Inmates Who Attempted Suicide in Prison: A Qualitative Study

Ildiko Suto
Pacific University

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Abstract
Suicide is a leading cause of death in prisons across the United States. Existing research on prison suicides has been criticized for focusing on static variables such as demographics and ignoring process variables. The purpose of the present investigation was to study the experiences of inmates who attempted suicide in order to shed light on factors associated with the suicide attempts in prison. A qualitative research project was conducted. Twenty-four inmates who attempted suicide in prison were interviewed in six state prison facilities in Oregon. The results were organized into three categories: mental health issues, relationship issues, and prison factors. Within the mental health category, the themes were depressive symptoms, symptoms of anxiety, hallucinations and/or paranoid ideation, medication-related problems, impulsivity, and religious beliefs. Inmates described their depressive symptoms in detail; several sub-themes emerged in this area. The relationship issues category was represented by themes of relationship problems involving one's family of procreation/partner outside of prison, family of origin/adoptive family, inmates, and staff members. Sub-themes were also identified in the latter theme. Prison factors included moves within the prison, employment/activity related difficulties, and placement in segregation. Inmate recommendations for suicide prevention are also discussed, along with other data such as psychosocial history of the participants, personal accounts of the suicide attempts, summaries of the individual attempts, and precipitating factors.

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Committee Chair
Genevieve Arnaut, Psy.D., Ph.D.

Second Advisor
James B. Lane, Ph.D.

Third Advisor
Michel Hersen, Ph.D., ABPP

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INMATES WHO ATTEMPTED SUICIDE IN PRISON:
A QUALITATIVE STUDY

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ILDIKO SUTO

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APPROVED:
Genevieve Arnaut, Psy.D, Ph.D.

James Z. Lane, Ph.D.

PROFESSOR AND DEAN

Michael Hessen, Ph.D, APR

ABSTRACT

Suicide is a leading cause of death in prisons across the United States. Existing research on prison suicides has been criticized for focusing on static variables such as demographics and ignoring process variables. The purpose of the present investigation was to study the experiences of inmates who attempted suicide in order to shed light on factors associated with the suicide attempts in prison. A qualitative research project was conducted. Twenty-four inmates who attempted suicide in prison were interviewed in six state prison facilities in Oregon. The results were organized into three categories: mental health issues, relationship issues, and prison factors. Within the mental health category, the themes were depressive symptoms, symptoms of anxiety, hallucinations and/or paranoid ideation, medication-related problems, impulsivity, and religious beliefs. Inmates described their depressive symptoms in detail; several subthemes emerged in this area. The relationship issues category was represented by themes of relationship problems involving one’s family of procreation/partner outside of prison, family of origin/adoptive family, inmates, and staff members. Subthemes were also identified in the latter theme. Prison factors included moves within the prison, employment/activity-related difficulties, and placement in segregation. Inmate recommendations for suicide prevention are also discussed, along with other data such as psychosocial history of the participants, personal accounts of the suicide attempts, summaries of the individual attempts, and precipitating factors.
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INTRODUCTION

In the United States, suicide is two times more common among prison inmates than in the general population (Kupers, 1999). Approximately 200 prison suicides occur in this country each year (Gater & Hayes, 2005), and suicide is the third leading cause of death in prison, after natural causes and AIDS (Hayes, 1999). According to Haycock (1991), the rate of suicide in prisons is expected to grow due to new mandatory sentencing laws, increase in the rate of incarceration, increase in the number of life sentences and death penalties, overcrowded correctional facilities, increased prevalence of AIDS, and the aging of the inmate population. Additionally, the trend of deinstitutionalizing mental health patients after 1963 and societal trends of migration and loss of traditional social networks (Westermeyer, 1987) has led to a greater proportion of incarcerated individuals with mental health problems, including those at risk for suicide. For example, in New York state correctional facilities, there was an increase from 13% to 24% of admitted inmates with mental health needs between 1991 and 1998 (Kovasznay, Miraglia, Beer, & Way, 2004). In California, the 2005 state prison suicide rate almost doubled over the 2004 rate, from 26 to 44 cases (Dannenberg, 2006).

Suicide rates may be actually higher than what statistics show, due to a tendency to underreport such incidents. For example, many suicides are categorized as accidental deaths (Danto, 1973). Staff at some facilities may choose to not report some deaths as suicides for fear of litigation (Daniel, 2006). If an inmate dies in the hospital following a suicide attempt, the records may not indicate that he or she died in the prison (Daniel,
2006). Hayes (1989) stated that during 1981 and 1982, only 22 inmates were reported to have been victims of suicide in Ohio penal institutions, when, in fact, an examination of hospital death certificates showed that 46 inmates took their own lives during this period. Furthermore, Kupers (1999) contended that certain escape attempts, engagement in physical fights with an armed guard or a tough prisoner, and failure to pay off a drug dealer or a gambling debt may constitute “invisible suicides” (p. 179)

Suicide is a recognized problem in jails, where over 400 inmates commit suicide in a year in the United States; however, prison suicides have not received comparable attention (Hayes, 1995). One reason for the lag between prison and jail research is the assumption of many researchers that the risk for suicide dissipates in prison as inmates adjust to life behind bars. Hayes stated that this assumption is simplistic and has not been empirically validated.

Haycock (1991) suggested that the lack of research on suicide among long-term inmates can partly be explained in the historical view of suicide as a form of punishment. Haycock argued that in several ancient societies suicide constituted a respected option for prisoners. He further noted that the Romans sentenced prisoners to compulsory suicides. Suicide is no longer sanctioned as an official punishment, but “the prisoner warehoused in a penal system everyone deplores who then commits suicide finds an understanding and perhaps quietly grateful reception” (Haycock, 1991, p. 83).

Hayes (1995) observed that the majority of the research in the domain of custodial suicide has been retrospective and descriptive, characterizing suicide as a “static, isolated event that is simply associated with other static factors (e.g., demographics)” (p. 4). Along those lines, Way, Miraglia, Sawyer, Beer, and Eddy (2005) noted that a great deal
of suicide research conducted in prison has been focused on calculating and comparing suicide rates. Similarly, Liebling (1999) stressed that prison suicide researchers have largely ignored the affective understanding of prisoners in favor of reliance on records. Additionally, studies of suicide statistics have often yielded unreliable results due to difficulties establishing appropriate comparison groups (Way et al., 2005) and limitations of recorded information, such as bias in and incompleteness of the data (Liebling, 1993). Liebling also noted that inmates' understanding of their suicide attempts may be different from accounts recorded in prison files. Retrospective and descriptive studies fail to describe the process by which inmates decide to take their lives (Hayes, 1995). In this regard, “quantitative data are only capable of capturing a portion of the reality. Interviews would provide a glimpse into the minds of inmates who attempted suicide, providing explanations that mere numbers are unfit to describe” (Winter, 2003, p. 143).

The above critiques suggest that the affective component and process of suicide could be more effectively studied by direct interviewing of inmates. However, such qualitative studies are scant, and the majority of them have been conducted in countries other than the United States. The purpose of this study was thus to investigate through interview the experiences of inmates who engaged in serious suicide attempts in one U.S. prison system (in Oregon). Attempts that would have been life-threatening without medical intervention qualified as serious attempts.

Within the last 12 years, the yearly rate of suicide in Oregon state prisons has fluctuated between 0 to 20 cases (Williams & Bellatty, 2005). Oregon Department of Correction (ODOC) liaisons requested this qualitative study in order to obtain information to assist them in reducing the number of suicides in Oregon correctional
facilities. Interviews with inmates who attempted suicide while incarcerated could provide valuable data for deciphering unknown risk factors for suicide in Oregon prisons as well as in other correctional facilities nationally and internationally.

In this study, my aim was to contribute to the knowledge base about factors that are associated with suicide in prison. No preconceived hypotheses were formulated because the purpose of the study was to identify factors not yet identified in the scientific literature; however, the information may be used to validate factors that have already been identified by other researchers. Inmates were also asked to make recommendations, based on their experiences, about ways to better prevention programs at ODOC or other correctional facilities.
LITERATURE REVIEW

Theories of Suicide

In one of his writings, Menninger (1993) commented with respect to suicide that "no other mysterious phenomenon of human activity has excited so little scientific investigation" (p. 22). Menninger noted that no such lack of interest was observable in the understanding of the motivation for murder, given the great volume with which mystery and detective stories are produced. However, in spite of this, some theorists have addressed the issue, and their theories will be discussed here.

The first psychological theories concerning suicide were formulated by Freud. He conceptualized the still debated theory of suicide as anger turned inward, as well as formulated views of suicide as representing guilt over death wishes toward others, an expression of the death instinct, identification with a suicidal parent, and/or ways of escape, revenge, and masochism (Litman, 1996).

One of the most influential theories of suicide is that of Durkheim (1951). According to this theory two characteristics of a society affect its suicide rates. The first factor is social integration, in which a high level of integration is believed to lead to altruistic suicides (e.g., the person sacrificing him- or herself for others, such as a soldier in war), whereas low levels of integration are posited to lead to egotistic suicides (i.e., the person feels isolated and alienated from others). The second societal factor is social regulation; in this case high levels of social regulation are believed to lead to fatalistic suicides (the person wants to escape from the bonds of the society), whereas low levels of
social regulation lead to anomie suicides (the person feels that his or her desires are not
gratified by the society).

Researchers have applied Durkheim's theory to the prison environment. Lester
and Danto (1993) viewed prisons as institutions where social regulation is very high.
Therefore, the authors argued, some prison suicides may be fatalistic in nature. Tartaro
and Lester (2005) attempted to validate Durkheim's theory by using measures of social
integration in the general population outside prison, such as birth, marriage, divorce, and
unemployment rates, as predictors for suicide in prison. They hypothesized that measures
of social integration of a society could predict suicide rates in both the general population
and prison because outside social forces affect prisoners as well. The authors argued that
high marriage and birth rates strengthen social integration, whereas high divorce and
unemployment rates weaken it.

Tartaro and Lester found that birth and divorce rates were significant predictors of
prison suicide; however, in this study, these variables did not explain suicide rates in the
general population. This finding was surprising because in an earlier study Lester and
Yang (1998, as cited in Tartaro & Lester, 2005) supported Durkheim's theory by
predicting suicide rates based on marriage and divorce rates in the general population.
The authors speculated that the outcomes of the present study did not support Durkheim's
hypothesis in the general population because of the changing meaning of social
indicators, such as increasing number of remarriages, in recent decades. The authors
failed to explain, however, why differences occurred between predictions made for the
general population and prison.
Some theories of suicide are specific to prisoners as well, such as Danto’s (1971) formulation. He identified three categories of suicidal types among prisoners to offer a conceptualization of different motivations for suicide. *Morality shock* was Danto’s first category; individuals in this category become suicidal because of feelings of disgrace and embarrassment that overwhelm them shortly after their incarceration. These individuals often have no previous criminal histories. *Chronic despair* was another category; these inmates develop a sense of hopelessness and futility about the future several months into their incarceration. Typically inmates with criminal history fall into this category.

Danto’s third category was *manipulation*; that is, suicidal gestures are exhibited to obtain preferential treatment from staff. And finally, Lester and Danto (1993) later added another category to this list: *self-punishment*, characterizing some inmates who wanted to humiliate themselves because of feelings of guilt related to certain sexual desires or behaviors viewed as sinful.

Theories of suicide could also be classified by their emphasis on internal or external factors. Danto’s (1971) conceptualization is a system based on internal psychological factors. Within the external or environmental theories there are two major schools of thought: the deprivation and the importation theories. Deprivation theorists (e.g., Jackson, 1983) hold that structural conditions within prisons, rather than internal factors, are the most significant determinants of indices of prisoner distress, including high suicide rates. Lester (1982) showed that the restrictive environment of prisons contributed to a higher rate of suicide. By comparing suicide rates in U.S. prisons to those of the general population by state, he concluded that the effects of the prison environment were stronger than the effects of the region. However, some authors have argued that
comparing the suicide rate of the prison population with that of the general population is inappropriate due to the fact that the characteristics of the two populations are different (Payson, 1975). For example, inmates often struggle with addictions, have poor work histories, and have disturbed familial and personal relationships. This line of thinking implies that inmates, rather than environmental characteristics, are responsible for the differing rates of suicide in prison and the general population. Clearly, external and internal risk factors can be difficult to differentiate.

Proponents of importation theory hold that inmates' behavior in prison is a reflection of forces operating in the free world. Jacobs (1977), for example, described in his book, Stateville, how the legal system, special interest groups, and gangs have continuously impacted daily life at this Illinois state prison. Authors of comparative racial studies also claim that a similar suicide ratio of different ethnic groups in and outside prison boosts the importation theory because the relationship between ethnicity and suicidal behavior reflects "the same demographic forces operating on the outside" (Anson & Cole, 1984, p. 566). Nonetheless, some researchers interpret importation theory as suicide risk derived from social and environmental risk factors that are present in an individual before his or her incarceration, such as economic deprivation, lack of education, and history of violence (Grossman, 1992). Grossman, who studied aboriginal female suicide in Canada's federal prison for women, argued for an interactionist view of deprivation and importation theories.

Liebling (1999) advocated the integration of psychological and environmental variables in explaining suicides in prison. She asserted that prisoners who attempt suicide are psychologically vulnerable individuals who carry their vulnerabilities while living in
the community and who fail to develop personal and external resources while living in the community. The lack in resources then contributes to poor adjustment to prison life. The prison environment is very stressful, and those with vulnerabilities in coping experience even greater problems than the average prisoner because they are less likely to obtain employment and are more likely to become targets of bullying.

Along the same lines, Bonner and Rich (1988) developed a transactional stress-vulnerability model of suicidal ideation and behavior. The authors conceptualized suicidal ideation and behavior as a multidimensional process that is the result of intrapersonal, social, and environmental variables. Using multiple regression analysis, Bonner and Rich (1990) showed in a cross-validation study that the interaction of loneliness and irrational beliefs with environmental stress best explained suicidal intent in a jail population. Additionally, Hatty and Walker (1986), who conducted a national study on deaths in Australian prisons, found evidence to support both internal and external theories.

Psychosocial Risk Factors

Overview

In this section I review studies by researchers who described the relationship of different factors to suicide in prison, such as common mental health symptoms; demographics variables such as age, gender, and race; bullying behaviors; impulsivity; physical health; modeling; religious beliefs; cognitive abilities; and social desirability. I also provide a review of precipitating factors associated with suicide attempts.

Some single factors commonly associated with suicide in the general population are the following: a psychiatric disorder, alcohol or drug abuse, suicidal ideation, prior
suicide attempts, use of lethal method, isolation, hopelessness, occupational or economic problems, marital problems, stress, anger, physical illness, and older age (Maris, 1992). These same suicide risk factors hold up in prison, except for age: more than half of all inmates who die in prison as a result of suicide are relatively young (25 to 34 years old; Daniel, 2006). Adolescence is also a high-risk period for suicide in the general population (Mazza, 1997). Along these lines, Daniel found that prisoners younger than 21 who were housed in adult institutions had risk for suicide that was eight times greater than that of juveniles placed in juvenile facilities.

Researchers do not seem to have reached consensus about whether women or men carry a higher risk for suicide. Earthrowl and McCully (2002) indicated that women had high suicidal risk because they experienced high psychological distress in New Zealand correctional facilities, partly due to the fact there are few custodial facilities for women in that country and thus confinement means geographical removal from dependents and social support networks. This would certainly hold true in other countries because there are more facilities housing men than women around the world. However, White and Schimmel (1995) determined that there were no suicides committed by females in United States federal prisons between 1971 and 1992.

Racial differences exist in rates of suicide in the general population: Both African American and Latino populations have a lower rate of suicide than Whites (Lester & Danto, 1993). African American prison inmates also have lower suicide rates than White prison inmates (Anson & Cole, 1984). The suicide rate for African Americans prisoners is even lower than the suicide rate for African Americans in the general population because they tend to have a stronger peer group in prison than Whites do (Lester &
Dantó, 1993). However, in contrast, some authors have found that the suicide rate of African American jail inmates is higher than that of the general African American population. Esparza (1972), for example, found the suicide rate to be two times higher in county jails than in the general Black population.

Hispanics, on the other hand, have a higher rate of suicide in prison than in the general population because, due to their culture of strong family ties, they suffer more from loss of family support in prison than people of other races (Lester & Danto, 1993). Detainees of Cuban descent have an even higher suicide rate than other Hispanic groups: Suicides of Cuban descendants accounted for 19% of all federal prison suicides between 1983 and 1987, despite the fact that detainees of Cuban descent represented only 6% of the federal inmate population during that time period (Schimmel, Sullivan, & Mrad, 1989). Their detainee status may explain their high suicide rate due to possible deportation and the uncertainty of their future (Bonner, 1992). Similar patterns exist in other countries as well. For example, Aborigines in Australia reportedly have a high rate of suicide in custody (Lester & Danto, 1993). Statistics on prison suicides in other racial groups, such as Asians and Native Americans, are difficult to find.

Racial hostilities may be perceived as being so threatening that some inmates may choose to take their lives to avoid being killed. The prison subculture is frequently an extension of gang life on the streets and, in fact, interracial hostilities often intensify in prison (Jacobs, 1979). Similarly, conflicts related to the prison culture may constitute antecedents to suicides. For example, suicide may become a solution for those inmates dealing with an internal conflict that involves a choice between joining a gang or
becoming a “rat,” or for inmates avoiding involvement in a homosexual relationship (Danto, 1973).

Blaauw, Winkel, and Kerkhoff (2001) examined the relationship between bullying and suicidal behavior in jails. They found that files of 34% of suicide victims contained admissions of having been bullied by other inmates. Sexual assaults in prison are also likely to contribute to increased suicidal risk (Salive, 1989). However, such activities are seriously underreported, which restricts the possibility of undertaking studies that would map this relationship (Salive, 1989).

Impulsivity has also been investigated. For example, Dear (2000) looked at whether impulsivity was associated with suicidal ideation in prison and found that a correlation between impulsivity and suicidal ideation was not present when depression was controlled.

Poor physical health has also been found to be a factor in suicide risk. Meltzer, Jenkins, Singleton, Charlton, and Yar (2003) looked into data from a survey of psychiatric morbidity in England and Wales prisons and found that 28% of inmates who attempted suicide rated their physical health as bad or very bad. These researchers also found that those who tried to kill themselves were twice as likely to be heavy smokers as those inmates who never attempted suicide. However, the definition of “heavy smoker” was not provided in the article.

The influence of modeling within the family on suicidal risk is a well-known phenomenon (e.g., Agerbo, Nodentoft, & Mortensen, 2002). Hales, Davison, Misch, and Taylor (2003) studied the impact of witnessing suicide in a correctional institution for young male prisoners (ages 15 to 21). The researchers found that contact with a non-fatal
suicide attempt by another inmate was associated with self-harm. Hales et al. also found that knowing somebody who attempted suicide in a correctional institution was most strongly associated with length of imprisonment. The authors argued that one of the reasons why prolonged imprisonment constitutes suicidal risk is that imprisonment increases the risk of exposure to suicidal behavior by other inmates. Interestingly, Hales et al. found no association between witnessing fatal suicides and self-harm. The researchers speculated that young inmates may be more likely to risk taking their own lives when they see others survive their attempts and possibly achieve some perceived gain because of it.

Religious beliefs, especially Christian ones, are commonly thought of as protective factors due to reference to suicide as a sin in the Bible. However, people who believe in an afterlife may commit suicide because they believe that they will be reunited with loved ones who died before them (Maltsberger, 1992).

Suicidal risk in prison has not been linked to deficits in cognitive abilities such as problem-solving. For example, Ivanoff, Smyth, Grochowski, Jang, and Klein (1992) showed that difficulties in problem-solving do not predispose inmates under stress to suicidal ideation. They found no correlation between risk for suicide and either a history of suicidal gestures or current suicidal ideation.

Social desirability has been theorized to be linked to suicidal risk (Linehan & Nielson, 1981); however, others demonstrated that the conclusion of whether such correlation exists depends on the measurement tool rather than the construct itself (Cole, 1988).
According to Hayes (1995), who conducted a literature review on prison suicides, determined that the profile of the inmate who committed suicide most frequently was as follows: relatively young (35 years old), White, male, poor education, high mental health needs, previous suicide attempts, marital or family problems, and no gang affiliation. Hayes also found that these inmates tended to be quiet and aloof individuals living in single cells in maximum custody facilities, who attempted suicide by hanging.

Precipitating factors for suicide in prison are varied. White and Schimmel (1995) conducted a suicide review in federal prisons between 1988 and 1992 and concluded that the precipitating factors for suicides were new legal problems, marital or other relationship difficulties, and inmate-related conflicts. Danto (1973) asserted that retaliation against or manipulation of staff and induction or delay of transfer were also reasons inmates decided to kill themselves.

Kupers (1999) described precipitating factors to suicide from an inmate point of view. Kupers worked as a psychiatric expert in over 12 class action lawsuits concerning the quality of mental health conditions within jails and prisons and as a consultant to the U.S. Department of Justice and to Human Rights Watch during an investigation of the state prison system. Based on her interviews with inmates, she detailed the reasons behind inmate suicide attempts, as follows: anxiety over upcoming release, denial of parole, a positive test for HIV, disconnection from loved ones, jealousy (e.g., learning that a mate started an intimate relationship with someone else), physical threats, rape, indecision about “snitching,” thoughts of failure in employment and personal life, depression due to solitary confinement, and psychosis. According to the author, “the reasons in each case of suicide are nuanced and complex” (p. 178).
In summary, several factors have been linked to inmate suicides, such as mental health symptoms, demographic variables, bullying behaviors, physical health problems, modeling, and religious beliefs. I explore in more detail the relationship between mental health and suicide in the next section.

*Suicide and Mental Illness*

Mental illness is common among prison inmates. It has been estimated that in 1999, 20% of prison inmates were seriously mentally ill (American Psychiatric Association, 2000b). In addition, a substantial number of prisoners have less serious mental disorders. In a literature review, Stuart (2003) found that the number of incarcerated individuals had grown by 56% in the United States within the prior decade. It comes as no surprise that O’Grady (2004) went so far as to state that “if you change the name ‘prison’ to ‘hospital’, you might not notice the difference” (p. S26).

Boothby and Clements (2000) noted that depression was the most often treated psychiatric condition in prison. Their national survey of correctional psychologists showed that 80% of their respondents cited depression as one of four most frequently treated problems in the U.S. prison system. Daniel (2006) also noted that depressive disorders are more closely linked to suicide than any other psychiatric illness. According to Rowan and Hayes (1988), depression is the best predictor of suicide; 70% to 80% of all suicides are committed by people who are severely depressed (Rowan & Hayes, 1988).

Depression and hopelessness are often associated with overall emotional distress (Mills & Kroner, 2005). Several researchers have demonstrated the relationship between hopelessness and suicidal behavior (e.g., Ivanoff, Jang, & Smyth, 1996). For example,
Palmer and Connelly (2005) compared depressive characteristics of prisoners who reported previous self-harm with those who did not. The researchers administered the Beck Hopelessness Scale, the Beck Depression Inventory, and the Beck Scale for Suicide Ideation to inmates in an England prison within four weeks of their arrival. Results indicated that prisoners with a history of self-harm scored significantly higher on all three measures, suggesting continued risk for suicide attempt.

Reizel and Harju (2000) argued that depressive symptoms were relatively predominant in newly incarcerated prison inmates and that therefore it would be valuable to know more about the nature of the depression. The authors classified inmate depression as short-term reactive depression or as more serious and chronic prison-adjustment depression. They theorized that over time inmates may experience an exacerbation or alleviation of depression based on their personal locus of control orientation. Reizel and Hajdu concluded that inmates with high internal control experienced less depression than inmates with high external control, and they theorized that individuals in the first group had developed a realistic view of the prison setting and adjusted accordingly, whereas the individuals in the latter group had a sense of helplessness. Thus, in this study, inmates identified as having high external control carried a higher risk for suicide than did those with an internal locus of control.

Somewhat distinct from researchers focusing on depression, Shneidman (1993) held the viewpoint that suicide is the result of “psychache,” or the “hurt, anguish, soreness, aching, psychological pain in the psyche, the mind” (p. 145). According to Schneidman, this psychache stems from frustrated psychological needs. The author argued that depression and suicide are “quite different” (p. 146) because depression never
causes suicide, given that many depressed people can live unfulfilling but long lives. Depression is a psychiatric disorder that has physiological, biochemical, and genetic components, whereas suicide is a phenomenological event, "a transient tempest in the mind....a nervous dysfunction" (p. 146). Shneidman (1998) argued that other suicidologists have tended to focus on four aspects of suicide—fight (aggression), flight (escape), fright (isolation), and familial issues—but that they have missed the pain aspect of the phenomenon.

Using Shneidman's (1993) conceptualization, Holden, Mehta, Cunningham, and McLeod (2001) constructed the Psychache Scale, purporting to measure psychache as an index of current emotional functioning. Based on their psychometric property measures, they found support for the validity of the concept of psychache. They theorized that suicide is a developmental process: depression leads to hopelessness, which then is followed by psychache and ultimately by suicidal behavior, as an attempt to escape the psychache. Mills, Green, and Reddon (2005) evaluated this scale for use with an offender population, and their results offered tentative support for the use of this instrument in the prediction of suicide. However, more studies are needed to establish the validity of the psychache concept and the practical value of such an instrument over established measures such as Beck's Hopelessness Scale (i.e., discriminant validity).

Anxiety has also been associated with risk for suicide (Apter et al., 1990). Apter et al. found a particularly high correlation between trait anxiety and suicidal behavior. Past traumatic events, such as physical and sexual abuse, also predispose inmates for suicide risk (World Health Organization, 2007). Stressful events such as violent episodes in prison or suicide of other inmates may trigger feelings of powerlessness, and suicide
may be considered as an option to escape such feelings (World Health Organization, 2007).

Schizophrenia also contributes to an increased suicidal risk in prison (Daniel, 2006), probably because of symptoms of social isolation and command hallucinations. Borderline personality disorder also constitutes a risk factor (Daniel, 2006), most likely because of symptoms of affective instability and poor interpersonal skills. Verona, Patrick, and Joiner (2001) showed a correlation between antisocial personality disorder and suicide risk as well.

**Suicide and Suicidal Behaviors**

The view that suicide attempters are manipulative was pervasive a few decades ago. For example, Johnson (1973) wrote: "The habitual interpretation of prison administrators is that self-mutilations are exclusively motivated for secondary gain, rather than seeking to terminate life. New employees...are indoctrinated in this interpretation of prisoner self-injuries" (p. 241). Today it is more widely believed that self-harming behavior may be a precursor to suicides.

To better understand the continuum of suicidal behaviors, many researchers have looked into similarities and differences between suicide attempters and completers. Daniel and Fleming (2005) reviewed data obtained from prison records of prisoners with serious and completed suicide attempts in a state correctional system (a footnote indicated this may have been conducted in the state of Missouri) during a 30-month period between 2002 and 2004. They found that serious suicide attempters were most likely to have the following characteristics: being White male property offenders, serving less than 10 years by the time of the attempt, having a diagnosis of depression or a
personality disorder, experiencing psychosocial stressors, having a cellmate, and using cutting and slashing as a method of attempting suicide. Those who completed suicide did not differ significantly from attempters in gender, race, crime, diagnosis, and psychiatric care; however, completers tended to have more psychiatric symptoms, medical conditions, and new convictions. Completers also experienced more interpersonal problems and psychosocial stressors, they were more likely to be held in single cells of maximum security facilities, and they had engaged in previous suicide behaviors more than attempters.

Jones (1986) examined the characteristics of prison inmates who engaged in self-mutilation while incarcerated in the Virginia Department of Corrections within a 1-year period between 1983 and 1984. The author found that, compared with inmates in the control group, "self-mutilators" were more likely to have been convicted of more felonies, to have been charged with more assaults, and to have more disciplinary actions on their records in prison. Using results of other studies as well, Jones concluded that there was a correlation between self-mutilation and attempted suicides and that self-mutilation should be regarded as seriously as attempted suicide, rather than as an act of manipulation. As Daniel and Fleming (2005) observed, some inmates harm themselves without having the intention to kill themselves; however, others employ more and more lethal methods until their attempts end their lives. Therefore, all suicidal gestures should be taken seriously.

Suicide and Violence

The question of whether a correlation exists between potential for violence and suicide is an interesting one. Inmates who exhibit violent behavior are considered to be
security risk and are often placed in maximum-security facilities. This suggests that comparing the number of suicides committed in maximum-security facilities with that in medium- and minimum-security facilities could indicate whether such a relationship exists. Similarly, the type of crime (e.g., murder) or length of sentence (e.g., life sentence for murder charges) can also suggest potential for violence. For example, DuRand, Burtka, Federman, Haycox, and Smith (1995), based on research conducted in a large Detroit jail, asserted that a charge of murder or manslaughter was present in 39% of the 37 suicide cases that occurred between 1962 and 1992, whereas only 2% of all inmates were incarcerated for these charges.

Researchers have found that inmates serving a life sentence were more likely to kill themselves than were other inmates (e.g., Salive, Smith, & Brewer, 1989). Unfortunately, the presence of multiple correlations muddles the usefulness of such studies. Inmates who are sentenced for murder charges usually receive long sentences and are placed in maximum-security facilities. The higher suicide rate could be related to an underlying tendency for violence but also to conditions existing in maximum-security facilities, as well as to hopelessness due to long sentencing. Salive et al. conducted a stratified analysis to determine whether the type of crime, length of sentencing, and maximum-level custody were independent variables. The authors concluded that the factors were so interrelated that they could not be separated in the analysis.

Plutchik (1994) theorized that violence and suicidality are interrelated in that both are manifestations of aggressiveness: the former outward directed, the latter inward directed (the roots of this theory are found in psychodynamic formulation). Plutchik based his view on his literature review of risk factors for violence and suicide. He found
that 40 variables had been identified as risk factors for suicide and 37 as risk factors for violence. Plutchik showed that 23 of the variables overlapped. Additionally, he found that 17 common variables had been identified to reduce the risk of both suicide and violence.

Apter et al. (1990) hypothesized that violent and suicide potential are interrelated because they arise from a common biological basis: low levels of serotonin. In a literature review, they searched for variables related to serotonin-level abnormalities. In addition to violence and suicide potential, they also identified impulsivity, anxiety, and depressed mood as having been associated with disturbances in serotonin level. With their correlational analyses of psychological variables measured by self-report scales, they provided support to their assertion that low levels of serotonin may be the biological basis of both violent and suicidal behavior (as well other psychological problems such as impulsivity and anxiety).

Yet, other researchers have arrived at different conclusions. Lopez-Ibor, Saiz-Ruiz, and Perez de los Cobos (1985) measured levels of 5-hydroxyindolacetic acid, a breakdown product of serotonin excreted in urine in their subjects. The authors found that low levels of this substance were present in individuals with suicidal behavior but they were not correlated with measures of aggressiveness.

Despite results showing correlations between low serotonin levels and suicidal behavior, biological explanations may not be useful in explaining suicidality at our current state of knowledge because of barriers in studying causality. Low serotonin levels may be the cause of depression, but they may also be the consequence of psychological distress or, alternatively, both may be true in different situations or different people. This discussion parallels treatment effectiveness issues, in particular whether medication or
Talk therapy is more effective in treating depression. Because several studies have shown that the combination of the two is the most effective way to treat this disorder (e.g., Petersen, 2006), it could be assumed that depression—including suicidal ideation—could be induced by both biological causes and cognitive/emotional states, or the combination of the two.

Nonetheless, association between suicidal and homicidal risk have been found by other authors as well, such as Blaauw, Kerkhof, and Hayes (2005). They reviewed 95 of 100 completed suicides committed in the Dutch prison system between 1987 and 1998 to develop prediction models for identifying prisoners with risk for suicide. Based on demographic, psychiatric, and criminal characteristics, the researchers used stepwise logistic regression analyses to develop prediction models. They found that a combination of two demographic variables (being older than 40 years and homeless), two criminal variables (having one prior incarceration and a violent offense), and two psychiatric characteristics (a history of inpatient or outpatient psychiatric care and drug abuse) permitted identification of 82% of the suicide victims in the Netherlands. The researchers then applied this model to other countries but, due to lack of data, the researchers used fewer variables for prediction. For example, by relying on three variables (age older than 40 years, prior incarceration, and violent offense) to predict 209 suicides committed in holding and detention facilities in the United States in 1986, 37% of the suicides were predicted. The same variables led to 40% correct prediction of the Dutch suicide sample. When only one variable—violent offense—was used, the same suicides committed in the United States were predicted with 53% accuracy, whereas a 76% result was attained in the Dutch comparison group. This study shows that there are likely both similarities and
differences in factors associated with inmate suicides in different countries. It also indicates that there is a correlation between violent crimes and suicide in prison.

Environmental Factors

Environmental factors related to confinement may partly explain why suicide occurs more frequently among inmates than among the general population. Research generally indicates that greater deprivation of freedom and loss of control over personal autonomy leads to higher risk for inmate suicide (Huey & McNulty, 2005). For example, Adams (1992) found that suicide rates were higher in maximum-security facilities than in minimum- and medium-security prisons. One likely reason for this increase is social isolation from other inmates, because the development of social networks and informal groups are inhibited in such settings (Huey & McNulty, 2005). Additionally, there is less availability and access to rehabilitative programs in maximum-security than in minimum- and medium-security facilities, which can increase a sense of idleness and isolation among inmates (Huey & McNulty, 2005).

Researchers have shown consistently that the risk for suicide is higher among inmates confined to social isolation or placed in single cells (Kupers, 1999; Tatairelli, Mancinelli, Taggi, & Polidori, 1999; White & Schimmel, 1995). Rowan and Hayes (1988) similarly reported that two thirds of jail suicides occurred in isolation. Inmates placed in isolation for reasons unrelated to suicide risk may end up injuring themselves as a result of the isolation (Hayes, 1995). The social isolation and the lack of stimulation may induce psychotic symptoms and uncontrollable impulses such as random violence and self-harm (Hayes, 1995).
Huey and McNulty (2005) argued that, besides deprivation, overcrowding must also be considered because many prisons in the United States "routinely operate over capacity" (p. 493) and because several researchers found that overcrowding has negative effects on the inmates' psychological states. Conditions of overcrowding are not unique to prisons in the United States. England and Wales have one of the highest rates of incarceration in Western Europe (Fazel, Benning, & Danesh; 2005). Davies (2004) reported that, according to the annual report of chief inspector of the English and Welsh prisons, two people kill themselves each week in prisons across England and Wales and that the high suicide rate was attributed to conditions of overcrowding.

In their archival study of four state prisons combined with field studies in several prisons and jails, Cox, Paulus, and McCain (1984) distinguished between social density (number of occupants in housing units) and spatial density (space per person). They reported that social density appeared to be more detrimental to the mental health of the inmates than spatial density. Institutions that housed larger population of inmates had higher number of suicides, other deaths, and psychiatric commitments than did institutions that housed smaller number of inmates. Inmates in dormitories that housed over 30 inmates had more psychological and physical problems relative to inmates residing in single and double cells. The authors attributed the higher number of inmate problems to effects of crowding, cognitive strains, and feelings of anxiety, fear, and frustration.

