

II. Literature Review

a. General Suicide Research

The term “suicide” is defined in the Merriam-Webster Collegiate Dictionary as “the act of killing oneself voluntarily and intentionally” (2004, p. 1249). Various data have been reported regarding the prevalence of suicide among the general population. A 2007 United States report on suicide highlights incidence and prevalence rates, as well as its impact on society at large (McIntosh, 2010). Suicide is considered the eleventh leading cause of death for people in the United States. In 2007, 34,598 people committed suicide (approximately 1 death every 15.2 minutes). Males were 3.6 times more likely than females to take their own lives. Overall, the use of firearms was the most common method of suicide (N=17,352). Additionally, the risk for suicide has also been analyzed among various subpopulations. According to research, suicide rates among adolescent youth, the elderly, and military members are higher than those in the general population (Bryan, Cukrowicz, West, & Morrow, 2010; Joiner, 2010; Kang & Bullman, 2008; McIntosh, 2002).

Suicide impacts not only close family and friends but also those who hear about the suicide. For every person who commits suicide, there are approximately six survivors, a total of 4.6 million people, described as family and friends of the deceased (McIntosh, 2010). Surviving family members and friends of the offender are often left with questions and want to understand why he/she chose to commit suicide. A suicide note left by the individual is often the only source of this information. There is a common misconception that most people leave a suicide note. Joiner (2005) reports that leaving a suicide note occurs in only about 25% of suicides, which is rather uncommon among the general suicide population (Joiner, 2010).

Even in the midst of suicidal thoughts, people typically have an equally and usually greater need to preserve life. This distinction is important, as one-third of the US population has felt suicidal at some point in their life; however, only 0.01% of the population actually die by suicide (McIntosh, 2010; Paykel, Myers, Lindenthal, & Tanner, 1974). So how do individuals get to the point of ending their lives? The vast research on

suicide has produced a variety of theories on suicide risk factors. Beginning with the seminal works of Shneidman (1987), the cubic model explained factors related to suicide and incorporated three factors impacting suicidal behavior: (1) press (e.g., external events that impinge on the individual), (2) pain (e.g., thwarted psychological needs such as autonomy or avoidance of humiliation), and (3) perturbation (e.g., state of being upset and possibly a cognitive constriction). Thereafter, other psychologists expanded the understanding of the dynamics of suicide based on their clinical work and research (Bongar, 2002; Jobes, 2006; Joiner, 2005; Maris, Berman, & Silverman, 2000; Silverman, Bongar, Berman, & Maris, 1999).

From the research, specific factors subsumed in the affective, cognitive, behavioral, and alcohol/drug categories have been consistently reported to increase an individual's risk for suicide. Individuals who are less capable of controlling their emotions, including feelings of depression, anxiety, and "psychache,"¹ have increased risk for suicide (Chance, Kaslow, & Baldwin, 1994; Harrington, Fudge, Rutter, Pickles, & Hill, 1990; MacLeod, Williams, & Linehan, 1992). They tend to be more temperamental, unpleasant, submissive, and easily aroused (Mehrabian & Weinstein, 1985). From the cognitive realm, there is an increased risk for suicide by individuals who experience greater helplessness, hopelessness, perfectionism, irrational beliefs, and a weaker reason for living. In addition, those who have a greater external locus of control² are also at increased risk because they expect negative outcomes, think things will never change, and are less able to come up with alternative, more appropriate solutions (Beautrais, Joyce, & Mulder, 1999; Blatt, 1995; Cole, 1989; Kehrer & Linehan, 1996; Linehan, Goodstein, Nielsen, & Chiles, 1983; MacLeod et al., 1992; Schotte & Clum, 1987; Woods, Silverman, Gentilini, Cunningham, & Grieger, 1991). Westfield et al. (2000) stated that "...ineffective belief systems and weak problem-solving skills mean that suicidal individuals lack the personal resources they need when they experience strong negative feelings" (pp. 451).

The American Association of Suicidology (2003) presented the main risk factors exhibited by individuals who are considering suicide through a mnemonic device, IS PATH WARM (ideation, substance abuse, purposelessness, anxiety, trapped, hopelessness, withdrawal, anger, recklessness, mood changes). Additionally, the literature consistently reports various risk factors for suicide to include mental disorders, past suicide attempts, social isolation, family conflict, unemployment, and physical illness (Van Orden et al., 2010).

The vast majority of people who die by suicide (i.e., approximately 95%) suffer from a mental disorder (Cavanagh, Carson, Sharpe, & Lawrie, 2003). It is often assumed that the remaining 5% suffer from previously undetected mental disorders (Ernst et al., 2004). In addition, certain mental disorders correlate with higher risk for suicidal behavior compared to others. For example, bipolar disorder presents a

¹ "Psychache" is defined as intolerable emotional or psychological pain that cannot be terminated by previously utilized coping mechanisms (Shneidman, 1993).

² Julian Rotter (1966) developed the idea that individuals typically believe that their destiny or situations are controlled or influenced either by themselves (internal locus control) or outside factors (external locus of control).

15-fold increased risk for suicide (Harris & Barraclough, 1997) as compared to a major depressive disorder with suicide rates between 2% and 6% (Bostwick & Pankratz, 2000). Studies examining mental disorders and suicides reveal that the vast majority of individuals diagnosed with a mental disorder do not die by suicide (Van Orden et al., 2010).

