Self-Directed Violence: Differentiating Between Suicidal, Malingering and Self-Mutilating Behaviours

Psychologists, psychiatrists and other mental health practitioners working in prison settings are often required to assess and treat potentially suicidal inmates. The challenge facing the practitioner is to determine whether or not an inmate is genuinely suicidal.

It is unlikely that all inmates identified as suicidal by prison staff actually are suicidal. Although the suicide rate for prison inmates is much higher than for the general population, the number of inmates who commit suicide is significantly less than the number who are thought to be potentially suicidal.

A recent study reviewed a sample of psychology files of inmates in medium-security federal institutions.(1) Approximately 18% of the files contained reports indicating concerns about suicide. In 70% of these cases, inmates had a documented history of suicide attempts. Assessment revealed that although some inmates had suicidal thoughts, they were not judged to be a high risk for suicide. In other words, the presence of suicidal thoughts does not always lead to suicidal behaviours. It is the mental health practitioner who must gauge the magnitude of the inmate's suicidal intent and the likelihood that the inmate will turn thoughts into actions.

In addition, the practitioner must attempt to distinguish suicidal inmates from other inmates who exhibit "suicide-like" behaviour such as malingering (i.e., those who imitate or feign suicidal intent) and self-mutilation. In this paper, we suggest that under close scrutiny, suicidal behaviour, malingering and self-mutilation represent distinct clinical syndromes, each warranting the development of individualized treatment plans and intervention strategies. Unfortunately, the boundaries between each of the disorders are not always clear, making the practitioner's task of diagnosis all the more difficult. Past Research According to the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III-R), malingering refers to a general class of dysfunctional behaviours involving the "intentional production of false or grossly exaggerated physical or psychological symptoms, motivated by external incentives." (2) Inmates who feign suicidal intent by superficial cutting of the skin (commonly referred to as "slashing"), for example, are generally not trying to kill themselves. On the contrary, by their actions and verbalizations, they are attempting to force institutional administrators to provide some form of secondary reward, such as removal from situations they perceive as undesirable or dangerous within the general inmate population.

Although there may be some authenticity to these inmates' claims of suicidal thoughts because of the dangerous situation they perceive themselves to be in, their behaviour is coercive. Despite the fact that they have engaged in or are threatening to engage in self-injurious acts - a dysfunctional behavioural pattern warranting treatment - self-preservation is the primary motivating factor for their behaviour. They are attempting to avoid personal injury. As a result, they are generally at low risk for suicide.

Walsh and Rosen, in their book, Self-Mutilation, define self-mutilating behaviour as "deliberate, non-life-threatening, self-effected bodily harm or disfigurement of a socially unacceptable nature."(3) Examples of self-mutilating behaviour demonstrated by inmates range from somewhat more common acts, such as self-inflicted wrist and arm cuts, to rarer and more bizarre acts such as self-castration. Despite the dramatic and often shocking nature of their behaviour, self-mutilators do not usually kill themselves. In fact, some

investigators have suggested that self-mutilation is "anti-suicidal"[4] and that one of the motivations for such behaviour is a wish to punish or hurt oneself.

Little research has been done on the prevalence of suicide, malingering and self-mutilation in prisons. Our combined clinical experience working in correctional settings suggests that genuine suicidal behaviour and malingering are the most common of the three disorders. Self-mutilation is rarely seen. This may be due to the low frequency overall of self-mutilation in our society, the higher incidence among women and adolescents, and the secretive nature of self-mutilators' behaviour. Nevertheless, self-mutilation does occur in prison settings, making it critical that the correctional practitioner consider each possibility when attempting to diagnose accurately and to treat an inmate.

Although still in its infancy, non-correctional research has begun to differentiate suicidal behaviour from self-mutilating behaviour. Investigators[5] have recently developed tentative guidelines to help differentiate self-mutilation from suicide. These include the intent of the self-harm, the degree of physical injury sustained, the frequency or chronicity of acts of self-harm and the methods used to inflict self-harm. Walsh and Rosen conclude that, in contrast to suicidal behaviour, "self-mutilation is a direct, physically damaging form of self-harm, generally of low lethality, often repetitive in nature, and commonly employing multiple methods."[6] However, there is no conclusive empirical support for the validity of these conclusions, particularly as they apply to inmates. Three Cases We will now consider summaries of three clinical cases involving potentially suicidal inmates. In each case, staff requested the involvement of a psychologist in evaluating the risk for suicide. Case 1 Mr. A is a 25-year-old, first-time federal offender serving 30 months for armed robbery. He was referred to the psychology department by an institutional nurse who found him to be quite depressed during a routine medical history review.

During the interview, Mr. A expressed little emotion of any kind. However, he was co-operative and expressed interest in addressing his problems. He explained that he was experiencing a number of serious problems involving his girlfriend and that he had recently begun having difficulty sleeping. He also admitted to a loss of appetite and to frequent crying spells, but he denied having suicidal thoughts or having attempted suicide previously. Given his unstable emotional status, Mr. A began seeing the psychologist regularly.

During the course of several sessions, Mr. A revealed that he had been raised in an extremely dysfunctional family, experiencing severe physical, emotional and sexual abuse. He ran away from home at age 14, began living on the streets and eventually became heavily involved in substance abuse. He then met his present girlfriend and the two began living together. Like him, she had been a victim of abuse and was a drug abuser.

Although there appeared to be improvement in Mr. A's mental state after several sessions, he began to have difficulties with other inmates and was therefore admitted to the institutional hospital. Daily therapy sessions continued, and he appeared to be coping well with his problems. However, three days later, during the night, he attempted to hang himself. The attempt failed as a roof anchor gave way. He was found, semiconscious, during a routine bed check and was subsequently placed in an observation cell on suicide watch.