Nevertheless, some researchers have challenged the hypothesis that overcrowding leads to an increase in the rate of prison suicide. Fruehwald, Frottier, Eher, Ritter, and Aigner (2000) approached this issue by studying whether legislature had an impact on the
number of suicides in Austrian jails and prisons. They compared statistical data on suicide in the country’s penal system during the five decades between 1947 and 1996, controlled by the suicide rate of the general population. They concluded that the inmate population’s significant decrease after the Austrian law reform of 1975 was not accompanied by a decrease in inmate suicides. The authors ruled out the possibility that this lack of decrease in suicides was attributable to possible social isolation related to new housing arrangements because after the implementation of the law reform more single-cell housing was not provided in the Austrian jails and prisons. Nonetheless, other variables may be present, such as changes in the characteristics of the inmate population. Fruehwald et al. speculated that after the legislative change the Austrian jails and prisons had more inmates who committed dangerous crimes than before 1975; therefore, the inmates’ social contact in correctional institutions involved interactions with more disturbed individuals. Fruehwald, Frottier, Ritter, Eher, and Gutierrez (2002) arrived at similar findings after studying the effect of legislatiional change on suicide in custody in Austria during the period from 1967 to 1996.

Huey and McNulty (2005) argued that deprivation and overcrowding were not distinct but were in fact interrelated variables. Using U.S. Census data collected in 1990 and 1995 of a sample of 1,118 prisons, they found that in minimum-security institutions, at high levels of overcrowding, the risk for inmate suicide is as high as in medium- and maximum-security facilities. Lower risk for suicide was only found in minimum-security facilities with low levels of overcrowding.

In addition to the social environment, the building design can also create a climate that may foster suicidal ideation. Light, air, and the size and division of space
influence feelings of well-being in prison (World Health Organization, 2007). However, Tartaro's (2003) results question this factor. Tartaro evaluated environmental influences on suicidal behavior in jails by comparing linear and podular facilities and direct, indirect, and intermittent supervision types. Administrators of 646 U.S. jails in which suicides had occurred responded to survey questions regarding their facilities' designs and types of supervision provided. The author found that neither jail design nor supervision style were significant factors in predicting suicide.

Staff-to-inmate ratio has also been cited as an important factor in suicide rates under confinement. Using National Jail Census data obtained from 1978, 1983, and 1988, Wooldredge and Winfree (1992), studied male inmate suicides and natural deaths in 204 U.S. jails. They concluded that suicides were less likely to occur in facilities in which the staff-to-inmate ratio was increased. The authors also found that suicide rates were lower in facilities where medical tests had been administered at intake for detection of drug problems and physical ailments.

Danto (1973) asserted that the "effect of institutionalization on the staff" (p. 300) was also a contributing factor to prison suicide. He argued that some staff members may lose their sensitivity to observing depressed inmates and they may come to place institutional policies higher than human needs. Danto argued that the same phenomenon can be observed in other institutions as well, such as mental hospitals, general hospital, and nursing homes. Rowan and Hayes (1988) called officer insensitivity a "victim of environment" (p. 4-3) phenomenon. They noted that the longer officers worked in the criminal justice field, the more insensitive they could become toward the emotional effects of incarceration. Additionally, in some institutions guards are discouraged from
interacting with inmates, which, in fact, can increase the risk of inmate suicide (Rowan & Hayes, 1988).

In prison, suicides are no more likely to occur on weekends or holidays than during regular weekdays (Daniel, 2006). However, time of day is important: Most suicides occur between 7 p.m. and 7 a.m., most likely due to less staff supervision during the night (Daniel, 2006). Fruehwald et al. (2003) investigated the weekly, monthly, and seasonal distribution of suicides committed in the Austrian penitentiary system between 1947 and 1999. The authors found no seasonal variations in the rates of suicide attempts in their sample. Fruehwald et al. concluded that bioclimatic factors were “less influential in industrialized, urban areas where the majority of jails and most prisons are located” (p. 267) and that heating and air conditioning systems further reduced seasonal differences. They hypothesized that social isolation may be the cause for the lack of seasonal changes in the number of suicides, because in correctional facilities social isolation is independent of seasonal changes.

Finally, according to Lester (1986), the rate of suicide is high for inmates on death row. He speculated that this may be due to the high stress associated with being on death row.

Focus on International Studies

Prison suicides are not unique to the United States. For example, Fazel, Benning, and Danesh (2005) calculated that in England and Wales between 1978 and 2003 five times more male prison inmates killed themselves than did individuals in the general male population of similar ages. In the penal institutions of Ontario, Canada, 134 inmates took their own lives during the 1990-1999 decade, which is about as many as the number
of deaths attributed to natural causes that occurred in the same institutions (Wobeser, Detema, Bechard, & Ford, 2002).

International studies have been traditionally ignored in literature reviews conducted in the United States, due to different sentencing laws, systems of imprisonment, and prison conditions in other countries. However, many common factors characterize suicide under confinement; therefore, studies conducted in other countries could lead to insights about understanding suicide in all prisons. Additionally, specific findings in different countries could warn about possible future problems in the United States as well.

Probably the most important difference between the correctional system of the United States and many other countries is that jails and prisons are not differentiated in many foreign countries. Prison and jail suicides share common characteristics in that both involve profound despair during confinement. However, substantial differences exist as well. Most importantly, the suicide rate in jails is much higher than the rate in prisons: according to Kupers (1999), in the United States suicide in jails is nine times more common than in the general population (whereas, according to the same author, suicide in prison is twice more common than in the general population). According to Bonner (2000), prison suicide victims are serving long sentences, have serious mental health problems, have had previous suicide attempts, and tend to kill themselves in segregation or isolation as a response to institutional or personal problems. They also tend to be older than jail suicide victims. Individuals who kill themselves in jail tend to be first-time and nonviolent offenders and to have been intoxicated at the time of the arrest. They also tend
to be placed in an isolated cell and to kill themselves within the first day of their confinement (Bonner, 20000).

A study conducted by Frottier et al. (2002) provides an explanation for underlying causes of differences between jail and prison suicides. These authors conducted research in Austrian jails and prisons by analyzing all jail and prison suicides between 1975 and 1996 with regard to the time of occurrence of the suicides. They determined two different periods of high suicide risk under confinement: the first 24-hour period, when the individual is in the “shock of imprisonment” (p. 71) and is experiencing feelings of isolation and insecurity, and after 60 days, when a state of emotional exhaustion arises. The authors did not differentiate between jail and prison time; however, the length of these time periods suggests that these findings refer to jail time, and these findings could explain why suicide in jail is more common than in prison. Frottier et al. also found that sentenced prisoners had a lower risk for suicide than did inmates awaiting sentencing during the respective first 5 months. The authors also reported that long-term prisoners (sentence longer than 2 years) had higher suicidal risk than short-term prisoners and that the longer the term the higher the risk for suicide, possibly due to effects of isolation and hopelessness. Schimmel, Sullivan, and Mrad (1989) found that, in the Unites States, suicide victims who were sentenced for 20 years or longer committed suicide after 4 or 5 years following incarceration.

Jenkins et al. (2005) analyzed the prevalence of suicidal ideation and suicide attempts in prison, based on a comparative analysis of data obtained from a survey of all prisons in England and Wales and a national survey of psychiatric morbidity in adults in Great Britain. The authors found that suicidal thoughts and suicidal behavior were more
common in prison than in the general population. Suicidal ideation and suicide attempts in prison were associated with the presence of psychiatric disorders, personality disorders, substance use, and social risk factors. Psychosis and neurosis were highly correlated with suicide attempts; only 3% of the inmates who attempted suicide were not diagnosed with a psychiatric disorder. Comorbidity of a mental disorder with a personality disorder or substance dependence led to increased risk for suicidal behavior. Social risk factors associated with suicidal ideation and suicide attempt in prison were being young, White, and single, and having poor education, small primary support group, lack of social support, and previous adversity. The authors also found that two-fifths of remand male prisoners (i.e., those awaiting sentencing) who attempted suicide had been threatened with violence. Another interesting finding was that prisoners who were alleged to have committed drug offenses or who had been convicted of drug offenses were less likely to have attempted suicide than were those who committed other offenses, possibly because inmates with drug offenses tended to be dealers rather than addicts in Great Britain. The major strengths of this study were its large samples (3,139 interviews conducted in prison and 8,886 in private households) and comprehensive statistical calculations.

Tatarelli, Mancinelli, Taggi, and Polidori (1999) conducted an epidemiological study of Italian prisons between 1996 and 1997 using data provided by the Italian Prison Administration Department. They found that the suicide rate was approximately 30 times higher among female inmates than in the general population (presumably women only), whereas for males the suicide rate was 10 times higher than in the general population (presumably men only). These suicide rates for both female and male inmates appear to
be higher than rates in other Western countries, and it would be interesting to understand the possible reasons for such elevated statistics. However, the authors did not report or speculate on the relatively high rates of suicide in Italy. It is possible that cultural explanations may contribute to this difference. Alternatively, the data may not reflect decade-long patterns: the authors based their conclusions on 100 cases of suicide that occurred in Italian prisons during a two-year period.

Matsumoto and Toshihiko (2005) looked into the possible correlation of suicidal ideation with bulimia and dissociation symptoms in Japan. From responses to questionnaires administered to 796 inmates in a juvenile facility, they determined that such associations existed and were statistically significant. If further studies strengthen these results, such findings may be incorporated in future screening instruments.

Blaauw, Arensman, Kraaij, Winkel, and Bout (2002) looked at the relationship of traumatic life events and suicide risk by studying two samples of inmates across 30 correctional facilities in the Netherlands. They found that traumatic life events were common among all participants; however, the high-suicide-risk group (inmates who attempted suicide in the past) had experienced more traumatic life events than controls, including sexual abuse, physical maltreatment, emotional maltreatment, abandonment, and suicide attempts of significant others. Additionally, they had also experienced more traumatic events during childhood, during later life (15 years or older), and during detention, as well as more trauma associated with parents, siblings, partners, and strangers.

Blaauw et al. (2002) also developed a suicide-risk prediction model based on a logistic regression analysis. According to this model, traumatic life events involving
siblings and strangers during childhood, parents during later life, and the partner during incarceration were the strongest predictors for suicide of all the traumatic experiences reported. Based on the results, the authors suggested that there was a need for development of trauma-focused treatment for inmates.

Fruehwald, Frottier, Eher, Gutierrez, and Ritter (2000) reviewed all the 220 jail and prison suicides that occurred in Austria between 1975 and 1997, using statistical data from the Austrian Ministry of Justice and prison archives. In Austria, prisoners classified as mentally ill are placed in specialized institutions. The authors found that the suicide rate of the mentally ill prisoners were about eight times higher than the suicide rate for the country’s general population. The majority of the jail and prison population consisted of males (95.6%), and the majority of suicides were committed by males (96.4%). The authors indicated that the rate of suicide for sentenced offenders was about twice the suicide rate of Austria’s general male population. Hanging was the most common method of suicide (82.3%), followed by drug or intoxicant overdose (7.3%), cutting arteries (5%), and other methods.

Using a similar data set of suicides that occurred in Austria between 1975 and 1999, Fruehwald, Frottier, Matschnig, and Eher (2003) studied 220 out of 250 suicide cases. They found that 68.6% of suicides were committed in single cells. The authors also found in 36.8% of suicides that suicide threats had been documented by staff. Among other results, the authors also reported that in 21.5% of all suicide cases, despite documentation by staff members of previous suicide attempts, self-harming behavior, or suicide threats, inmates had not received psychiatric assessment and treatment.
Research at Oregon Department of Corrections

Williams and Bellatty (2005) conducted a statistical analysis of variables related to prison suicides at the Oregon Department of Corrections (ODOC). This study is of particular significance to the current study because it was conducted in the same state prison system. Williams and Bellatty compared characteristics of 45 inmates who had attempted or completed suicide between 1994 and 2005 with a randomly selected sample of 1,000 inmates who had not attempted suicide. They used three statistical procedures to identify characteristics associated with higher risk for suicide and concluded that seven variables increased an inmate’s risk for suicide: higher mental health need, recent cell changes, being housed in the Disciplinary Segregation Unit or the Intensive Management Unit, having an unknown marital status at intake, having more time remaining on the current sentence (on average, 153 months remaining on sentence), and having a maximum or close custody classification. Additionally, in combination with the other variables, young age and lack of gang association were also indicators of high risk for suicide attempt. Overall, inmates with four or more of these factors had a higher risk for attempting suicide. Williams and Bellatty found that 83% of the inmates with the highest mental health needs (inmates classified as Level 2 or 3, with 3 being the highest level of mental health need on ODOC’s scale) had four or more factors present, whereas only 28% of the general population had four or more factors present.

Based on the above findings, Bellatty (2007) constructed an as yet unvalidated equation to estimate an inmate’s risk for suicide, using the following factors: ODOC mental health code, level of custody, marital status at intake, gang involvement, housing,
months in current cell, months spent at ODOC on current incarceration, and months left on sentence.

Qualitative Studies

Liebling (1995) asserted that a new direction was needed in suicide research, toward a "more ethnographic approach aimed at understanding the real life world of prisoners at risk for suicide" (p. 175). She demonstrated that there are inherent limitations in statistical procedures due to the difficulty of defining and recording a behavior that exist on a continuum. She summarized the findings of two long-term (1987-1992) projects in which researchers compared the semi-structured interviews of 112 suicide attempter and 130 randomly selected non-attempter inmates. The studies were aimed at understanding the vulnerability of prisoners who attempted suicide in prisons across England and Wales. Liebling reported that the most important difference between suicide attempters and controls was found in coping skills, with suicide attempters having poorer coping skills than the other participants in the studies. Besides having more adverse life histories than non-attempters, suicide attempters described their life in prison as being more difficult in many aspects as than did the control group. For example, attempters were found to be less likely to be engaged in activities, to have a job in prison, to be receiving contact from the outside, or to occupy themselves when left alone in their cells, and more likely to have difficulties with staff and other prisoners as compared with the controls.

Dear, Thomson, Hall, and Howells (1998) interviewed inmates in a maximum-security prison in Western Australia to compare the coping strategies of prisoners who had attempted self-harm 3 days or less prior to interviews to that of prisoners of a
controlled group matched on age, sex, race, and remand or sentenced status. Definitions of coping strategies such as distraction, situation definition, direct action, catharsis, acceptance, seeking social support, and relaxation were read aloud to inmates who were then asked to describe coping mechanisms they had employed in response to their most significant stressor within the prior week. The authors found that prisoners who self-harmed reported using less active behavioral and cognitive strategies than did those in the control group. Dear et al. noted that the major limitations of their study were that it provided no data on either how well the indicated strategies were executed or how suitable they were to specific situations.

In order to shed light on these qualitative aspects of coping, Dear, Slattery, and Hillian (2001) used the same interview materials for a second study. The researchers utilized three groups of blind raters chosen from prisoners, prison officers, and forensic psychologists to rate the coping responses of the prisoners of the two groups. Dear et al. could not determine how competently the chosen strategies were implemented; however, they found that self-harmers employed coping strategies that were less suitable for the situation than the strategies used by the prisoners of the control group. Across all three groups of raters, direct problem-solving strategies (direct actions) were seen as beneficial, whereas ventilation (catharsis) and distraction strategies were not. Besides tending to use fewer problem-solving strategies, inmates of the self-harm group also differed from the inmates of the control group in that the cathartic strategies the former group members used (such as venting anger and despair in appropriate or socially unacceptable ways) were judged more frequently to be counterproductive than the cathartic methods used by members of the control group.
Intuitively, it appears logical that people who engage in self-harming behaviors have less adequate coping skills than people who do not attempt such behaviors, at least at the time of the attempt. However, the above two studies can be criticized in that a possible confound may have skewed the results: the timing of the interviews. The self-harming inmate interviews took place within 3 days of the self-harming event, whereas the inmates of the control group were probably interviewed on an average day. It is possible that the self-harming inmates could have described more active coping strategies if they had been asked on an average day; they might have been able to use more active coping skills during times of less distress. Additionally, self-harming inmates may have been in depressed states during the interviews and thus, they may have experienced difficulties in concentration. They may have been more likely to recall state-consistent negative cathartic emotional responses rather than attempted cognitive solutions.

One qualitative project focused on understanding coping skills was conducted by Medlicott (1999), who studied the experiences of male prisoners in a large prison in the United Kingdom. She identified prisoners as either “coping” or “not now coping” (the latter defined as individuals who experienced suicidal ideation at the time of the interview) with passing time in relationship to personal identity. She found that “not now coping” prisoners experienced time as a source of suffering, which led to deterioration in their sense of personal identity.

Another qualitative study was done by Borill, Snow, Medlicott, Teers, and Patton (2005). These researchers explored the motivation, precipitating factors, and post-incident experiences of female prisoners in the United Kingdom who had serious attempts of suicide. They also asked the inmates for suggestions about prevention of
suicide attempts. Based on the interview materials, Borill et al. offered several recommendations for interventions with the goal of reducing suicides in prisons, such as availability of purposeful activities, staff support, mental health services, and individualized and proactive identification of high-risk times and situations.

A focus group design was used in studying detrimental factors on prisoners’ mental health in a qualitative study conducted in a local prison in United Kingdom by Nurse, Woodcock, and Ormsby (2003). Themes that emerged were isolation, lack of mental stimulation, drug use, negative relationships with prison staff, bullying, and lack of family contact.

In summary, qualitative studies have yielded rich information about the coping skills and experiences of inmates who have attempted suicide. However, only a few qualitative studies have been conducted to date. In addition, all of these qualitative studies have been conducted in countries other than the United States.

Suicide Prevention

Suicide risk is difficult to predict because suicide is an infrequent behavior. In statistical terms, the base rate of suicide is low. Even measures with high specificity and sensitivity will result in a large number of false positives, decreasing their clinical utility (Murphy, 1983). For example, Pokorny (1983) reported on a study in which 4,800 psychiatric patients were followed for 5 years and determined that the predictive value of the tests utilized to predict suicide was only 2.8%. Given such studies, many researchers are skeptical about the usefulness of any suicidal assessment and prediction tools (Maris, 1992).
Additionally, suicide is difficult to predict because suicidal intent varies within an individual over time; thus, besides knowledge of the phenomenology of suicide, knowledge of the individual case is also essential (Murphy, 1983). However, a failure to predict suicide and potential loss of human life has a much greater consequence than overpredicting its risk. Therefore, the usefulness of a procedure aimed at ruling out a mental health condition such as serious suicidal ideation depends more on the rate of false negatives rather than false positives (Kamphuis & Finn, 2002). Despite the difficulty of the task, suicide prediction is a worthwhile endeavor for obvious reasons of morality.

Another reason that suicide prevention is difficult may be due to the fact that most commonly used instruments for suicide risk assessment have high face validity (e.g., Beck Depression Inventory, Beck Hopelessness Scale), thus having a potential for the individual being assessed to mislead mental health professionals. This may hinder the identification of high-risk inmates in prison, especially when a combination of lack of rapport with staff and serious intent for suicide is present. However, some researchers have advocated the use of multiple measures to decrease the number of missed cases (Mills & Kroner, 2005). Others, such as Correia (2000), have excluded face-valid measures from their risk assessment protocols.

Despite inherent difficulties in prediction, great progress has been made in this area within the last decades. In correctional settings, litigation involving jail and prison suicides further contributed to the continued development of suicide prevention standards (Danto, 1997). The two most widely used suicide prevention standards were developed
by the American Correctional Association (ACA) in 1981 (and revised in 1990) and by
the National Commission of Correctional Health Care (NCCHC) in 1987 (Bonner, 2000).

According to Gater and Hayes (2005), the attitude of correctional facility staff
about suicide prevention influences the number of inmate suicides: "Systems that believe
suicides are preventable will instill the proper attitude among staff and create
mechanisms of prevention. Systems that make excuses and instill negative attitudes that
inmate suicides are not preventable will continue to have suicides" (p. 33). However, the
authors also acknowledged that it is impossible to prevent all suicides under confinement.
Gater and Hayes listed eight essential components to effective suicide prevention
programs that will be discussed in some detail here.

First, training of all personnel who are in contact with inmates is essential. Gater
and Hayes (2005) argued that suicides are rarely prevented by mental health, medical, or
other professional staff because suicides often occur in housing units and at late hours or
weekends. Other researchers have also observed that correctional officers can prevent
more suicides due to their 24-hr presence in correctional facilities (Fruhwald, Frottier,
Ritter, Eher, & Guttierrez, 2002). Therefore, correctional staff represent the "front line of
defense" (Gater & Hayes, 2005, p. 34).

Second, identification and referral of the at-risk inmates should be regarded as a
process rather than a single event due to the fact that inmates can become suicidal at
various times during their incarceration. The authors underlined the importance of this
step by indicating that research findings show that about two thirds of all suicide victims
communicate their suicidal intent before carrying through the attempt.
Third, Gater and Hayes (2005) advocated for effective communication between a variety of individuals: inmates and staff, correctional and other professional staff members, and prison and outside entities such as family members and arresting agencies (e.g., an inmate’s behavior during arrest can be indicative of suicide risk). Fourth, Gater and Hayes recommended that “suicidal” inmates be housed in the general population, mental health unit, or medical infirmary because isolation further increases one’s sense of alienation and decreases supervisory contact. Physical restraints should be used only as a last choice.

Fifth, the authors suggested the use of close observation (every 15 min at a minimum) for inmates who communicated suicidal ideation but had no specific threat or plan and constant observation for inmates who had engaged in or had threatened with suicidal behavior. Sixth, because life or death often depends on the promptness of the interventions during suicide attempts, Gater and Hayes (2005) recommended that all staff members who interact with inmates be trained in CPR. Seventh, all appropriate inside and outside authorities, as well as the victim’s family should be notified immediately about the death, and all staff who came in contact with the victim prior to the suicide should submit a statement describing their knowledge of the incident.

Finally, both affected inmates and staff members should be offered critical incident stress debriefing or other assistance after a suicide occurs, and both completed suicides and serious suicide attempts should be studied with mortality reviews. Overall, this comprehensive program discussed by Gater and Hayes (2005) is promising. However, no information was provided about the effectiveness of such a program.
Biggar and Neal (1996) described a new approach to suicide prevention in England and Wales. According to the authors, it was indicated in the country's Prisons' Inspectorate report of 1990 that the current suicide prevention strategy was "too defensive and too dependent on medical solutions" (p. 209). The authors noted that distressed inmates wanted to communicate with, feel understood by, and relate to other people. The new program emphasized a multidisciplinary approach relying on teamwork and relationships, with shared responsibility among all staff and volunteers (belonging to The Samaritans organization) who had contact with inmates. As a result, in each prison a multidisciplinary suicide prevention group was established. One of the prisons reported no suicides within the first year of the implementation of the program. It would be instrumental to see the results of follow-up studies regarding the effectiveness of the program, as well as details about the collaboration of the multidisciplinary teams.

Devilly, Sorbello, Eccleston, and Ward (2005) conducted a literature review on the utilization of peer-led programs in correctional facilities. Such programs have been implemented in the area of suicide prevention, as well as for health education, prison orientation, sexual assault/offense prevention, and alcohol and drug abuse treatment. Among other learning theories, Bandura's (1986) social learning theory served as a theoretical basis; that is, increased learning can occur by observation of models with whom participants can identify. Additionally, based on Festinger's (1957) cognitive dissonance theory, the authors argued that when inmates act as agents of change they become more likely to change their beliefs in accordance with their new roles as models. Thus, both teachers and students are likely to change. Devilly et al. concluded that
preliminary support for peer-led programs was promising but that controlled research was lacking for demonstrating the effectiveness of such programs.

Devilly et al. (2005) indicated that there were several benefits to peer programs, such as higher credibility of inmate counselors than of professionals due to differing life experiences of these two groups, potential self-healing for inmate counselors in addition to helping other inmates, and cost-effectiveness in the running of the peer program due to increased time availability of professionals. However, Devilly et al. found that there were several risks associated with prison-based peer programs as well, such as a lack of empirical studies that demonstrate the effectiveness of such programs, the possibility that inmates may prefer professional counselors to peer counselors, the need for considerable time and resources for the education of peer counselors, the potential alienation of professionals from inmates which may negatively impact the management of the prisons, potential negative effects on inmate counselors by impeding their own progress in healing, as well as ethical concerns involving accountability, competence, and confidentiality. Overall, the authors asserted that benefits outweighed risks in implementing peer programs.

Liebling’s (1995) finding that prisoners who had experienced suicidal ideation were more likely to express empathy toward suicide attempters offers another basis for the support of peer-counseling programs. Additionally, a report from the World Health Organization (2007) adds support to the use of peer-based programs. According to this report about 100 correctional facilities in England have adopted a listener model in which prisoners who experience suicidal ideation can have unlimited access to a fellow inmate screened and trained for this role.
Some evidence exists to support the use of trained inmate observers for suicide prevention. Junker, Beeler, and Bates (2005) calculated that, when inmate observers were used at a Federal Bureau of Prisons Medical Center, individuals with psychotic disorder spent significantly less hours on suicide watch and individuals with personality disorders had significantly fewer suicide watch placements than they did prior to the implementation of the peer program.

In their analysis of federal prison suicide prevention programs, Schimmel, Sullivan, and Mrad (1989) found that within the issues addressed in a survey of psychologists, the strongest opinions emerged regarding the use of inmate companions. Positive evaluations emerged from facilities in which such programs were used, whereas psychologists working in facilities in which inmate companions were not employed tended to cite philosophical, ethical liability, security, or logistical problems in explaining the lack of use of inmate companions.

Inmates who admit to suicidal thoughts are regularly placed under suicide watch in isolation and stripped of their clothes. This practice is often experienced by inmates as degrading and can lead to increased feelings of depression (Rowan & Hayes, 1988). Additionally, inmates typically are aware that communication of suicidal intent can result in suicide watch placement and they tend to resent being sent to a strip cell (Bell, 1999). Therefore, fear of consequences may make it less likely for inmates experiencing suicidal ideation to communicate their intentions to personnel. Kupers (1999) indicated that a punitive approach to suicidal threats and attempts, including solitary confinement and additional sentencing, were counterproductive. Policies in several countries now discourage the use of isolation for suicidal individuals. For example, the Code of Practice
for England and Wales states that the use of seclusion for inmates with suicidal ideation is contraindicated in psychiatric hospitals (Coid et al., 2003). Furthermore, the current prison policy in these countries aims at eliminating the use of strip cells in the management of inmates with suicidal ideation in order to avoid exacerbation of distress (Coid et al., 2003). The World Health Organization (2007) also recommended averting social isolation as a primary suicide-prevention intervention.

Based on the conceptualization of suicide as a coping problem, Liebling (1993) also advocated for the implementation of listening and communication techniques in suicide prevention programs. The author suggested that inmates should actively participate in their own suicide risk evaluation by assessing their own vulnerabilities and stresses.

Fink (2005) conducted a literature review on the effectiveness of electroconvulsive therapy in suicide prevention. He concluded that this treatment, although only a transient solution, was the most effective emergency treatment in reducing self-harming behavior. However, Fink reviewed only seven studies, and three of those were conducted in the 1940s. Even if electroconvulsive therapy would prove to be an excellent treatment modality, the ethical concerns related to the intrusive nature of the treatment would speak against its implementation in prison settings where the coercive use of psychotropic medications is already an ethical concern.

As a way of increasing the effectiveness of suicide prevention programs, changes may need to be implemented on a societal level as well. Isenstadt (1972) conducted a survey of job importance to society. Out of seven professions, participants rated the job of the jail or prison guard as the second least important job to society. Interestingly,
participants ranked the job of police officers in the third most important position despite the fact the many guards were police officers. Isenstadt argued that police officers have received considerable media attention due to the Omnibus Crime Control Safe Streets Act of 1968, whereas the role of the correctional officers remained in a low status. Isenstadt stated,

In contrast to the rising esteem granted the law enforcement officer, the correctional officer often sees his role as dehumanizing and degrading. Must the portrayal of the correctional officer as sadistic, uneducated, “hack” prevail? It will remain as such until the field of corrections decides to recognize the priority of professionalization of the role of the correctional officers. He must be more than a “turn-key.” He must become a behavioral specialist whose contributions can be and are now valuable. The management and prevention of suicide remains one critical area in which he can serve a major and beneficial function. (p. 179)

Fruehwald and Frottier (2005) have also recommended that suicide prevention should be approached on three levels: the societal level (addressing the absence of traditional mental health institutions), the prison level (adequate psychiatric care), and the individual level (assessment of individual needs).

In summary, several prevention programs have been implemented around the world. Follow-up studies are still needed to demonstrate their effectiveness. In the next section, food refusal will be reviewed. Due to controversy about whether food refusal is a form of suicide, food refusal has not been included in previous discussions.

Food Refusal

The most frequent ways inmates kill themselves are by hanging and overdose (Daniel, 2006), followed by wrist-cutting. The latter is considered the most frequent method used by attempters (as opposed to completers of suicide; Daniel, 2006). Some authors consider death from hunger strike to be a form of suicide as well (e.g., Smith, 1984). Others reject this idea, arguing that food refusal is only a form of weapon used to
fight for improvement in prison conditions, access to legal help, or a way to make a political statement (Gregory, 2005). Others see food refusal as possibly representing both a means of suicide and a means of expressing dissent. For example, Brockman (1999) speculated on motivation for food refusal for prisoners based on case studies. She concluded that prisoners' motivation for this behavior were varied and depended on the prisoners' status in the corrections system (e.g., pre-sentencing or sentenced prisoners, asylum seekers, and illegal immigrants had different motivation for engaging in this behavior). For sentenced prisoners, food refusal was a form of self-destructive behavior (but not a suicide attempt) in which impulsive, emotionally immature individuals and people with personality disorders often engaged. She also argued that some inmates engaged in food refusal in an attempt to escape punishment. Nevertheless, she indicated that some sentenced prisoners chose to engage in this behavior in order to kill themselves because of grief or feelings of guilt.

The question of whether food refusal constitutes suicide is an important one because prevention and treatment depend on the definition. For example, if a hunger strike is viewed as a method to effect change, it can be understood as a human right (e.g., the right to refuse medical treatment). However, if it is viewed as a suicide attempt, the question arises whether suicide can be committed by people who are not mentally ill. Theoretically, if an inmate diagnosed with major depressive disorder refused to eat after several thwarted attempts to hang him- or herself, his or her lack of eating could be classified as suicide. However, clarifying the presence of mental illness may be complicated in other cases (e.g., before committing a crime, an individual decides that he
will starve him- or herself to death if he or she is arrested and placed in a correctional facility).

Furthermore, food refusal has a different meaning in prison than in the free world, not only because it can be used as a weapon against the correctional system, but also because there is a danger that the practice may spread and other inmates may learn to engage in food refusal for manipulative purposes. As noted by Williams (2001), prevention of suicide and maintenance of prison order is in the interest of the state.

**Ethical Issues**

Suicide is considered to be a basic human right under particular circumstances by some people. Those believing that suicide can be a human right may argue that some inmates may have legitimate reasons for wanting to take their own lives: What about repeat suicide attempters who experience continuous suicidal ideation between their attempts? What about inmates on death row who would die anyway in an electric chair, but who believe that taking their own lives would be a more dignifying personal choice? What about inmates with life sentences who after several years of incarceration could not find new meaning in their lives? Such scenarios raise difficult questions.

In Oregon, the Death with Dignity Act (Oregon Department of Human Services, 2007) allows terminally ill people to take their own lives using a doctor’s prescription. This law requires that the mental health of the terminally ill individual be assessed prior to the granting of a prescription. This same concern about mental health is important when considering prisoners. That is, most suicides in prison are committed by mentally ill individuals who are not in their right mind to make an informed choice whether they should live or die.
However, one ethical dilemma mentioned in the literature on suicide is prison is the question of how much coercion is acceptable to exercise in order to save life. For example, coercive administration of psychotropic medications and placement in strip cells are viewed as unethical by some (Bell, 1999).

Nevertheless, at this point in time these are more philosophical questions than real points of consideration. The Western World's contemporary value system dictates that suicide prevention is a clear responsibility of prison personnel, and the present study is one attempt to improve prevention of inmate suicides. Having considered theories of suicide, psychosocial risk factors, environmental factors, some international studies, research at ODOC, food refusal, and ethical considerations, I now turn to the method of the current study.
METHOD

General Considerations

By their nature, quantitative measures seek to present findings in objective, summary statements. However, such an approach cannot readily describe the subjective experiences of people who attempt suicide. Questionnaires, for example, do not allow for idiosyncratic and detailed responses, and statistics can only inform of group risk factors. Every suicide attempt is an individual event shaped by a myriad of unique circumstances. Qualitative research has the capacity to capture such details that may lead to suicide attempts.

Qualitative research is not a new methodology; however, in today's postpositivist era of research, it has gained a progressive flavor. As a philosophical background, I relied on Lincoln and Guba's (1985) axioms regarding the naturalistic paradigm: (a) realities are multiple, constructed, and holistic; (b) the knower and known are interactive and inseparable; (c) only times and context-specific hypotheses exist; (d) no linear causality exists because entities mutually and simultaneously shape each other; and (e) all inquiry is value-bound. Adhering to this line of thinking, I chose to use a phenomenological method applying the following features: recognizing the value of qualitative research in the studying a human experience, focusing on the wholeness of the experience rather than on parts, searching for meanings rather than measurements, regarding experience and behavior as inseparable, and obtaining descriptions of first-person experiences (Moustakas, 1994).
Creswell (1998) stated that a phenomenological study may be challenging for the following reasons: The researcher must be knowledgeable in the philosophical underpinnings of phenomenology, participant selection may be difficult based on the criteria of the phenomenon under study, bracketing of the personal experiences may be challenging, and a decision must be made about the role of personal experiences in the study. Prior to conducting this study, I considered each of these concerns and concluded that no significant barriers existed in carrying out this research.

Lincoln and Guba (1985) asserted that activities involving "prolonged engagement" (p. 301) were necessary to establish credibility of findings resulting from qualitative data. Margaret Mead's study of Samoan adolescent girls has been criticized, for example, for lack of general familiarity with the Samoan culture (Lincoln & Guba, 1985). Prolonged engagement activities include learning about the culture, testing for misinformation, and building trust. I learned about life in prison by performing psychological evaluations at three sites (Coffee Creek Correctional Institution, Oregon State Correctional Institution, and Oregon State Penitentiary) as a clinical fieldwork experience for eight months prior to as well as during the data collection period. The weekly individual and group supervision I have received helped me to deal with my biases. To further increase my knowledge of prison life, I read books and articles written about this topic, such as Ross and Richard’s (2002) Behind Bars: Surviving Prison.

Because narrative truth may be different from historical truth (Lieblich, Tuval-Mashiach, & Zilber; 1998); I compared the reports in the inmates' mental health files with the accounts of the suicide attempts given during the interviews. I considered this an important step due to the fact that lying is one diagnostic criterion for Antisocial
Personality Disorder and the incidence rate for this disorder is higher in prison populations than in the general population (Daniel, 2006). Comparison of the data confirmed that all inmates had provided the same basic information about their suicide attempts that were described in their charts. Although it was not possible to test this assumption, it was assumed that the absence of any reward might have decreased the probability of the provision of misinformation.

Definition of Suicide

For the purposes of this study, I adopted the ODOC's definition of suicide attempt, which includes five types of behaviors (ODOC: Counseling and Treatment Services Corrections Program Division, 2005): (a) hanging that leaves ligature marks or unconsciousness, (b) cutting that requires sutures, (c) overdose on medication or other toxic substance that requires stomach pumping or other medical intervention, (d) drowning that requires medical intervention to remove fluid from lung or resuscitate, or (e) other behavior that involves significant risk with intent to harm self. I defined suicidal ideation as thoughts involving a wish to die, with or without a plan to kill oneself.