Research supports the theory that individuals who have also been diagnosed with a personality disorder have an increased risk for suicidal behavior (Duberstein & Conwell, 1997; Kullgren, Tengstrom, & Grann, 1998). Personality disorders indicate an enduring pattern of characterological traits that deviate from the expected behaviors of the individual's culture. Personality disorders manifest in two or more of the following: perception and interpretation (cognition), emotional response (affect), interpersonal function, and impulse control. The pattern of behavior is stable and pervasive across a broad range of personal and social situations, which results in clinically significant distress and impairment in important areas such as social situations or occupational settings. The pattern can be traced back to adolescence and early adulthood. The Millon Clinical Multiaxial Inventory III (MCMI-III; Millon, Millon, Davis, & Grossman, 1997) personality scales: schizoid (scale 1), avoidant (scale 2), dependent (scale 3), and passive-aggressive (scale 8) were elevated among those who had suicidal ideations and attempts (Hull, Range, & Goggin, 1992; Lall, Bonger, Johnson, Jain, & Mittauer, 1999; McCann & Suess, 1988). In addition, antisocial personality disorder (ASPD) and borderline personality disorder (BPD) were associated with suicide among the general population (Duberstein & Conwell; Patrick, Zempolich, & Levenston, 1997; Verona, Patrick, & Joiner, 2001).

An earlier analysis of suicides by Baechler (1979) presented four reasons why someone chooses to die by suicide: (1) suicides which occur during the commission of a crime, (2) suicides which allow the individual to maintain honor and/or save face, (3) suicides which occur while a person is engaged in high-risk behavior, and (4) suicides which are the result of flight or escape from an intolerable situation (Shneidman, 2001). People who engage in the escapist suicide act often experience shame, guilt, fear, and worthlessness.

The suicide trajectory model (Stillion, McDowell, & May, 1989) indicates that the suicidal individual experiences a triggering event that becomes the last straw resulting in the suicidal behavior. The model includes biological factors, such as a predisposition to commit suicide; psychological factors including depression, hopelessness, helplessness, low self-esteem, and poor coping abilities; cognitive factors such as cognitive rigidity and cognitive distortions; and environmental factors including losses, negative events, poor family experiences, and the presence of firearms.

Strayer and Marzani (2011) reported a distinction between subjects who engage with law enforcement. Some "want to die" and others are "ready and willing to die." Individuals who want to die might engage in suicidal behaviors to reach their goal. For others, suicide might not be their main goal, but they may be willing and ready to die as a result of their potentially high-risk action(s). Researchers, such as Joiner (2005), argue that the person who commits suicide must have the courage to do so, while others believe that suicide is the product of fear and an escape from pain:

“Suicide sometimes proceeds from cowardice, but not always; for cowardice sometimes prevents it; since as many live because they are afraid to die as die because they are afraid to live” (Colton, 1829, p. 156). A CSO interviewed by the Federal Bureau of Investigation’s (FBI) Behavioral Analysis Unit (BAU) stated he was too afraid to kill himself and could not think of a way to commit suicide that was guaranteed to end his life without being painful.

An awareness of risk factors does not allow for accurately predicting a person’s eventual suicide given the converging internal and external factors in an individual’s life (Joiner, 2005). Risk factors are only indicators of a possible suicide. Threatening suicide, talking or writing about suicide, and buying a weapon are often considered warning signs and imply imminent risk for suicide, demanding specific interventions (American Association of Suicidology, 2003). Even exhibiting these types of risk factors does not predict an individual’s suicide. Researchers believe an individual’s resiliency – degree of resourcefulness – is key to coping with stressors and thus avoiding suicide. People with greater resilience have protective factors, such as positive emotions, that ward off mental disorders like depression or anxiety and decrease vulnerability to suicide (Johnson, Gooding, Wood, & Tarrier, 2010). Therefore, resiliency may be the key component that enables CSOs who do not choose suicide to cope with the shame they experience as a result of the investigation.

Joiner’s (2005) Interpersonal-Psychological Theory (IPT) of suicidal behavior has received an increasing amount of empirical support. Joiner’s model proposes that three important features must be present for an individual to die by suicide: (1) perceived burdensomeness, (2) thwarted belonging, and (3) acquired capability for suicide. Joiner proposes that these three domains can be used to determine not only who desires to die by suicide but also who is most capable of lethal self-injury (Selby et al., 2010). These two important concepts of the IPT (desire and capability) are important especially when considering that despite the approximately 15% of the US population who seriously consider suicide, only 1.4% actually die by suicide (Nock, Borges, Bromet, Cha, et al., 2008; Nock, Borges, Bromet, Alnoso, et al., 2008). This disparity suggests that something prevents suicidal people from dying by suicide, despite their desire to do so.

Perceived burdensomeness and thwarted belonging are two of the three domains which constitute one’s “desire for death” (i.e., *why* someone would die by suicide) (Selby et al., 2010). Perceived burdensomeness is the sense that the individual feels he is a burden to others, does not contribute to a group, and poses a liability to the group’s well-being or safety. His feeling of an inability to make meaningful contributions to society also adds to his sense of burdensomeness and allows him to assume that his death is worth more to others than his life (Selby et al.).

