavy drinking pattern.

Subject 7: He was 37 years old. He had a "moderate amount" of alcohol in his system at the time of his death. He had used the medical roll extensively for flu and stomach problems. He had two arrests, both precipitated by women friends where violence was involved—once at a tavern. Though drinking was not specifically noted in the record, one could infer the association and infer drinking to be a problem.

Subject 8: During a 5-year period, this officer was hospitalized on four occasions for "alcoholic rehabilitation." His entire history reveals problems related to drinking.

Subject 9: He was 54 years old. He was known to have been unsuccessful in prior treatment for alcoholism. The toxicologist's report indicated a "high level" of alcohol in his system at the time of his death.

Subject 10: He was 35 years old. Before his suicide, a diagnosis had been made of late-stage alcoholism as evidenced by delerium tremens. His treatment had not been successful. A "large quantity" of alcohol was found in his system at the time of death.

Subject 11: He was 27 years old. This young officer had been on the job only a year at the time of his death. There is no data in his record to indicate an alcohol problem, but at the time of death, he had a "substantial quantity" of alcohol in his system.

Subject 12: He was 30 years old. This officer's 3-year police career was fraught with disciplinary investigations and medical roll abuse. A long history of financial problems may be a further indication of an alcohol or drug problem. The woman with him at the time of his suicide stated that "he did not use narcotics and was a light drinker." A "large quantity" of alcohol was found in his system at the time of death.

Subject 13: He was 48 years old. Before this officer's 19 years on the police force, he was arrested twice for public intoxication and drunk driving. Minor rule violations throughout his career indicate that alcohol could have been a problem. At the time of death, he was found in his garage in a car that had signs of being in a "recent collision." A "substantial amount" of alcohol was found in his system.

Subject 14: This officer was in his early thirties. His record reveals an inordinate number of reprimands and suspensions for failure to attend court, negligent use of department vehicles, and reporting late for work. Though these patterns are commonly found in alcoholism, there is no history of alcoholism treatment and no evidence of drinking before his death. Approximately 1 month before his death and following a nonfatal suicide attempt, the department's Psychiatric Advisory Board diagnosed his condition as "severe depression in a schizoid character." A suicidal risk was noted. From these records it appears that this person had a psychiatric problem.

Subject 15: This officer was 50 years old. He suffered for many years from a back injury and heart condition. Though alcohol is not specifically mentioned in his history, he was suspended from duty for inattention to duty, violation of medical roll procedures, and assaulting his wife. He had been receiving "psychiatric therapy" for family and financial problems.

Subject 16: He was 36 years old. This officer's police record indicates areas of good performance; he once received the Superintendent's Award of Valor. Though he showed heavy use of the medical roll, he sustained 11 onduty injuries. Four sustained disciplinary complaints were for negligent use of department vehicles. He had been having "serious marital problems" and shot himself after an argument during which his wife told him to leave.

Subject 17: This officer was 29 years old. His history contained repeated incidents of unacceptable behavior. A large quantity of morphine was found in his system at the time of his death.

Subject 18: He was 32 years old. There are no indications in the records that this officer was troubled or ill. He had been on amphetamines for weight loss just before he died. There is no evidence of drug use in the toxicologic report.

Subject 19: He was 55 years old. This officer had suffered from kidney disease; treatment included dialysis three times a week. On the day of his death, the officer complained of pain. He had been depressed about his condition.

Subject 20: He was 37 years old. This officer had a history of personal and work-related problems. The work problems were indicated in his disciplinary and medical histories. The suicide was precipitated by a broken-off relationship.

". . . Alcoholism exists when drinking affects any major area of one's life—physical illness, work problems, or personal life."

Discussion

Alcoholism and drug abuse are cited throughout the literature as behavior that is aimed at warding off feelings of depression. However, the use of alcohol and other drugs is common in our culture. According to the National Council on Alcoholism, the disease process is evident in approximately 10 percent of drinkers and drug users. In these individuals, continued drug usage leads to decreasing tolerance for the drug, increasing denial of its effects, and loss of control over the drug and the individual's life.

From the experience of the Alcohol and Drug Assistance Unit of the Chicago Police Department and employee assistance programs in large companies throughout the country, it is evident that medical and discipline histories at work reflect the progression of illness among employees who suffer from alcoholism and other substance abuse problems. On-the-job accidents and alcohol-related incidents also are indications of the disease. If one looks at the data that are available on each officer in this sample, one could deduce that three-quarters of the victims suffered from alcoholism. These 15 cases indicate that the individuals either had been diagnosed as having alcoholism or displayed the kind of work and life behavior patterns that are common among people with alcoholism. Of the other five individuals, two appeared to have had indirect, self-destructive behavior patterns, and three appeared to have suffered from psychiatric problems.