Participants

The target population consisted of ODOC inmates who had attempted suicide in prison between 1994 and 2005; however, in the final sample all participants had attempted suicide between 2004 and 2005. According to prison statistics, there was a sharp rise in the suicide rate at ODOC from an average of 2.2 between 1995 and 2003 to 20 in 2004. (Williams & Bellatty, 2005), which most likely influenced the availability of the more recent suicide attempters for this study. Nonetheless, when inmates indicated that they had attempted suicide on other occasions before or after the target dates, I
gathered information about those attempts as well. The potential participant pool resided in six facilities of the ODOC in the General Population, the Disciplinary Segregation Unit (DSU), or the Intensive Management Unit (IMU). From my experience at ODOC I learned that the General Population consists of inmates who are not in segregation, protective custody, or medical units. The DSU is often referred to by ODOC personnel as the “prison within prison;” inmates who do not comply with rules can be held in this unit. Inmates who consistently disobey rules can be held in the more restrictive environment of the IMU.

A list of inmates who attempted suicide between 1994 and 2005 was provided by a prison liaison. The 32 inmates were asked by their case managers to participate in the research project. The case managers described the study to the inmates based on the Consent Form (see Appendix A), answered questions, and asked inmates to sign the Consent Form if they agreed to participate. This procedure involving a third party was employed to ensure that inmates were in a familiar environment and felt no pressure to enroll in the project. Participation was completely voluntary; no benefits were provided to participants, and refusal did not result in any penalty or loss of rights to which inmates were entitled. Participants could also withdraw from this study at any time without penalty or loss of benefits.

Of the possible participant pool, 4 inmates refused to participate when asked by their case manager, and another 4 inmates were not available due to other circumstances such as unstable mental health condition or recent parole. The final sample consisted of 24 inmates who had attempted suicide in prison and were currently incarcerated in an ODOC facility. All 24 participants were able and willing to discuss their experiences
related to their suicide attempts. Three participants were female, the rest were male. All of the women resided in the medium security wing of the Coffee Creek Correctional Facility (CCCF). The residences of the 21 male inmates varied. Nine were in Oregon State Penitentiary (OSP), located in Salem. Of these, 7 were in General Population, 1 was in DSU, and 1 was in IMU. Four inmates were in Two Rivers Correctional Institution (TRCI), located in Umatilla. Of these, 3 were in General Population and 1 was in DSU. Another 4 participants were in Eastern Oregon Correctional Institution (EOCI) in Pendleton. Of these, 2 were in General Population and 2 were in DSU. Finally, 4 participants were in Snake River Correctional Institution (SRCI) in Ontario. Of these, 3 were in General Population and 1 was in DSU.

Participant’s ages ranged from 21 to 53. The races of the participants included White \((n = 22)\) and Hispanic \((n = 2)\) based on prison statistics; however, during the interview 5 individuals listed as White identified themselves as biracial with Native American identity and 1 as biracial with Asian identity. Their religious beliefs at the time of the interview were reported to be the following: Christian \((n = 8)\), Native-American/Christian \((n = 5)\), Atheist \((n = 3)\), Jew \((n = 2)\), Buddhist \((n = 1)\), Hare Krishna/Christian \((n = 1)\), Sufi/Christian \((n = 1)\), Wicken \((n = 1)\), and unknown \((n = 1)\). The reported sexual orientations and identities were the following: heterosexual \((n = 19)\), bisexual \((n = 3)\), unknown \((n = 1)\); and transgender \((n = 1)\) respectively. Psychiatric diagnoses included Schizophrenia, Bipolar Disorder, Major Depressive Disorder, Dysthymic disorder, Posttraumatic Stress Disorder, Adjustment Disorder, Attention Deficit/Hyperactivity Disorder, Polysubstance Dependence and Abuse, Alcohol Dependence, Methamphetamine Dependence and Abuse, Opiate Dependence, Cannabis
Abuse, Borderline Personality Disorder, Antisocial Personality Disorder, and Gender Identity Disorder. The range of time served at the time of the interview was 1 to 24 years. The range of remaining time to serve was 3 months to life. Criminal charges included driving under the influence of alcohol, delivery or manufacture of controlled substance, burglary, robbery, unauthorized used of a firearm, assault, kidnapping, sexual abuse, sexual penetration, sodomy, and murder.

Research suggests that addressing suicidal thoughts and actions does not cause suicidal ideation (e.g., Rowan & Hayes, 1988). However, it seemed plausible that in-depth discussions about painful personal experiences could induce a particular person into a negative mindset or even lead to suicidal ideation. Therefore, several steps were taken to protect inmates against developing such ideation. First, if an inmate indicated suicidal thoughts at the beginning of the interview, the interview would have been postponed to a later date. However, this did not happen during any of the interviews. Second, if an inmate expressed that he or she was upset in any way or was feeling suicidal during the interview, I would have stopped the interview and immediately notified the inmate’s mental health case manager. A suicide risk evaluation would have followed. It is the policy of the Counseling and Treatment Services of the ODOC to require evaluation by a mental health provider of all inmates who express suicidal ideation (ODOC: Counseling and Treatment Services Correctional Programs Division, 2004). However, none of the participants reported current suicidal ideation during the interview. Finally, all interviews were followed by a counseling session with the respective case managers to process the inmates’ experiences during the interviews to
assure that no suicidal ideation had been induced during or immediately following the interview.

Procedure

The data gathering method was an in-depth personal interview. As noted above, I obtained inmates’ written consent to participate (see Appendix A) through their case managers several days prior to the interview. I began each interview by presenting the purpose of the study, discussing the informed consent they had already signed, and obtaining the oral consent of the participant to proceed with the interview. The interviews were 40 min to 2 hr long. I used a semi-structured interview format (see Appendix B). The questions were developed to obtain a thorough description of the reasons leading up to the inmates’ suicide attempts, including perceptions about the current suicide prevention system of ODOC. The majority of the questions were open-ended (e.g., What did you do to harm yourself?). I followed up with additional questions if the client did not give detailed explanations to the main question (e.g., Were you on suicide watch at the time?) or to clarify content (e.g., Was that person a friend or just another inmate?).

I audio-recorded all interviews on a digital recorder. During the first interview a technical difficulty occurred, and parts of the interview were lost. Therefore, I interviewed the first participant on a second occasion. Both interviews were used in data analysis. I assigned numbers to all participants based on the order of the interviews. Only participant numbers were included in transcribed material.

Data Analysis

In order to fully attend to the experiences of the participants, to put aside prejudice, and to avoid concentrating on certain aspects of the data, bracketing is
important step used in phenomenological research (Giorgi, 1985). My bracketing methods consisted of using a research diary throughout the project and attending a research group during which I presented my initial results and received constructive feedback from participants and my dissertation chair.

Initially I analyzed two of the transcripts using grounded theory (Charmaz, 2003). With this method, I used line-by-line coding to establish meaning units. I then selected subthemes based on the most significant and most frequent codes. Finally, I grouped the subthemes into overarching themes. Comparing the two interviews it became apparent that a large amount of idiosyncratic material made the line-by-line coding method unwieldy, particularly in light of the fact that I had 22 remaining interviews with very different content to code. Therefore, I analyzed the remaining of the interviews using Lieblich, Tuval-Maschiach, and Zilber's (1998) holistic-content perspective. According to this method, I read the material several times to obtain an understanding of the whole and patterns in the stories. My next step consisted of grouping the quotes of each participant based on similarity of content. Then I compared the grouped quotes and identified similar themes which I named subthemes. I then grouped the subthemes into larger categories which I identified as themes. Based on the themes, I constructed general categories. Only themes and subthemes that appeared at least five times across the interviews were included in the findings.

For validation purposes, I engaged in triangulation to corroborate my findings. A coding partner conducted a theme analysis for three interviews as a cross-validation procedure. To reduce bias, I did not discuss results with the reader until she analyzed the data. We then compared our findings. As a result of her input, I expanded some of my
themes and collapsed others. Overall, our findings were consistent. Additionally, I used the method of thick description, such as providing numerous quotes and negative case analysis by looking for disconfirming evidence to support the authenticity of the findings.

In addition to the main findings, I have also listed and quoted the participants' recommendations for suicide prevention. The recommendations do not represent codes or themes; even ideas mentioned by only one inmate appear on the list. The purpose of this section is to offer suggestions for improvement of suicide prevention programs based on inmate experiences rather than theoretical hypotheses.
RESULTS

The results are organized in two sections. Factors associated with suicide in prison based on data analysis are presented in the first section. These findings were obtained by the coding of the interview data. The second section contains the inmates' recommendations for suicide prevention. Furthermore, additional data about the interviews is provided in Appendixes, including information about the psychosocial history of the participants (Appendix C), personal accounts of the suicide attempts (Appendix D), summaries of the individual attempts (Appendix E), and precipitating factors (Appendix F).

Factors Associated with Suicide Attempts in Prison

The results are organized here in meaning units by categories, themes, and subthemes. These meaning units are demonstrated with the use of quotes from participants. Quotes not only provide examples of meaning units but they also give voice to participants in illustrating their subjective experiences. Three categories with several themes and subthemes emerged in the study of reasons leading up to the suicide attempts: mental health issues, relationship issues, and prison factors (Table 1).

The boundaries between categories were somewhat fluid due to the complexity of the processes that led to suicide attempts. Individual factors, for example, were intrinsically intertwined with the other categories. A relationship problem would often lead to feelings of hopelessness, an individual factor. However, individual factors
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<th>Categories</th>
<th>Themes/Subthemes</th>
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<td>Mental Health Issues</td>
<td>Depressive Symptoms</td>
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<td>• Depressed mood</td>
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<td>• Depressive thoughts</td>
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<td>• Feelings of hopelessness</td>
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<td>• Feelings of loneliness</td>
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<td>• Feelings of guilt and/or shame related to crime</td>
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<td>Symptoms of Anxiety</td>
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<td>Hallucinations and/or Paranoid Ideation</td>
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<td>Medication-Related Problems</td>
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<td>Impulsivity</td>
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<td>Relationship Issues</td>
<td>Relationship Problems with Family of Procreation/Partner Outside of Prison</td>
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<td>Relationship Problems with Inmates</td>
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<td>• Not getting along</td>
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<td>Prison factors</td>
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<td>Placement in DSU</td>
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appeared to warrant a category by themselves because many inmates indicated experiencing feelings of hopelessness periodically without obvious external causality and also because many inmates in prison do not experience significant feelings of hopelessness and adapt relatively well to prison life without attempting suicide. Similarly, relationship issues involving inmates reflect difficulties in interpersonal functioning, but they are also related to prison factors.

I have attempted to select the most representative quotes to illustrate meaning units. The number of quotes demonstrating themes varied greatly from theme to theme primarily because of the differing emotional content of the meaning units. For example, inmates described their feelings of hopelessness in great detail, whereas medication-related problems (e.g., noncompliance with prescribed medication) was most frequently described in simple language, such as, “I’ve cheked them” (Participant 15).

As noted above, several themes and subthemes emerged within each category. In all cases, a combination of several factors led to suicide attempts. For example, Participant 1 summarized the reasons that led up to her attempt the following way:

I’d have to say probably the fight with mom was the biggest thing. And then, I mean, work being stressful was a really big thing, a really big factor. But not having support here is really like…it’s important to me to have support and to have people who really do care and know that they care, you know; inmates at least. Probably that was the second most important and then the job. And then reading the articles was kind of a pushover.

Similarly, Participant 14 listed several events as contributing factors to his suicide attempt:

I found out the stuff about my sister in what, September, and then I was supposed to get married in October. And right before I get married, I mean not more than a month, I’m getting a letter saying: Guess what, I’ve been screwing around with this dude, I’m pregnant, and I’m marrying him, so I can’t marry you. So that falls on my head. I hadn’t had contact with my birth family at that time, I couldn’t find
anyone. So those two things were happening all at once. I was being told about my parents’ divorce about December, and that hit me pretty hard. Plus the fact that I had just gotten a pretty good physical beat down. At that time I had three dudes come from behind and beat the shit out of me.

Mental Health Issues

The themes in the mental health issues category were depressive symptoms, symptoms of anxiety, hallucinations and/or paranoid ideation, medication-related problems, impulsivity, and religious beliefs.

Theme 1: Depressive Symptoms

Five subthemes were identified within the theme of depressive symptoms: depressed mood, depressive thoughts, feelings of hopelessness, feelings of loneliness, and feelings of guilt or shame related to crime. Given that depression has been found to be the best predictor of inmate suicide (Rowan & Hayes, 1988), it is not surprising that several subthemes could be identified within this theme.

Depressed mood. Most of the participants indicated that they had a depressed mood prior to their attempts. Some inmates reported this state in very simple language. For example, Participant 24 said, “I just didn’t feel right.” Participant 11 indicated: “All my attempts were around the same type of feeling. I probably felt depression, despair, despondency.” Participant 1 described her symptoms more elaborately:

I think that night was like, just felt like right now I am not feeling okay and right now is the point where I am going to go and do something to... myself because it didn’t feel like in that moment that I was getting help and I that I was getting support.

Participant 1 believed that she was struggling with severe symptoms of depression:

I was just really, I was really depressed. And I did not realize it until just all it came down on me at once.... looking back on it I was probably pretty depressed, I
think. I was probably pretty...I’ve been down for the last couple of months and I’ve just been really out of it. I think that that contributed to it as well, like lack of sleep. You know what I mean? Just really just not into doing anything or going outside, or being active. And I think that’s really a part of it.

Participant 7 described his experiences the following way:

I got to a point where I just got so low, depressed, and it was just that point where...it’s like there’s a pit and you fall into it. And it’s just darkness. And you are trying to get out but you can’t. Hands are pulling you back down.

Participant 9 also indicated signs of severe depression:

As a matter of fact, I was experiencing very acute depression. It’s been worse than I’ve ever been. I’ve started bailing up on my bed and rocking myself. I’d start getting on the floor like this (shows fetal position).

*Depressive thoughts.* Inmates tended to ruminate on a variety of topics, such as inadequate parenting skills, letting family down, negative self-evaluation, and the state of the world. Participant 3 was distressed over her past parenting:

And that’s another reason why, because I haven’t been a mother to my children. They lived with their daddy. And my oldest son, he was in M. with my aunt. I never took care of my kids (sobs)... then my daughter told me that S. my son, was mad at me because I’m in prison again, I got locked up again.

Participant 11 believed that he had let his family down by his incarceration: “Just my incarceration: leaving my family behind, my mom and my sister. For them to come up and see me in blue, having to see them leave. It was just real hard on me at that time.”

Participant 7 ruminated over feeling that he was a burden on his family:

And the things I looked at was my family would be better off without me, that I wouldn’t be a burden anymore, that they would know that,- being a better place, and I wouldn’t have to see the pain in their eyes anymore, known that I caused it.

Participant 14 struggled with feelings of rejection stemming from his adoption:

You get 50 different stories on why you were adopted so the only excuse you can give yourself as a kid is, you know, nobody wanted you. And then you find out at 16, I didn’t even know I had older brothers and sisters, until I was 16. Then you find out my parents had kids before me, so why weren’t those kids adopted, you
know. Why were you the chosen one. You just get depressed over that stuff, man, and there's all kind of stuff loading up on you.

Participant 13 reported that negative news in the media could contribute to his suicidal ideation:

Or the world turns to hell, like bombings and Iraq or stuff like that, people dying every day, handicapped people getting kidnapped, you know what I mean? All the bad stuff in the paper: kids getting kidnapped or raped, families getting murdered for 40 dollars, you know what I mean? It's retarded. That's the stuff that builds up after a while. I just get real stressed out.

A few inmates indicated that grief-related feelings and thoughts also contributed to their suicidal ideation. For example, Participant 24 said, “I just didn’t want to live no more because I was-tired of being in prison and I was thinking of my [dead] sister.” Participant 2 reported, “My grandfather had also just passed away and I was very upset about that.” Participant 10 attempted to kill himself the night he received a letter informing him about the death of one of his friends:

I've read that letter that that person passed away and then put out with everything else that was going on in my life you know. I was looking at what was going on in the outside world: I just don't feel that anything ever was gonna get better. I basically wondered, was there another side where all the crying and pain and hurt stops?

Feelings of hopelessness. A great number of participants reported feelings of hopelessness. This was described by some participant as encompassing all areas of their lives, whereas others linked them to specific circumstances. Participant 2 described her feelings of hopelessness as stemming from numerous events:

I knew that he was mad at me. And my grandfather's death, and everything that my family has said and the fact that I had just lost my sister and alone I felt, and I just...with all my time, not knowing whether I was gonna die in prison and when nobody even cares, nobody would notice if you are gone, I just said "You know what? I am done." I lived my life. I have done enough, you know, I am tired ...all the pain in all my life. I never had a chance, I’ve never been... everything had always been ugly and bad, and I’ve never known anything else and I keep hoping
for everything else but there was nothing. And so I just let go. Up until then I have feared death and then I just made my peace and I said, “I am ready. Let’s go. Let’s do this.”

Later in the interview, she added:

I was just like, “Huh. I am done. I don’t care anymore. You know, just, I am tired. I lived my life. If this is everything that my life consists of, I am done, I don’t want any of it, just, let me die.” I didn’t care if I’d get out, I didn’t care if I’d die. Actually I did care whether I died: I wanted to die. I didn’t care what happened afterwards; I just wanted it to be done.

Participant 6 said: “I felt I was done. I’ve done of life as much as I could possibly do. I felt at the very end. At that moment I felt like I couldn’t do anything anymore.”

Participant 5 reported: “not wanting to be, or nothing will make me happy or anything.... At that time I was pretty messed up.” Participant 3 alluded several times across the interview to feeling hopeless:

Sometimes I get to the point when it doesn’t matter to me if I’m alive or not. And I hate getting in that spot because it’s really hard that I know; I don’t know what to do.... my son just told me that he is mad at me because I’m back here again. It seems that I just can’t do anything right (sobs).... It wasn’t getting better, you know. It kept getting bigger and bigger and bigger, like the snowball effect, you know.... I was hopeless about the whole situation. And my life was hopeless and useless.

Participant 6 explained: “I felt I was done. I’ve done of life as much as I could possibly do. I felt at the very end. At that moment I felt like I couldn’t do anything anymore.” Participant 12 thought “that I would be better off dead, that I had nothing to live for, that nobody loved me. Just stuff like that.” Repeated incarceration was a major reason that led to the feelings of hopelessness of Participant 3:

I just felt hopeless, like here we go again, I’m just a fucking loser, you know. I mean after five times, it’s like, you’d think I get it right, you know.... I was so sick of being here and coming back again (sobs). And I am so sick of this. I was like, “When it is going to stop?”
Participant 4 also indicated that his feelings of hopelessness were related to his repeated incarcerations:

I might not even go on doing this because I keep getting up here.... The life that I chose, the things that I do, about my past, how I led up to this point in my life, wondering why I was so stupid doing the things that I do, just things started feeling hopeless.

Participant 23 reported that his feelings of hopelessness were related to the long-term consequences of his crime:

It was more or less, what future is there after this? This is how inmates in here treat me, what does the street... what will people on the streets treat me like? Because I haven't done anything to any of them. And then how the whole thing is set up because you get out in the registry. I get all that, but it seems to me that they always come down on you. Do you know what I mean? You got to tell people all, “Well, I had this.” When you get a job you'll have to be...whatever you do you'll always have to live with that.

Participant 7 indicated that his hopelessness was related to his fear of dying in prison: “I didn’t want to die in here. I’ve seen people die in here. I just didn’t see a life for myself anymore.”

Feelings of loneliness. Several participants reported that feelings of loneliness were a significant factor in their suicide attempts. Most of the inmates who expressed such feelings said that they felt isolated from both the outside world and within the prison. These feelings were related to relationship difficulties; however, in many cases inmates felt lonely despite communicating with other inmates and family members, and thus this subtheme appeared to be more a part of depressive symptoms than of relationship issues. Participant 18 said:

Nobody is keeping in touch. That’s the main thing about depression in prison, being alone. Here in prison you’re alone, you don’t have nobody. I tussle myself all day long; that’s the only person I got. Sometimes...I would not wish it to my worst enemy I guess, you know what I’m saying?
Participant 23 felt abandoned by his outside friends:

I want to say that people from the streets weren’t turning against me. They didn’t turn against me, they were just forgetting me. You write them a letter and it just doesn’t come. With some of these people I’ve gone through, we’ve done a lot of stuff together.

He also added later:

Who sent money? None of them sent money for my books, none of them visit me. There’s one that sent me a letter when I first fell. I got like three letters during the whole time I’ve been in here. What are they for? They’re obviously not my friends.

Participant 10 reported that he lacked any outside support:

I lost all my friends. Nobody. Nobody writing, nobody having any contact with me. I didn’t know anybody in this state, everybody I knew was in [another state]. All I knew was this family. I came to this family but I didn’t know them because I haven’t been around in years.

He further clarified later: “I mean, I lost my family, my mom, my kids were over in [another state]. I’m in a state that I don’t know anybody.” Participant 15 also felt lonely:

I have no family out there, no friends out there. I have some friends in Texas but they don’t know where I am. My parents, my mom… my dad is dead, but my mom may also be dead, I don’t know. She doesn’t know where I am. No letters, no phone calls, no visits, no nothing.

Participant 14 believed that he had nobody in the prison to be on his side when he needed protection:

Normally I don’t got no problems with physical violence. I’ve been through enough that the physical stuff didn’t matter. That fight wouldn’t have mattered had it not been for the fact that I had two or three of my buddies, one of which I babysit his niece and nephew on the outs. They were on the same unit when it happened. None of them come to bat for me. This Mexican cat that I hardly knew was the only one that came up and told them they were a bunch of punks for hitting a little dude from behind…. He can’t speak no English. I mean he can barely speak a lick of it, but I would hang out with him in the yard, I would hang out with this guy… and I’m like, man, my own home boy won’t stick up for me but this guy that I barely know who can’t even speak my language, who can’t
even talk to me, he’s the one going to the back, you know. It was all that stuff adding up all at once. Nobody’s support.

He also believed that he had no outside support: “I knew that nobody on the streets cared. If I disappeared, ain’t nobody that was going to care at that time.”

Nevertheless, Participant 14 indicated that he conducted phone calls on the day of his suicide with a former girlfriend and three family members, which reflect that his perceived lack of support rather than lack of contact might have been at the core of his suicidal ideation.

Similarly, Participant 1 complained:

I was just really down, I was really out of it and my friends, the ones that I have kept, weren’t anywhere around. And I had absolutely nobody there. I felt that I had nobody to support me.

Participant 1’s feeling of loneliness did not necessarily coincide with lack of support. She had a conversation with an inmate friend on the night of her attempt. She experienced an increase in her feelings of loneliness after the end of the conversation, when Participant 1 started to ruminate about the upcoming parole of her friend:

At the same time I was feeling like okay, well, she’s leaving... God, she left probably 2 months after I got out of SMU, so probably 5 months after. You know...it was like a short-term relationship and I’m feeling: How is this going to work when she is out and I don’t have anybody in? I mean, she was pretty much the only person that I really talked to about my feelings.

Feelings of guilt and shame related to crime. Several interviewees indicated that the crimes for which they served time haunted them so badly that it contributed to their suicidal ideation. For instance, Participant 1 said:

And I was starting to think about my crime a little bit more and that night I’d been talking with a friend about it and showing her some of the articles in the newspaper that had been written about me and it just really...I think all those just came all down on me all at once.
Later she explained it in more detail:

I was sitting on my bed, I was reading an article about my crime that they have written in *The Oregonian*.... it was talking about how we were, how the people in the crime that we were involved in, all of us, were horrible people and how we were just these monsters. And I felt so misunderstood and so alone, and just hopeless, and that there was nothing that I was going to be able to do.

Participant 7 reported that he “felt very bad about what I did.” Participant 21 also indicated that he struggled with feelings of guilt.

I was ashamed of why I came and all the people that I hurt.... And the whole...it was...my mom and dad had problems with the family over it and other things that happened. I was...I hated myself. I hated myself most of my life that I remember. I hated what I did, I hated...the people that I hurt.

Additionally, he also imagined that he would have felt shame if inmates would have found out what his crime was. In his case, fear of shame contributed to suicidal ideation:

I was my own worst enemy.... fear of shame, should nature of crime come out.... I grew up in the woods pretty much out [a rural area]; physical pain is normal for me. I don’t, you know, I don’t really worry about it. I wasn’t scared of getting in a fight or something. I was scared of people knowing what I have done. That’s way worse than any physical pain that they could cause.

Participant 22 described his thoughts the following way:

*I know I did something that was seriously wrong. Even though it happened to me, I can’t let that be okay for me, to say it’s okay for me to do that. That’s no excuse for me to do something like that. And I still get angry at myself and stuff for what I did.... I think about that, how bad I’ve hurt that child. I took a part of that child’s life - that was wrong for me to take advantage of. The way I hurt my family, the child’s family, her mother, things like that. And I didn’t want to live with it. I wanted to take the easy way out. I was depressed, I was angry with myself.*

He then further explained later in the interview:

That’s when it really started to hit me that I am in prison, how much I’ve screwed up other people’s lives and how much I’ve hurt other people. And it started to really hit me that I did something to somebody else and all those thoughts of
hurting people... I didn't want to live with it anymore because I was crying... I was stabbing myself in the arm with pens, and I wanted to feel pain. I was punching walls because I wanted to feel pain because I hurt them, so why should I, you know, I should be hurting. And I’ve started hurting myself and I just kept in a low and hard deep depression.

Participant 11 asserted:

At knife point I robbed her [his victim during his crime]. And it just started bearing down on me. I couldn’t live with it anymore, with the fact that I have victimized a female.

*Theme 2: Symptoms of Anxiety*

Inmates reported different reasons for worrying. As an effect of institutionalization, some of the inmates reported feeling anxious because of their upcoming release. Participant 20 reported he had fears along these lines:

Every time I got close to paroling, I ended up doing something to get me more time. And I’d get really, really close to...I’ll be doing good, and doing what I got to do, and they start talking about we are going to send you home, I’d mess up. And I continued to do that.... I’ve never cashed a check, I’ve never collected a paycheck, I’ve never held a real job, I’ve never had my driver’s license, I’ve never even balanced a checkbook.

Participant 14 explained that he feared that he would fail his future parole:

If I came out today, if I left today with what I have up here, if I stayed in Oregon, if I stayed with what I have up here, I’d be on drugs within a week. Because I would do good for a week, I’d try to find a job, and I’d get told by everybody that you’re a felon, we don’t want you, like I did the last time, and then.... I would have to take the transit bus since I don’t have a license anymore, I’d end up downtown taking transit bus from interview to interview for jobs. I’d see some guys that I know, they’d tell me: “M., why you’re even looking for a job? I got $200 worth of dope here, I know you could get this off in less than a couple days, why don’t you come back to work?” Then I’d be right back in the game, within a week.

Because of an investigation regarding a stealing incident in prison, Participant 15 feared that if certain inmates found out that he told the officers what he had seen, he would get beaten by them:
And I don't like thieves, liars and thieves.... So then they started interviewing everybody.... [After he cooperated, the officer told him:] “Go back to your bunk.” I said, “You are sending me back to my bunk? You send all these other guys to segregation, rolling them up, and sending me back there? Now what’s that going to look like?” You know?

Participant 18 said he was mostly afraid of the humiliation that accompanies a physical beating:

My first attempt was because some guys were picking on me. They didn’t leave me alone: I was scared. I told the officers, “Hey, you need to move me.” They’re like “Nah, we’re not gonna move you,” which kind of meant we’re gonna let these guys beat you up. I don’t like getting beat up. I’ve been beat up so many times, it’s pitiful. I don’t like fighting. I work out, but, it doesn’t mean anything, I’m not a fighter. So they didn’t want to move me, so I was really depressed and I didn’t know what to do. I went down to the lieutenant’s office; this was at Two Rivers. I went to the office and said, “There are some guys after me, I’m scared.” They were like, “We don’t know, just hang in there.” Hang in there...so I was like, “No, I’m not gonna get beat up and humiliated any more,” so I went back to my cell, took a sheet, I ripped it in three strands. There were 3 strands about an inch thick. I braided the sheet up then I tied knots, put it around my throat; tied knots until I couldn’t see. I woke up in the hospital.

Participant 22 was extremely afraid of threats received from other inmates:

“Maybe I should just kill myself so they won’t kill me.” Participant 16 also experienced fear that was related to either real or imagined threat:

And also it was fear because, remember I told you, I was kind of worried because there was a couple people on that unit that were from my jail. I was being paranoid, and maybe even delusional, thinking people are talking about me.

Participant 13 reported that his anxiety built up over small matters:

I cut my arm real bad. It was probably around 1 or 2 o’clock in the morning. It was just from being stressed out; I just let myself get worked up for like 2 or 3 weeks. It just built up.... The war in Iraq, just the people who lived around me, officers — some of them, not being able to call people and talk to them, not knowing what I’m going to do when I get out, stuff like that. A lot of combination of stuff. Feel hopelessness.

Participant 5 felt anxious when he witnessed unwanted sexual behavior from his cellmate:
One time when I was straightening my bed, he masturbated at the side of the bed, and told people that I did everything. So they put me in a different cell. But it was something big for me. When I was a kid they raped me, so that’s why all this affects me and everything.

Participant 9’s specific anxiety stemmed from his fear of not wanting to appear masculine due to the female gender identity of this physically male inmate:

The drive behind a lot of my depression, anxieties, gender identity disorder, and the symptoms that I developed, it’s because of male pattern baldness. I am actually balding. I am 26 years old. Testosterone is causing me this receding hair line; that’s why I’ve tried to castrate myself over a dozen times before. Two were more serious; I was hospitalized.... I use shaving as a form a relief to feel more feminized. That’s why I have long hair and...appear very feminine.

Participant 4 said he was afraid of becoming a child abuser even though he had no history of such charges:

I got the spirit that I don’t want to be like the abuser who abused me. I don’t want to hurt anyone like I was. I started thinking that something was wrong with me, I should just kill myself because I’ll never be well. I always had those thoughts about what if, what if I’ll turn out like that.... If there was a way I could do well with my life without thinking that it wasn’t such a big deal but it isn’t. It is a big deal. It shouldn’t happen to anybody. You know? People are sick. I don’t see how they’re getting pleasure from a child, you know. I start worrying that I’d be like that and I don’t want to be like that. It bothers me. You know? Sometimes I just think that there’s something’s wrong with me that it’d be better to kill myself and not go on with the possibility with me being like that.... I was being watching TV or whatever, and I’ll focus in on areas that I shouldn’t be focusing and I’ll ask myself, “What’s that about? What are you doing, you sicko?”

A few inmates reported experiencing problems with sleep that appeared to reflected underlying anxieties. For example, Participant 5 recalled: “I was to the point that I was waking up screaming in the night.” Participant 7 said: “I started having these bad dreams, and that’s one of my triggers.”
Theme 3: Hallucination and/or Paranoid Ideation

Several participants reported experiencing hallucinations and paranoid ideation.

Participant 22 described his auditory and visual hallucinations the following way:

They are familiar voices from people that I used to know in the past, from people that abused when I was younger, a child. So when I start hearing these voices I start losing control a lot quicker... I would see things like blood coming out of walls. I would see faces in the windows like angry demon type faces which made me... freaked me out, scared me. And I couldn't, didn't really want to talk with nobody about it.... At that time, I was believing that it was right there because it seemed so real. And now I can say that I can know now that it was not real but back then it seemed real.

Similarly, Participant 3 explained that the voices she heard also seemed real to her:

I was really having a real bad day. I was over there in the dorm and all of the people there, they were like mean, you know?.... They told me I was stupid. And I could hear them talking about me in the bathroom and stuff.... I thought it was actual inmates but Dr. XX thinks that it was me, that it wasn't...It feels to me like it was real.... it's just that people, you know, bothering me, calling me names, and stuff; I just couldn't handle it. Just didn't know what to say, didn't want to say anything, you know. I just wanted everybody to go away. You know? I just thought that I'd just take those pills and then everyone would go away. I would be dead.

Later she explained in more detail:

It was when I asked them to take me to the hole because people were yelling at me telling me that I was stupid and they were being mean. And I just couldn't handle it anymore. And I was afraid, you know? I heard one girl saying, "I'll wait until she gets out of the shower then I'll beat the shit out of her." And that's when I asked the officer, you know, to take me to some place, to the hole, you know. He said, "I can't do that." And he goes, he made a comment about, you know, "You did the wrong thing by coming up and asking me. Now you're gonna have to deal with them because they'll all gonna be mad at you," coming to an officer, you know.

Participant 24 reported experiencing command hallucinations:

Plus the voices in my head, they trick me sometimes.... They act like my sister's voice and then they act like God. I believe that they are God because they give
miracles like sunshine: they can make it in low and dark, light. And there will be all kinds of stuff. And I can hear God sometimes. He tells me to sacrifice myself.

He also had delusional beliefs that were intertwined with his religious beliefs:

I was on suicide watch and I had a suicide blanket. And I was in a cell by myself. I started hearing voices, telling me to get under the blanket because evil spirits were coming to kill me. I got under the blanket. I was curled up like a ball. And there’s no air coming in. And there’s spirits in my cell, evil spirits; they are in my cell. They smell like dogs because they are sniffing around the edges of my blanket, trying to get under my blanket. And my door opened and the dogs, the evil spirits disappeared at my feet. I told them I don’t want it. When they shut the door I was trying to get back under my blanket. There was one crack left, and the dogs’ noses came under the blanket and they touched my hand. And the door opened again with my medication, and the dogs disappeared. And I called out of the cell. “Put him back in there, put him back in there,” evil spirits and that. That’s why if someone would tell me there is no Heaven I wouldn’t believe him because there’s evil spirits in my cell. I know that. I know that. I know there’s Heaven. I know there’s a God because if there’s evil spirits, there’s Jesus. I have strong beliefs in that.

Theme 4: Medication-Related Problems

Some of the participants indicated that their feelings of depression were connected to their lack of psychotropic medications. Participant 5 asserted that he was not taking medications because they had not been prescribed, despite his efforts:

I was in prison for a year, and then one time I went to see the prescriber and I told her that the medication she was giving me was affecting my liver. I think it was Anatriptoline [sic]. And then she said, “Okay, I am going to take you off.” That’s how it happened. I tried really hard to get it back but somehow I wasn’t making it. And they changed the chiropractor, I mean the prescriber, it changed to a different guy. And I remember I went one time to the guy and told him that I needed my medication and he just told me “Hold on,” or he just told me, “I’ll think about it.” I told him I need my medication and he said, “I’ll think about it,” let me think about it.”... Without the medicine I was losing myself. I was like losing it, until it came the day that I was to the point that I was waking up screaming in the night.... And then, when they found out I was waking up screaming, the cops took me into an office and start asking me questions. And I was just losing it bad. I wasn’t myself anymore. I started cursing up at the lieutenant.
In the other cases, inmates did not comply with taking their prescribed medications. For example, Participant 22 refused to take his medications:

I was just like, I'd just tell myself I don't need these things, I don't need them, de-da-de-da-de, this and that. So by the time somebody would say take them, I said, "No, I wouldn't take them" or I'd put them in the cell, and I'd check them, and I'd flush them in the toilet. Nurses thought I take them but I really wasn't taking them. And I was basically manipulating the staff: they'd think I've had taken my medications but I wasn't, and this and that. And I just decided to stop taking my medications; I started flushing them and not taking them at all. It helped my depression, it just got deeper and deeper, and I started hearing voices and just losing control of my own thoughts.

He believed that by taking his prescribed psychotropic medication he would become vulnerable in prison:

I was thinking that they were giving me medications... at the time I was thinking like, "These guys, they are gonna put me on these medications and I'm gonna get out of it. They are gonna take advantage of me and they'd come and beat me up if I'd take these medications." That's the point where I got.

Participant 15 reported:

And at the time I was getting my meds, I was getting a variety of medications and I've cheeked them. I went back to my cell and I spit them out. And I could either trade them for coffee or trade them for a pen or trading for whatever. So I had a stockpile... I would take some and I would keep some, like a squirrel, ok? I would do some and if I didn’t feel like it, felt fine, I wouldn’t do any of them, I'd just put them aside, and then just watch out for when they come and do cell searches.