Individuals with thwarted belongingness have an unmet need to belong which comes from a lack of frequent and positive social interactions as well as feelings of not being cared about by others (Baumeister & Leary, 1995; Selby et al.). They lack important connections to others and previously meaningful relationships have been strained or lost. Some individuals may have made attempts to belong, but various obstacles have prevented them from fitting in and connecting with others. Thwarted belongingness can be applied to those individuals who are physically isolated as

well as to those who have contact with family and friends. In many cases, the individuals who have frequent contact with others feel they are not genuinely connected to the group and that their contributions are insignificant at best. Various studies have confirmed the concept that thwarted belongingness is highly correlated with suicidal ideation, suicide attempts, and completed suicide (Conner, Britton, Sworts, & Joiner, 2007; Joiner, Hollar, & Van Orden, 2006; Van Orden, Witte, Gordon, Bender, & Joiner, 2008).

The third feature, acquired capability, is the degree to which an individual is able to actually commit suicide (i.e., *who* can commit suicide). The act of suicide is extremely fear inducing and often pain inducing; therefore, habituation to the fear and pain involved is required for suicidal behavior (Joiner, 2005; Van Orden, et al., 2008). Joiner uses the example of jumping out of a plane (skydiving) or parachute training to illustrate this concept. With each jump, the individual feels significantly less terror. Acquired capability develops through a variety of experiences to include medical problems, surgeries, drug use, exposure to violence, military experience, past suicidal attempts, and repeated tattooing and piercing (Joiner). The impact of these experiences does not fade quickly; once in place, acquired capability is relatively static and does not come and go over time (Joiner). Acquired capability for suicide separates individuals who desire to die by suicide from those who actually commit suicide. Although each feature of Joiner's IPT is necessary for suicide, each feature in isolation is not sufficient. Joiner proposes that only when both desire and capability coexist will suicide occur.

Suicide has also been analyzed among various subpopulations to include active military members and veterans. Previous studies have indicated that individuals with military service may be at increased risk for suicidal behavior (Kaplan, Huguet, McFarland, & Newsome, 2007). Recent research has proposed that military service increases one's acquired capability since combat and training exposes an individual to pain, fear, and death (Selby et al., 2010). Combat experience may help an individual develop a sense of "invincibility," which can lead him/her to engage in more risky behaviors and develop a greater sense of fearlessness. War zone violence is likely to be the greatest contributor to acquired capability. Recent studies have shown that military training alone can increase one's ability to commit suicide (Bryan et al., 2010; Selby et al.). During military training repeated injuries, use of dangerous weapons, simulated combat activities, and other intense situations are common. This can decrease one's fear of death and one's sensitivity to pain (Joiner, 2005; Selby et al.). Access, familiarity, and comfort level with firearms is also likely to be higher among military members. If one is trained in firearms, then using a gun to commit suicide may not invoke as much fear as other potential methods (Selby et al.). In addition, military members are more likely to own a personal gun than are members of the general population (Hepburn, Miller, Azrael, & Hemenway, 2007). The nature of military service decreases one's fear of death through the reoccurring experience of pain and possible death. This habituation process (acquired capability) may extend to suicide if suicidal ideation (the desire to die) is present (Selby et al.).

Risk for suicide is not limited to those in an active duty status. Veterans are also at risk for suicide due to increased problems with families, difficulties at work, chronic combat injuries, and depression. For example, depression causes difficulty dealing with loneliness and lack of connection, maintaining an occupation, and it contributes to feelings of worthlessness (Koren, Norman, Cohen, Berman, & Klein, 2005). Post-traumatic stress disorder (PTSD), a common disorder among military veterans, is strongly associated with suicidal behavior (Kessler, 2000). Many of the clinical features of PTSD, such as agitation, insomnia, and nightmares, are also identified risk factors for suicide.

In addition, veterans can experience difficulties integrating back into civilian life, which can increase feelings of burdensomeness and lack of belonging. Whether veterans are physically or psychologically injured upon discharge or retirement, they may lack a sense of purpose and may feel they are a burden on society. Burdensomeness may be increased if one abandons or is expelled from the military. A recent study of soldiers who died by suicide found that involuntary discharge was a significant risk factor for suicide when compared to those who completed their military service (Thoresen & Mehlum, 2006).

While among the general population suicide is the 11th most frequent cause of death, inmates in state and federal prison have higher rates of suicide than the general population. Maruschak (2004) reported that suicide is the third leading cause of death for inmates. Among a sample of inmates in a study by Lamis, Langhinrichsen-Rohling, and Simpler (2008), personality disorders were associated with suicide proneness, especially borderline and schizotypal personality disorders. The behaviors exhibited in individuals with borderline personality disorders included instability in their interpersonal relationships, increased impulsivity, and suicidal behaviors. Among individuals with schizotypal personality disorder, odd or bizarre cognitive functioning influenced their perception that the world was unsafe, causing them to feel greater distress. A finding among this study was that inmates scoring higher on the sadistic (aggressive) scale on the MCMI-III were more likely to be cruel, angry, violent, demeaning, and manipulative. They more frequently spent more time in isolation, and therefore, developed less supportive relationships with others. They also indicated greater signs of suicide proneness and distress. Interestingly, the study found that increased signs of obsessive-compulsive personality disorder contained symptoms of psychological distress as well, possibly due to the individual's rigidity, inflexibility with others, and expectations of perfectionism (Lamis et al. 2008).