A distinction is made in the suicide literature between direct and indirect self-destructive behavior. In both, the behavior is assumed to injure the individual's health and hasten his death. The distinction between the two types of self-destructive behavior relies primarily on the individual's intention. When the primary conscious goal is self-injury, the term "direct self-destructive behavior" is appropriate. Suicide is the extreme form of direct self-destructive behavior. Indirect self-destructive behavior involves self-injury, but here it may be an undesired effect, not a primary goal. Examples of indirect self-destructive behavior include drug abuse, alcoholism, cigarette smoking, reckless driving, and various ways of neglecting one's health.[18]

The individual who chooses a direct form of self-destructive behavior usually is in great psychological stress, and in the case of suicide, there is often a precipitating event. We see this clearly in the three situations in our sample involving psychiatric problems (subjects 4, 16, and 20).

Indirect self-destructive behavior typically occurs without acute stress. However, all of us have some kind of indirect self-destructive behavior. It becomes dangerous and life threatening only when it is habitual. One theory holds that destructive behavior patterns develop as a way of defending against mental pain that threatens to result in depression.[19]

One authority says, "According to these criteria alcoholism with its characteristic pattern of denial, low frustration tolerance, need for immediate gratification, and self-centeredness qualifies as an indirect self-destructive condition; nevertheless, alcoholism can also greatly overlap with direct self-destructive behavior as seen in the frequent association of the condition with depression, with feelings of hopelessness, and with high risk taking behavior."[20]

Most suicide studies are conducted by psychologists and psychiatrists examining their hospitalized patients. These studies and most others do not correlate alcoholism and suicide. However, a few studies do.

In one study, conducted in 1962, all suicides attempted during a 4-month period at King County Hospital in Washington State were examined. Twenty-three percent of the attempted suicides and 31.4 percent of completed suicides involved alcoholics. An earlier study on suicide in Sweden found that 30 percent of those who attempted or completed suicide were alcoholics.[21]

One study notes that a comparatively high proportion of alcoholics commit suicide and consequently "a high suicide rate among alcoholics appears to be unquestionable."[22] In a description of the relationship between alcohol and suicide, one expert notes that the physical deterioration caused by alcoholism hastens natural death; it is also well known that a significant proportion of fatal accidents are the result of alcohol.[23]

Traditionally, however, mental health experts have seen the use of alcohol as symptomatic of an underlying psychological or psychiatric problem. Only recently has alcoholism been identified as a disease—a primary disease that exists in and of itself—that is not caused by other underlying problems. Those familiar with the treatment of alcoholism are aware that suicide is associated with alcoholism.

The definition of alcoholism used in the policy statement for the Alcohol and Drug Assistance Unit in the Chicago Police Department is as follows: Alcoholism exists when drinking affects any major area of one's life—physical illness, work problems, or personal life. As one examines the records on the lives of the 20 police officers who committed suicide, it becomes clear that physical symptoms commonly seen in alcoholism had been identified. These included cirrhosis of the liver, organic brain syndrome, stomach problems, and flu-type symptoms that are associated with hangover and delerium tremens. Other physical and emotional symptoms are associated with alcoholism, but they were not noted in the existing study records.

Many behavior patterns described in the records of these 20 police officers are common to alcoholism. Heavy drinking resulted in arrests for disorderly conduct—often associated with blackouts, drunk driving, and automobile accidents. Financial problems, due to irresponsible patterns and the denial of other problems, were evident. And frequent medical roll abuse and a pattern of being late for work were apparent.

If the psychological studies are set aside for the moment, one can focus on the fact that some individual depression is not a psychological problem but a biochemical process. The research in this area is not definitive at this time. However, because we know that alcohol is a drug—a mood-altering chemical, a depressant—we can see that it is important to look at alcoholism in relation to depression.

An essential precursor of suicidal behavior is a feeling of powerlessness, of having no control over various aspects of one's life. The factors vary tremendously. They could include a personal loss, an illness, a job failure, etc. Clearly, the issue of control is important in alcoholism, too, because as an individual loses control over his drinking, he increasingly loses control over his life.

Practically all suicidal behaviors stem from a sense of isolation and from distress at some intolerable emotion or situation. It is the individual's attempt to regain control and to halt an intolerable existence that leads to suicide. What is intolerable for one person, however, may not be intolerable for another. Although the act of suicide is an all or nothing action, thinking about the act ahead of time is a complicated process. It is often a shock to family and friends that a loved one has committed suicide. Somehow they have not been aware of the clues leading up to the suicide, which might have prepared them for the actual event. This is doubly true where individuals have taken an oath to preserve life.

As we have seen, alcoholism and its attendant symptoms may be one of these clues. The conclusion seems to be that if we want to prevent suicide, we must be willing to intervene in the indirect self-destructive behavior of others. Knowing individuals with alcoholism, we tend to watch their work life, relationships, and health deteriorate, aware that we are watching the progress of a fatal illness. **FBI**

Footnotes

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[12] Supra note 6, p. 9.
[13] Supra note 6, p. 11.
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[17] Ibid, p. 37.
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[22] William A. Zushing, "Individual Behavior and Suicide," *Suicide*, ed., Jack P. Gibbs (New York: Harper and Row, 1968), p. 104.
[23] Supra note 6, p. 311.

END