Theme 5: Impulsivity

Even though most inmates realized that a series of events and circumstances led up to their suicidal ideation, many of them also recognized they had decided to kill themselves impulsively, often within an hour of a triggering event. Participant 12 mentioned that: "One minute I was just so depressed I couldn’t deal with it anymore. That was another thing: I was always the person of the spur-of-the-moment, spontaneous
person.” Participant 5 indicated: “I wasn’t thinking at that time at all. It all just happened within an hour.” Participant 7 reported:

And after that fight, I wasn’t even down the hall 15 minutes they said when I hung myself. I even told them when they were taking me down there that I was having thoughts of hurting myself. And I asked them, “Can you get my CTS case manager? At least SMU? You don’t want to put me down here.” He refused to do it. And after I pleaded with them some more, he finally said, “Look, do what you feel you got to do, but you’re going to go into this first cell right here. You’ll be okay in this first cell.” And I said, “You don’t understand it all.” And when I went in there I just sat, screamed, “I’m sick of this.” Here I am losing everything again for something I felt I shouldn’t get blamed for any of it.

Participant 20 noted:

It was kind of spontaneous. It was like here’s the situation, what can I do about it? Nothing can happen. I can’t get out of the situation. Yes, I can get out of the situation. Alright, that’s about my only way out, so it’s kind of where I go with it.

Participant 1 observed:

It was just kind of, it was really a spontaneous thing. . . . I think that night was like, just felt like right now I am not feeling okay and right now is the point where I am going to go and do something to... you know?... to do something to myself because it didn’t feel like in that moment that I was getting help and I that I was getting support and that I’d be like that forever. It just felt like [that], you know.

Participant 6 attempted suicide by overdose:

I remember right up to that point of doing it. . . . I was in a hurry, more in a hurry than usual. I wanted to hurry up and get over with. I was almost anxious to be done with all things.

Participant 16 detailed his thoughts about his rushed decision:

When I get into that space, I don’t care what it’s going to accomplish. . . . I think like this: Either if I die, if I die then I’m dead, you know, but if I live, then maybe that’s the way it’s supposed to be. That’s the way I would think and I didn’t care, you know. . . . I’ve been told before that even when I was younger that I’m very impulsive. . . . I didn’t really plan ahead, it’s just that, I think it was kind of in the back of my head, you know, ’cause, I mean, I didn’t know until that exact minute that I was going to do that. I hadn’t been thinking about that or nothing.

And then he added:
By the time I pushed my button and started cussing him out, I knew what I was going to do, you know. I mean it started from that cell-in, and then right from there I thought well, you know. Something clicked, and I just said, I'm going to do this,” you know.

The impulsivity of some inmates may have been related to underlying feelings of anger, given that some of the participants indicated that prior to their attempts they had experienced strong feelings of anger. Participant 23 said, “I was angry and I was looking for trouble. I'd go out and look for trouble.” Participant 20 described his feelings elaborately:

I was kind of a moody, angry person down there so people kind of stayed away from me because I was a pretty angry person.... I would throw things, fight, get in people's faces, just kind of all-around generally moody, I guess, picking on people.... It seems like I was out on a self-destructive mode. I didn't really care about anything, I didn't care about myself or what people thought about me, or anything like that. It was like a false, like a pretend—not a pretend—a false projection of this I-want-you-to-see-me, this is...you know. But really inside I wanted someone to really pay attention to me. I thought if I acted like that people would go, “Hey, this guy is cool or not cool.” Either way, they had to pay attention to me.... I took people hostage to pay attention because I wanted attention. Just being real selfish. Kind of real stupid about how I acted and I didn’t look at how other people would feel, it was more of, “Me! Me! Me! Me! Me! Pay attention to me. Look what I am doing. Look what I can do!” type of thing.... Ain't do that no more. It's a good thing.

However, not all participants indicated that they had acted impulsively. Some inmates said that they spent considerable time planning their attempts. Participant 21 recalled: “For a week—I had two tries in the past—and for a week I thought about how I would do this.”

Theme 6: Religious Beliefs

Religious beliefs played both a protective role and a risk role in the suicide attempts of the inmates. For Participant 5, religious beliefs ultimately saved his life; he called for help before losing his consciousness: “If I kill myself I'm not going to go to
heaven. That’s what stopped me the last minute.” However, for Participant 14, the belief in suicide as a sin did not serve as a protective factor. Having earlier talked somebody out of killing himself, he believed that this action freed him to take his own life:

I had always been told by my dad, he’s a huge Christian type, he always told me this is a sin, you know, killing yourself is a sin, you’re going to hell. I’m thinking that whole night, I was thinking in my head this is a sin, but then I got that going for me, I saved somebody else’s life, so maybe the two can even out and I won’t have to go to, you know.... It might even things out.

Participant 16 indicated that he believed in the Christian interpretation of suicide; however, his hopelessness surpassed the strengths of his religious beliefs:

At that point in time, I felt like, you know, if I die, and if I go to hell, then you know if that’s what there is, then obviously I’m not forgiven. But you know, once you’re willing to take that step, you know, it’s like you just got to give up pretty much on everything, you know.

Participant 21 experienced disillusionment in faith which ultimately contributed to his decision to kill himself:

And the reason why [an officer] was saying [to go back to my cell and wait until tomorrow after I requested to be moved] was because I was carrying the Bible and stuff. I took this as guidance from God and I went back up to the cell. And [my cellmate] got mad, but he really didn’t say anything, you know, I thought maybe something might happen. So I did what I was supposed to and that’s put my faith in God, and, you know, I was positive nothing’s gonna happen. I got beat up pretty good.

And then he added:

And it was like, you know, obviously everybody knows now, and that poked me, my religion. I put faith that God would protect me. I looked at the sergeant as being an answer from God for directions and so that my religion was pretty much what was keeping me level...

Participant 8 reported having Buddhist beliefs. He claimed that he attempted to kill himself for the greater good of humanity. That is, he believed that killing people causes bad karma; therefore, he had decided to avoid getting killed by someone else (who
therefore would incur negative karma) by committing suicide, which causes less bad karma than homicide:

I felt like if I remained in that environment my life would be terminated by them and I did not want to be a source of negative karma for them.... I can be sure that neither one [of my attempts] was induced by emotional reasoning. It was induced by some form of logical reasoning even if it was relatively twisted.... [Suicide is] negative, but that's less of a negative than what they would get. One has to show more concern for brothers than oneself.... The only way that we can truly help all is by being more compassionate for others than oneself. We should have absolute compassion for all, no matter what their intentions are for us.

And he added later:

Before I have been thinking that I want to avoid causing them harm..... Let them do this body as they will. Nothing to be afraid of. The body gets hurt. The body gets hurt.

Participant 24 believed that he could get to Heaven only if he sacrificed himself by committing suicide:

I want to die to make it to Heaven.... I know in all testaments they do a sacrifice of themselves. They think God told them to sacrifice. I hear voices and I think it’s God, sometimes. And sometimes the voices talk normal: a lady’s voice I hear and a girl’s voice I hear, that and my sister’s voice. They just start saying “N., we are in Hell, help us,” like they are in Hell – my sister, my stepdad, and my brother-in-law, and my family that has passed away. The voices keep saying, talking like them because voices can change – the voices. They start acting like my family. They start blaming me. They start telling me to do suicide, so they can come out of Hell and go to Heaven.... [If I had succeeded] I think I’d be in Heaven.

Participant 24 incorporated other religious elements in his belief system as well:

“I believe that my stepdad’s mom and grandmas, my stepdad’s family, they practice voodoo. They have my air. They worship the devil. They are witches.”

Modeling did not emerge as a theme; however, 4 participants indicated that thoughts of attempts of other inmates had contributed to their decision making.

Participant 6 reported that “for some reason it feels like it makes it more okay.”

Participant 14 said:
I mean, not more than an hour before I had tried to commit suicide, I had just been in that day room with one of my best friends who had loaded his coffee up with so many pills that I couldn’t even name half of the name of the pills.

Participant 22 elaborated:

One tried to commit suicide, but... he kind of drove me crazy. Because he didn’t have a suicide attempt because he wanted to die or anything but he just wanted out of the institution, he wanted to leave because he was telling on people and he didn’t want to get beat up, so he faked a suicide attempt, that’s what it was. And that kind of started my thinking... and doing that, started me thinking like well, maybe I should die, maybe I should be dead, I should try and kill myself and stuff. So I started thinking, going back into the thought process of maybe I should die, maybe I should kill myself, I don’t deserve to live.

**Relationship Issues**

Four themes emerged in the relationship issues category: relationship problems with family of procreation/partner outside of prison, relationship problems with family of origin/adoptive family, relationship problems with inmates and relationship problems with staff.

**Theme 1: Relationship Problems with Family of Procreation/Partner Outside of Prison**

Four inmates indicated that the loss of their intimate partner outside of prison had contributed to their suicidal ideation. Participant 14 said:

I had been thinking about it, probably seriously thinking about it for 3 or 4 months. As soon as I got that letter that T. had been screwing around, I mean me and her were close, she was coming up to visit once a month. You know, I thought there was nothing that would interfere with our marriage.

Participant 11 indicated that the most significant factor in his decision to attempt suicide was the loss of his significant other:

I believe it was my girlfriend leaving me. She had her daughter getting on the telephone telling me that she had a new boyfriend. She didn’t have the heart enough to get on the phone and tell me and it really pissed me off. So I believe that was the last straw that did it.

He further explained later in the interview:
I had pictured it in my mind. I had made the plan like 5 minutes after I went into my cell, 5 minutes later I went into my cell for that night. And I got thinking about the breakup with my girlfriend, and about 5 minutes later I said, you know, I’m gonna do it. I’m just gonna end it.

Other inmates complained about lack of contact with their partner. Participant 6:

I wanted her to be in a different relationship. She was always saying, "No, no." And I’m like, "No, I got too much time," and I’m not selfish like that. But I just wanted her to always know that I’m part of that family no matter what. But it wasn’t working out like I planned.

He also missed seeing his son:

I was talking to my son, he was gonna bring his soccer trophy. She was supposed to come in on the 20th, 21st, 22nd in December. So this is what happened: It was a bad day. I was very excited. The 20th went by, nobody showed up. The 21st I got a visit. So I go out there and I look over there where we usually sit, right, and I’ve thought I have seen them. Weird, huh? So I put my ID there, and M., the woman there says somebody is there, and I go, “No, they are right there.” Then I kind of look and it wasn’t them. And it looked like A., my wife, right, but it wasn’t. So then I went over the family area and then I waited and then my mom, my stepdad, and my sister showed up. And it was so hard.... so disappointed! And it was so hard to go through with that visit and be cheerful, you know what I mean. But I did do it, but I left a little early off that visit. I let them go.... I cut her off short this time, and I came back, asked the guy. I said, “You’ve got some of the stuff [heroin]?”

Participant 6 indicated that he missed his children as well: “My kids mean so much to me. You wouldn’t know because I put myself in here, it seems such an oxymoron, but I hadn’t seen them.” Participant 18 felt helpless when he learned about the abuse of his daughter:

I couldn’t do anything about a dude hitting on my older daughter who at the time was like 4. Hitting her? No! I flipped out. I couldn’t do anything about it. I was crying because I was so stressed out because I couldn’t do anything, because I don’t want my kids to be beat up by some dude. And me not being like my dad, I am like my dad because of me being here. But I’m not like my dad when they’re abusing my kids.
Theme 2: Relationship Problems with Family of Origin/Adoptive Family

Several problems were reported regarding families in which participants grew up. Participant 8 indicated that a physical health problem in his family added to depression that fueled his suicidal ideation prior to his attempt: “What was going on at that time is that my mother had just lost her vision.” Participant 14 felt that he received no support from his family when he contacted them to complain about his suicidal ideation:

I called my sister in the middle of January and basically she was, you know, “I don’t really care, it’s none of my business. If you’re going to do it you’re going to do it.” Then I called my dad and he’s saying, “We’ve been like this your whole life. I’ve pretty much accustomed myself to the fact that one day you’re gonna do it, and you’re gonna, you know, and there’s not gonna be any amount of doctors to pump all the drugs out of your system that you put in there....” I mean he’s [adoptive father] the real soldier type and he’s, you know, “You just need to buck up, cowboy up, and take care of your problems....” After I got off with my dad, I said “You know what, this is not working out,” and I went back to my bunk and I said, well, I thought in my head: “What time would be the best time when nobody would notice? And how would I go about doing this to make sure nobody would even notice?”

He then described his conversation with his sister in more detail:

I told her, “This isn’t working out, I’m done, you know. I’m out.” And she said, “You’ve said this a hundred times, you either need to do it or you need to stop saying it.” So I said, “Well, if that’s how you feel.” I hung up on her. And I went back to my bunk, and I let the emotions that I had been dealing with her get to me, and I said, “You know what, forget this. I’m not going to even go to the hole, I’m just going to do it from here.”

Participant 1 felt that her verbal fight with her mother the night of her attempt was the last and most important event that triggered her suicide attempt:

I was having a lot of problems with my mom, like fights with my mom.... My mom comes to see me once every two months and we usually don’t fight when she comes but that month had been particularly hard. So I call her once a week. And we’d fight over the phone a little bit more than we would when she came to see me in person. And, it was more about money and just about me asking her for things and being needy, because I was. You need things in here and you don’t really have anybody to ask except for her. Then it just kind of just escalated to the point where she was yelling at me about it and I just really got under the weather.
Theme 3: Relationship Problems with Inmates

The themes that emerged in this area of relationship problems with inmate were not getting along, threats from inmates, and physical fights. Although problems with inmates as intimate partners did not emerge as a clear theme, 4 inmates indicated that such events were precursors to their attempts. For example, Participant 2 developed an intimate relationship with another inmate:

I needed her and I needed somebody to validate that I even needed to exist and to know that somebody would care or notice if I ever died, basically. And I also used her to take care of her and let me know that I’m not the evil person everyone said that I was.... I was really dehumanized and everyone said that I was evil and that I had no heart, no conscience, and I deserved to die and so what I had actually gotten with her originally it was because, you know, she had known that I was going to kill myself and she got me and told me, “No, you matter to me, you matter to me.” And I held on to that.

Participant 2 attempted suicide the day her partner communicated that she had gotten involved in another relationship:

L. sent me a letter that morning, and I was already upset, telling me that. I don’t even remember what it said. She hoped I was happy, and she was happy with her girlfriend and whoop, whoop, whoop. I was just done. That was what finally triggered it.

Additionally, one inmate attempted suicide when his non-intimate relationship with an inmate friend had terminated:

I felt depressed because of relationships with inmates; nothing sexual just friendships. Friendships, sometimes they go to hell sometimes, especially in this environment.... when you are friends with somebody for a long time, for some reason they don’t hang out with them no more, talk to them no more, you know.... My friend came up to me and told me he couldn’t hang out with me no more because I was a bad influence on him.... I was there and I was his friend. We did all the bad things together, smoked cigarettes, chewed tobacco, and stuff like that. We had hang out, played card, and had fun and all that. And then people started trying to brainwash him about how he is supposed to do something this way and hang out with only these people, and if he gets hungry he can borrow no food only from this person. It was just a form a manipulation.
Not getting along. Several inmates complained about an inability to fit in with other inmates. Participant 13 reported: “Some of them played little games, like you can’t pass a magazine, or you can’t loan some of your soup, you can’t get ice at a certain time. They nitpick at you until you flip out on them.” Participant 18 felt he could not get along with other inmates: “I was having a lot of trouble with a lot of people. A lot of people didn’t like me. I don’t know why because I never really had any guy-friends. Never.” He then elaborated in great detail:

Here in prison it’s kind of hard, some people think that you’re somebody that you’re not, they want you to be someone you’re not. So they pressurize you to do things you don’t want to do. They pound on your wall, they make you really irritated…. There’s really nothing you can do about it, you can try to ignore them, but it’s mostly the people that are in prison are the gang-affiliated people. That’s it. They give you suicide attempts. I’ve tried to kill myself a few times over the fact that people wouldn’t leave me alone.

Then he also added:

They tell me, you know, you should kill yourself, they want me to leave that cell and stuff…. Because they don’t want me there, because I’m not what they are, what they want me to be. In their eyes – I guess – I’m not a solid dude…. Like, they think, because I hang out with sex offenders that I’m a sex offender too. I only hang out with them…. When we’re at showers, they’re trying to throw feces at me. So I stay away from there. I don’t like feces being thrown at me…. I mean it’s like I need to worry about me all the time, like what’s gonna happen to me. These guys are telling me I’m never gonna walk mainline, that I’m not gonna have anything. They are telling me I’m gonna pay rent. I’m gonna be a torpedo the rest of my time down.

Participant 18 also explained why he believed he did not fit in:

If we were on the streets right now, all of us, no one would care about our past. Here is like a past-consuming place. It grabs your past, it brings it forward and it says: “Look what I’ve found! Guess what, I don’t like you because your past is not what I think it should be.”

Participant 1 indicated that she could not get support from inmates:
I think I was really scared when I first came in because it’s prison, of course, my first time being anywhere like this. God, how did it fluctuate? I was really... I didn’t make a lot of friends at first; not antisocial, but very hesitant because I didn’t know who I could trust and who I couldn’t trust. As I made friends my mood got kind of gradually better. And, you know, I began to find out that people in here are a lot different than they are on the streets, you can’t really... you can’t tell them the kind of things you can tell them outside and trust that they won’t say anything to anybody else. So, a lot of my case... and I was really honest with everybody, I wasn’t saying anything that was not true. But a lot of my case got out to everybody and I was really... it wasn’t harmful to me, but I was just very... it was crushing that people would actually, you know, go and repeat stuff that I’ve said to somebody else. I asked them, “Don’t tell anybody.” So that was really harmful definitely to my mood and just my social life, I think. So I started isolating myself a lot more when I came, cause I was on H unit, which is the intake unit. And I was there 2 months, 60 days. Then I came over here; I was over here for about 8 months. And I gradually, just like as my friends left because they were short-timers or as they started talking more about me to other people, my mood just kind of went back down.

Participant 23 experienced a souring of his relationship before his attempt: “Then people were falling off. So not only did I have like no support from the outside and what little kind of people I knew in here were starting to turn against me like ‘That dude is not good’.” As inmates found out that he was serving time for a sex crime, they started treating him very harshly:

You know, in the hole you have cellies. He’s like, “I’m doing clean time, you know, I don’t cell up with anybody who’s done a sex offense. We’re gonna have to go to totally different cells”... So he moved. They put somebody else in my cell... He’s like, “You are not going to live in this cell. Period. You fight me and I lose or I win, either way, if you’ll fight me and all, when you’re gonna get your ass on mainland you’re gonna get stabbed....” So they moved me into a single cell.... And then they tried to move me with this Mexican dude. And one of his home boys said, “Dude, that dude is a sex offender. Don’t move...” So the Mexican guy started acting up and they took him out of the cell and they put me in a cell by myself.

He further elaborated:

We were all handcuffed, you know what I mean? [An officer] made me stand away from other inmates. He’s like, he says real loudly, “We move you over here so you won’t get attacked while you’re here.” You know, so it’s obvious he knew
exactly what was going on. He was playing up for them. They’re all yelling, “Rapo, sex offender,” all these.

Threats from inmates. Eight inmates indicated that they had received threats of physical violence prior to their suicide attempts. Participant 17 explained his circumstances:

Basically in here it doesn’t matter whether you told on them or not, if you told on anybody, they consider you a snitch quite and simple, which puts me in about the same boat as a sex offender.... They’ve tried to extort me, they’ve tried to make me do stuff for them, make me beat people up for them. And when I said no, they sent someone after me.... No matter how many of these guys I fight, no matter how many I beat up, they just keep on coming. They never stop.

Participant 23 explained that inmates who are imprisoned for sex crimes are “extorted” by gang members: “They have their little thing where everybody that has any kind of sex offense has to pay them a certain amount a month; they call it ‘rent’ and all that. That’s a really big extortion thing.” Sex offenders are also at increased risk to be threatened by physical violence. As Participant 23 said:

And you come here and it’s hard to relate to anybody who has sex crimes. They jump on that. “What are you in here for?” They are going to try to beat you up. That’s why I was fighting and doing all that other stuff when I first came in here, proving that, “Hey, I’m going to fight.”

Participant 23 was threatened with violence when news about the nature of his crime (sex offense) started to circulate in prison:

All the people that said they’re going to testify for me and my child for that 30 months, said basically, “Fuck you, we don’t want to have anything to do with you. Just kick rocks.” And some of them said, “When you are going to get out we’re going to have word with you.” In other words, they were gonna try to send me back to the hole, to IMU, when I get out. So it was like, this is great, this is really just great.

Participant 8 was also subject to extortion:

During the following few months, even after the attempt, they would approach me—usually one by one, but sometimes two or three at a time—they basically
said, “You have a choice: You can either pay or die....” In here, that’s a given [method of killing]. There’s no need to say. What they do is they use an improvised blade, just commonly called a shank in this environment.

Participant 8 further commented:

One group of people at the institution, who made it clear that they would prefer to see me in a form of a corpse.... I felt like if I remained in that environment my life would be terminated by them.

Participant 15 received threats for being a “rat,” telling on other inmates: “I wouldn’t want to be in your bunk tonight.” They come by and say that as a welcome pass.”

Physical fights. Besides the threats, the toll of physical fights further added to the stress level of the inmates who later attempted suicide. Participant 8 recalled:

First one of their initiates came up because they decided to use him against me as a test and attempted to use a term that’s going on in here; get me to pay rent that is attempted to extort me.... That particular confrontation ended in a physical confrontation in a restroom....

He also recounted another confrontation:

So it happened the day before at the lending library at BOCI, in the rearmost aisle. I was looking through certain encyclopedias and one of them approached me. I can’t recall word for word how the conversation went, but it was basically the same threat that has been repeated numerous times. And as a number of times before, the conversation ended with him trying to shank me.

Participant 18 also participated in many physical altercations:

I’m a nice guy, it’s just I’m not a gang banger, I’m not a fighter. People want me to be that, I’m not. And there’s no way to change that. I try to act tough sometimes, just on a show. I’m not tough. I might be tough mentally, not really.... It’s like you gotta beat someone up to prove your point. I don’t like beating up people. I’ve been in 13 fights since I’ve been down. That’s a lot of fights. I haven’t lost that many, because when you’re scared your adrenaline gets built up and you don’t feel all of those punches hitting you and the kicks hitting you, you just go with it. But afterwards you realize that was pretty scary. You don’t want to do it again.... I’m not what they want me to be. I’m not gang-affiliated, that’s why they don’t like me. It’s because I’m not the person they want me to be.
Participant 10 indicated that his engagement in physical fights may have reflected suicidal ideation:

If somebody said something to me out of the way, I don’t care. He could be 300 pounds, 250, it doesn’t matter. I’d run up on them because what’s the worse they can do to me? Anything that I haven’t already done to myself? What can they do? Kill me? Take me out of my misery?

Participant 23’s opinion was that physical fights had protective value because they could increase one’s status:

And people here respect people that fight in here, I think it’s just like pecking order among animals. If you fight and stand up for yourself you’re a lot further on than somebody who doesn’t. And I would actually create problems with the guards to enhance my status, cursing at the guards so they’ve had to come and get me. There’s a lot of guards who know who I am just because I spent a long time doing stuff like that to him. Like go down to my job and I don’t like the way a guard is looking at me. So, I have a broom in my hand and I act like I snap on him. He called the response team. I knew that if I actually did something to him I would get in trouble, but if do something I create a little bit of name for myself.... I was angry and I was looking for trouble. I’d go out and look for trouble.

Participant 14 had a similar opinion:

I’ve learned that at my size you can’t even allow a sign of weakness in here. I haven’t had a fight in a long time.... In the beginning it’s a size thing. They wanna make sure of that, you know. At my size, if they think they can take advantage of me, they’re going to, and as long as you’re willing to put a fist in their face its kinda like a dog; he’ll take a bone from another dog if it’ll let him but if it starts to bite back, he’s more willing to...there’s plenty dogs out there that ain’t gonna fight for giving up that bone.

**Theme 3: Relationship Problems with Staff**

Relationship problems with staff predominantly involved officers. Participant 13 indicated: “The officers...and it’s not just the officers, the inmates too, but the officers put a lot of stress on inmates.” Participant 16 felt that he wanted to show that he—and not the officers—had the ultimate control over life.

I was just very upset. I finally I pushed on the officers. I pushed my intercom button, and I cussed at them. And I knew what that would do. I knew that they
would take me to the hole for that, but I wanted them to because I was so outraged. I knew when they came, I had it already planned and everything. I had everything. I had a razor blade and I jammed up my door with fingernail clippers and got paper so I could put over the window so they can’t see. I knew when they’d come I was going to do this, you know. I just felt like, I felt like I was saying to them: You know what? Screw you! What can you do to me now? What can you do to me? You can’t do nothing to me if I take my own life even. You have no control over me. This is how I felt, you know. I felt like, I’ll show you, you know, that’s how I felt.

Participant 16 further explained that his suicide attempt was a statement made to officers:

It’s not that I wanted to be saved: I wanted to scare them...I guess I almost felt like maybe it’s been rooted in me from the stuff that happened in county that I feel like I wanted them to see that they’re responsible for what, you know. It’s almost like a get back I guess. It was out of anger like, just a deep anger like, you know. I say that’s why I did that. They asked me before why I did that. I guess I did it for the whole shock. It’s just ‘cause I knew they’d be shocked if they saw a big puddle of blood coming out the door, you know.

Participant 18 asserted: “I really did want to get back at [a correctional officer]. He really hates me now. I think it was to prove my point that I was serious.” He further explained:

I don’t know, maybe I felt like I proved a point to them that they cannot control me. Or they can’t have every single part of me, you know. I have my own free will to do, if I choose to, to do whatever I want, you know.

Then he also added:

I think it’s just that I would think in my head that, you know, I have control over myself. Even though it’s not a good way, I’m not going to accomplish anything by doing that but I guess I just felt that I didn’t care to live or die, you know.... So I just used that, that officer making me mad, I used that as an outlet, as an escape. To get out, you know, I figured if either I’m going to die or they’re going to have to move me so I won’t be in this situation.

“Getting back” at CTS personnel was a theme in Participant 9’s attempt:

I see a lot of angst among inmates about them reporting they feel suicidal and not being taken seriously and then doing it. That’s an observation, that’s something that I’ve seen. It makes them more suicidal. It makes them, “You won’t believe
me? Fine. I'm going to do it. You don't care.” It's the mode you go into. As a matter of fact, that's the mode I went into on [date]. I've told them I felt suicidal and I was a 5 on suicidality, and I needed help.

Two of the inmates claimed that their suicide attempts were only tools used to elicit institutional moves. Participant 17 said:

When they wanted to move me out of the cell, you know, they told me I don't have a choice, they're going to move me out of that section. I was like, no, I'm gonna stay in this section. I think I do have a choice because if I tell you I'm gonna kill myself you'll have to keep me in here. Another one is just staying here in segregation.... One of the big things that's more just a kind of showing them I have a choice.... So by me refusing to leave the hole and staying in here I'm kind of saying, "Oh, yeah, actually I do have a choice where I live," because I can choose between living here or living on the mainline. Guess what? You want me to live on the mainline, but I'm gonna choose to live here.

**Prison Factors**

The themes that emerged in this category were moves within the prison, employment/activity-related difficulties, and disciplinary reports. Additionally, some inmates indicated that the prison environment itself was feeding their suicidal ideation.

For example, Participant 12 said:

I take responsibility for being in here and stuff like that; I did crimes and I have to do my time, but it just gets so tiring. I mean, doing time alone it's enough to break a person's spirit. You have suicide attempts in prison.... So, just being in prison only can trigger it, you don't need other reasons.

Similarly, Participant 23 indicated:

I remember talking to a prescriber for medication because when I came in I was not doing well, when I came in. I was kind of having suicidal thoughts then too because that's scary too, when you come to prison first time, and then come to prison for the first time for sex offense. I was like, you know, you got two things working against you.

**Theme 1: Moves within the Prison**

Some of the inmates found their transfer within the institution (such as from a single cell to a dorm housing) or to different institutions led to feelings of depression, and
reported that it was a contributing factor to their suicidality. For example, Participant 10 indicated:

Two Rivers is unlike any institution probably I have ever been to: very strict, very depressing. It's just like being in a dungeon; really, it's a lot more depressing.

Theme 2: Employment/Activity-Related Difficulties

Participant 1 felt that her job was more stressful than what she could handle:

I was working at DMV, I've just gotten the job and I started working on the phone and that's really a big thing here. It's a high-paying job and it's a high-energy...you have to be on task all the time and it's very tough.

Later she added:

The load was just so overwhelming to me there. It was just like, "What do I do with this, how do I talk to somebody about being...just being overwhelmed?" because nobody...I was like, "Nobody will understand."

By contrast, Participant 8 thought that for him unemployment was a contributing factor to his suicidal ideation:

I had been working for about 3½ months to get a paying institutional job at EOCI. It seemed as each attempt was a dead end because I had put numerous kyles into the dining hall where I have worked before that as well as I put in requests to the other departments of food services, kitchen, bakery, production kitchen. I also put in requests to every job that I was aware that I would qualify for at that time.... They weren't directly refusing me, it's just that they were taking so long in responding that it felt as if nothing was happening because normally in this environment if they're going to do something you hear about it within a week or two. For the most part I didn't get any reply. There were a few places I did get a reply from; they said, "You're on the list."

Participant 14 also complained about his lack of employment. He felt that boredom might also have been an important factor that contributed to his suicide attempt in prison. He said:

I realized that a lot of what was causing my depression was sitting around and having nothing to do. Once it gets quiet and late at night, I start thinking about stuff, so I told myself I had to have something outside of that.
Participant 10 also indicated that boredom contributed to his suicidal ideation:

“I’d lay in bed at night and I’d say I have nothing else to do but think.”

**Theme 3: Placement in DSU**

Placement in DSU, or the “hole,” is often a punishment for misbehavior in prison. Such placement involves a change in housing, more restrictive conditions of living, and a possible loss of previously earned privileges. Inmates placed in DSU often had a particularly hard time adjusting to the new conditions, which in turn led to deterioration in mental health. Adjustment to DSU was also difficult because of differing dynamics between inmates. As Participant 23 put it:

There’s a big thing in here with people who are going there [DSU]and they think they are safe all of a sudden because they have the big door behind and they talk smack to everybody for hours and hours and hours and hours. And those people then get out on mainline and within 2 hours a whole bunch of people jump on them and beat them down.... Because, you see, out here is a lot different, on mainline. Nobody really talks smack to your face; they all talk sideways, “this dude and that dude,” because they are afraid. They are afraid that you are going to do something to them. You know what I’m saying? I never had anybody say, “You’re fucking this,” nobody said that to me, ever, on mainline. But in the hole it’s a different thing because of the door.

Participant 22 said: “That’s when the voices had gotten worse, hallucinations and everything. And I just started going on a real steep downhill slow.” Participant 10 indicated that he found serving time in DSU draining: “I ain’t never really done this much hole time. I’m used to being out on the yard a lot. This is really getting the best of me in here.” He claimed he had ended up there for petty reasons:

I guess I never did so much hole time, and I went from doing certain kind of rules down south to doing things completely different. And they kept locking me up, putting me in the hole for every little thing.... they were watching every move I made like I had a red sign on my head. You know, you got some inmates that go about their business, they do their thing, and then you get some inmates they’re gonna keep an eye on because they know they never gonna basically obey by the rules.... You know, they locked me up one time for having a paper clip and an
aspirin that wasn’t in a pack, you know. Just bam, anything. I got my whole list of things up there, being out of place, and they consider being out of place being five steps out of your room. They locked me up for that. I’d had never been in anything like that.

He then summarized his difficulties: “The police were always on me, at every turn. They’d lock me up for little, simple things that I did, I mean minor things, you know. I couldn’t live like that.”

Participant 22 experienced paranoid ideation in DSU:

I started hearing voices and just losing control of my own thoughts.... I have problems hearing voices and visualizing hallucinations.... I had them for a long time. I can’t remember when it started but I really started noticing more when I started being in the hole and locked in a cell. It just started getting worse for me.

However, a few inmates preferred to stay in DSU. For example, Participant 3 said: “[DSU] kind of felt good because I wanted to get away from everybody.”

Participant 17 reported: “Ever since my last fight I pretty much just have been staying in here on purpose. As soon as my hole time is up I just disrespect one on the staff.” DSU was calming for people who felt overwhelmed. Participant 19 declared:

I noticed a profound change in my stress level between being in here in segregation and being out on mainline.... my stress level coming in here drops. Completely. It’s like, I don’t know whether it is...whether I’m agoraphobic or antisocial. I don’t know if one or the other, or a little of both but I know that if I am sitting out there on mainline I can’t get away from people. And it starts...it starts bothering me. Real bad.

Although legal problems did not emerge as a theme, 3 inmates indicated that legal problems contributed to their suicidal ideation. Participant 23 felt bad about the prospect of the extension of his incarceration. Participant 15 thought that there was no development in his legal case: “The courts were not working in my favor.” For Participant 9, loss of his appeal to receive hormone treatment for his gender identity disorder was the primary precipitant to his suicide attempt:
The reason why r took it to suicide is because it’s over, I thought; that I wasn’t getting help. The administration at EOCI, they were denying the specialist to come in to evaluate me, so we could present that evidence to the judge that I suffered and I need hormone therapy.... But that’s what caused it [castration/suicide attempt], that they were not letting [a specialist to evaluate my gender identity disorder] in. It forestalled all of my hopes, and I didn’t want to live no more...I got to talk to a counselor this morning, her name is S. He had a very good observation and it’s true: The prospects of whether I’m winning the lawsuit or not about winning or losing but getting the necessary treatment. It’s all I care about. My mental health is based on a hope for that because I do experience significant pain daily.

As a result, he started to sink into depression:

And finally, on [date], I received the final appeal saying you’re not getting treatment. Then I went (exhales deeply)...I was getting worse and worse and worse. And I couldn’t regroup. I was in the COPE program at EOCI at the time. It’s an inpatient mental health program. And I was on medication and everything but it was doing nothing for me. That’s why I told myself if I’ll be in trouble for being suicidal I might as well try it. It’s better than killing myself. I have at least this chance.

Inmate Recommendations for Suicide Prevention

In this section I list and quote interviewees’ recommendations for improving suicide prevention in prison. These recommendations are not grouped into themes; even ideas communicated by only one inmate appear in this section. A list of recommendations is provided in Table 2, and each recommendation is subsequently discussed.

Implement More Mental Health Programs

A few inmates expressed occasional dissatisfaction with a couple of CTS staff members, but the overwhelming majority of the interviewees indicated that they found CTS services to be very helpful for their mental health. For example, Participant 10 succinctly explained: “Because people in street clothes, they actually give a shit, and they come down, and sit down, and talk to you for a minute. That helps.” Participant 3 reported that she learned coping skills: “I went to a group, one of [a therapist’s] groups
Table 2

Recommendations for Prevention

- Implement more mental health programs
- Introduce animal-assisted therapy
- Encourage involvement in spiritual/meditation programs
- Make crisis counseling available
- Consider crisis counseling before placing inmates on suicide watch
- Ensure easier access to mental health counselors
- Take every statement of suicidal intent seriously
- Do not punish inmates for suicide attempts
- Modify suicide watch
- Change the design of the safety smock
- Introduce peer counseling
- Allow more family support
- Provide extra protection for inmates who committed sex crimes or who have other mental health needs
- Increase the number of correctional officers
- Provide more training to correctional officers about mental health issues
- Reduce staff turnover
- Implement various activities to keep inmates occupied
- Help inmates gain employment
- Set aside a place to release anger
- Allow the use of cigarettes
about coping skills. So I'm trying to work around this feeling I get when I feel like I want to die." Participant 11 found SMU helpful:

But being up there in SMU it's a way to stabilize a person's mind. It sucks up there, it's bad up there because you do a lot of cell time, but it's safe up there for people that are feeling real suicidal. And they've improved it over the years: they put groups up there where people could work on their problems, they got staff and counselors.