b. Suicide Notes

Suicide notes are considered to be an excellent archival source of direct information about the individual who died by suicide (Leenaars & Balance, 1984) and are "windows to the mind of the deceased" (Leenaars, 2004, p. 84). Among the general suicide population, the percentage of people who leave a suicide note ranges from 15% to 55% (Callanan & Davis, 2009; Joiner, 2010; O'Donnell, Farmer, & Catalan,

1993). O'Donnell et al. (1993) found among a sample of 242 probable suicides, 15% (36) left at least one suicide note. In a sample of 621 suicides over a 10-year span (480 males; 141 females), 37.2% left suicide notes (Callanan & Davis). From this study, individuals living alone were 2.5 times more likely to leave a suicide note, were more likely to be depressed and/or socially isolated, and were less likely to have made a prior suicide threat. Joiner (2010) reports that 25% is an average percentage of individuals who die by suicide who leave a suicide note. Ho, Yip, Chiu, and Halliday (1998) report that when individuals leave a suicide note, the suicide act does not tend to be a random phenomenon.

Some researchers have analyzed the similarities and differences among those individuals who leave notes and those who do not. Shneidman (1996) theorized that, in general, different samples of individuals who died by suicide have greater commonalities than differences, including being stressed by unmet psychological needs, feelings of hopeless or helpless, feeling ambivalent, and having cognitive constriction.¹ In addition, the individual may be seeking a solution to a perceived problem, communicating his/her intention to commit suicide, attempting to escape, and/or becoming unconscious to avoid unbearable psychache.

Black and Lester (1995) found no significant differences in their sample based on gender or age among the suicide notes they examined. In a study by Foster (2003), no statistically significant differences were found between individuals who left a note prior to their suicide and those who did not. The variables examined were age, sex, marital status, previous history of deliberate self-harm, and contact with a primary care physician or mental health professional.

Some studies have reported differences among samples based on gender, age, and method. Lester (1990) and Chynoweth (1977) indicated that the following are more likely to leave a suicide note: predominantly younger individuals, women, elderly, and those who used medication, poison, or a firearm as their suicide method. Individuals who were mentally disturbed were less likely to leave a note. More recently, Ho et al. (1998) examined 769 individuals who died by suicide (461 males and 308 females). The group of subjects that left a suicide note was more frequently young females; individuals with non-widowed marital status, who reported no prior suicide attempts or prior mental illness; and those with religious beliefs. Additionally, individuals who used suicide methods that were easily available, such as jumping or cutting their wrists, were less likely to leave a suicide note (Ho et al.).

Incorporating a method of analysis initially used by Shneidman and Farberow (1960) and Darbonne (1969) categorized suicide notes from 156 individuals based on five general categories, including to whom the note was addressed, reasons for the suicide, emotional expressions, content expressed by the suicide writer, and the overall tone of the suicide note. Darbonne found that the individuals who wrote suicide notes did not typically discuss issues related to finances and did not indicate

¹ Cognitive constriction is a term that was introduced by Edwin Shneidman to describe the suicidal individual's state of mind as a narrowing of one's focus and includes all-or-nothing (dichotomous) thinking. The individual is unable to consider other alternatives to overcome the "psychache" they are experiencing and subsequently see the only solution being suicide (Shneidman, 1996).

confusion or bizarre psychotic thoughts. Results indicated that younger individuals (ages 20–39), who wrote a suicide note prior to committing suicide, more frequently expressed feelings of rejection and difficulty in coping with problems in their interpersonal relationships. The younger individuals did not comment on illnesses or pain, and they often internalized blame and guilt while expressing self-depreciation. The group of individuals between 40 and 49 years of age more frequently endorsed themes related to the demands of life, being tired or bored, and wanting to escape. This group often focused on obtaining forgiveness from God and expressed hopelessness that the future would change for the better. Individuals in the 50–59-year age group, who wrote notes prior to committing suicide, rarely offered a reason for the suicide, and the tone of the notes was less emotional. They often conveyed practical information in their suicide notes. The authors theorized that individuals in this age group have experienced failing health and were more rational in their decision to die by suicide. Finally, the individuals 60 years and older more frequently reported reasons as to why they committed suicide, which included illness, pain, physical disability, loneliness, and isolation. They expressed feelings of sadness and a desire for forgiveness from identified person(s). Although this group expressed a greater sense of positive self-image and less self-depreciation and guilt, they reported being rejected by others (Darbonne).

Similarly, Leenaars and Balance (1984) conducted a study of 52 suicide notes (48 from suicide and 4 from suicide attempters). The mean age of the sample was 42, and the range was 18–74 years of age. The sample was divided into two groups: under 42 years of age and over 42 years of age, with 25 suicide notes in each group. Results of the study indicated that the younger group was more self-critical, harsher toward themselves, and expressed less self-worth than the older group. In addition, the younger group more frequently referred to others and expressed positive and negative feelings about them.

A number of studies examined themes that individuals often expressed in their suicide notes, such as blame toward self and others, consideration of others, anger, low self-esteem, difficulty coping, obtaining forgiveness, taking control, and pessimism (Bhatia, Verma, & Murty, 2006; Darbonne, 1969; Foster, 2003; Leenaars & Balance, 1984; Lester, Wood, William, & Haines, 2004; Linn & Lester, 1996; McClelland, Reicher, & Both, 2000). McClelland et al. (2000) reported that the concept of blame was the most frequently cited theme within their sample of 172 suicide notes, with 88% of the subjects mentioning blame in their notes. In addition, Linn and Lester reported the presence of 15 characteristics to include: sparing the feelings of others, blaming oneself, blaming others, clear anger, subtle anger, low self-esteem, grief-stricken widow(er), feeling defeated/overwhelmed, feeling hopeless/helpless, unable to show feelings, feeling unworthy, having an incurable disease, performance failure, feeling sorry for oneself, and a failed relationship. Foster found six themes were more commonly present in their sample of suicides notes. The themes included apology/shame (74%), love for those left behind (60%), life too much to bear (48%), instructions regarding practical affairs postmortem (36%), hopelessness/nothing to live for (21%), and advice for those left behind (21%).

Based on Joiner's IPT model, individuals who left a suicide note(s) often included statements supporting the model's three components: lack of belonging, perceived burdensomeness, and acquired capability (Joiner, 2005). Joiner, Pettit, Walker, Voelz, and Cruz (2002) examined how perceived burdensomeness relates to suicidality. They included five dimensions: sense of burdensomeness, regulating emotion, regulating interpersonal relations, degree of emotional pain, and a sense of helplessness. In their study, 20 suicide notes from those who attempted and 20 notes from those who completed suicide were examined. Their results revealed some support that burdensomeness or a feeling that one is a liability to one's loved ones correlates with those who completed suicide. Joiner et al. (2002) found that those who have greater burdensomeness chose more lethal methods of suicide. Higher lethality included those deaths attributed to gunshot, hanging, falling under a vehicle, and electrocution. Lower lethality encompassed methods like poisoning, drug overdose, cuts, and suffocation. This classification scheme is similar to those used in past work (e.g., Card, 1974). Joiner's results showed that those individuals with greater lethality methods endorsed more burdensomeness in their notes than those with less lethal methods. Some studies have suggested that age appears to be a factor in degrees of burdensomeness. In a report by Foster (2003), individuals over the age of 65 who left notes were more likely to contain the theme of burden to others.

Among the suicide notes analyzed in one study, the majority (80%) stated a reason for the suicide (Bhatia et al., 2006), while the remaining 20% did not. Bhatia et al. found that from a study of 40 suicide notes (26 from males, 14 from females), different reasons were expressed for the decision to commit suicide, such as a disturbed love affair (25%), financial problems (15%), family disputes (10%), property disputes (10%), physical illness (10%), adultery (5%), and problems at work (5%). Kuwabara et al. (2006) presented six subgroups of reasons for suicide as reported in their notes, including: physical illness, pessimism, psychiatric disorder, problems in relationships, socioeconomic problems, and along with other reasons.

Lester et al. (2004) examined 262 suicide notes and incorporated Menninger's three motivations² for suicide to include to die, to kill, and to be killed and two additional factors (work/school and love/romance). Lester et al. found that older people who died by suicide were more likely to endorse the "to die" motive and less likely to have the "to kill" motive in their notes. The older group was also likely to use suicide to escape as a motive and less likely to have anger toward others as a motive. This finding was supported by a study which reported that the older group in the sample expressed less inwardly directed aggression in their suicide notes than the younger group (Leenaars & Balance, 1984).

Ho et al. (1998) indicated that the majority of individuals leaving a note provided practical instructions or directions regarding the handling of their affairs. The authors indicated that note leavers needed to communicate or disseminate specific information to others. In addition, the writer's age was related to whether the

² Menninger's three motives for suicide included expressions of anger (to kill), self-blame (to be killed), and the desire to escape (to die) (Lester, Seiden, & Tauber, 1990)

individuals addressed someone specific in their notes, with younger individuals more likely to write to parents, siblings, and friends and older individuals more likely to address spouses and children. Bhatia et al. (2006) reported that 35% of the sample did not address their suicide note to anyone, 20% of the subjects addressed their suicide note to a sibling, 15% to the police, 10% to a spouse or friend, and 5% to a parent or colleague.

Ho et al. (1998) theorized that an individual's religious beliefs might influence his/her need to write a note. Such individuals also tend to lack prior suicidal behaviors and often beg their readers to forgive them for committing suicide. Ho et al. wrote that, "In their last writings, suicide subjects reveal their remaining wishes and concerns, sometimes colored by their intense emotions" (p. 472).