Similarly, Participant 2 indicated:

I am normally balanced, you know. I mean sometimes when I get to think about some things it can get me down and it will take me down hard, but I said I've learned the skills to be able to cope with those times as well. ... I was in SMU, I graduated, well, I completed this, the SMU program, and I've done DBT, and coping skills, and anxiety management. I graduated like eight groups in the past year. So, I've been in a lot of groups and the SMU program that helped me a lot.

Participant 20 also had a positive experience with SMU:

It's helpful. It's a really quiet environment. ... They are constantly, "How are you feeling, are you doing ok?" They sit down to talk to you if you need someone to talk to, whenever you ever need somebody to talk to. They are there to talk to you.

And Participant 18:

I like SMU because everybody is like on a first-name basis and everybody wears plain clothes, everybody is pretty respectful, treats you like a human being. Here it's kind of like, it's always you against the world, you know?

Because of their positive experiences, many inmates expressed a wish to participate in more therapeutic activities. Participant 13 wished he could obtain individual therapy:

More available people, just talking to people, CTS. That's the main thing right there actually, having a support group in prison. ... [Provide individual counseling rather than groups] because people don't want to talk in groups. You can't trust people; you have to be careful what you tell them and stuff like that.

Participant 20 thought that group therapy could help inmates best because group members could provide additional support to each other:
More programs based on that and not forcing people to do it. People that want to, people that really want to go to these groups - they realize that they need help.... Maybe people from the same unit because people from the same unit get along with each other a little more.... Because when you live on the unit, you get to know them. You learn their sleeping patterns, their eating patterns. You learn everything about them. Not intentionally, just because you are there. You see these people all day long. And when you get people that are willing to do this, they are gonna go to the group and they do the groups, and they are on same unit, then they themselves can help each other out: "Hey, you are feeling down, are you doing ok? You want me to stay so you can talk to me?"

Participant 1 thought that periodic check-up by mental health professionals could have preventive value:

I think it would have been a lot better for me had somebody came and talked to me, had anybody said...the staff like came and sat down, not the ones in here but the CTS, and said, "So, what's going on in your life? Are you doing OK?" And shown a concern for me.

Participant 23 felt that providing emotional support is the key component to reducing suicide risk:

I think the solution is more towards more support thing while you are in here.... I recognize it's hard to support everybody that comes in because it's 3,000 just here, but, you know, if it would be a little easier to get...say, "Hey, I need to talk to somebody."

However, Participant 6 thought that therapeutic activities were not helpful to everybody: "I am not really good about talking. When it's going on, if I am feeling depressed nobody knows. It's my problem, not anybody else's. It's not something that it could be fixed for me."

Introduce Animal-Assisted Therapy

Participant 19 suggested that taking care of animals could decrease one's sense of hopelessness:

There are some people who really believe they've got nothing better, nothing to live for in the world. Well, show them that there's something to live for, encourage them, give them a hobby, something to take their mind off of that. Give
them something to do. Like the 10-year-old boy; he felt that his family didn’t love
him. Okay, so what happened if I had dropped a puppy in his lap? Okay, granted
that you can’t do that all the time, you know; well, maybe you could. There are
pets all over, there the shelters, and there are pounds that have kittens, that have
dogs that need love. Okay, granted that love is generally an answer to almost
everything.

Encourage Involvement in Spiritual/Meditation Programs

Participant 11 suggested:

When I chant it releases a lot of pressure, and purifies my mind of hard stuff. I
would recommend that to any person that is struggling with suicidal thoughts or
any kind of thoughts to take a spiritual program. It doesn’t necessarily have to be
that, it could be anything. I would recommend that though because I find that to
be the most helpful.

Make Crisis Counseling Available

Several inmates indicated that talking to professionals could increase their coping
ability when they are experiencing suicidal ideation. Participant 3 wished that there
would be some kind of crisis counseling available:

Have somebody that’s here or that’s available to, for an emergency, or something,
when somebody starts feeling that way. Some place that a person can go to and
talk to somebody professional, you know, to calm a person down, I guess.

Consider Crisis Counseling before Placing Inmates on Suicide Watch

Participant 22 reported that:

If you tell medical, “I’m feeling like this,” they don’t try talking out of it, they just
put you on suicide watch. They could be trying to talk to you to see what’s going
on and trying to figure out what you could do to or what could be possibly be
done to avoid that situation. And it’s not possible in this place right now to do
that.

Ensure Easier Access to Mental Health Counselors

Several inmates indicated they found it difficult to get hold of CTS personnel
when they were in distress. Participant 6 thought that easier access to CTS personnel
could be helpful:
Better availability to talk to someone without having to go through the whole writing a kyte, sending it to somebody. Maybe in a week you can see somebody. If I needed to talk to somebody about how I’m feeling, maybe not suicidal but maybe not feeling real good, if I could talk to somebody without having to wait a week, that would be better.

Participant 13 suggested:

Sometimes you need to talk to people. And from my experience, CTS is just sometimes not as quick as... They are busy people, but sometimes when I put in a kyte saying that I need to talk to them, underlying it, and then I didn’t get a response. Then I get a call-out in two weeks.

Participant 1 believed that an easier access to CTS could be attained by improving the communication between officers and CTS:

I feel like it’s so important to have that communication between the officer and inmate and for the officer to take it seriously. Because if they don’t then there is no communication with CTS, there is no communication with people who actually do understand.... And people down in CTS totally understand how we feel because they see the same thing; they see the officers not coming to them with important things like that. You know? And if somebody really does kill themselves, that’s not on CTS: that’s on the officers. And I don’t want that to have to happen. You know? I would, huh... do anything to keep that from happening in here, especially just because... the officers are people too, and you know,... that shouldn’t have to be on them, and especially if they are not trained to see the signs and to interpret what people are saying to them.

Participant 9 asserted:

There’s a discouragement to tell the officers to talk to them to see CTS. They tell you to write a kyte or something. It’s a breakdown in communication. If there’s an inmate they don’t like they’ll think he’s trying to manipulate them.... When someone says someone’s not feeling good, then report, get a quick follow-up by CTS.

He then recommended the following priorities in communication:

First of all, in an emergency, tell the correctional officer and if they refuse, go to the sergeant or captain, and if that don’t work, then the kyte as a last resort with reply no later than next day.

Participant 2 recommended that inmates who report suicidal ideation to officers be allowed to see their counselor of choice:
Do whatever you have to do to get them to a person that's close to them. Because they aren't gonna tell somebody with badge and they aren't gonna tell anyone but the person they are asking for. They will sit there and die. And that's the truth. Because they do not...and especially at some point like that, because hearing the voices of somebody that they care about, that itself can have them pour out, "What? I just took 100 pills and this is what I took. Fix me." They would've never got that out of me had they had brought somebody else.

Take Every Statement of Suicidal Intent Seriously

Participant 1 believed that both real and manipulative suicidal statements reflect emotional problems; therefore, such inmates should be taken seriously: "Even at the level if you are trying to getting attention you are still depressed." Similarly, Participant 2 remarked:

Don’t always assume that it’s drama because there’re some people that when they say it they mean it. And it’s a silent, when they’re saying that, it really is a quiet cry, you know, even somebody even to say that. If the thought entered their mind they also wouldn’t say it.

Participant 9 thought that not responding to suicidal ideation reports may increase suicidal feelings in inmates due to anger at the staff's ignorance:

I see a lot of angst among inmates about them reporting they feel suicidal and not being taken seriously and then doing it. That’s an observation, that’s something that I’ve seen. It makes them more suicidal. It makes them, “You won’t believe me? Fine. I’m going to do it. You don’t care.” It’s the mode you go into. As a matter of fact, that’s the mode I went into.

Participant 16 also suggested taking any reports of suicidal ideation seriously:

I think that if a person keeps coming, because I was coming weekly, you know, every...at least once a week, and I’d come get medication or something. I think over so many times, you got to realize that the person is going to eventually do something. So if they're going same pattern, same pattern and having to come back, then they're obviously reaching out, trying. They need something, you know. And just the medication, you know, for me it wasn't something that a medication is just going to make go away. Okay, I’d take the medication, go home, go to the cell, go to bed, and I’d feel good but next day I’d feel the same, you know. So it was continual.... I mean it’ll make you relax but that does not solve the problem of what’s causing your...So I think what they could have did or what they should have did is probably, you know, every time I was coming back
like that, they should have did something with me. Take me out of the situation, maybe let me think clearly. You do something like that, you know...but the thing is, is they have a hard time 'cause a lot of people in here, they just go through that routine because they want to take the medication, they want to get high or something. It's hard for them to know, I mean like me, they would take it seriously because I almost died but before that they have to kind, I mean they're working with criminals, you know. I mean we're all criminals in here. So I mean they never know when they're being conned or when they're being...so I think it's really hard for them, you know.

He added later in the interview:

I just think they should, you know, continue to do what they're doing. Maybe take people a little bit more seriously sometimes 'cause I've seen some people that, you know, that they are very vocal or they give a lot of hints that they're having problems and sometimes the staff, they won't do something unless if they think it's an actual immediate danger or something. But even since I've been here in prison, I see they're taking more and more steps. They're getting better and better about it, you know.

_Do Not Punish Inmates for Suicide Attempts_

One inmate claimed that the prospective punishment made him more likely to plan his next suicide attempt more carefully. Participant 14 spoke about this:

I would have talked to CTS, if they would have really, honestly, if... I honestly think it would have helped. The way that it's set up in here, it wouldn't have helped, you know.... I've seen a guy cut his leg, and he went to the hole, and he got a DR, and got fined $100, for a suicide attempt. I've seen a guy hang up, he got an escape plan, got fined $200 and 120 days in the hole. So all that tells me, when I go to CTS is...now if I go to CTS and tell them I'm going to commit suicide I'm going to get a DR. I'm going to the hole and paying $50 fine. Why should I pay $50 fine, why shouldn't I just go ahead and...you know, I don't want to pay no money. I don't want to pay the state to tell them I'm going to commit suicide.... If I didn't think I was going to get punished, you know, for trying to do it, if I didn't think I was, you know, there was going to be a monetary punishment, all that, if I didn't succeed. I wouldn't have tried it. And if I didn't think that I was going to get punished for talking over about it, if they would honestly listen and not just right off the bat say, "He needs to be put in the blue suit..."

He then further detailed his ideas:

The first thing I did when I got back to the facilities I got a DR that tells me I'm going to pay for the whole medical bill. I'm sitting here, you know, alright, and the first thing that goes through my head is, I need to figure out how to do this
right the next time, you know, I need to do this right because I'm not going to pay no 3,000...you know.

Modify Suicide Watch

Some of the inmates indicated that the isolation of the suicide watch increased their suicidal ideation. Participant 2 said: “The isolation made me dwell on it and want to do it even more.” Participant 13 observed: “There’s nothing helpful about suicide watch. It gives you more time to think.” He also explained in more detail:

If you say you feel suicidal they are going to put you in suicide watch. What they’re gonna do is put you in a cell with a smock with like no mattress for like 24-48 hours, and then let you out and put you out in population. That’s not real functional, not really beneficial for anybody really. That’s what they do, that’s the way they deal with it. And when you go to suicide watch they don’t give you...when you go to the hole it’s when they give you envelopes, and you get a mattress, and blankets. But when you go to suicide watch they don’t give you nothing. So, you’re up in a cell with no mattress, a smock, and there’s nothing to do, except pound your head on the wall. You have nothing to read, you can’t think about nothing except what’s messing up your head right that moment... They just put you in a cell by yourself with nothing. What you do is dwell. It just makes it worse.... They don’t do nothing in there to help you. They just put you in there and they think that that’s gonna help you calm down.

Participant 20 expressed similar feelings about the suicide watch:

It’s like when you get there you’re like, “Man, what did I get myself into?” You know? Either not do it again or next time succeed so I ain’t come to this. You are sitting in the room, it’s quiet, you got nobody to talk to. When I am in a situation like that I want to talk to somebody. “Look, this is what I’m thinking, this is what’s going on.” And you can’t do that, you’re there by yourself. Thoughts are running through your head constantly. Personally, I’ve looked for anything that I can use to try to attempt again... because when you are there...I can’t think of any more dehumanizing, worse situation to be in than that. You have nothing.

Participant 2 found that the solitary conditions were depression-inducing:

Suicide watch is a good thing, but not when you put somebody in solitary to do it, you know what I mean? Because taking those people away and not letting them being around other people and stuff, it increases the depression and it makes them more hell-bent to kill themselves.... Just God, anything, just let the ceiling fall on my head and kill me. That’s what you’re thinking when you’re in something like
that. That’s kind of a feeling you get anytime you think you’re gonna spend a long
time in a little cell like that by yourself. It’s hard.

Participant 19 complained about the hard mattress: “None of these cops had ever
had to lay down on that thing and sleep for 3 days.” Participant 17 recommended
allowing phone calls for inmates who were on suicide watch to change the condition of
isolation:

In the case of people who truly intend on killing themselves, I think they should
allow phone calls to friends or family on the streets because I think that would
help them. But I mean the way they’re doing it now, in my opinion, if I were truly
suicidal and they took all my stuff away, they wouldn’t even allow me to write a
letter, I think that would just make me more suicidal, I would have much more
intent on killing myself.

Nevertheless, a couple of inmates indicated that the suicide watch was helpful for
them. Participant 4 reported: “[Being on suicide watch] was helpful. I probably would’ve
tried again if they would’ve put me back in my cell.” Participant 11 indicated:

When a person goes to suicide watch such as myself, it’ll give that person a
chance to think about his actions without being around anything that he could put
his hands on to hurt himself, or hurt myself or whatever.

Change the Design of the Safety Smock

A significant number of interviewees complained about the safety smock for its
skirt-like look which made many feel dehumanized when wearing it. Participant 21
noted:

When I’m in that cell by myself with the blue suit on I’m like, this is treatment?
I’m like it seems to me it’s nothing done where it could be something done and I
understand trying to be safe and stuff, but then again, I mean, people spend
sometimes months in there by themselves and that alone can make them go crazy.

Participant 18 stated: I lied to them because the fact is I want to have the chance to
kill myself. I don’t want to be in some smock. Because if someone says, “Are you feeling
suicidal?” I will say, “Nah, not today.”
Participant 20 said:

They stick you in this room for 3-4 days. It’s no fun.... When you go in you are already feeling bad, you are down and depressed. You go in there and it’s just like... they humiliate you. It almost forces you to...It kind of forces you to change your thinking because nobody wants to be in the situation...You are in this purple dress-type gown thing and no privacy, nothing. It’s kind of dehumanizing. It’s pretty bad, it’s no fun.... It’s just that you are there and that’s the only thing you have to wear. You are naked underneath. And the cops walk by, the officers walk by, they look in. You feel dirty because the cell’s dirty. You are all greasy; they don’t let you shower.... you start stinking and it’s gross. The floor’s all dirty. You walk around bare-footed on the floor.... When you get in this situation, it kind of brings your morale down.... Those first 48 hours you really feel like nobody. You just feel worthless.

Participant 14 noted:

There’s no man who wants to be put in a dress except for maybe some of the gays over at EO. Ain’t no man who wants to put on a dress; that’s the first thing that keeps a lot of these guys from doing it is, you know, they think, well I’m going to have to wear a dress. It feels like if you admit to it before you do it, if you admit you want to talk about it, even if you’re not seriously thinking about it, you’re going to end up either paying for it, you know, money for it, or you’re going to end up going to the hole for DR, or you’re going to end up demeaning yourself.

Participant 12 noted the following:

I’m the kind of person when they put me in a smock it makes me more angry because I think if a person’s gonna do something...I look at it as they humiliate you; put you in a smock and humiliate you. It’s not a matter of keeping you safe. If a person’s gonna hurt themselves there’s other ways of doing it.

Participant 16 declared that he would not report suicidal ideation to staff due to his fear of placement on suicide watch:

I wouldn’t tell them I’m going to kill myself because if you tell them something like that, they put you in a cell and they take all your clothes and they make you wear this.... If you tell them something like that, yeah. So I would just, instead of telling them I’m going to kill myself, I would just say I’m not feeling very good, you know, I’m feeling very anxious and you know I wouldn’t tell them, “Oh, I’m going to do something,” because I didn’t want to be put in a cell.

Participant 19 spoke with emotional involvement:
It gives you nothing but time to think, and it’s not that I mind that but it’s the fact that they put you in a dress, in a blue dress; they call it a safety smock. Call it what it is. It ain’t no safety smock, that’s a dress. Okay? Granted that I don’t mind wearing the damn thing, it’s the fact that I get bored. And I don’t mind having a guy sitting out in a life guard chair looking through the window in my house, I wouldn’t mind that either. But the whole thing is that ...yeah, I know, the light sockets are on closed circuits and what not. But I mean in all honesty, I know that if I was gonna do it there’s no way you guys can stop me. No way.

He also offered an idea about how to modify the smock:

That safety smock, that do no good to people, granted that being partially homosexual I don’t mind running around in a dress; I’ve done it a few times on the streets myself. But...if you could make it into a jumpsuit. And you could use the same material to make a jumpsuit. You know, there wouldn’t be a problem.... Granted that I think it would be rather hot but it’s better than running around half cold all the time anyway.

Some inmates would prefer staying in DSU than being placed on suicide watch.

Participant 13 said, “I like the hole, actually, because I’m away from everybody. They bring you the food, you go to shower every day or every other day. You just relax, read books, do nothing. I guess it’s alright.” Participant 6 reported:

The hole is actually a little bigger than my cell. The hole’s not bad, not at all. The worst part is getting out and having to start all over. You have to wait 60 days before you can even get on the work pool, and you are supposed to work 30 days in a kitchen.... You’re knocked down to nothing. When you are in the hole it’s not so bad but when you get out you’re at the whole beginning part. That’s what is hard.

Participant 21 expressed his thoughts as follows:

I was by myself. I was in a single cell. That, the hole, is nice for me. I didn’t want to go at first, but I was by myself, I was reading books—I read a lot; that’s how I spend much of my time—so the hole was actually pretty good.

Introduce Peer Counseling

Several inmates thought that peer counseling could be a successful preventive program. Participant 1 said:
I think especially because I’m an inmate, I think it’s easier to talk to your peers than it is to talk to somebody who’s in gray and black. It’s just so much easier. And the CTS people are so few... they can’t exactly see everybody so it’s like some people fall through the cracks, like I did, you know.... People remember in those times that there were people who were nice to them. And that could stop somebody from even doing something to harm themselves.

Participant 2 indicated that in some way she already engaged in peer counseling:

A lot of time, often my time when I come out, people will ask me to talk to me because they are sad so because they know that they have done the coping skills so they, I guess, in a way, I use myself as an example to other people who’ve gone through things because a lot of people know that I’ve tried to kill myself. A lot of people know that I’ve tried to commit suicide, and they know that I’ve almost; they’ve had to resuscitate me and stuff, and a lot of people know that, so when they get down they come to me and they want to talk to me and know, I think, in a way, they want to come to me to know how to get through it but they can’t really ask.

Later in the interview she also added the following:

But, they do come to me...and I told them, you know, you don’t know how it feels when you have to explain your family and everyone who loves you that you just did that and to hear them cry and call each other crying. And you know, they don’t think about that. So I guess, I get them to think about stuff like that or I try to. And that’s why they probably come to me a lot of times.... I always tell them, “I care about you; otherwise I wouldn’t be sitting here talking to you. Most of the time they got kids and stuff and I’ll be like, “You can’t tell me your kids don’t care regardless whether they are in your life or not or you have them. They know that you are here. They know that they have a real mom whether they are adopted or whatever. And one of these days they’ll want to find you and how do you think they’re gonna feel if they know that you committed suicide. How do you think that’s going to affect them? What if they glorify that? Do you want your kids doing that? What kind of example are you setting?” Yeah, depends on the situation.

Similarly, Participant 7 indicated:

I’ve shared it with some people. And I have talked to some people who were brought to me who tried to kill themselves, and I’ve talked to them. I told them my experience, what led up to it, the reactions of my family, you know, and even the reactions of my friends. You hurt more people other than just yourself. And I go like, “What do you like to do, what do you do, what are you thinking about, how come you are feeling that way?”, because since I’ve been here I have just shared with them. I couple of them say hi to me, how are you doing; they’re still here.
Participant 11 would have wanted to offer his support to another distressed inmate:

I was down at one bar and a guy was cutting on himself. I don't know whether he was trying to kill himself. But I’ve seen the guy being taken out of his cell, I’ve seen blood coming off. And it affected me.... It just affected me in the fact that I understood where the guy was coming from. I wished I could’ve talked to the guy.... And I says, “You don’t want to do that. I’ve been there.” And I’ve shown him my arms, “I’ve been there. It’s not worth it.”

Participant 19 claimed that he only “faked” suicide, yet he respected inmates who truly tried to kill themselves because “it took me like a day and a half to work up and do that.... I did not realize how much courage and how brave those dudes got to be to do that.” His words of wisdom were the following:

Well, when you commit suicide you’re actually not only hurting yourself, but you are hurting your family, you are hurting your friends and you put your thumb in your nose at the world.... I think a lot of the people who want to commit suicide—yeah, there are those people who cry out for help, okay—but if you could actually sit down and explain to them that suicide is a selfish act.

Participant 9 reported that he felt a sense of responsibility about protecting inmates’ lives:

And if I see someone doing something I’m gonna go to an officer and I’ll tell everyone. There’s no shame in that. In here there’s a political system, “Oh, yeah, that’s rat.” Not many people have that stance on suicide. If someone means suicide I’m not going to let him.

Participant 21 felt that an inmate saved his life on one occasion:

I didn’t cut myself because C., he’s a pretty good friend of mine. I was so depressed people could tell. I couldn’t hide it. I’m pretty good at hiding things, but I couldn’t hide it. C. said, lift your head up. Don’t you dare do that again on me.... I’m pretty sure that’s what saved my life.

However, a few inmates recognized that possible problems may arise with inmate counselors. Participant 13 warned about confidentiality issues:
And you got to be careful what you tell some people because they'll use it against you sometimes, later, later in the future. Not anybody, but there are some people.... sometimes you have to be careful what you tell people because you are vulnerable.

**Allow More Family Support**

Two inmates indicated that outside support could be beneficial. Participant 16 said:

I love my grandmother and I appreciate it and everything but when you come into a place like this, you grab onto any kind of support. You just want to cling onto anything you can get. To feel like you mean something, to feel like you still have something; even though you lost your freedom, you're still thought of, you know.

Participant 14 noted:

I know right now it is, for a lot of guys in here, it is extremely hard to talk to family and any kind of support out there, man. I mean you've got guys in here who ain't got... they are on incentive, they don't even got the money for envelopes, so writing their family is impossible, let alone calling it.

**Provide Extra Protection for Inmates Who Committed Sex Crimes or Who Have Other Mental Health Needs**

Most of the inmates who were incarcerated for sex crimes expressed a need for special services. In the social order of the prisons, sex offenders ranked low, as Participant 19 explained:

There's a social order here. There's what's know as the fellas, the guys who have non-sex beefs, non-sex offenses, granted that you haven't classified being a pimp and prostitution as a sex offense, but there's the fellas who are actually the shot callers, guys who run the yard, who says what goes on and what not.... the gang leaders. And then the fellas who are part of the gangs or who are on clean beefs.... Anything that is not sex offense we call it clean beefs in here. Then you got the sex offenders who will stand up for themselves who take no shit from nobody like yours truly here, like me. And then you got the extortees, the sex offenders will not stand up for themselves and will pay to walk mainline and things like that. Then you've got the rats, people who tell on other people, simply to stay out of trouble. There are rats who simply get beat down on.... just because they are rats—same thing with sex offenders. And that's the social order here.
Participant 17 thought that sex offenders had high risk for suicide: “Most of the people I’ve seen that were really serious about it [suicide] were sex offenders.”

Participant 23 advocated for special housing arrangements to inmates sentenced for sex crimes because of their “subclass of citizens” status in prison:

In terms of sex offenders, it’s a different thing, I think, from everybody else. It’s a whole different thing. A lot of it, I think, a lot of it it’s just separating us from everybody else. ... It sounds discriminatory and it kind of is, but I was like that in County. It’s a whole different way of doing time. ... Because the troublemakers in here, the ones... the predators, if you will, they’re always looking for somebody to prey on. And a lot of these dudes, a lot of people that are sex offenders, but not all like me, they’re old dudes; they are typically, the majority are older dudes and they past the time when they can fight and along that have health issues going on. And they are really easy to extort. There’s a lot of drama with those involved with that. It’s like they’re a subclass of citizens; we are a subclass of citizens. If something goes wrong, a lot of times somebody tells on us, somebody gets in trouble, then who’s to blame? If you don’t know for sure who it is, well, you blame the sex offender.

He believed there would be less violence in prison if such arrangements took effect:

Then it’s more like a...you form into groups still, like in my County sex offenders would separate. You form...you have your own little group. Younger people and people that are maybe not quite so far out there, they’re hanging together. And then you have people who are weirder, and then the people who just kind of stay by themselves. And there is no violence among...I mean there are still fights, I’ve seen a couple of fights, but they are not like, “I’m gonna beat his...” It more or less like, “That dude took my chair.” It’s the stupid shit, not like, “I’m going to kill you.”

Then this inmate explained why a different facility rather than different units would be more appropriate:

But the thing is you may need to separate them completely because it creates all kinds of problems because people would find out these are PC; they are in protective custody. Well, the people that figured out worked with trays would go down there, so they would spit in the food, they would piss in the food, they would do all kinds of things to their food. It would be the same kind of situation, they would be the target; so you would need to isolate them completely otherwise it would be a logistical nightmare. That’s why I say a prison is almost what needs
to happen, but that creates other problems. So I don’t know. In the county they knew what we were on, what units we were on, but they couldn’t target us because the cops were watching the food being prepared. And they prepared all the food at the same time and put it on all the carts and the last minute they would pick which cart goes. And yard is another thing because if you go to yard at the same time with everybody else obviously they can go like, “Oh, yeah?” They can do that that too. And they’ve done it a couple of times. Or they can still have the extortion thing going on too, “If you want to come to our yard, with the good people, then you have to pay us. It’s our yard,” you know what I’m saying? That goes on a lot too.

A similar view was expressed by Participant 18:

But I think the main thing is they should build a prison for sex offenders and CTS people. Because mostly the reason why people commit suicide is because of other people, it’s because what people say to them. Some of them includes gangs; gang-affiliated people. They do this to people and they make them want to do stuff. Because of what they say or what they do…. No gang-affiliated people will mess with you because that’s where it usually comes from. Their politics suck, they suck, for picking on people that they can belittle because they have problems. I feel that there should be a separate prison for people that have problems, because the fact is, if you did that there would be a lot less fights, a lot less trauma.

Participant 23 was also aware that separating inmates who committed sex crimes could bring powerful stigmas:

And not all sex offenders would be happy about that because, as I said, a percentage of them are gang members. They’re going to be very unhappy that now that they are in a facility safe…they do move in into a facility like that, then they would be all, you know, the guards there would know that everybody in here is a sex offender so they could perpetrated all kinds of abuses on them. And people could say that everybody who is from this prison, it goes on, people around there could say, “We have a bunch of sex offenders here,” it would create a bunch of hate towards the whole thing. So I don’t know what the solution is.

However, Participant 8 felt that less rather than more protection from staff was needed:

I would say that the best thing that staff could do to prevent the situation from happening is not step in to situations so readily, not be so ready to do something because by them stepping in it usually creates a worse environment. Usually things could be handled much better if the population is given the room to resolve its own problems.
Participant 15 thought that older inmates were vulnerable for being bullied; therefore, age should also play a role in arranging housing:

Maybe just about the segregation.... A lot has to do with status. They come from the outside. A lot of those kids, they know each other from the outside, they used to hang together, so to speak, “We are more intimidating and therefore you got to pay attention to what we say when we say it”....they would hang with their own, their own kids. And if young kids would want to fight, let them fight.

*Increase the Number of Correctional Officers*

One inmate suggested that more officers could mean the availability of more individual attention to inmates. Participant 12 spoke on this issue:

I think if you would get more officers there would be more understanding. When you have to attend 140 people you can’t deal with everybody. I just feel that if there’s more people there’s more understanding. You want them to listen, have more time to spend talking to you, you know what I’m saying? Here they don’t do that.

*Provide More Training for Correctional Officers about Mental Health Issues*

A substantial number of inmates expressed dissatisfaction with many correctional officers partly because the inmates believed that many officers lacked knowledge about mental health problems. Participant 1 complained that, “Some of the officers that are in our dorm don’t treat us like people, like humans.” She believed that officers were not trained well enough to recognize signs of mental illnesses:

And the officers need to be trained, like they have specifically trained officers down in SMU to recognize signs of depression, of illness, of mental illness of anything, and of suicidal people especially. And that’s really important for in here because when people come and tell you, “I’m going to kill myself,” they’re being serious and it should be taken seriously even if somebody is just off to the side and you notice the signs of suicidal thoughts or feelings or whatever. It’s important to know and to be able to contact her, communicate with somebody else even if you are an officer, to tell somebody else, “This is what’s happening.”

Participant 22 offered his observations as follows:
Basically have staff trained that work in these units to understand psychiatric needs of an inmate that has these because a lot of officers don’t understand the problems because they don’t have the problems. They don’t understand why they have these problems. So for an officer to be on the unit, he should be trained to understand and to act mellowly and not aggressively when someone’s feeling suicidal. Or have the ability to talk to an inmate that’s having an anxiety or panic attack. Find out what’s going on and why because right now their reaction is, “Oh my God! He’s going to kill himself, call, get him to the hole, put him on suicide watch, give me the nurse.”…” If there was an officer or staff member that is on the unit that is able to understand the needs of someone with paranoia, anxiety, or schizophrenia, or stuff like that... understand what’s going on, or understand what the problem is. To make it easier for someone to be like, “Hey, look, I’m going to this, this is what’s going on.” And with them not being able to do that they just can’t and they are quick to send us down over to the hole on suicide watch.

Participant 14 said:

You’ve got guys in here who specifically want to beat on Jews and you’re going to sit there right with them and joke with them and show that, you know, that’s what kind of power your badge has, man... Most of them, they just don’t have the training.

Participant 19 hoped to see more emotionally involved officers:

If you look in here, a lot of the staff here disassociate themselves from these inmates; that’s the way they treat them. They are just a number, not someone they have to deal with on a society day-to-day basis. They are work, they are a check, I am a babysitter, and they are just a paycheck. If they would lose that opinion and actually sit down and actually talk to them... I mean, show some emotion, show some caring, I mean, because this guy wants to hurt himself.

Participant 11 felt that the officers’ attitudes toward him played a role in one of his suicide attempts:

Attitudes of different people. Basically the officers at that time. I felt like they were bringing their problems into work with them, their personal problems they had at home into work, and take them out on the inmates, such as myself... [The most hurtful thing they have done was] probably growling, like we were animals, like I was an animal. Just because I was in a cell, a 6-by-9 cell, bars on it, I felt they’ve seen me as an animal, and that gave the right to growl.
Participant 12’s opinion was that correctional officers who were treated disrespectfully by inmates “should be professional; they are supposed to be professional.

That’s part of their job.” Participant 23 indicated that:

The guards were the ones who told the inmates that I may have a sex offense. They did, originally. Because I cursed one of the guards out, and they got tired of it. So they’re like, “Let’s see what is this dude in prison for?” And they found out and they went and told...They are not supposed to do that but I never told on them because, it’s like, how can I fight them? Because I know one of the sergeants was one who told. So it goes all to the top out here. It’s like they have their own little prison gang going on.

However, some inmates indicated that they had no problems with correctional officers.

Reduce Staff Turnover

Participant 15 implied the above recommendation:

I hate to say it but a little closeness between inmates or either staff or other inmates in responsible position where they can talk. A lot of times you don’t see somebody in here for two weeks and they are gone. You can’t really base any kind of a relationship on that.

Implement Various Activities to Keep Inmates Occupied

Some of the inmates have nothing to do and their boredom could propel them into depression. For example, Participant 14 implied that staying busy could have made a difference for him: “A lot of the guys that do that [attempt suicide], do it because, like me, I had nothing. I spent my time thinking about it. I had nothing to do with my time.”

Participant 13 thought that a moderately busy schedule would be the best: “But you don’t want to get too busy either. If you got 50 things going on you don’t have enough time to relax. So you got to balance it out.”
Help Inmates Gain Employment

Three inmates indicated that they had difficulties finding jobs. Participant 14 reported:

The things that would help you get taken away. You can't get a job, you know... I just had the best job that you can get in here offered to me down at the physical plant and because I’m CTS they’re afraid I would use the tools down there to kill myself. So I got turned down for someone else who isn’t CTS, I mean, just soon as they see the CTS jacket, it doesn’t matter if you’re suicidal. None of that matters, they won’t give you a job in here. The kitchen, I’m restricted from working in the kitchen.

Participant 16 noted:

They have me on all these holds and stuff because they don’t want to put me in stressful situations. They have all these different holds, so I’m very limited to jobs. I don’t feel like I need those holds anymore but still they are very cautious with me.

Participant 2 shared:

It was really hard to get hired for a job. The officers, even 2 months ago were like, “Wow, I don’t want her to be working around razors, or I don’t want her working around this. What if she hurts another inmate?” And, you know, that’s something that got me the whole time. I didn’t try to hurt anyone else; it was against me, not about anyone else. “Don’t personalize that, make that about you, because it wasn’t about you, it wasn’t about another inmate, it wasn’t about staff.” That doesn’t mean that I would hurt staff, anything. I was in the process of hurting myself, not anyone else. You know?

Set Aside a Place to Release Anger

One participant recommended the reservation of a room for anger release.

Participant 13 recommended:

You can’t let it out, you need to get a way to intervene and then you have to find a way to let it out, all energy, or that negativity, or that anger. And you see, DOC doesn’t have lots of places where you can do that. Like at the State Hospital, at Cornerstone, they had a room, it was called the “quiet room” or something like that. You’d go in there and scream, and yell, and kick the door, and all that. They have a punching bag out there.
Allow the Use of Cigarettes

One participant requested the reintroduction of cigarettes in prison. Participant 13 suggested:

Actually they should bring back smoking. It helps with the stress, believe it or not. It's a whole lot cheaper too. Now it costs 100 bucks a pack.... Smoking is bad and all that, but that could take off a lot of stress from people of all sorts. Smoking helps, chewing helps. I can understand them not having chewing tobacco, people spit all over.... Really, that would help with a lot of stress.
DISCUSSION

In the present study, I aimed to investigate factors associated with suicide in prison through analyzing the subjective experiences of inmates who attempted suicide in prison. Additionally, inmates were also asked to make recommendations to improve the suicide prevention program of ODOC, based on their experiences. A qualitative research design was selected in order to rely on subjective perspectives of the participants rather than on researcher hypotheses. Therefore, the focus of this discussion is a comparison with the research literature. I also provide an evaluation of the current study based on its strengths and limitations, and I offer directions for further research.

Findings and Implication

Factors Associated with Suicide Attempts in Prison

The 13 themes that emerged from the interviews that describe factors associated with the participants' suicide attempts in prison were the following: depressive symptoms, symptoms of anxiety, hallucinations and/or paranoid ideation, medication-related problems, impulsivity, religious beliefs, relationship problems with family of procreation/partner outside of prison, relationship problems with family of origin/adoptive family, relationship problems with inmates, relationship problems with staff, move within the prison, employment/activity-related difficulties, and placement in DSU. I classified these themes into three broader categories: mental health issues, relationship issues, and prison factors. By doing so, I have attempted to capture the affective components of the factors associated with suicide.
Mental Health Issues

Within the mental health issues area, the theme of depressive symptoms was consistently reported across almost all participants. This finding is not surprising, given that suicidal ideation appears in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, American Psychological Association, 2000a) only under symptoms of depressive episodes in the Axis I diagnostic section. Daniel (2006) also reported that depressive mood disorders were more closely related to suicide than to any other psychiatric conditions. The research literature is rich in depicting the relationship of depression and risk for suicide during incarceration (Rowan & Hayes, 1988).

The emergence of the subtheme of feelings of hopelessness is consistent with other studies showing that hopelessness and suicidal behavior were associated (e.g., Ivanoff, Jang, & Smith, 1996). Many researchers have focused on quantifying hopelessness. For example, Palmer and Connely (2005) used the Beck Hopelessness Scale to measure the strength of this feeling in participants. The present study goes beyond these prior assessments in that it sheds light on thoughts and feelings that may underlie hopelessness in prison. Many inmates associated their feelings of hopelessness with specific thoughts, feelings, and events that preceded their suicide attempts, such as repeated incarcerations, fear of dying in prison, long-term consequences of incarceration, seeing oneself as a failure, feeling unloved, and a series of negative events.

Interviewees in this study also described other aspects of depression not explored in other studies, such as the subjective experience of depressed mood and the nature of depressive thoughts. Inmates reported varied topics focused on depressive rumination, such as thoughts of letting one's family down and being a burden on the family, negative
evaluations of one's parenting skills, grief issues, a sense of rejection related to circumstances of adoption, as well as general negative news in the media.

Lack of outside contact has previously been associated with increased suicide risk in prison (e.g., Liebling, 1995). In the current study, lack of outside contact was also reported by some of the inmates as a factor contributing to suicide. However, I found that the subjective feelings of loneliness rather than the objective absence of support was the more important contributing factor to suicidal ideation. For example, one participant talked on the phone with a former girlfriend and three family members on the day he tried to kill himself. His subsequent appraisal of having "nobody’s support" increased his suicidal ideation. This finding is strengthened by results of social psychology research conducted on social support. Rhodes and Lakey (2000) reviewed studies that focused on measuring the correlation between enacted and perceived support. They found that, across studies, the highest correlation was .3, suggesting a weak relationship between enacted and perceived support. The implications of this finding are that the assessment of inmates’ feelings of loneliness/perceptions of support may be more beneficial than relying on inmates’ reports on number of visits received or phone calls made.

Feelings of guilt and/or shame related to the crime for which the individual had been convicted constituted another subtheme not found in the literature. Whereas many individuals commit suicide following the commitment of their crimes, presumably out of fear of consequences (e.g., possibly the mass shooting perpetrator at Virginia Tech in 2007 or the shooters at Columbine High School) or shame (e.g., White-collar criminals), suicide in prison appears to be less likely to be connected to the index crime due to the length of time it takes to get to prison and the opportunity the individual has to process thoughts with passing time.
However, several participants in this study indicated that shame or guilt about their crime played a role in their suicide attempts. This finding may be partially explained by the findings of a report from the World Health Organization (2007) in which it was noted that traumatic events predispose inmates to a risk for suicide. It is possible that committing certain crimes traumatizes perpetrators as well. However, this is a highly speculative hypothesis and research would be needed to test its validity. Moreover, the validity of such self-reports could be questionable because inmates, like most people, are aware of social norms, and they might have put their best foot forward during the interviews.

Symptoms of anxiety, the second theme in the category of mental health issues, were widely reported by participants. Anxiety has been linked to suicide in prison (Daniel, 2006). The present study highlights the reasons behind anxieties. Stressful situations such as bullying behavior have been described previously for inmate populations (Blaaw, Winkel, & Kerkhoff, 2001) as factors contributing to suicide. Knowing interpretations of events and thoughts, however, can be more important than the simply identifying the feeling and the reasons that cause them. For example, one of the participants in the present study attempted suicide on the night of the receipt of a threats from a group of inmates, whereas another inmate attempted suicide after a 2-month period filled with consistent threats and physical confrontations committed by various gang members. Thus, the threat itself may be less indicative of suicide risk than the subjective interpretation of the threat and the level of anxiety associated with it. Sleep problems that appeared to reflect underlying anxieties were also reported in this study by a few inmates.

Schizophrenia has previously been associated with an increased risk of suicide in prison (Daniel, 2006). The theme of hallucinations and paranoid ideation was identified
in this study as well. In some cases, command hallucinations and paranoid ideation had a
great influence on inmates’ decisions to harm themselves. Religious beliefs have been
found to be both protective and risk factors for suicide risk (Maltsberger, 1992). This
study validates both of those findings: One participant requested help before losing
consciousness because of his religious beliefs. For another participant, the combination of
religious and psychotic symptoms was extremely influential in the decision to attempt
suicide.

Impulsivity was another theme in the mental health issues category. Several
participants attempted suicide within an hour of a triggering event. However, results of some
other studies do not indicate a correlation between impulsivity and suicidal ideation. For
example, Dear (2000) showed that when depression was controlled, impulsivity and suicidal
ideation were not linked in his sample. Participants in the present study may have acted
impulsively because they were also depressed or anxious (as opposed to being impulsive by
trait). This explanation is supported by the fact that the majority of inmates reported that a
combination of factors led to their attempts rather than a single event. Anger also appeared to
have contributed to impulsive decision-making in this study. The association of anger and
depression has been well documented in the psychology literature (e.g., the concept of
depression as anger turned inward: see for example, Litman, 1970). Maris (1992) also found
that anger has been linked to suicide in the general population. Given these findings, the link
of anger and suicide was expected, though it has not been specifically described in the
reviewed literature on suicide in correctional populations.

Substance use has been found to be associated with risk for suicide in prison
(Jenkins, 2005). In the present study, one inmate attempted suicide by overdosing on
heroin, but there was little other mention of illicit substance use as a factor in suicide. Rather, psychotropic medications (specifically, non-compliance with medications and interruption in prescription) appeared to be a more important factor. Prior authors have not discussed the effects of medication-related problems on risk for suicide in prison.

**Relationship Issues**

Relationship issues both within the prison and outside prison have previously been connected to increased risk for suicide (e.g., Kupers, 1999). In this study the inmates gave detailed accounts of their relationship difficulties, allowing an in-depth look into the nature of their problems. Relationship issues appeared to be a larger category encompassing four themes. The first theme, relationship problems with one’s family of procreation or partner outside of prison, involved lack of contact, breakup of intimate relationships, conflict, and outside problems. One example of this theme would be the attempt of the participant whose primary reason for attempting suicide was his disappointment in his wife and children’s lack of visit at Christmastime. Relationship problems with one’s family of origin or adoptive family included lack of contact, verbal fights on the phone, and outside problems. For example, one participant attempted suicide following a verbal fight on the phone with her mother.

The third theme of relationship problems with inmates was diverse and included three subthemes: not getting along, threats from inmates, and physical fights. Such relationship problems have been described in the literature (e.g., Kupers, 1999). The subtheme of not getting along most likely could be included in the larger term of having coping difficulties, which has been described by many researchers (e.g., Dear, Slattery, & Hillian, 2001; Liebling, 1995; and Medlicott, 1999). Because of the phenomenological
approach of this study, expressions used by inmates rather than psychological terms were employed to describe factors associated with suicide risk.

The relationship between bullying and suicidal behavior under confinement has been demonstrated in the literature (Blaaw, Winkel, & Kerkhoff, 2001). The present study provides strong support for this assertion. Eight inmates indicated that real or perceived threat played a role in their suicide attempts. Six inmates indicated involvement in physical fights as well prior to their suicide attempts. Physical fights were perceived as either draining or protective factors by participants.

Finally, the theme of relationship problems with staff was represented by intentions of “getting back” at correctional officers. This “getting back” attitude reflected the use of suicide as a tool to assert control in the relationship with officers. Suicides in prison have been habitually viewed as mostly actions fed by secondary gain (Johnson, 1973). Although in this study 2 inmates claimed that control of their environment was the sole purpose of their “fake” attempt, the rest of the participants indicated that, even when intent of manipulation was present, a variety of factors contributed to their suicide attempts. Therefore, the results of the present study suggest that even manipulative actions should be thoroughly assessed both because manipulative actions may lead to unintentional death and also because other risk factors may also be present that may increase an inmate’s suicide risk.

Given the large power differential between officers and inmate, some degree of relationship difficulties are expected between them. Nonetheless, it should be mentioned that several inmates indicated that they got along well with officers and one inmate
recommended, in regard to suicide prevention, an increase in the number of officers so as to increase their availability to talk with inmates.

**Prison Factors**

The third category, prison factors, is a well-researched area. The themes that emerged in this category were moves within the prison, employment/activity-related difficulties, and placement in DSU. Such factors could explain why suicide is two times more common among prison inmates than in the general population (Kupers, 1999).

Moves within the prison (such moves involved within- or between-facility moves) has also been shown by Williams and Bellatty (2005) to be a variable associated with suicide risk in ODOC prisons. This finding is not surprising on a common sense level either, given that changes are frequently perceived as stressful by many individuals. In addition, changes in assigned housing in prison could be interpreted as increase in helplessness.

The theme of employment/activity-related difficulties appears to be a new finding. Indirect validation is provided by Liebling (1995), who found that inmates who attempted suicide tended not to occupy themselves in their cells. Along similar lines, Nurse, Woodcock, and Ormsby (2003) found that lack of mental stimulation was judged to be detrimental for the mental health of research participants who attempted suicide in prison.

Placement in DSU was the third theme in the prison factors category. Nine of the participants attempted suicide at least once in the DSU. Williams and Bellatty (2005) also found this to be a risk factor for suicide attempt in Oregon prisons. In fact, several researchers indicated a relationship between confinement in isolation and suicide risk (Kupers, 1999; Rowan & Hayes, 1988; Tatarelli, Mancinelli, Taggi, & Polidori, 1999; White
Schimmel, 1995). The results of this and other studies clearly point toward a need to avoid placement in isolation when suicide risk is a factor.

Additionally, what personal accounts of the events, thoughts, and feelings that led up to suicide overwhelmingly reflect is that these inmates were in distress at the time of their suicide attempts. Whereas signs of mental illnesses were present, the decisions to attempt suicide were preceded by a series of difficulties that drained the inmates’ ability to cope. Inmates overwhelmingly indicated that they wanted to talk about their problems. Interestingly, no inmate requested a higher dosage of medication as a tool to reduce his or her suicidal thoughts, but almost all participants expressed a need to be heard and be emotionally supported. This observation underscores Liebling’s (2001) suggestions in that prison suicide is not exclusively due to psychiatric disorders but also to problems in coping. The implications of these findings are that non-medical solutions that boost inmates’ coping abilities also need to be implemented in any effective suicide prevention program.

**Recommendations for Suicide Prevention**

Inmates, in general, expressed great satisfaction with CTS programs, and they indicated a desire for more services, such as individual and group therapy, and more availability of staff for support. One inmate suggested encouraging involvement in spiritual/meditation programs. The effectiveness of meditation programs for increasing the wellbeing of inmates has been demonstrated in some previous research (G. A. Marlatt, personal communication, May 4, 2007).

Another inmate suggested the introduction of animal-assisted therapy, possibly using dogs and cats. Studies have shown the effectiveness of this type of intervention to combat
recidivism (Schwartz, 2003). These treatment modalities are promising; however, studies would be needed to establish their usefulness in suicide prevention.

One of the participants alluded to a wish for availability of crisis counseling. Such services would be especially valued by inmates before placement on suicide watch. Inmates indicated that often they would have only needed somebody to talk to about their depressive thoughts when they felt suicidal in the past. Most of them found that the conditions of isolation of suicide watch resulted in an increase in their suicidal ideation. The increased risk isolation induces for suicide risk for incarcerated individuals is well known (e.g., Rowan & Hayes, 1988). Although most inmates were physically safe under suicide watch because they had no means for attempting to kill themselves, one participant attempted suicide while on suicide watch by managing to obtain materials with ingenuity.

Inmates implied that there was nothing soothing in their experience while they were on suicide watch. Several of them indicated that they liked being in DSU better than on suicide watch because at least they could read there. The bare room and the hard mattress contributed to their sense of despair while on suicide watch. Most of all, the majority of inmates complained about the safety smock for its dress-like look and the lack of underwear. They complained that they found the experience to be dehumanizing. Some of the participants indicated that the fear of placement on suicide watch made them more likely to avoid reporting suicidal thoughts in the future. One inmate claimed that his fear of punishment following an unsuccessful attempt made him more likely to prepare better for a successful attempt next time.

Inmates also strongly suggested that staff should take every suicidal threat seriously. They were aware that some inmates, including some of the participants, used threats as a
form of manipulation. Yet, some said, the mere presence of a suicidal thought already indicates some distress. Additionally, ignorance of their threats often triggered suicidal behaviors in inmates because they felt the need to prove their point to staff members. Along these lines, research evidence suggests that suicidal gestures and attempts exist on a continuum. Daniel and Flemming (2005), for example, concluded that some prisoners employ more and more lethal methods until they end their lives. Furthermore, inmates not only become more “effective” with repeated attempts, but they may also become less fearless because of lost sensitivity at the physical point of self-harm. As one participant said, “I’ve cut for so many times that my arms have no feeling in them. I can do this [applies pressure] and I don’t feel nothing.” Balancing the recommendations to take all suicide gestures seriously with the need to distinguish clear acts of manipulation, such as hope for an institutional move, could be very burdensome to staff. A means of distinguishing behaviors along the continuum of suicidality would be helpful.

The suggestion for the introduction of peer counseling transpired from statements from inmates who showed concern and empathy toward others who expressed similar emotional turmoil. A review of peer-led prevention programs in prison by Devilly, Sorbello, Eccleston, and Ward (2005) offered preliminary support for the use of such programs. Devilly at al. asserted that when inmates act as counselors they not only give support to their peers but they also become more likely to change their beliefs in accordance with their new roles as models.

Employment and need for activities to stay “moderately” busy was indicated by inmates to be an important factor in suicide prevention. A few participants have indicated that lack of employment and boredom played a role in their attempts. Findings from social
psychology strengthen this finding. For example, Nolen-Hoeksema (1993) found that distraction can effectively control negative mood, if the detractor is positive and engrossing.

Inmates also suggested that staff allow more family support because of an increased need to feel connected to the outside world in the prison. The introduction of a place to release anger, such as a room that contains punching bags, was suggested as useful. An inmate also thought the reintroduction of cigarettes would decrease inmates’ stress level.

A clear finding in this study and in prior research (e.g., Kupers, 1999) is that inmates who receive physical threats from others have an increased risk of committing suicide. Provision of extra protection for inmates who have committed sex crimes or who have other mental health issues was recommended by a great number of inmates. Some of them indicated that the problem was so pervasive that they saw the solution to be housing the at-risk inmates in separate institutions.

One of the inmate recommendations, allowing the use of cigarettes, is controversial. Some prison staff members I worked with prior to this study argued that cigarettes have temporary calming effects (despite being stimulants) and that it may reduce crime in prison by eliminating the black market for it. However, it is common knowledge that cigarettes are addictive and damaging to health. The suggestion to set aside a place to release of anger is clearly not supported by the literature. Catharsis has been found to increase anger and aggressiveness (Aronson, 2004).

I believe that the single most important recommendation that was derived from the interviews is to implement several staff changes, specifically with correctional officers. As Gater and Hayes (2005) put it, correctional staff represent the “front line of defense” (p. 34) because officers generally spend the most time with inmates. Interviewees in this study
recommended the following changes involving officers: increase the number of correctional officers, reduce staff turnover, provide more training for officers about mental health issues, and provide easier access to CTS staff.

Increasing the number of officers, at a common sense level, could lead to more observations of inmates by staff and more inmate-staff interactions, which may reduce suicide risk. Reducing staff turnover may lead to an increase in the trust level of staff by inmates. However, the value of this recommendation is contradicted by some authors who argue that long service in the criminal justice field can lead to insensitivity to distress (Danto, 1973; Rowan & Hayes, 1988). Based on their findings, frequent rotations may be more helpful for suicide prevention because reducing the length of service in a particular setting may decrease the chance for the development of burnout and insensitivity.

Providing more training to correctional officers about mental health issues was suggested by several inmates. Related to this recommendation, the request to have easier access to CTS staff and services implied that one reason for the lack of communication between officers and counselors was that officers did not understand the distress of the inmates. Complaints about officers' lack of understanding of symptoms of mental illnesses were in contrast to the inmates' overall satisfaction with the CTS staff's treatment of them. Obviously, the roles of correctional officers and counselors are very different, which influences the quality of the inmate-officer relationships from the outset. However, most suicides occur at nighttime (Daniel, 2006) when CTS personnel are largely unavailable; officers have a 24-hr presence in prison, and thus, the training of officers can not be overemphasized. Similarly, experts on suicide prevention also place priority on training of all personnel who come in contact with inmates (Gater & Hayes, 2005). Nonetheless, this
recommendation does not imply that correctional officers at ODOC are predominantly negative figures. Many inmates indicated that they got along well with officers. And, more importantly, many of the inmates interviewed were alive because correctional officers took action to save their lives.

In his survey of job importance, Isenstadt (1972) found that jail or prison guards were not well-respected; their roles are viewed as “dehumanizing and degrading” (p. 179). I similarly believe that correctional officers generally have a negative reputation. They are often portrayed in movies as uneducated and sadistic (e.g., Papillon, The Shawshank Redemption), and the media often present sensationalized negative examples of inhumane treatment of the mentally ill by officers (Hewitt, 2007). Therefore, I believe efforts directed at improving suicide prevention programs may need to include an approach at the societal level. For example, television shows or investigative special reports could be produced to depict correctional officers’ job in a more realistic light, emphasizing the importance of their work, their challenges, and their life-saving functions. Within the prison, officers could be recognized when they demonstrate a role in the suicide prevention of an inmate or when they consistently treat inmates respectfully.

In summary, improvement in suicide prevention programs should involve multifaceted changes that consider individual inmate, prison features, and societal aspects.

Strengths and Limitations of the Current Study

Some of the strengths and weaknesses of this study are inherent in the qualitative nature of the study. Considering strengths, this study was initiated without the construction of a priori hypothesis. Findings emerged solely from reading the collected material. Additionally, rather than following a rigid format, openness and flexibility was allowed to
lead to rich idiosyncratic data. These characteristics of the study contributed to the emergence of new findings not reported yet in other research articles.

A characteristic qualitative studies is that no reading is free of interpretation (Lieblich, Tuval-Mashiach, & Zilber; 1998) which may be seen as a major limitation. To overcome this, I had another reader code three of my interviews, I had input form members of a research group, and I kept a research journal throughout the process of the investigation. Another limitation tied to the qualitative nature of the present study is that generally narratives presented in interviews are a function of the context in which they are told, such as the aim of the study, the rapport between the interviewer and interviewee, the mood of the narrator, and momentary influences. However, several steps were taken to minimize this limitation (e.g., no benefits were provided to participants, rapport-building questions were asked at the outset of the interviews, and basic information of accounts was compared to staff reports).

Another strength of this study is its large sample size, as 24 inmates were interviewed for the purpose of this study. Another strength lies in the selection of the participants. There was no random selection involved, but all inmates who attempted suicide in prison between 1994 and 2005, who still resided in prison between May and September 2006 and who agreed to be interviewed were included in the study. Only 4 declined to be interviewed. Thus, the sample represented 83% of the inmates who had attempted suicide in Oregon prisons between 1994 and 2005 and who still resided in prison.

A limitation of the study is that the inmates interviewed may not be representative of the population of inmates who attempted to commit suicide in prison. Because this study involved interviewing inmates who attempted suicide in the prison between 1994 and 2005,
inmates with shorter sentences were released from prisons. Therefore, more inmates with longer sentences—and thus, those with more severe index offenses—were available to be interviewed. Similarly, because participation is voluntary, inmates with similar characteristics (such as a desire for attention) may have chosen to participate in the project. However, as just noted, only 4 inmates refused to participate when they were asked by their case managers to do so. Furthermore, because this is a qualitative rather than quantitative study, the representativeness of the sample of the population is not pivotal; it is more likely that the somewhat skewed representation did not interfere with theory generation.

Another strength of this investigation is its relative diversity. The sample included inmates aged 21 to 53 years. Two inmates had Hispanic ethnicity. Out of the 22 inmates reported as White on prison statistics, 5 identified themselves as biracial with Native American identity and 1 as biracial with Asian identity. The absence of African American participants is not surprising because ODOC imprisons primarily White inmates, and African American inmates have been found to have the lowest suicide rate of all ethnic groups (Lester & Danto, 1993). The participants indicated that they held various religious beliefs, such as Christian, Native-American, Atheist, Jew, Buddhist, Hare Krishna, Sufi, and Wiccan. With regard to sexual orientation and identity, 3 participants acknowledged a homosexual orientation and 1 participant identified himself as a transgender individual. Criminal charges varied from theft to aggravated murder, and the sentences varied from a few months to lifetime left to serve. Unfortunately, only 3 women could be interviewed. However, given that women constitute a minority ODOC prison population, this number could be representative.
Furthermore, another strength of the study is that inmates were interviewed at several sites, including six institutions, medium- and maximum-security facilities, as well as DSU and IMU units, contributing to greater generalizability of the findings. However, the data were collected in Oregon prisons only; therefore, findings may not generalize to the other correctional populations because standards for general care of inmates and suicide prevention policies vary within the United States and other countries.

The time period between the suicide attempt of an inmate and the interview varied from within a few months to 12 years; therefore, it is expected that the amount of detail given by inmates varied depending on the elapsed time. In addition, some environmental factors may have changed within this time frame, possibly rendering some findings irrelevant. Nevertheless, the majority of the suicide attempts occurred in the 2004-2005 period, and no substantial changes in environmental factors were apparent when less recent suicide attempts were discussed.

Finally, I believe that a major strength and unique contribution to the literature of this investigation is the description of the idiosyncratic combination of events, feelings, and individual thoughts that contributed to each inmate’s decisions to attempt suicide. These presentations attempted to highlight the process rather than the static variables that contribute to suicide in prison.

Future Directions

Further research is needed to investigate the experiences of women because only 3 women were available to be interviewed in the present study. Despite the relative diversity of the sample, further research is needed to include experiences of different ethnic minorities.
such as African Americans, to understand the cultural factors that may contribute to suicide in prison.

Because of the qualitative nature of this study, results are not intended to generalize to large populations but to offer hypotheses for future research and ideas for prevention programs. Controlled, empirical studies could be useful to validate the findings of the present investigation.

Empirical studies on the most effective treatment of inmates with major depressive disorder could also be beneficial, as several symptoms of this disorder have been found to be present in the participants of this study at the time of their suicide attempts.

Finally, ODOC could benefit identifying and implementing pilot suicide prevention programs to the existing protocols, based on recommendations suggested in this study. Suicide research and prediction is difficult at best, given the low base rate of the event and the lack of available predictors when suicide attempts are prevented. However, the current results suggest that there may be benefits to implementing improved prevention programs in prisons.
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APPENDIX A

PACIFIC UNIVERSITY
INFORMED CONSENT TO ACT AS A RESEARCH PARTICIPANT

Interviews with inmates who attempted suicide in prison

Investigator(s) Contact Information

Principal Investigator:
Ildiko Suto, M.A., Psy.D. Candidate
Pacific University, School of Professional Psychology
503-352-2400

1. Introduction and Background Information

You are invited to be in a research study of suicidal behavior in prison. The first part of the study will consist of conducting interviews with inmates who attempted suicide in prison. After all interviews are done, the results will be analyzed and given in a summary form to Oregon Department of Corrections. Recommendations may also be made about ways to improve suicide prevention programs in prison. You were invited to participate because of your experiences related to this topic. Please read this form carefully and ask any questions you may have before agreeing to be in this study.

This research study is being conducted by Ildiko Suto and Genevieve Arnaut. It was requested by Oregon Department of Corrections. The purpose of this study is to better understand the reason behind suicide attempts in prison and to contribute to reducing the number of suicide attempts in prison.

2. Study Location and Dates

The study is anticipated to begin in April 2006 and to be completed by August 2006. The location of the study will be different Oregon Department of Correctional facilities.

3. Procedures

If you agree to be in this study, we will ask you to participate in a one- to two-hour long interview about your suicide attempt in prison. The interview will be audio-recorded so that it may be transcribed at a later date. The audio-material
will be destroyed immediately following the completion of the transcription. A copy of each transcript will be kept on a password-protected hard disk to serve as a back-up. Your name will not appear on the transcript to protect your identity. All information regarding your identity will be kept confidential. You ID number will be recorded at the beginning of the interview and only Ildiko Suto will have access to both your name and your ID number.

4. Participants and Exclusion

Only participants who meet the following conditions will be included in the study: inmates who attempted suicide while incarcerated. Participants who do not meet the above criteria will be excluded from the study.

5. Risks and Benefits

There are risks and benefits to participating in this research. Possible risks include experiencing discomfort during the interview. It is most likely that you will experience relief in discussing your suicide attempt in prison; however, there is a small chance that you may also experience discomfort. If any problem arises as a result of your participation, Ildiko Suto will help you obtain the appropriate assistance from mental health staff at the facility.

Possible benefits include the likelihood that talking about your experiences may be beneficial to you by providing you a better understanding of your past experiences.

6. Alternatives Advantageous to Participants

Not Applicable.

7. Participant Payment

You will not receive payment or compensation for your participation.

8. Promise of Privacy

The records of this study will be kept private. There will be no copies made of the audio-recording and the audio-material will be destroyed immediately following the completion of the transcription. Your name will not appear on the transcript to protect your identity. All information regarding your identity will be kept confidential. You will be assigned an ID number at the beginning of the interview and only Ildiko Suto will have access to both your name and your ID number. Data will be kept in a password-protected computerized database. This informed consent form will be kept separately from any data we collect. If the results of this study are to be presented or published, we will not include any information that will make it possible to identify you as an
individual. Ildiko Suto must follow Oregon Department of Correction Counseling and Treatment Services reporting regulations. These include reporting danger to self or others; child, disabled person, or elder abuse when the victim can be identified, staff abuse of inmates, escapes plans or attempts, and sexual assault.

9. Voluntary Nature of the Study

Your decision whether or not to participate will not affect your current or future relations with Pacific University and Oregon Department of Corrections. If you decide to participate, you are free to not answer any question or withdraw at any time without prejudice or negative consequences. If you choose to withdraw from the study during the interview, the obtained material will be used in data analysis, unless you indicate that you do not want the information obtained from you to be used.

10. Compensation and Medical Care

During your participation in this project you are not a Pacific University clinic patient or client, nor will you be receiving psychotherapy as a result of your participation in this study. If you are injured during your participation in this study and it is not the fault of Pacific University, the experimenters, or any organization associated with the experiment, you should not expect to receive compensation or medical care from Pacific University, the experimenters, or any organization associated with the study.

11. Contacts and Questions

The experimenter(s) will be happy to answer any questions you may have at any time during the course of the study. The experimenter can be reached at 503-352-2400 or sut01294@pacificu.edu. If you are not satisfied with the answers you receive, please call Pacific University’s Institutional Review Board, at (503) 352 – 2215 to discuss your questions or concerns further. All concerns and questions will be kept in confidence.

12. Statement of Consent

I have read and understand the above. All my questions have been answered. I am either 18 years of age or over, or my parent / guardian has given consent for my participation. I have been given a copy of this form to keep for my records.

Participant’s Signature and SID# Date

Participant contact information:
Street address: ____________________________

______________________________

Telephone: ____________________________
Email: ______________________________

This contact information is required in case any issues arise with the study and participants need to be notified and/or to provide participants with the results of the study if they wish.

Would you like to have a summary of the results after the study is completed?

___ Yes  ___ No

Investigator's Signature
Date
APPENDIX B

Semi-structured interview questions

Thank you for agreeing to be interviewed. I explained my study, invited the interviewee to ask questions, went over the informed consent, and asked him or her to sign the consent form. The purpose of our meeting is to learn lessons, with the hope that in the future fewer people will attempt to harm themselves.

(The questions below are separated into main questions that were asked of all participants and possible follow-up questions to address specific content if the participant does not address that content when answering the main questions. The order and wording of the questions were changed to integrate them in the flow of the conversation. Follow-up questions were asked if the client did not discuss the content of the follow-up question when responding to the main questions. Additional questions may be asked.)

I. INTRODUCTION

Main questions:

1. How are you doing today?
2. How long have you been in prison?
3. How much time is left on your sentence?
4. Why are you in for?
5. Describe your typical day in prison.
6. As you know, the purpose of this interview is to address prior attempts to harm yourself. Before I begin those questions, I would like to know if you have any current suicidal thoughts.

Follow-up questions:

a) What are the activities you enjoy here?
b) Are there days when you feel low?
c) How do you get along with other inmates?
d) How do you get along with the staff?
e) Do you have outside support?

II. DESCRIPTION OF SUICIDE ATTEMPT

Main questions:
1. Think back to the time when you attempted suicide in prison. When was that?
2. What was going on in your life at that time? How were you thinking and feeling?
3. What did you do to harm yourself?
4. What happened following your attempt?
5. What are your religious beliefs? What role, if any, did they play in your decision to kill yourself?

Follow-up questions:

A. What was the very first moment when you made the decision to kill yourself? Did you want to die?
B. How long in advance did you plan your suicide attempt? How many times a day did you think about it?
C. Did you ever waver about this decision (maybe I don’t want to do it)?
D. Why did you do try to kill yourself on that particular day (not the day before or a week later)?
E. What time of day did you do it? Was that part of the plan?
F. Did you use alcohol or drugs prior to your attempt? Did that have anything to do with your attempt to kill yourself?
G. Did you have a cellmate at the time? How did you get along with him/her?
H. Were you on suicide watch at the time? Tell me more about that.
I. Have you received any threats of harm from anybody before your attempt? If yes: What kind of threat: physical or sexual? Tell me more about that.
J. Did you try to talk to staff members about your feelings or plan? If yes: What happened? If not: Why not?
K. Was there any staff member that you would have wished to talk to?
L. Was there anybody at the prison, including inmates, who, you think, could have talked you out of trying to kill yourself?

III. ENVIRONMENT/SOCIAL SUPPORT

Main questions:

1. Did people who care about you know about your attempt? If yes: How did they respond?
2. How did inmates treat you?
3. How did staff treat you following the event?
4. Had you then, or have you since, heard of anybody else attempting suicide in prison, either around the same time as your attempt, or at any other time? If yes: Did that have anything to do with your decision to kill yourself?
5. What is the value of suicide watch, in your opinion?
Follow-up questions:

A. Did you talk to other inmates about wanting to harm yourself? *If yes:* What happened? *If not:* Why not?

B. Did you talk about your attempt with other inmates after it happened?

III. PREVIOUS ATTEMPTS

1. Have you had previous attempts outside the prison? *If yes:* Please describe them briefly: How were they different from your attempt in prison?

2. Has anybody in your family committed suicide?

IV. CONCLUSIONS

Main questions:

1. What are your feelings and thoughts about that decision and behavior today?

2. How did your attempt influence your view on the value of life?

3. What do you think the staff could have done differently to protect you from harming yourself (except, of course, to release you from prison) or from having suicidal thoughts in the first place (so that your mood stayed relatively good)?

4. What lessons did you learn from your suicide attempt in prison?

5. Now let us pretend that you work here (you can be an officer, a case manager, a psychiatrist, or have any other job you want): What would you do to protect inmates from trying to kill themselves?

6. What would you tell another inmate who was considering suicide?

V. TERMINATION

Main Questions:

1. Do you still experience suicidal thoughts?

2. How are you feeling now?

3. Do you have any suicidal thoughts now?

A case manager will meet with you today or the next day to follow up about how you feel after the interview. Thank you for the interview. I am glad you are alive!
APPENDIX C

Psychosocial Background of the Interviewees

In this section I provide information on the interviewees regarding their childhood experiences, early problems with drug use and delinquency, as well as prior suicidal ideation and attempts. The aim is to shed light on the roots of the inmates’ difficulties in coping with life prior to incarceration and their subsequent suicide attempts in prison in order to further address the criticism about the lack of emotional understanding of suicidal prisoners. This material has not been coded.

The overwhelming majority of the participants reflected back on their childhood as being problematic and filled with adversity. For example, Participant 23 reported that he “was kicked out of my house when I was 13 by my parents.” Participant 14 summed up his experiences the following way:

I was adopted when I was born. So it was like my first, my birth family couldn’t take care of me, and then my adopted family really didn’t want to do the job. And every time it got a little difficult for them they shoved me from one place or another, and then when the state finally told them it was okay to stick me in detention they called the cops every chance they got.

Participant 12 observed:

My dad was an alcoholic. He was Indian; he drank a lot. He was very abusive with my mom. It wasn’t really a pretty family life.... I was usually in trouble with the law and stuff like that. I was acting out trying to get my mom’s attention. I was locked up in juvenile institutions throughout the years. I was very uncontrollable. Back then they could award to the state and stuff like that. My mom would put me in institutions.

Participant 12 further explained about the nature of his problems:
Just a lot of depression, the feeling of my mom not wanting me, loving me. When she would come to counseling and stuff like that, she would tell counselors stuff like, “I love my other kids than I love you. They are not in trouble all the time.” Just things you don’t want your mom saying as a kid.

Participant 8 elaborated on his difficulties:

My mother had got separated from me.... And not knowing where to go at this time, I went across the river and walked down the river to get to downtown .... And a friend of my mother’s noticed me, took me into her apartment, contacted my grandmother in California who paid for the plain ticket for me to be sent out to California, who, my grandmother was my legal guardian anyway. She no longer had the resources to take care of me so she sent me to her ex-husband, who was the father of my mother, my maternal grandfather. And he not having the resources, he had the material resources, but he did not have the emotional or time resources to deal with a child, so he made the decision to hand me over to the state.... I had been separated from my mother a few times in my life, so...And then I was put in a few temporary foster homes while they were trying to find a placement for me. And ended up being placed in a boarding school.

Participant 1 observed:

Just a lot of stuff, just like emotionally...like my dad died when I was 13. So I was going through a lot of...I repressed a lot of my emotions and I was really... was just fairly... I was really, I was going through a lot of anger at myself and at everybody else and at my mom and feeling like I was really alone.

Participant 9 said:

I was very intelligent and my teachers were always interested in me, in helping me out. It wasn’t that I wasn’t able to do work. I had no support at home. My dad would actually discourage me from doing homework. He had me do house chores and stuff. And there’s a tension I had in feeling insecure and not being able to focus too much in class because always tension... And I had high anxiety growing up. So, it was really bad environment for a person to get educated, trying to relax, enjoying their life.

Later in the interview he added:

So me and my sister were separated. And my mom chose her over me and gave me to my dad. And my dad didn’t know me; he thought he’s getting a boy. He was an ex-marine. It’s harsh. He definitely had an agenda. He wanted a tough boy to be proud of, you know, he was going to have me all masculinized and everything. Once he saw what he was in for...he didn’t understand, of course.