Among the suicide notes in a study by Bhatia et al. (2006), over half of the sample indicated hopelessness and depression, 25% reported anguish and hostility, and 5% indicated signs of delusions. There was no clear indication that any of the individuals who died by suicide had a clear psychiatric illness (Bhatia et al.). In 80% of the suicide notes, death was reportedly the only option from the individuals' perspective.

c. Child Sex Offender Dynamics

CSOs often engage in a variety of behaviors to satisfy their sexual arousal to children. They may sexually molest children, produce sexually explicit images of children, download images of child pornography, distribute images of child pornography, and/or travel to have sex with a child. There is a diverse range in the intensity, frequency, time, effort, and motive for a person who sexually victimizes or exploits children. The FBI's BAU has been analyzing the behavior of CSOs for over 30 years and has developed the sex offender continuum, which has been instrumental in assisting law enforcement in understanding the sex offenders law enforcement investigates (Lanning, 2010). Two descriptive categories emerged within this continuum to provide a better understanding of the differences among this population. The continuum includes the situational CSO and the preferential CSO. A situational CSO is one who tends to be more opportunistic and impulsive in his sexual offending against children. This offender does not have an inherent sexual preference for children, but will take advantage of an opportunity to access children for a sexual purpose. Some studies have found that the situational CSO prefers adult partners, starts offending later on in life, has fewer victims, offends when stressed, and often offends against family members (Abel, Mittleman, & Becker, 1985). Alternatively, a preferential CSO has a long-standing, inherent, sexual arousal to children and often starts earlier in his offending (Lanning). The preferential CSO may incorporate ritualistic and/or obsessive actions in his collection and maintenance of child pornography to fulfill his arousal.

The majority of individuals who have a true sexual preference for children meet the criteria for pedophilia diagnosis if the child's age is 13 years or younger

(Lanning, 2010; Seto, 2008). The term pedophilia comes from the Greek words, “philia” meaning love and “pedeiktos” meaning young children (Seto). “Pedophilia erotica” was a term coined by Krafft-Ebbing (1886) in his book *Psychopathia Sexualis*, which described individuals who commit a violation against children under the age of 14 years. In the twentieth century, the term was broadly used and accepted to describe individuals who have a sexual interest and preference in children. The Diagnostic and Statistical Manual (DSM) of mental disorders first introduced the term in 1952. The DSM IV-Revised criteria for pedophilia includes the sexual interest in prepubescent minors (13 years and younger) by individuals who have had fantasies, sexual urges, or behaviors causing significant distress or impairment in social, occupational, or other areas and which has continued for 6 months or more. Some individuals diagnosed with pedophilia may not have acted upon their arousal, and some may not be distressed by their fantasies and urges. Acting on their arousal includes a broad list of behaviors and can include annoyance sex crimes with children such as exposure, voyeurism, frotteurism, and collecting child pornography. The diagnosis includes exclusive or nonexclusive types of pedophiles. The exclusive (sometimes referred to as a “true pedophile”) type is only sexually interested in and aroused by children, while the nonexclusive type has a sexual interest in children and adults. In a study of 2,429 adult male pedophiles, only 7% self-identified as an exclusive type (Hall & Hall, 2007). Hence, most pedophiles fall into the nonexclusive category.

Additional changes are planned for the DSM-5, which is scheduled to be released in 2013 (www.dsm5.org) and includes revisions to the criteria and labels for the diagnosis of pedophilia. An additional category, “Pedohebephilic Disorder,” is being proposed and would include prepubescent and pubescent children.

An accurate prevalence rate for pedophilia is difficult to obtain because an individual is typically identified by the legal system only after he acts on his sexual arousal to children. From an analysis of the studies to date, the best prevalence rate for individuals who meet the criteria for pedophilia among the male population is less than 5% with some studies ranging from 3% to 9% (Ahlers et al., 2009; Seto, 2008).

Finkelhor (1984) reported that individuals who meet the criteria for pedophilia have been found to have certain personality characteristics, such as low self-esteem and poor social skills, along with impaired interpersonal functioning (Cohen et al., 2002). Wilson and Cox (1983) reported that a sample of pedophiles showed elevations in the three factors of the three-factor model by Eysenck (1991) including psychoticism, introversion (extraversion), and neuroticism. A limitation of the research includes issues related to sampling. Most of the studies have focused on pedophiles who are in a correctional setting or in a clinical setting, and therefore, the results might be skewed.

CSOs act upon their sexual urges through online and contact offenses involving children. A question often asked of researchers studying CSOs is what likelihood exists that an online CSO has committed a sexual contact offense against a child (criminal history) or will engage in a sexual contact with a child in the future (recidivism)? There are limited empirical data to answer that question. A study by Bourke and Hernandez (2009), at the Bureau of Prisons, examined 155 online CSOs who were in a treatment program utilizing cognitive and behavioral treatment modalities.

The majority of the sample was Caucasian, and 74% had no known prior contact sexual offenses against children. When the polygraph was used in the treatment of the offenders, 85% admitted to having past contact sexual offenses against children and often had multiple victims. Although there are some limitations due to the fact that the sample is composed only of offenders who volunteered for treatment, this sample indicates that online CSOs were likely to have had a prior contact sexual offense against a child. Seto (2008) found that approximately 55% of a sample of pedophiles self-reported a prior sexual offense against a child and 12.5% had a documented prior contact sexual offense. In an unpublished study of online CSOs conducted by the FBI's BAU, approximately 33% had a prior history of or a subsequent contact child sexual offense. Of those who had a prior criminal history, 26.8% had been charged with a felony sex crime against a child. In addition, recidivism data was known for 189 online CSOs in the BAU sample. Of those offenders, the recidivism rate was 32% ($n=61/189$) with an average risk in the community of 4.4 years ($SD=3.90$ years) (FBI, 2010).