And then he also noted:
When I was 14, or around that time, I ran away. I went recluse. What happened is that I took a tent and a bunch of canned goods... into the forest. And I had no skills, and survivals skills, or nothing. I just went to live in a forest. I wanted to go live by myself and be away form everyone. I was through with society and I went recluse. Like Ted Kaczynski (laughs), except I had no intentions of bombing anyone. I was gonna go back as a genius (laughs), but I wasn't psychotic. Just the world was at odds with me, I was very hurt.

Participant 2 complained:

I lived a very ugly life. I spent the first, I think from the time that I was 18 months old until I was 5 in a foster home, which, then was a really good place. The foster home, I vaguely remember the foster home and that was one of the best places I’ve ever been in my entire life. But my life growing up, it was... half the time we were homeless living in travel trailers; they were giving me to their friends. They gave me back when I was like five, and I think by the time I was 5, maybe 6, I have been raped. Viciously raped.... And then my dad drinking all the time and beating on us... it was just a very ugly, dysfunctional place. And I never had that love or nurturing or anything like that from my family. And so, by the time I was 10, I was taking pills and trying to kill myself.

Participant 22 said:

My childhood was kind of rough growing up. I wasn’t a popular kid or nothing like that. I got picked on a lot.... My mom, she was gone a lot, doing working and stuff. We always had babysitters and stuff like that. We had some babysitters that took advantage of me as a kid, you know, I was hit when I was a child by babysitters, and I was molested by a babysitter and that caused a lot of trouble mentally with me. And with my mom not being there, my dad left when I was 3, I felt a lot of neglect when I was a child which brought a lot of resentment and hatred towards family and myself even. So I would fight everything and stuff like that.

Participant 16 remarked:

I guess I felt kind of hurt [after his mother’s suicide attempt], you know. I was worried, you know, but I felt hurt cause it was: my mom and dad had broke up and I guess I felt like my mother didn’t want to live for me, you know. So I felt kind of hurt because of that, like she doesn’t want to live for me and my brothers.

Participant 20 indicated:

I mean he was working a lot and it wasn’t him, it was more me. I was a troubled kid. I did a lot of stuff as a kid; they got me in a lot of trouble. And I’d always go “I want to live with my mom. I want to live with my mom to live with my mom,”
and I'd go live with my mom. And three, four months later: "I want to live with my dad, I want to live with my dad." Back and forth, back and forth and finally my dad says "No, you are gonna live with your grandparents." So they stuck me with my grandparents and I lived there for quite a while. Probably, I don't know, half the time of my childhood I lived with my grandparents. It was... quite an experience.

Many interviewees indicated that they had been abused as children. Participant 13 said that his childhood in general was "not good: foster homes, group homes.... My daddy was beating me with the iron and stuff like that. Participant 19 remarked:

And my dad had beaten me and my brothers for 13 years since as far back as I can remember with the stinging belt. As far back as I remember. If I remember that correctly he still got that damn thing, pure leather belt.... I was too much of a coward to run away from my dad while he was beating us. Too much to give up. And I couldn't believe and I still don't that I knew that somewhere deep down he honestly believed that he loved us and he was just running a tough love scenario. I believed that. I look at my life now, and I look at how cruel my father was and is, and it's like how the hell did I ever believe that that man ever loved me. How?

He then explained his experiences in more detail:

Thirteen years, and it wasn’t just beating that he did. I can remember back when he taped me and my baby brother; he taped us to a wall. I remember one time when me and my baby brother didn't get along: he tied us together, back-to-back. We had to get along that way, you know. And it was stupid little things that we get beaten for. He used to use Tabasco sauce sometimes when we were kids when we lied to him. He put it in our tongues. And Tabasco sauce to a little kid is...I can drink that stuff now, you know, but certain things, certain spicy things will make my stomach upset. And nobody really understands what kind of...it wasn’t so much physical abuse as it was emotional and mental. And it’s like with some of the things like the Tabasco sauce, I mean, there were times when ain't nobody really understands. They say this is segregation. As far as I know is the same. They segregate us from the general population. Ok. Real isolation? Cross your legs, put your head on your shins and don’t move for the next 6 hours. You eat, you’re gonna eat peanut butter and jelly on white bread with two cups of water. Two sandwiches and two cups of water. That’s it. I still refuse to eat peanut butter and jelly together. I still refuse to do that.... And nobody knows. And my answer of the question why didn’t we ask for help: We did. But everybody believed that my father was too much of an upstanding citizen to do that kind of stuff.

Participant 7 remarked:
I grew up in a real abusive family. My stepfather sexually abused me when I was young, not by him but by my step-grandfather, which went on for probably a year. Then I was molested by some kids when I lived on the streets. I was about 7 years old then.

He then explained the effects of the abuse on him:

My dad's voice going in my mind, "You're worthless. You're never going to be anybody. You're stupid," you know. The man beat me with a razor strap, locking me in my room for 3 to 6 months at a time, grounding me, you know, stuff like that. So that carries on with you, that I'm worthless.

Participant 4 observed:

I've been doing this [serving prison time] for off and on for most of my life, in and out. I'm just getting tired of it. You know? A lot of it has to do with I was sexually abused when I was 7, and you know, just dealing with that. It's hard to deal with that. Sometimes things seem to be hopeless.

Participant 1 elaborated on her past the following way:

That and I always had a real low self-esteem. I mean people... my whole life, I've been kind of treated like that, you know, how to deal with a lot of sexual and physical abuse. And those things come back to haunt you when you look at yourself. You feel tainted and, like, no one would want you. So, even if somebody else may say that you deserve more, you deserve to be treated better than that, in your mind you know, because you have been tainted because you let it happen at some point and that makes you unworthy to even be alive, so be thankful for what you got, if you have it.

She then explained why she ended up in a foster care:

I believe it was because my dad threw my mom out of a moving truck and he tried to kick my car seat out but my car seat got stuck in the door. And when he finally slowed down enough where the door would open it fell out but a police officer had seen that. And then when they came to investigate they found us kids with cigarette burns and all kinds of stuff.

Participant 9 reported:

I had an E.T. doll. I was so clinched to it. He took it away because he thought I was too feminine. I was a gay, you know? He's a Marine and he wanted to put me through a regime of becoming toughened up, you know. So that's what he did, he tried to do. And he was successful after a few years. I didn't understand what the heck he was doing, what he expected of me. I had no idea what the problem was.
Participant 4 explained in great detail his memories of abuse:

My stepdad came home, asked for where mom was. I said I didn’t know. I just got home myself. It was getting dark. He asked where mom was. I said I don’t know. He gets disappointed and he kind of gets a smile on his face and looks back at me asking if I wanted to make any money. I was like “Yeah, sure.” He’s “No, you’ll tell mom.” I say “No, I won’t. I won’t tell her. What do you want me to do?” He usually he had me walk on his back or walk on his knees or scratch his back and stuff, so I didn’t know this was going to be different than that. And he told me it was like, like sucking a hot dog without biting. And he ... went into the bedroom and did what he wanted me to do. But I felt that it was sick, there was something wrong with it. Those thoughts were ruining my life. And why he didn’t me want to tell my mom. Anything he asked me to do should be alright with my mom too. I trusted him. If it was a stranger it would’ve not went so far. I went against all my feelings when I was doing it. I wanted him to quit; to stop. He gave me some money; I think it was like 10 or 20 bucks. I went into the bathroom and brushed my teeth and looked in the mirror. What was that? I was curious why it felt so wrong. Mom caught me holding the money and she asked me how did I get it and I told her for sucking and she didn’t tell me it was wrong or anything.... She’s had me, she just had me repeat what I’d had told her to a few family members. My aunt almost hit me; I knew there was something wrong with what was coming out of my mouth. So I went back to the bathroom mirror and I told myself never to tell anybody again, you know, that I was stupid, you know, for doing what he asked. You know? I kept the feelings inside from then on and then didn’t know what to do with all the emotions I had.

Several inmates indicated that they have abused drugs and alcohol at an early age.

For example, Participant 16: “First time...well, I smoked pot when I was 12, but I was 13 when I first used methamphetamine.” Participant 23 indicated:

I was self-medicated with alcohol and drugs and all that, trying to take the edge off of it. And then it makes me not function anymore, where all I do is just do drugs and drink, you know, so that’s obviously not becoming very productive for the society.

Participant 6 also indicated that he used alcohol extensively. He also engaged in delinquent acts as a teenager:

Drinking was bad. Everything...running away, stealing a little bit: stole a car, broke into the high school into the snack thing, and stuff. Yeah, that’s why I got parole for. Then I got (...) in adult court when I was 17. It all happened...I’m pretty quick at ruining my life.
Participant 4 also engaged in stealing as a child:

I'm trying to figure myself out. Just kind of why I was doing this behavior, stealing stuff. When I go to school other kids would tease me. I just felt dirty. I needed to feel something else other than what I was feeling.

He then further reflected on his past behaviors:

This is not the life I wanted. I get on myself for being as stupid as I was to do things that I do [crimes].... I didn’t do my schoolwork or anything after the abuse happened.... I didn’t learn, I didn’t try to do anything positive with my life. I just went off on sabotaging myself.... Every time I’ve tried to change my behavior from stealing I’ve get stuck into thinking about the abuse.

Participant 14 remarked that his experiences with the legal system began at an early age:

I’ve started going to juvi when I was probably 10, and I’ve been in and out of treatment hospitals since I was 7. Since I’ve been 10 I’ve probably spent three years on the streets, compared to all the programs at the children’s farm homes and all that stuff out in the valley. So it’s, you know, I’m kind of used to it, all of the guys in here that are younger probably knew me at [a juvenile institution].

Participant 13 said: “I actually grew up in the Department of Corrections. Basically I was on skid row for a long time and then I ended up here.” Participant 16 mentioned:

I pretty much grew up in the juvenile. I lived with my mother until I was about 12, then I started getting in trouble and ended up in juveniles and stuff. Then I ended up living with my grandmother for about a year until I started getting in trouble again.

Five of the inmates indicated no suicide attempts prior to their attempts at an ODOC institution and a lack of history of suicidal gestures. Many of the inmates had struggled with suicidal ideation throughout their lives. For example, Participant 11 said that he used to experience suicidal ideation frequently: “It’s usually every 4 to 6 months, my cycle of hurting myself. It’s usually suicidal or out of anger.” He distinguished between his motives for suicidal gestures and attempts:
It's only been a few times that I actually wanted to kill myself. The rest of the times were either to get attention or I was angry; it was my way of lashing out at myself and stuff... When I do it [self-cutting], it's like releases a pressure button in me... I feel better... I feel no pain when I cut myself. I numb myself of all pain... I cut for so many times that my arms have no feeling in them. I can do this and I don't feel nothing.

Participant 24 indicated, "I stabbed myself like 50 times [occasions] in my stomach because I can't feel it.... [I do not] really feel pain but I want to die and make it to Heaven." Participant 3 reported a long history of depression accompanied with frequent suicidal thoughts:

I think I have been depressed for a long time. Then just trying to hold it back, that’s why I would drink. That’s all the way I could control it. Not even all the time. Sometimes even still, you know, hear voices and stuff that would tell me that I’m stupid, there’s no use of me being around, I should just commit suicide, that I’m a terrible mother, I just get in trouble all the time, my life’s wasted. It just keeps on going, you know, over and over in my head (sobs) and I can’t stop it.... And my doctor says that he thinks that I’m probably really not hearing people say things about me, but it feels like, it’s feels like it’s real to me.

Participant 2 reflected on the issues that used to lead to suicidal ideation:

You know, there are days when I feel that the whole world is crushing me.... sometimes when I get to think about some things it can get me down and it will take me down hard.... there are some days when it’s triggered by things that happen, somebody getting sick, and those are by far the worst.

Participant 2 elaborated on her suicidal ideation:

It was a day-to-day war with me. An everyday war on the reasons I would convince myself why I don’t want to do that. A lot of times I would run out of reasons and I would go tell somebody, “I’m gonna kill myself,” and, you know, a lot of people, they think when somebody says that they don’t mean it, and then it’s just drama. But I was going up to them “Tell me, I’m gonna kill myself, I need somebody else to convince me why I shouldn’t do it.” You know, because I wasn’t strong enough in myself to find the reasons, you know.... Because once you get suicide in your head I think it’s a war. It’s a war you wage with yourself and with everyone who’s ever put you down, and everything that anyone thinks of you, every bad thing that ever happened to you, every bad thing that’s ever been said.... You try to find positive and you try to think that you would be noticed or you would be wanted or that there is a reason for you to be here. But everything weighs on you about what other people think, the fact that other people didn’t feel
like I should live, that I deserve to be alive. You know? I had people tell me that the only thing I could do for them is to kill myself. And so that too, it made it a constant war for me, every day.

Participant 12 explained:

It starts out to be small things, a bunch of things like not getting my way. That irritates me. I start out being angry, and then it goes from being angry to becoming depressed. It can be a tiny little thing, being told no about something. A small thing can lead to something big. For instance, at DSU I get a certain thing on my tray and they weren’t talking to me about it, then I flip out on them and start, you know, and then I get from there to angry to being tired of this; just small things leading to big things. Or just a certain way they talk to me, they’re smart to me, you know, you get so many options here.

Participant 13 described his thoughts that led to frequent self-cutting:

Relationships with people, close relationships. I don’t like to get close to people and then when I do something always happens. I get depressed. Or the world turns to hell, like bombings and Iraq or stuff like that, people dying every day, handicapped people getting kidnapped, you know what I mean? All the bad stuff in the paper: kids getting kidnapped or raped, families getting murdered for 40 dollars, you know what I mean? It’s retarded. That’s the stuff that builds up after a while. I just get real stressed out.... It’s progressiveness.

Eleven inmates reported engaging in suicide attempts that appeared to fit the ODOC’s definition for suicide prior to their current incarceration. Participant 3 reported:

When I was with my first husband, he was cheating on me and I took a bunch of pills and I tried to commit suicide. They made me stay the night and put that charcoal and make me spit up the pills. And then they made me stay overnight so they could watch and they let me go the next day.

Participant 22’s recollections were the following:

The first time I tried to commit suicide or threatened to commit suicide, probably, I’d say, I was around 7 years old.... The reason I was at the point of wanting to do it was because my babysitter was molesting me. I was afraid to tell my mom; didn’t want to get in trouble because I thought I’d get in trouble for doing it.... it was a male and he was a friend of the family. And I thought I couldn’t tell, if I said something about it.... it was happening over a period of time. And one day I just couldn’t take it no more and I just broke down; I got angry with him, I got angry with my whole family. My mom was gone with my grandmother doing some shopping or something. And there was a hide-a-bed and a couch. And I unfolded the bed and lift it up back into the bed and put my head underneath and
if I would have let that go it would had have smashed my head. And my mom
came in and saw me before I did it because everyone else that was there was in
another room. And then my sister came in the room and saw me, and she started
yelling, and I started yelling. I didn’t let go. My mom grabbed my bed, and my
grandmother and my mom pulled me out.
APPENDIX D

Accounts of the Suicide Attempts

The subjective experiences of inmates during their actual suicide attempts can serve to highlight their emotional pain and thinking processes at that time. Because of this, a sample of descriptions of the actual suicide attempts is provided in this section. Personal reflections on the meaning of the attempts are also included. This material was not coded to find consistent themes, and I provide it here with no discussion or elaboration.

Participant 8 described his memories in this way:

The first couple, the first 40-50 seconds - I’m guessing on time of course, because I don’t have actual correct reference – my head was pounding. Then the pounding just went away. My body began to throb for a short time. Then sensation apparently stopped. Then there was unconsciousness.

Participant 3 explained:

He told me to go back to my bunk. So I went back to my bunk. And I had percogesics in my cell and, so I’m like, so I ate like 40 percogesics.... And I sat on the floor in front of my locker, pulled out the pills and ate them.... And I just remember that I kept popping them out, popping them out, popping them out. I just didn’t want to take it anymore (sobs).... And it was during count time. And then I started thinking, started to think about my babies and everything, and I decided I didn’t want to do it. So when count cleared, I went off up to the officer and told him that I ate 40 percogesics. And then he called for the OCI. And they were, they looked like they were gonna try to put me in the hole because they went that way. But then, because I started to pass out and stuff, they called an ambulance and I went to the hospital. And they were afraid, because my liver’s really bad, that it might shut down my liver, but it didn’t. So they let me come here and I then was in the infirmary for 2 days.

Participant 18 said:
I crushed up 20 Wellbutrin and I swallowed them all. They’re time released so it takes time for them, for you to be ready to go, so...I pretty much...that was probably my end right there. I came to. I was still shaking, I guess I went into a seizure, I started going into convulsions. They had to give me CPR and everything. I couldn’t feel my legs, I couldn’t remember my name. I couldn’t do anything, I just couldn’t remember nothing. They asked me what my name was, I couldn’t remember. I couldn’t move my legs, I couldn’t do nothing. I was basically paralyzed. Sent me in the hospital, they pumped my stomach, I was there for like 4 days, it was bad. It was the most scariest thing I have ever had in my life. The most scariest thing about it was that I couldn’t remember who I was. And I couldn’t feel my legs, couldn’t move them. I could move my hands but I couldn’t move my legs. It was really, really scary.

Participant 9 reported:

I got through all the layers, the outer layers of the scrotum. And I’ve actually gotten one of the testicles out. It wasn’t cut out, it was out,... I wasn’t going to cut both sides so I wouldn’t bleed to death. I was going to get it with dental floss. I washed it in a bottle. And I was going to pass out. And I could tell I was half passed out, and I kept bleeding, bleed to death or something. And I panicked, and I stopped, stopped short. If I had the ability to...it was just too painful. I am glad I didn’t have that outcome. The reason why is because I may have made my condition worse by damaging interiors that are needed for the actual SRS which is the sexual reconstruction surgery. And since then I’ve never tried it again because I’ve never been more aware of that I can’t do it. I am trying my best. That’s why I tried to commit suicide instead of trying to castrate myself.

Participant 16 indicated:

I started jogging in my cell, to get my blood pressure pumping a lot. Then I had a pen, a regular writing pen, and I felt my pulse in my leg. And then I marked with a pen and then I kept jogging till...and they were out there telling me “Come cuff up” and stuff.... So then I cut up and I just kept running.... I cut right by the groin, the artery right there. I tried to hit that but I couldn’t because it was so deep. It hurt, I kept doing it and doing it and doing it, and I couldn’t. I kept hitting things, I might have nicked it. I don’t know. It bled pretty good. So then I did my wrist right here, and I hit the artery there. And I was bleeding. And they’re trying to talk to me and stuff. And they didn’t know what I was doing, if I was bleeding or what. But I filled up a cup, a tumbler cup full of blood. And I threw it under the door cause I wanted them to see, you know. So I threw it under the door. And it’s just blood. The whole cup. And they started screaming. They started flipping out, and shut down the whole place and stuff. Then they kept trying to talk to me, trying to talk me out of there. Telling me I shouldn’t be, you know. “Don’t do this to yourself” and thing like that. Then they brought a nurse, and they were trying to get me to show the nurse.... So I pulled it back, and showed the nurse. And it was squirting because it was bad. So I was just yelling at them, letting it squirt.
against the window and stuff. And she was just flipping out, trying to get me to come out. I never came out. Then they ended up getting there with suit up, and got the door open. And they got in. They just took me out and took me to the hospital and stuff.

An attempt of Participant 16 was similar to the first one described above:

So he came on the intercom and told me that he was celling me in. So then I was like, you know, I just said...I didn’t say nothing. And then a couple minutes later I pushed the button and I told him, you know, I started cussing him out again and just telling him, you know, what I thought and stuff. Just being very hateful. Then it’s the same exact process as the first time. They came to take me to the hole, and it was the same officer that had tried to take me the first time. And he was scared, because he was like “Will you, please just cuff up,” you know. And I told him, “I’m not going nowhere.” I was just telling him I’m not going anywhere. I said “This is going to be worse than the last time,” you know. And he’s like “Oh, guard...” As soon as I started doing the paper they tried to get in there because they knew I was going to do it, you know. So I did the same thing, except I did it worse on the wrist, cut it probably three times in the same spot so I made sure it was real deep. So I severed the artery and I did the same thing with the blood in the cup. Same thing under the door. That time I did it so bad I passed out... they were talking to me, trying to get me to talk to them, to give up and stuff, and I just kept jogging in my cell, back and forth, doing jumping jacks trying to bleed out, you know. And they would tell me “Cuff up, cuff up,” and the next thing I know my whole body was tingling and I just fell out on the ground. They ended up taking me out and they had to Life Flight me from here to Portland. And I had surgery in Portland.

Participant 4 recalled:

I was working in the canteen. I set myself up to get caught stealing a bag of Taster’s Choice, diverting everybody’s thinking, you know, they were all thinking about the bag of coffee that I stole, other than what I was planning on doing. And then I knew I wouldn’t be going to work that afternoon because I got in trouble for stealing the bag of coffee. So I just was going to lay up in my bed and die... I went in the cell, you know, I thought about everything: not hearing from my son, you know, thinking that this just not working, the depression. I tore my razor out of the plastic bag and just cut there and there, try to keep the blood...trying not to make a big mess. This one and this one (shows cuts). This one is the one the most blood came from. I hit an artery. I tried to keep the cell clean; I tried to not have the officer see any blood from walking by the cell. I got between my covers and laid in bed, just kind of bleed to death. And then the cop lets people out for chow, to eat. When he lets everybody go he walks around. When he walked by my cell, he walked past and kind of backed up because he saw something. I guess he saw a little bit of blood on my arm or something. Asked me if I was all right and I ignored him. Then he calls “Man down. Back up.”...I was pretty weak. I was
breathing hard.... I lost a lot of blood....and then everything went black. I hear
them say that “He’s going into shock.” And that’s the last thing I remember
before I woke up in the hospital, like a day and a half later.

Participant 2 stated:

I could feel myself getting ready to throw up. So I’ve known that everything had
dissolved. And with my vision and everything, I remember thinking everything is
dissolved now and that I would be okay, they wouldn’t be able to help me, is what
I was convinced of. But I wanted somebody that I felt like cared about me to be
with me when I died. And J. had asked me what I did and I finally told her I took
pills. And then the nurse was out there and then they went and walked me in the
medical, took me into a trauma room. I laid on the table.... And then I remember
vaguely somebody turn me over on my side and somebody trying to get an IV in
my arm, but they couldn’t. I remember a buzzer going off and somebody
screaming “Man down” or something like that. And then I opened my eyes for
like one second and then I remember saying in my head “Please take me. Let me
die.”

And then she further explained:

They took me to the hospital. I woke up I think 2 days later or something like that,
2 days later. And I remember, I don’t know, I don’t know if it’s dying, but I think
I remember dying. It was just like, I remember feeling real...everything was black
and I remember saying I don’t want to go back. I don’t want to wake up, I
remember that, when I was out. And it was just, everything was black. There was
no light, no nothing. But I was thinking Oh, my God, it feels so good, I don’t ever
want to go anywhere. It was just, I don’t know, I think it was one of the most
potent feelings of release, relief and release that I ever had in my entire life....
There is no explanation for why I am still alive. I took enough pills to kill a
person three times my size. They couldn’t pump my stomach, it was already all
dissolved. They had to flush my system. I had IVs everywhere when I woke up.
And they thought that I was gonna be brain dead and my liver wasn’t going to
work, but they didn’t know. Until I woke up they didn’t even know whether I was
going to wake up, that I was going to make it.

Participant 6 said:

When I’ve seen [a nurse] she looked at me like how can this be? You know what I
mean? She said that when she walked in there I looked like I’ve been thrown
around, like a demon, or something she said, I can’t remember what she said. She
said the cell was all trash and she said that my legs looked like they got cut off
because, I guess, from my hip I was bent over backwards. She said she even heard
on the radio that somebody cut off his legs.

Participant 9 described his attempt this way:
I’ve studied Gray’s Anatomy book. And I’ve studied it for hours and hours and hours, and it told how to do a castration. And I purposely went to the hole, to segregation, so I had my own private room. And I realized that I needed tissue for the surgery. So I figured out that I’d just castrated down... I realized it’s much more complex than I thought. And I was very unsuccessful. But I cut myself open.... I started bleeding so much that I got really scared. And I started to kick my door but I couldn’t hit hard because I started passing out. I told my neighbors I needed help, call a sergeant. And they came. They came and their faces were ash; they couldn’t believe it. I went to the hospital and they had surgery on me.

Participant 21 reported:

It didn’t take as long as it took the first time. But for some reason, after I started it, the damn razor wouldn’t cut (chuckles), and I sat there and I cut myself and sawed it until it reached the artery. It took like forever, it seemed forever. And finally it started squirting. And I spent another 5 minutes at it. And lay down and went to sleep. I made sure the covers weren’t going stop the blood flow and stuff.

Participant 14 said:

I had been told before that if the person you’re celled up with, people in your cell area, had seen you do something, try to commit suicide or plan, and they don’t say something, that they can get charged. Because, you know, he’s killing himself and you’re an accessory to it. So I didn’t want nobody in my area to think I was going to do anything, I wanted to have an excuse. So most of them are fast asleep, I mean this is close to 12 o’clock, most of them are fast asleep. My cellmate was in there watching...they had a late night that night because it was a weekend and he was in there watching TV. And I took the pills while he was gone, and made it look like I was fast out by the time he came back. I guess, from what I heard, I woke up at 3 o’clock in the morning foaming in my mouth and having, throwing around seizures. Some kid that was less than three beds away had a mom commit suicide, so he went and told an officer that he thought I was dying.

Participant 17 reported that he never intended to die:

[An officer] said, “If you’re not taking it down [the paper towels from his window], we’re not moving you out of that cell.” I said, “We’ll see about that.” He goes, “Yeah, we will. I just need you there not suiting up on you.” I waited about another half an hour after that. And nothing happened, and they just kept running showers. I had about 12 packets of Tylenol pills. So I opened the bottle up I got them wet, scratched all the numbers off and made them look like, you know...they’re about the same size of 50 mg Trazadone tablets. So I scratched them up, made them look like...they were all wet and they dried off. So they looked likes someone just had them in their mouth, put them in their cheek, and just spit them back out, swapped away. So I got about 20 of these pills, scratched
off the numbers. And next time an officer walked by I tapped on the window and said, "Hey officer, look at this," and I popped them all in my mouth and swallowed them. Then they asked me what they were, I told they were Trazedone. They didn’t do anything to me. Supposedly, they said, that I could’ve hurt myself with that much, which I didn’t know. I’ve taken almost that much for a [headache] before and never did anything.

Some inmates also reflected back on the lessons they learned from their suicide attempts. Participant 4 explained his thoughts the following way:

It gave a little bit of insight on myself and things that I am dealing with, the things I need to work on, some issues, that things are not as bad as I make them. I know myself a little bit more and I do write in my journal…. I should’ve been more willing to talk about my thoughts and deal with the issues instead of keeping everything in myself, and, just faking it wasn’t any help…. I miss my son, what can I do about that? I got a…just take one day at a time. Things will come around. I’ve been doing it so long. If I just stop and talk about my thoughts I won’t do this crazy stuff that I tried to do to myself.

Participant 1 believed her attempt provided her with an opportunity for growth:

I’m definitely a more positive person now. I am more optimistic about my future, more optimistic about getting out of prison and doing well and being an influence. I definitely want to be an influence on people who are here because I think that it’s really important that they see that there is a positive...that somebody is getting something positive out of being in prison, you know. And hopefully they can take that and use it in their own lives, you know? That’s kind of like what I’d like to emulate to everybody else, it’s just that I’m being helped and I’m trying to help other people. I’ve been in a position where I was down but at the same time I got something out of it.

She further explained her thoughts:

It kind of made me see that there is a reason to live. There is a reason, there’s people who care about you, there’s people who are...the people that want to help you. And those people are important and they have, you know what I mean? And that was like, I think, the big thing for me was that there were a lot of people who cared about me. Even on the outside and on the inside. Both.

Participant 2 saw both positive and negative consequences to her attempt:

It had pros and cons. It took away my fear of death. I am thankful that it happened though because it changed my entire life. It changed the entire person who I am and, I don’t know, it irrevocably changed me in a deep and shocking way. Even the staff here are like “What’s happened in the past year? What happened?” You
know? I tried to kill myself and then I survived. And I worked, I worked my butt off to get where I am.... Well, one thing is that there is no reason that I shouldn’t, that I should be alive right now. There is absolutely no reason I could think on how I survived what I did. That only leads me to think that there is some point in me being here because I took myself out, and somebody else, stronger than me got me out of it.... And then having all the people in my life and everything now that I have, that changed me too.... And then so many things fell into place. It makes you think that there has to be some reason that I am here. I killed myself, you know, and I didn’t want to come back. There was a power bigger than me that kept me here.

Participant 23 said:

So I started doing my time in a more positive way. Now I don’t care. Everybody on my unit knows that I have a sex offense, you know what I’m saying? But I don’t let that.... I find that there’s people who don’t want anything to have with me. And there’s a lot of people like that. But there are still some people who say, after I get to know them for a while, “Hey, you’re a good dude. We like you. Do you want to come and play cards?” You know? Everybody doesn’t have that narrow view. It’s just the people that you hope to see. I see that my situation, my surrounding is influenced by how I think. If I am always negative, the situations tend to be more negative. If I try to be a little bit more positive than my situation is a little bit more positive.... There are some people who run around here saying, “I didn’t do it. I didn’t do it.” And I don’t like hanging around with people like that because I think a lot of them are lying to themselves. If you are honest with yourself you say, “Yeah, I did what I did to get to prison.” That doesn’t matter because I’m paying for it now. That’s taking years off my life.... they can’t punish me anymore with this. The worst punishment that can be inflicted is the punishment that I inflict on myself.... And I saw there were a lot of people worse off mentally than me. I can function pretty well. I have a better situation than I thought. You know, everybody has to have somebody that they say “I could be that.” And that could be me, but I’m not there so I’m fortunate I’m not there. I need to stay away. Because my thing was that later I thought that was really stupid. If I had done something, if that had worked, and they’d have found me and I came along and have brain damage. Maybe just temporarily or permanently have broke my neck, or have paralysis, unable to defend myself in here that would be very, very bad (laughs). A very, very bad situation, to be in prison and be like that.

Participant 11 looked at his visual reminders of his suicidal gestures and attempts:

Like right there, that’s permanent, that’s from cutting, that will never go away. So that little lump right there, same way I have. Sometimes there is a little dip, it goes down from there. That’s the one, the wide one, that’s the actual suicide attempt; that was my first suicide attempt. I am not proud of any of these, you know. But people ask about them and I don’t lie about them. I tell them that I’ve
cut on myself, so...I used to lie about it, but practicing my spiritual beliefs, I don’t feel right about that anymore...it’s not worth it; there’s a lot of things to live for. Even the little things, being able to go out and see flowers in the yard.... My scars are a reminder of what I’ve been through, what I’ve tried. They used to get me depressed but they don’t know more. I look at them as a reminder that I’ve been there. I don’t want to be there anymore again.

Participant 18 believed that his suicide attempt affected him in a negative way: “I think it’s made me a worse person... Because it makes me feel weak.” Participant 12 expressed mixed feelings over his attempt: “There’s times I still sit back and think I wish it would’ve happened. I wish that I would have succeeded. Then there’s the days I think that I’m glad that I’m here.”
APPENDIX E

Summaries of Reasons for Suicide Attempts

The following summaries are meant to illustrate the subjective processes by which each inmate arrived at his or her decision to take his or her life. I attempted to follow the timeline of the events and the thinking processes that led up to the suicide attempts. The amount of details varies greatly from case to case because of the idiosyncracies of each case, differing memory abilities of the inmates, as well as varying levels of insight and/or willingness of the participants to share details about their suicide attempts.

I have specified the nature of the crime only in the cases of sex offenses when this appeared to be of significance in the events that led up to suicide attempts due to vulnerability of inmates with such crimes in prison. I have not distinguished between overdose caused by psychotropic and over-the-counter medications; I have only specified the substance when an illegal drug was used for an overdose attempt. I have specified the location of the attempt only if it took place in DSU or SMU. I have added chart note descriptions to summaries where I have observed that discrepancies or additional information was present in notes written by staff members. I have described additional attempts when inmates reported that they had attempted suicide in ODOC prisons outside the target dates of the study (1994-2005) to shed more light on the inmates’ thinking processes involving decisions to kill themselves. The below noted ages reflect ages at the time of the interview.
Participant 1 (one prior attempt outside of prison): 21-year-old female

Attempt: Overdose after approximately 1 year of imprisonment

- Participant 1 experienced feelings of guilt and shame over the crime.
- She struggled with grief issues: Her uncle died 6-8 months prior to her attempt and it “started to hit” her.
- She experienced relationship problems at the prison: She felt betrayed by inmates who gossiped about her to other inmates, and as a result she started to isolate herself.
- She experienced symptoms of depression: depressed mood, lack of sleep, lack of energy.
- She started working for a high-paying job two months prior to her attempt. She found the job very stressful, though she wanted to keep the job because of the relatively high pay.
- Her back pain intensified as a result of having to sit for several hours.
- She had frequent verbal fights with her mother on the phone.
- Two days prior to her attempt, she had a conversation with her supervisor at her employment site; she interpreted the conversation as criticism of not doing a good job.
- She had one particularly bad verbal fight with her mother on the phone on the night of her attempt.
- After the phone call, she reread some of the newspaper articles written about her. She felt deeply misunderstood.
• Then she showed to her only inmate friend the newspaper articles written about Participant 1. The friend was supportive to Participant 1.

• After the conversation Participant 1 started to ruminate about the upcoming release of her friend in 5 months. She felt lonely and hopeless.

Participant 2 (history of frequent suicidal gestures): 22-year-old female

Attempt: Overdose after approximately 4 years of imprisonment

• Participant 2 became involved in an intimate relationship with her cellmate a year prior to her attempt. She described her partner as being mentally and physically abusive toward her. The relationship was wearing her down emotionally. She also felt confused about being in a homosexual relationship.

• She found out 5 months prior to her attempt that her grandfather had died 4 months earlier.

• Four months before the attempt, her partner got hospitalized and during this time she reported the abuse to a CTS counselor. She was placed on suicide watch in SMU because she cried “six hours straight” and developed “stress rash” in her neck, though she said she did not try to hang herself as was assumed by staff.

• While at SMU, she engaged in a romantic relationship with a male whom she met previously.

• Participant 2 felt she betrayed her female partner because she had promised to her that she, Participant 2, will never leave the partner. So she left the SMU program and reengaged in the relationship with her woman partner. She broke up the relationship with the boyfriend because she thought her male companion was “too good” for her.
• Her sister, who was the only family member who was still in contact with her at that time, refused to talk to her for a reason Participant 2 did not understand. Her sister’s refusal to communicate with her induced feelings of loneliness in Participant 2.

• She experienced disturbing thoughts involving childhood memories.

• She felt hopeless over her future.

• Three or 4 months prior to her attempt, one of her friends attempted suicide in prison, which may have made her “fear less” about attempting.

• At this time she also experienced physical problems and she feared that she had a serious condition.

• One month prior to the attempt the intimate relationship with the girlfriend ended and Participant 2 was placed in SMU.

• She was moved to the dorm 2 weeks prior to her attempt.

• Ten minutes prior to her attempt, she received a letter from her ex-girlfriend who informed her that the she, the ex-girlfriend, found a new partner with whom she was happy.

Participant 3 (one prior attempt outside of prison): 46-year-old female

Attempt: Overdose after approximately 1 month of imprisonment on current sentence

• Participant 3 experienced feelings of hopelessness due to repeated incarcerations and chronic alcohol use.

• She felt she was a failure as a parent.

• She found out from one of her children that another child resented her for having been incarcerated.
• She heard voices of women threatening to beat her (these were most likely hallucinations).

• She requested from a correctional officer a placement in DSU. She attempted suicide right after the denial of the request because she felt more threatened after the denial; she thought that the women whose voices she heard would be meaner to her because of her complaint to the correctional officer.

Participant 4 (two prior attempts: one outside of detention, one in jail): 37-year-old male

Attempt: Cutting wrists after approximately 2 years of imprisonment on current sentence

• Participant 4 experienced feelings of hopelessness over his future.

• He felt he failed in life and as a parent. ("This is not the life I wanted;" "I wanted to be there for him and I'm not")

• He struggled with issues related to his past abuse and he experienced fear over becoming a pedophile (he was not in prison for sex-related charges).

• He felt lonely for not getting visits and letters. He especially missed having contact with his 10-year old son and hearing news about him.

• One of his coworkers who was a good friend of his severed their relationship about 1-2 weeks prior to his attempt. He said he started to plan the suicide attempt immediately following this incident.

• He started getting agitated and having other relationship difficulties about a week prior to the attempt.

• On the day of the attempt he stole a bag of coffee for which he received a Disciplinary Report. Participant 4 said that he only did this action to divert the
attention from his suicide attempt, so while the staff would focus on the stolen item he would terminate his life in his cell.

- Chart notes indicated a rapid weight loss before the suicide attempt. Additionally, following the attempt, Participant 4 reported that by losing his job he lost his only remaining reason for living.

**Participant 5 (no prior attempts): 34-year-old male**

**Attempt: Overdose in DSU after approximately 2 years of imprisonment**

- Participant 5 was taken off his antidepressant medications 6 months prior to his attempt. (This happened when he complained of side effects of the medications.). He had hoped for a switch in medications. He said he consistently asked his prescriber for a different medication but was prescribed none.

- He experienced nightmares during which he was screaming aloud.

- Spent 14 days in DSU for swearing at an officer a few weeks before his attempt.

- It appeared from the interview that he believed that without medications he was “losing” himself. He attributed both his nightmares and acting-out behavior to not getting medications.

- He experienced depressed mood (“nothing will make me happy”).

- He caught his cellmate masturbating at the side of his bed. This upset him badly because he was raped as a child. He requested to be moved and his request was granted.

- His former cellmate spread rumors that Participant 5 had sex with him, which further disturbed Participant 5.
• One of his inmate friends accused him of fabricating mental health symptoms which he found hurtful. They got into a physical fight, and as a result he was sent to DSU.

• He attempted suicide at DSU after a few days after his arrival. He called for help in the last minute because of his religious beliefs (he was afraid he would not go to heaven if he died by suicide).

• Chart notes indicated that the Participant 5 was unable to cope with harassment by peers.

Participant 6 (no prior attempts): 44-year-old male

Attempt: Overdose on heroin after approximately 3 years of imprisonment

• Participant 6 felt hopeless about his future.

• He used heroin almost daily while incarcerated.

• He missed his children. There was a lack of visits for over 6 months. His wife used to visit him with their children every other month.

• His wife filed for divorce around this time. Participant 6 said that he had encouraged her to seek another relationship, but when she did so he felt hurt because he hoped that he still will be “part of the family no matter what.”

• At Christmastime he was expecting his wife and children for a visit. His son promised to bring his soccer trophy with him. They did not come and he felt disappointed. Even though his parents visited him on the day of his attempt, their visit did not make him feel better.

• Based on his comments, it is possible that Participant 6 did not want to commit suicide, just was more careless with his drug use.
Participant 7 (no prior attempts): 53-year-old male

First attempt: Overdose after approximately 22 years of imprisonment

• Participant 7 lost his final legal appeal for his release from prison 6 weeks prior to his attempt.

• He said he experienced feeling of guilt over his crime. (This may be an honest statement because of the renewed legal proceedings or it may be more of a rote response, given the long period since the occurrence of the crime.)

• He experienced feelings of hopelessness due to not wanting to die in prison.

• He missed seeing his family. He also felt he was a burden on his family; he felt that his family would be better off with him dead.

• He started having bad dreams that were related to painful past experiences every night.

• Memories of death of his brother who was murdered when Participant 6 was in his 20s bothered him more than usually.

• He waited 8½ months to join the hobby shop after getting approved to do so, and then he was denied participation in it shortly before his attempt.

Second attempt (after 2005): Hanging in DSU after approximately 23 years of imprisonment

• Participant 7 got in a fight with another inmate and received a new charge (Assault II) 15 min prior to his attempt.

• On his way to DSU, he made a request of a correctional officer to be placed in SMU because of suicidal ideation. His request was denied.
• The sight of blood that resulted from the fight brought back traumatic memories related to his crime.
• He experienced feelings of hopelessness for having lost the privileges he earned in prison.

Participant 8 (one prior attempt outside the prison and history of suicidal gestures): 28-year-old male

First attempt: Hanging after approximately 3 years of imprisonment
• Participant 8 felt frustrated because he could not obtain employment after trying for 3½ months.
• Two months prior to his attempt physical threats and confrontations for “rent” began. (Participant 8 is incarcerated for a sex offense.) He said he received about 20 threats during this period from various members of a gang.
• Two days prior to his attempt he found out that his mother lost her vision completely.
• The day before his attempt he had another confrontation during which his attacker attempted to “shank” him. Participant 8 indicated that this confrontation was not more threatening or violent than most previous ones.

Second attempt: Hanging after approximately 2 months following his first attempt
• Participant 8 continued to feel hopeless because of unemployment.
• Threats and confrontations for “rent” continued and intensified. His suicide attempt was used by the gang members to further threaten him.
• He was transferred to a different institution 1-2 weeks prior to his attempt because the staff thought that the new institution would be less stressful for him by
changing his dormitory bed to a single cell. Participant 8 indicated that the staff members were not aware of the threats he was receiving because complaining would have made him more vulnerable to violent actions of the gang members.

- He had four physical confrontations with members of the same gang at the new institution before his attempt.

- Participant 8 claimed that, rather than fear, his Buddhist religious beliefs about not wanting to cause bad karma by letting be killed led to his decision to kill himself. (He indicated that he chose to attempt suicide to benefit humanity; in his belief system, suicide is less of a sin than homicide.)

Third attempt (after 2005): Hanging approximately 1 year following his second attempt in prison

- Participant 8 continued to feel hopeless because of unemployment.

- Threats and confrontations for “rent” continued.

- He was transported to another institution for a psychological evaluation. He was sent back after the testing. He attempted suicide 3 weeks after he arrived back at the original institution.

- Threats intensified during this period because the gang members thought that Participant 8’s leave for testing may signal his permanent move to another institution.

- He continued to hold the aforementioned religious beliefs and they contributed to his decision to attempt suicide.

Participant 9 (one prior attempt outside prison and history of suicidal gestures): 26-year-old male
First attempt: Cutting on scrotum after approximately 4½ years of imprisonment

- Throughout Participant 9’s incarceration, he experienced anxiety and depressive symptoms related to his gender identity disorder. He indicated that he believes “male pattern” balding is the main reason behind his psychological symptoms.

- He lost his final appeal to get treatment for his gender identity disorder 6 weeks prior to his attempt.

- As a result, he felt hopeless about receiving treatment and “couldn’t regroup.” His symptoms of depression got increasingly more severe (he “started balling up on [his] bed and rocking” himself) despite receiving therapy and psychotropic medications.

- He started planning to castrate himself 2 weeks prior to his attempt (“If they were not going to give me treatment, I’ll do it myself.”), but initially he was afraid to get in trouble for it. When his depression got more severe and he started experiencing suicidal ideation, his fear disappeared. He also told himself that by not doing the castration he was causing more problems to himself (i.e., more balding). He believed he could be successful with the castration attempt. His intention was to castrate and not kill himself, but he was aware that the castration attempt could have been fatal.

Second attempt (after 2005): Cutting on veins approximately 13 months following his first attempt

- Participant 9 continued to experience anxiety and depressive symptoms related to his gender identity disorder.

- His lawyer had difficulties getting an expert witness to examine Participant 9.
• He felt hopeless about receiving treatment.

• He was told that castration attempts may damage tissue needed for sexual reconstruction surgery; therefore, he decided not to attempt castration again.

• One month prior to his attempt he felt “haggard” and “emotionally upset” because of the above-mentioned issues. He tried to “gain emotional control” by hitting the wall. As a result, he broke his hand and was transported to a hospital for emergency care.

• He experienced and reported suicidal ideation (self-report of 5 on a scale from 1-10, with 10 being the most severe subjective suicidal ideation) before his attempt.

• He was not seen immediately, which made him angry. His suicide attempt to some degree was meant to punish the staff for the lack of immediate follow-up. (“You don’t believe me? Fine. I’m going to do it. You don’t care.”)

Participant 10 (two prior attempts: one outside of prison, one in another state prison): 35-year-old male

Attempt: Hanging in DSU after approximately 2 years of imprisonment on current incarceration

• Participant 10 felt lonely (he received no letters or visits) and especially missed hearing about his 15-year-old son.

• He felt depressed about how he perceived things in the outside world (“there’s a lot of hurt and pain in the world”).

• He experienced frequent abdominal pain due to a chronic physical condition.

• He felt constantly bored. He felt he could do nothing else but think.
• He received frequent DRs and spent much of his time in the DSU which he found depressing ("getting the best of me here"). He believes the reason for his DRs was that he spent several years in another state prison and was used to different behavioral standards.

• He was transferred to new institution 2 weeks prior to attempt because of his involvement in a mass "suit-up" in DSU where he spent about 3 months prior to the transfer.

• He found this new institution to be very depressing.

• On the night of his attempt he received a letter that informed him about the death of a friend.

Participant 11 (two attempts outside of prison and history of suicidal gestures): 40-year-old male

First attempt (before 1994): Cutting on wrists after approximately 3 years of imprisonment on a previous incarceration

• Participant 11 experienced depressed mood. ("All my attempts were around the same type of feeling. I probably felt depression, despair, despondency.")

• He felt "tired of doing time" and hopeless over his future. ("I had no hope, no reason to go on anymore.")

• Issues of childhood abuse caused him inner "turmoil" and anger.

• Visits of family members evoked sadness in him because he felt guilty for letting his family down (including his mother and sister).

• His intimate relationship ended 1 week prior to attempt. (His girlfriend's daughter called the inmate to inform him that the girlfriend has a new boyfriend. The fact
that the breakup was not communicated by his girlfriend caused him additional hard feelings.)

Second attempt (before 1994): Hanging in DSU after a few years following his first attempt

- Participant 11 felt “tired of doing time.”
- He felt guilty about his crimes.
- He had negative interactions with staff members during which he felt he was treated like an “animal.”
- He was placed in the hole on a 2-year sentence for attacking an officer shortly before his attempt. Participant 11 said that he was experiencing a psychotic episode at that time of the attack during which he thought that the officer he attacked was the man who raped his sister.

Third attempt: Cutting on wrists after approximately 9 months of imprisonment on current sentence

- Participant 11 felt “tired of doing time.”
- He felt guilty about his most recent (not sex-related) crime, involving the thought that he “victimized” a female.
- He felt his hopelessness over his future was building up. He was on suicide watch a “couple of times” before the attempt.
- He was angry because he felt that “nobody was listening;” “nothing was being done.” He believes this attempt was an “angry” attempt not a real suicide attempt.

Participant 11 sees his suicidal gestures/attempts as either being actions performed out of anger/getting attention or a wish to die. He indicated that most
often he feels angry toward himself and that self-harm makes him feel better. (Self-cutting feels like releasing “a pressure button” to him.)

- Chart notes indicated that Participant 11 reported that voices tell him to cut on himself. During the interview he said that he was not hearing voices but that he mistook his negative self-talk for voices in the past.

**Participant 12** (three prior attempts: two outside of prison, one in another state prison):

- 44-year-old male

**Attempt:** Overdose at the DSU approximately 1 year following his imprisonment

- Participant 12 felt depressed during the 4 months he spent in the DSU prior to his attempt. (“I was depressed, not liking it being there.”)

- He felt “tired of being locked up” (“doing time alone it’s enough to break a person’s spirit”), “not wanting to live.”

- He felt he “was not caring” for his family and he did not want “to live with it.”

- About 2-4 weeks prior to his attempt, he found out that he would be placed at the IMU for continuing to engage in criminal behavior while at the DSU. He decided to kill himself after hearing about the IMU placement.

- At the same time, he stopped taking his psychotropic medications and started saving (“cheeking”) them for his suicide attempt.

- His plan made him feel more depressed because he started thinking about his family.

- The lack of medications also made him “more depressed.” He “was not eating” and he slept more than usual.
• He decided to commit suicide when he thought he had enough pills to kill himself. He also thought about committing suicide before getting “caught” with the saved-up medications.

**Participant 13 (history of frequent suicidal gestures): 41-year-old male**

First attempt: Cutting on arms approximately ½ year following his current imprisonment

• Participant 13 felt his stress level was building up over several matters during the 2-3 weeks preceding his attempt (“a lot of combination of stuff”) which made him feel depressed:
  • He believed that news, such as reports about the war in Iraq, had a negative effect on him.
  • He found it stressful to deal with inmates and correctional officers around him (“got to deal with idiots all day”).
  • He felt lonely (“not being able to call people and talk to them”).
  • He felt anxiety over his release from prison (“not knowing what I’m going to do when I get out”).
  • He felt hopeless about his future.

Second attempt (after 2005): Swallowing heavy-duty cleaner and pieces of razorblades

• Participant 13 felt that on the day of his attempt his “morning was all good.” About 1 hour prior to his attempt, a friend told Participant 13 that he could not hang out with Participant 13 anymore because others told the friend that Participant 13 was a bad influence on him. This “got” to him because Participant 13 and the friend shared many memories together. It also bothered him that other inmates were interfering with his (non-intimate) relationship.
Participant 14 (one previous attempt in jail and history of several suicidal gestures): 22-year-old male

Attempt: Overdose after approximately 2 years of imprisonment

- Participant 14 felt bored. ("I realized that a lot of what was causing my depression was sitting around and having nothing to do;" "just as soon as they see the CTS jacket.... they won’t give you a job.")
- He experienced feelings of abandonment related to the history of his adoption.
- He experienced anxiety due to his upcoming release from prison. He was worried that he could not comply with conditions of parole.
- About 5 months prior to his attempt, he found out that his sister had legal problems for leaving her foster home to live with an older man who was a drug dealer and who treated her badly. Additionally, he thought his mother intentionally lied to him by not telling him the news and this affected him negatively.
- About 4 months prior to his attempt and 1 month prior to his wedding, he has received a letter from his fiancée informing him that she was engaged in a relationship with another man and that she was pregnant by this other man.
- His parents continued to be supportive to his ex-fiancée following the breakup which he resented.
- During this time he tried but could not get in contact with his birth family.
- About 2 months prior to his attempt, as a “Christmas present,” he learned that his adoptive parents were divorcing which “hit (him) pretty hard.”
• About 2 months prior to his attempt, he was beaten up by three inmates both as an attempt at "extortion" (inmates saw him buy a large quantity of food) and as intimidation because of his Jewish beliefs (the inmates who beat him had a White Supremacist affiliation). What bothered him most about the incident was that none of friends came to "bat" for him but only an inmate he hardly knew.
• He hung out with depressed inmates.
• One or two months prior to his attempt, he has witnessed the suicide attempt of another inmate. This incident made him think that nobody was going to care if he "disappeared."
• He believed that the above events all contributed to his suicidal ideation. He felt he had "nobody's support."
• On the day of his attempt, he talked to several individuals by phone, including a former girlfriend, mother, father, and sister. He felt unsupported by them when he expressed that he felt suicidal.
• About an hour prior to his attempt, one of Participant 14's inmate friends prepared to kill himself. Participant 14 thought that this other inmate's reasons for committing suicides "weren't good enough:" the other inmate lost his intimate partner, was physically ill, and said he wanted to commit suicide because he was going to die anyway. Participant 14 talked him out of the act. Participant 14 believed that suicide is a sin; however, saving somebody else's life freed him to take his own life.

Participant 15 (no prior attempts): 49-year-old male

Attempt: Overdose after approximately 2 years of imprisonment
• Participant 15 felt lonely and lacked outside support. ("No letters, no phone calls, no visits, no nothing.")
• He felt hopeless about his future for lack of development in his legal appeal.
• Throughout his incarceration, he saved up his prescribed psychotropic medications to barter with them or to use them when he felt like taking them as sleep aids. While saving the pills, he never thought about using them for suicide.
• He witnessed the stealing of an inmate's watch. An investigation was conducted during which several inmates were interviewed. Participant 15 reported what he saw because he was afraid that if he were to be sent to segregation his saved-up medications would be found and he would get in trouble. As a result of his cooperation with the investigation, he was not sent to segregation, whereas the other inmates interviewed were. He got scared of repercussions from the inmates involved for being a "rat."
• He received threatening remarks such as "I wouldn't want to be in your bunk tonight."
• He went back to his bunk where he realized that the bunk next to him was all wet, which "freaked" him out. He was afraid of a physical attack from the group of people involved in stealing the watch, and he decided to kill himself right away.

Participant16 (history of suicidal gestures): 26-year-old male

First attempt: Overdose after approximately 3 months of imprisonment, during incarceration on a previous crime
• Due to Participant 16’s young age, the length of his imprisonment seemed “forever,” which made him feel depressed. He “didn’t want to do” his sentence; “didn’t want to face the time” he had to do.

• On the day of his attempt his cellmate paroled. Participant 16 believed this event in itself had no emotional effect on him; however, the cellmate left over-the-counter medications for him, which Participant 16 used for his attempt.

Second attempt (This attempt did not appear on the ODOC’s list of attempted suicides; however, the inmate indicated that following this event he received hospital treatment, including sutures): Cutting on legs and wrists after approximately 1 year of imprisonment on current incarceration

• Participant 16 experienced feelings/thoughts of paranoia and lack of trust involving both inmates and officers: He was afraid that some inmates might attack him due to a traumatic physical confrontation that took place when he was in jail. He felt that officers “set [him] up” with certain inmates of whom he was afraid of and with whom he had requested not to be placed.

• On the day of his attempt, he requested a cell move to be with a friend. The move was done, but after about 2-3 hr it was reversed. He felt angry.

• Right away, he suited-up his window (covered up his windows by placing wet towels on it to obstruct the monitoring of the cell) and prepared his razors. Then he cussed at officers on intercom, and he cut his veins at the moment when an officer appeared by his cell. After he started to bleed, he collected his blood in a cup and splashed out the blood under his door. He felt he wanted to show the officers that he has control over what happened to him.
Third attempt: Cutting on veins approximately ½ a year following his second attempt

- Participant 16 felt angry toward officers over his past trauma in jail.
- He was released from DSU 1 month prior to his attempt.
- He experienced feelings of fear and possible paranoia because he recognized some inmates on his unit who were in jail at the time Participant 16 was beaten up severely by some other inmates; he thought these inmates were talking about him, and he was afraid that he might be attacked again. He had nightmares and felt he “was out of control.” He wanted to be moved from that area.
- On the day of his attempt he was placed on an 8-hr cell-in for kicking on a door. (The officer on duty did not let him get to the dayroom area right away after Participant 16 finished taking a shower.) He felt angry for getting punished and repeated the actions described under his second attempt. He did not care whether he lived or died but he wanted to feel he had control over himself.

Participant 17 (He reported using two other suicide threats in prison as tools, once for protection from a group of inmates who threatened him with physical harm and another time for avoiding being moved to a certain part of the prison. He indicated experiencing suicidal thoughts while he was waiting for his trial in a county jail.): 25-year-old male

Attempt: Overdose in DSU after approximately 1½ years of imprisonment

- Participant 17 did not consider this incident a suicide attempt but a tool to be removed from his cell: While he was in the hole, about 10 inmates “suited up” their cells. Several inmates also flooded their cells with toilet water. His neighbor also flooded his cell, and in addition the neighbor urinated on the tier as well.
• The urine seeped into Participant 17's cell. Participant 17 requested to be moved or have his cell cleaned. He was told to wait. He stayed put for about 1½ hr until the suit-up situation was dealt with. Then he requested again to be taken care of. He was informed that he would have to wait until the showers were done which would have meant another 4-5 hr of waiting.

• Participant 17 felt that he was unable to smell the urine any longer; therefore, he decided to take charge of his situation. He suited up his window. He was told by an officer that he would not be moved if he did not take the paper off. He did not comply and waited for another half hour.

• Meanwhile, he took 20 Tylenol tablets, soaked them in water, scratched the numbers off them, and then dried them to make them look like “checked” Trazadone tablets. Then, when an officer walked by, he tapped the window to attract the officer's attention and popped the prepared tablets under the officer's observation. He pretended to be “out of it” when he was brought to the nurses' station, and refused to drink diuretics. He then was transported to a hospital where he admitted he took Tylenol. He was told that the quantity he took made it dangerous to his health anyway. Participant 17 indicated that he believed he has a high tolerance for Tylenol because he often took 10 pills at a time when he has a headache. He indicated that he never intended to die nor did he believe that his life was in danger.

Participant 18 (history of suicidal gestures): 22-year-old male

First attempt: Hanging after approximately 1½ years of imprisonment

• Participant 18 was threatened by a group of inmates with physical violence.
• He reported it to a correctional officer and unsuccessfully requested to be moved.
• He wanted to “get back” at the officer to “prove” that he was “serious.”
• To some degree he hoped that his attempt might get him out of his current environment; however, he “knew that wasn’t gonna happen.”
• He “really wanted to die” because he felt “scared” by the threat and he wanted to avoid getting “humiliated.”
• Chart notes indicated that he feared getting killed because he turned in an inmate for smuggling drugs.

Second attempt (after 2005): Cutting on veins in DSU approximately 1 year following his first attempt
• Participant 18 was feeling depressed about his past and present life.
• He was “extorted” at an institution and he complained about it to staff. As a result he was moved to another institution.
• A gang-member called him a “punk.” Participant 18 “didn’t do anything about it” initially, but a relative of Participant 18, the leader of another gang, was present during this event and he expected Participant 18 to protect his dignity.
• He engaged in a fight and beat the gang member.
• He was placed in DSU.
• While in DSU, another gang approached him and wanted him to become a member. He “played games” pretending he wanted to join them.
• Apparently he then became fearful of repercussions from both gangs.
• His intention was not to die but to obtain placement at SMU.
Third attempt (after 2005): Overdose on psychotropic medications a few months following his second attempt

- On the day of Participant 18’s attempt, he has received a letter from his mother who informed him that his children had been physically abused by a man. This news affected him very negatively because he was abused as a child and he wanted for his children not to go through similar experiences.
- He felt helpless because he could do nothing to protect his children.

Participant 19 (history of suicidal gestures): 21-year-old male

Attempt: Hanging in DSU after approximately 2 years of imprisonment

- Participant 19 was involved in an intimate relationship with an inmate. They were caught having sex in the library and were sent to DSU as a disciplinary action.
- He and his partner decided to attempt suicide hoping that they would be sent to SMU together. (“Faking suicide together. Do it in such a way that you can actually stop it if they don’t interrupt.”)
- Participant 19 claimed that he did not want to die and that it took him 1½ days to gather the strength to attempt suicide. However, he indicated that he “didn’t really care” whether he would have died. “But if I would’ve gone to a point where I couldn’t have stopped, I think the last thought going through my mind would have been “Oops. I fucked up. Oh, well…” (Both of them ended up in SMU but at different locations.)

Participant 20 (two prior attempts while incarcerated in a juvenile facility and history of suicidal gestures): 22-year-old male

Attempt: Hanging in DSU approximately two years after his imprisonment
• Participant 20 kept getting in trouble and receiving additional time because he was afraid of release from prison.

• He found it difficult to cope ("tired of dealing with everything").

• He was sent to DSU for having been caught having sex with an inmate.

• He started thinking "bad thoughts" in DSU, such as that his family did not care about him ("Stuff that is not even true...just like created this whole other life. It gave me an excuse, I guess.").

• He felt "tired of being locked up, tired of being incarcerated;" "done doing time."

• He felt hopeless about his future and he thought that suicide would be an "easy way out" ("If I continue the cycle, why continue do time in prison when I don't need to.")

Participant 21 (history of suicidal gestures): 29-year-old male

First attempt (This attempt did not appear on the list provided by ODOC. I have included it because the inmate claimed that he has received hospital treatment following the attempt.): Cutting on veins approximately 1 month following his imprisonment

• Participant 21 "hated" himself and "what [he] did," and he felt sorry for hurting people with his crime (sex offense).

• He was ashamed of his crime, and he felt bad that his parents got into familial problems over it.

• He was "scared" of people finding out what his crime was. He was not afraid of physical beatings but the shame he could have felt if the nature of his crime came out.

• He was moved to another institution 1-2 days prior to his attempt.
• He thinks adjustment to the move “added” to his feelings of depression, though he thinks it played only a small role in his suicidal ideation because he moved often as a child with his family and he was “used to going into strange places.” He felt he attempted suicide on the day when he “got the courage to do it.”

Second attempt: Cutting on veins approximately after 3½ years following his first attempt

• During the weeks prior to his attempt Participant 21 was “doing fairly well.” He was “still depressed like [he] had been [his] whole life” but it was “something [he] was used to.” He had been studying the Bible and Christianity and had learned “things about [himself] and other people.”

• One of the inmates on his unit “hated” Participant 21. This inmate said that Participant 21 was the “devil” and he was “extorting people.” Participant 21 believed that this inmate was jealous of him because Participant 21 studied the Bible and worked hard “not to hurt people.” Participant 21 got mad at this inmate and “chased him across the hallway several times.” As a result, he was transferred to another section of the institution.

• He was moved back to the same unit within a week because of reasons unrelated to Participant 21.

• A Bible dictionary got him talking with another inmate who invited Participant 21 to move in with him.

• It turned out that this inmate wanted to engage in a sexual relationship with Participant 21. Participant 21 was not interested. As a result the inmate, his new cellmate, “wasn’t the nice person anymore.”
To solve the tension, he told his new cellmate that he, Participant 21, would move out after participating in a religious service. Participant 21 was going to refuse to go to his cell and was ready to be sent to DSU as a consequence.

As he was coming back from his religious service, he thought that he did not want to go to DSU because he had accumulated over a year of clear conduct at the time. However, he planned to refuse to go to his cell anyway.

As he arrived to his unit, a correctional officer whom he knew advised him to wait until the next day; meanwhile, the officer was going to help him with the situation. Participant 21 thought that the officer helped him because Participant 21 was “carrying the Bible” and because the officer was “religious” as well.

As he was “struggling with trying to hear God,” he took the officer’s response as “guidance from God” and went back to his cell.

He got “beat up pretty good” by his cellmate (“broke my nose, maybe cracked my cheekbone”). He did not fight back “because of the religion.”

He would not tell staff about what happened when he was questioned because in prison if you do not want to have “trouble the rest of your time, you don’t tell.” He was sent to DSU for 10 days as a consequence.

In DSU he was continuously asked to report on the physical confrontation. He said he was told by an officer that he would be kept in DSU until he reported on the event, but if he confessed he would be moved to another institution. Hoping to get transferred, he reported on the events.
• The next day he was sent back to his initial housing area. It turned out that his former cellmate was a member of a gang. Within 16 hr of his arrival he was physically attacked by three inmates.

• He felt humiliated “in front of a whole dayroom” because people found out about either his reporting on another inmate or his initial crime involving a sex offense (I am unclear which one based on his statements). He felt as if the “floor fell out.” He became disillusioned in his religious beliefs because he thought that “God would protect him.”

• He was moved to another institution where he refused to eat for a couple of days.

• About 3 months passed, and he felt that “every day (he) got a little worse” with respect to his mood. He stopped taking his medications. He believed that nothing of significance added to his depression at this institution, “It was just that downhill spiral. I was just lost.”

• About 2 weeks prior to his attempt he started taking medications again for a week. He started feeling better. He then “finally just said ‘To hell with it,’” and started planning his suicide attempt for a week.

Third attempt (after 2005): Swallowing pieces of pencils sharpened at both ends, after approximately 1½ years following his second attempt

• About a year prior to his attempt, Participant 21 heard about an inmate who attempted suicide by swallowing pencils.

• During the weeks prior to his attempt, his medications “stopped working,” and he believed he was getting increasingly depressed (“a slow walk down”). He reported that he had “never been so depressed in [his] life.”
• He started to pay attention to “negativity that went on” around him.
• He swallowed chemicals as suicide attempts but they “didn’t do anything.”
• He was placed in SMU where he was “even more depressed.”
• He then remembered the inmate who attempted suicide by swallowed pencils. He thought that the sharpened pencils would puncture his stomach and he would die due to infections.

Participant 22 (two prior attempts outside of prison): 24-year-old male

First attempt: Hanging while in SMU after approximately 1½ years of imprisonment

• Participant 22 felt paranoid about sharing a cell with other people.
• He refused to live with a cellmate; therefore, he was punished by being sent to the DSU on several occasions.
• He experienced an increase in depression and psychotic symptoms while in DSU. (“I started hearing voices and just losing control of my own thoughts.”)
• Voices were telling him “that the officers were gonna come in and beat me up because of what I did.” (Participant was in prison because of a sex crime.)
• He stopped taking his prescribed psychotropic medications because he thought the officers “would take advantage of him” by beating him if he were on medications.
• He experienced feelings of shame and guilt over his crime.
• Voices were telling him to kill himself. (“They told me I didn’t deserve to live, I should die, I should kill myself.”)
• He was placed on suicide watch on several occasions. He experienced anxiety-provoking visual hallucinations, “things like blood coming out of walls. I would
see faces in the windows like angry demon type faces which made me... freaked me out, scared me.”

- He attempted to kill himself after a sleepless night on suicide watch.

Second attempt: Hanging about ½ a year following his first attempt

- Participant 22’s cellmate “faked a suicide attempt” to get out of the institution.

- His cellmates’ attempt evoked suicidal feelings in him. (“Maybe I should be dead, I should try to kill myself.”)

- He stopped taking his medications 2 months prior to his attempt. He was afraid that either staff or inmates “could take advantage” of him while not being “in the right state of mind,” either physically by beating him or sexually by molesting him.

- He did not get along well with inmates and officers and started “getting aggressive with people.”

- He quit his job because he did not want to interact with people.

- He could not get any time alone and felt claustrophobic. (“I felt that everything is closing in on me and I couldn’t get away.”)

- On the day of his attempt, he experienced auditory hallucinations and/or overheard inmates saying that sex-offenders deserve to be killed. He thought if he would kill himself others could not kill him.

Participant 23 (no prior attempts): 23-year-old male

Attempt: Hanging in DSU after approximately 1 year of imprisonment
• When arriving to prison, Participant 23 initially denied being incarcerated for a
sex offense. However, about 3 months prior to his attempt, inmates started to find
out about his crime. As a result, his inmate friends “turned” against him.

• He felt increasingly lonely because his outside friends were also “forgetting” him.

• He also felt angry and engaged in more fights than he did before.

• He started to “create problems with guards to enhance” his status (“to create a
little bit of name for myself”). He was sent to DSU several times.

• At DSU, he received new charges for a fight and weapon possession.

• The news about the nature of his initial crime continued to spread. About 2 weeks
prior to his attempt the situation became the “worst.” He felt bullied by both
inmates and correctional officers.

• Some of the inmates who were in DSU and who initially planned on testifying in
his favor during the court procedure that ultimately led to a 30-month prison
extension, not only refused to do so but they also threatened him to “send” him
back to DSU after his current sentence expired (because they found out about
Participant 23’s sex crime).

• He felt bad about the prospect of the extension of his incarceration.

• He felt “tired of fighting all the time” and “never coming out ahead.”

• He felt hopeless about his future. He thought if people treated him badly in prison,
it would be even worse outside where he would be registered as a sex offender
and be constantly discriminated against.

• The day before his attempt he was placed in a different side of the DSU. Here
three inmates refused to stay in the same cell with him because they did not want
to pair up with a sex offender (they wanted to do “clean time”). He spent one night alone in a double cell.

- Participant 23 was then moved to a single cell. He attempted suicide immediately after being placed in a single cell.

- Chart notes indicated that Participant 23 experienced sleep problems, including nightmares.

Participant 24 (history of frequent suicidal gestures): 26-year-old male

Attempt: Cutting his “stomach open” in SMU after approximately 4½ years of imprisonment

- Participant 24 felt “tired of being in prison.”

- He experienced feelings of grief over the loss of one of his sisters who died 5 years earlier.

- He “just didn’t feel right.”

- He frequently engaged in self-harm partly because of depressed mood and partly because he was hoping to be transferred to the state hospital where his father was and where his family could visit him more often.

- He felt that officers were “joking around that (he) was trying to kill (himself).” (“They were joking saying that I wasn’t serious.”) He wanted to show the officers that he seriously wanted to die.

- He was in SMU at the time of his attempt. He wanted to get out of SMU; he “didn’t want to be locked up.” He knew that a suicide attempt would not get him out of that placement but he “just wanted to die.”

- He experienced command hallucinations telling him not to eat.
Perha.ps the most influential reason to his suicide attempt was related to his interrelated religious and delusional belief system: He had a strong belief in God because he experienced the presence of “evil sprits” in his cell. (“I know there’s a God because if there’s evil spirits, there’s Jesus. I have strong beliefs in that.”) He also believed in an afterlife, and he wanted to get to heaven after his death. He was somewhat afraid that if he would have committed suicide he would have gone to hell because somebody told him this would happen. However, he did not really believe this individual because he thought that if he lived his life “for [God],” God would “find” him; therefore, he would go to Heaven. Additionally, he also believed that his stepfather’s family members were practicing voodoo religion and that they were witches who had Participant 24’s “air” and who made him experience auditory hallucinations. The voices belonged to Participant 24’s dead family members, including one of his sisters. The voices told Participant 24 that his family members were in Hell and that they would remain there until Participant 24 would commit suicide. This act would have freed them all and then they all would have gone to Heaven, including Participant 24. These hallucinations made sense to Participant 24 because they were supported by his understanding of sacrifice in the Bible (“in all testaments they do a sacrifice of themselves”). Furthermore, Participant 24 thought that he heard the voice of God as well, telling him to sacrifice himself.
APPENDIX F

Precipitating Events for Suicide Attempts

This section provides a list of events that took place immediately before the suicide attempts of the participants. These precipitating events reflect primarily relationship and prison factors, demonstrating that familiarity with individual cases is necessary for effective suicide prevention and that knowing diagnoses of mental illnesses is not enough. The precipitating factors of suicide events of the participants were reported to be the following:

- Phone call about break-up of outside intimate relationship
- Lack of promised visit from wife and child
- Receipt of letter about physical abuse of the inmate’s child
- Fight with mother on the phone
- Lack of support from family on the phone
- Receipt of letter about death of friend
- Receipt of break-up letter from intimate inmate friend
- Loss of non-intimate inmate friend
- Threats from inmates for “snitching”
- Continuous threats from inmates for “rent”
- Bullying related to nature of crime (sex offense)
- Move to another institution
- Attempt to leave SMU and increase in command hallucinations
- Receipt of Disciplinary Report for stealing and probably loss of job
- Placement in DSU for having sex with an inmate
• Placement in DSU for physical fight with an inmate
• Placement in DSU for attacking of an officer
• Denial of request by correctional officer for placement in DSU and hallucinations with threatening content
• Avoidance of placement in IMU
• Getting back at staff for perceived ignorance about suicidal ideation
• Getting back at staff for reversal of housing arrangement with requested cellmate
• Getting back at officer for cell-in for kicking door
• Pretense of suicide to be moved to different cell
• Pretense of suicide to be moved in SMU with intimate inmate friend
• Loss of final appeal and refusal for participation in hobby shop
• Loss of appeal for treatment
• Upcoming release from prison
• Parole of cellmate
• Modeling by another inmate