There are a number of factors impacting a CSO's decision to sexually offend against children. Seto (2008) reported that individuals who commit a hands-on offense against a child and are diagnosed with pedophilia offended against more victims. Eighty-eight percent of child molesters in the Seto sample met the criteria for pedophilia, and they committed most (95%) of the child abuse incidents. Factors influencing sexually offending against children can be organized by three main groups: (1) antisocial attitudes and behaviors, (2) sexual deviance, and (3) intimacy deficits (Finkelhor, 1984; Hall & Hirschman, 1992; Hanson & Morton-Bourgon, 2009; Seto, 2008; Ward & Beech, 2005). The antisocial category included those sex offenders who had a criminal history, a history of prior treatment for a sex offense, and a disinhibition due to alcohol, drug use, impulsivity, antisocial attitudes, and psychopathy. In addition, offenders who acted on their sexual arousal to children were able to overcome internal and external inhibitors and the child's resistance. The antisocial category also included cognitive distortions, which are used to justify sexual contact with children. Some CSOs also communicated with like-minded individuals, which reinforced their antisocial attitudes and beliefs. Finally, failing to comply with the requirements of their conditional release negatively impacts recidivism.

Another factor that impacts recidivism among CSOs is sexual deviance (Finkelhor, 1984; Hall & Hirschman, 1992; Seto, Hanson, & Babchishin, 2011). The following behaviors help to support and reinforce their physiological or deviant sexual arousal to children: possessing sexual material depicting younger children, sexual sadism, and possession of non-Internet child pornography. Research suggests that individuals who are strongly motivated by their sexual arousal to children would be considered preferential child sex offenders against children. Preferential CSOs typically have more victims due to their long-standing pattern of sexual interest and arousal to children. They often use less force as they are able to utilize well-developed grooming behaviors (Hall & Hirschman; Lanning, 2010).

The third factor, intimacy deficits, includes being unable to meet sexual and intimacy needs from adults, being more connected emotionally to children, having poor social skills, having affective dysregulation, being single, having prior male child

victims, and loneliness. CSOs with affect-related problems (affective dysregulation) are often opportunistic in their victim choices, use greater violence, and commit both sexual and nonsexual offenses (Hall & Hirschman, 1992).

Additionally, having a personality disorder impacts the antisocial attitudes and behaviors, sexual deviance, and intimacy deficits of CSOs. People who have personality-disordered traits often have a greater vulnerability, which increases affective dysregulation, impulsivity, sexual arousal, and thoughts about children.

The preferential CSO or pedophile who acts upon his sexual arousal to children utilizes varied methods to obtain his preferred child victim, including accessing the child through his neighborhood, employment choices or hobbies, marrying a woman who has children, marrying in order to have children, and meeting other like-minded individuals who may have access to children and who can support and condone such behavior (Lanning, 2010). He employs well-developed strategies to seduce and groom children for sexual purposes. The goal of grooming is to slowly build the child's trust in order to reduce the risk of exposure and/or disclosure, to gain access to the child through the parents, to obtain time alone to develop this trust, and to desensitize the child to eventually engage in sexual contact with the offender (Lanning).

The grooming techniques used depend on the age and specific needs or vulnerabilities of the child and may include giving the child gifts; support; treating the child as special; isolating the victim from his/her social support; gradually increasing the explicit talk about sex through jokes, education, use of pornography (adult and/or child); and gradually desensitizing the child to touch (e.g., tickling, wrestling, bathing) (Lanning, 2010).

In order to fully examine CSO dynamics, one must understand the internal conflict often experienced by offenders during their offending (Hoffer, Shelton, Behnke, & Erdberg, 2010). This internal conflict is often overcome by using cognitive distortions, which help an offender maintain a positive sense of self and suppress feelings of shame or anxiety. There is substantial literature exploring the cognitive, emotional, and behavioral deficits that CSOs exhibit and the relationship between cognitive distortions and child sexual abuse (Abel et al., 1989; Howitt & Sheldon 2007; Lanning, 2010; Murphy, 1990; Seto, 2008).

Cognitive distortions, such as denial, rationalization, and minimization, allow CSOs to misconstrue the nature of their sexual offending and defend against the full impact of their sexual arousal to children (Abel et al., 1989; Lanning, 2010; Murphy, 1990; Ward, 2000). Using these distortions allows the offender to excuse his behavior to himself and others (Howitt, 2005; Howitt & Sheldon 2007; Lanning). Examples of these distortions include, "I only looked at pictures of child pornography," or "I am addicted to pornography," "I'm not interested in child pornography," "I love children and would never hurt them," "that little girl came onto me by sitting on my lap," or "the child pornography just popped up on my computer, and I was just curious." Yet, when law enforcement knocks on the CSO's door, his secret is exposed, and the cognitive distortions he has used for so many years may no longer effectively protect him from feelings of self-loathing (Hoffer et al., 2010).

Based on an extensive review of studies, Ward (2000) established categories of cognitive distortions generated by CSOs. They include the following: (1) the offender

believes the child desires and needs sexual pleasure and can make an informed decision about sexual contact; (2) the CSO thinks he is entitled and his needs are more important than others; (3) the offender views the world as a dangerous place, and children are more trustworthy and safer than adults; (4) the offender believes that his behavior is out of his control, and other factors (e.g., alcohol, drugs) are responsible for his sexual behavior; (5) the offender perceives that the sexual activity with children is basically harmless compared with more severe behaviors.

d. Child Sex Offenders and Suicide

In exploring suicide among CSOs, only a few studies have specifically addressed the topic with earlier work consisting primarily of case studies rather than empirical analyses (Walford, Kennedy, Manwell, & McCune, 1990; Wild, 1998). Even among historical and more recent studies, trends and patterns have been observed and noted.

Brophy (2003) studied 32 subjects who committed suicide while under investigation for a sexual offense. Sexual offenses included offenses against adults or children; however, sexual offenses committed against children comprised the majority of the study. Findings revealed a sample of all males, on average in their mid-40s, whose deaths typically occurred very early in the criminal investigation. Nearly half were married and most died by hanging. None of the 32 men had a prior sex offense, and many were in good standing in their community. When comparing suicide risk with the general population of Irish males, the sex offenders who offended against children were 230 times more likely to commit suicide. Brophy found that the offender's shame and "catastrophic loss of standing and irreparable damage to [his] reputation" are most closely linked to the offender's subsequent suicide (p. 158). He attributes that shame affects these offenders more than despair. Biological influences also may be at play with CSOs under investigation as highlighted by Buck (1999) who found that decreasing blood serotonin levels (linked to impulsive aggression and suicide) followed a change in social standing (Brophy, 2003). Additionally, Brophy reported that offenders exhibit elevated stress and an increased risk of self-harm at *each* step of the legal process instead of at one particular stage due to the anticipation regarding future outcomes. For those CSOs who cope with the stress, the result is an acceptance and adjustment to each legal phase (e.g., awareness, arrest, detention, release, indictment, preliminary hearing, trial, plea, sentencing, incarceration). For CSOs who are not able to cope effectively with the elevated stress, the potential for self-harm increases.

Pritchard and King (2005) also found similar risk patterns and differentiated types of child sex offenders. Examining 16 suicides among 374 male CSOs, they divided the sample into three groups: (1) sex only (51%), those offenders whose only criminal offense was a child sex crime; (2) multi-criminal (27%), offenders whose offenses included a child sex crime as well as other nonsexual crimes; and (3) violent multi-criminal (22%), offenders whose criminal offenses included a

child sex crime, along with other nonsexual crimes, and at least one conviction for violence (Pritchard & Bagley, 2000).¹ Analyses revealed that 15 of the 16 suicides occurred among offenders whose only criminal offense was a child sex crime. Offenders in this group, who most often killed themselves around the time of the disclosure of the sex crime or trial, were 183 times more likely to die by suicide than the male general population. Pritchard and King (2005) discussed a variety of factors to explain why CSOs with no prior criminal offenses are at higher risk for suicide. These included shame or remorse, media exposure, threat and pressure of criminal proceedings, and future prison time (Pritchard & King, 2005).

Byrne, Lurigio, and Pimentel (2009) also highlight the need to study CSO suicide in order to reformulate suicide prevention policies and practices. This study examined suicides among alleged sex offenders in the federal pretrial system and what appears to be a significantly high risk of suicide in these defendants. Although extensive research has been conducted of prison/jail suicides, suicide among those on community supervision (pretrial, probation, parole) is lacking (Pritchard & King, 2005). Therefore, in response to the fast-growing number of federally prosecuted child exploitation offenses, and the number of suicides of pretrial sex offenders in two California federal districts, a pilot program was established to attempt to lower the risk of suicide in this population. The program allows for a multidisciplinary approach with mental health providers and the criminal justice system working together in crisis intervention, therapy, and incarceration preparations (Byrne et al., 2009). Since the program's inception, no suicides have occurred among participants. The researchers hope that it sets the example of how new and innovative strategies can prevent suicide among this population of offenders.

A more recent article explored the issues and widespread impact surrounding CSOs who commit suicide and underscores the potential risk to law enforcement personnel (Hoffer et al., 2010). Increased awareness by law enforcement of the potential for suicide in child sex crime investigations may mitigate the risk of suicide and improve operational responses, including officer safety. The article not only detailed how the offender is impacted by the investigation but also addressed how the offender's subsequent suicide affects his family, friends, and victims.

Because many CSOs experience high levels of fear, anxiety, shame, and helplessness after learning they are under investigation, suicide may be viewed as the preferred alternative when they consider the loss of their job, home, reputation, and freedom. Upon their death, their family suffers tremendous loss, which is compounded by the discovery that a loved one has committed sexual crimes against children. Family members may experience feelings of guilt, anger, denial, and shock, and may be left wondering if they ever really even knew their loved one at all. Quite similarly, victim(s) of the offender often experience a range of feelings after the suicide to include ambivalence, anger, and sadness. Depending on the type of relationship between the offender and victim, others may blame the victim for

¹ Violent offenses were defined as nonsexual offenses with actual or grievous bodily harm (Pritchard & Bagley, 2000).

causing the offender's death due to his/her disclosure of sexual molestation, thus increasing the victim's distress, guilt, and inner turmoil (Hoffer et al., 2010).

In addition to exploring the impact of CSO suicide on family members, victims of the CSO, and law enforcement, the purpose of this study was to examine the risk indicators for suicide, along with behavioral and personality factors of the CSOs who died by suicide by obtaining information from the investigation, lead investigators, along with family members and close associations of the CSO. In addition, the analyses of the suicide notes offered insight into the cognitive and affective state of the CSO. The results of the study impact multidisciplinary fields to include law enforcement, legal, mental health, and corrections.

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