The following morning, when asked why he had tried to kill himself, Mr. A stated that the therapy sessions had dredged up painful memories that he had repressed for years through drug abuse. He thought "dying would be easier than having to deal with [his] past." He also admitted that he had been contemplating suicide, even during the initial interview, despite his repeated denials.

Mr. A remained on suicide watch until an emergency transfer to a psychiatric facility could be arranged. During this period, he remained extremely depressed and was judged to be a very high risk for suicide. In fact, he continued to voice his desire to die and to think about how he might succeed in killing himself. Case 2 Mr. B is a 27-year-old recidivist serving the remainder of a four-year sentence for property-related offences and for being unlawfully at large. He was recently returned to the institution after his day parole was revoked.

While incarcerated, Mr. B has been given a variety of diagnoses ranging from psychotic illness to personality disorder. However, the severity, authenticity and exact nature of his mental illness have been repeatedly debated and questioned by mental health staff. Although he has been referred for treatment on numerous occasions, he has continually displayed a lack of motivation and co-operation toward all treatment programs and has failed to improve to any discernible degree.

Mr. B had been the victim of abuse. He also has a history of multiple suicide attempts including slashing and strangulation. On one occasion, he attempted to set himself on fire. While being treated at a prison psychiatric facility, Mr. B engaged in self-injurious behaviour twice: once, he attempted to strangle himself and on another occasion, he slashed himself superficially. It is important to note that Mr. B was not thought to be depressed. However, just prior to each self-injurious act, he learned that he was about to be transferred back to his parent institution due to his lack of involvement in programs. Treatment staff viewed each incident as purely manipulative in order to avoid transfer.

Mr. B demonstrated similar patterns of "suicide attempts" on numerous other occasions. In virtually every case, Mr. B threatened to engage or actually engaged in some form of dramatic self-injurious behaviour when he was feeling ignored or that his needs were not being met. For example, when told that he would be unable to see the psychiatrist immediately, he threatened to slash himself. When he was informed that his appointment would be further delayed for administrative reasons, he attempted to set himself on fire.

Mr. B remains under close supervision due to his potential to engage in self-injurious behaviour. Although he does not show symptoms of depression, he continues to verbalize suicidal thoughts and his intention to engage in self-harm, particularly if forced to return to the general inmate population. He remains in treatment. Case 3 Mr. C is a 45-year-old recidivist serving a three-year sentence for property-related offences. He was referred to the psychology department by a correctional officer after he had passed out in the living unit. At his interview, Mr. C appeared to be weak and tired with very poor skin tone. It was determined that he was anemic because of blood loss from self-inflicted lacerations to the arteries on the inside of his arms.

Mr. C has a history of depression, poor self-esteem and poor sense of self-efficacy. He disclosed that he had been a victim of physical and sexual abuse as a child and considered himself a "born loser."

Problems with his common-law wife led to the breakup of their relationship and separation from his two children. He has an extensive criminal history and has spent a considerable portion of his adult life in prison.

Mr. C claimed to have been the target of ongoing harassment by other inmates. Moreover, he claimed to have been threatened repeatedly with a knife by other inmates, forced to relinquish his inmate pay and raped by other inmates. In addition, he had recently applied for, but had been denied, release by the parole board.

Shortly after his parole had been denied, Mr. C distributed a handwritten letter to his case management officer and the psychologist. In the letter, Mr. C threatened that he was on the verge of exploding into violence because he was not receiving any assistance from staff to alleviate his problems in the institution.

With some reluctance, Mr. C admitted that he had intentionally cut himself to release built-up tension. He further indicated that over the course of several days he had severed the arteries in his arms repeatedly and had allowed himself to bleed into a plastic bag in order not to attract the attention of the security staff. After allowing himself to bleed, he then stopped the blood flow with bandages and went about his daily activities.

Mr. C said that he has done this self-inflicted "bloodletting" on numerous occasions in the past, both on the street and while incarcerated. As a result, he has been repeatedly diagnosed with anemia.

Mr. C was uninterested in remaining in treatment. He was released on mandatory supervision a short time later. Commentary A brief analysis of the three cases suggests a number of similarities and differences among them.

In terms of similarities, all three cases presented significant mental health concerns. Each had a similar history of childhood abuse. Each experienced significant problems with other inmates. Also important, all three were at risk for self-injury.

As for differences, Mr. A (case 1) and Mr. C (case 3) showed symptoms of depression, while Mr. B (case 2) was free of depression. Mr. B and Mr. C each had a history of multiple acts and methods of self-injury; Mr. A made only one attempt and had no history of previous suicide attempts. Mr. A expressed interest in receiving professional assistance. At times, Mr. C's behaviour was somewhat attention-seeking, but in general, he was secretive about his behaviour and was uninterested in treatment. In contrast, Mr. B was overtly seeking attention, in addition to being coercive and only superficially interested in treatment.

All three inmates had different motives for their self-injurious behaviour: Mr. A was attempting to end his life, Mr. B used self-injurious behaviour partly as an attention-seeking device and partly as a way of coercing others to satisfy his needs, and Mr. C engaged in self-injurious behaviour as an ongoing method of dealing with pent-up tension and frustration.

In summary, our analysis suggests that Mr. A (case 1) was genuinely suicidal, Mr. B (case 2) was

malingering (feigning) suicidal intent and Mr. C (case 3) was a self-mutilator.

This article demonstrates, using actual cases, that no analysis of self-directed violence among inmates is complete without an attempt to differentiate suicidal behaviour from malingering and self-mutilating behaviour. Actual cases frequently overlap in many areas, thereby further complicating the task of making an accurate diagnosis. To date, no established method exists to differentiate reliably between syndromes. Moreover, no attempts have been made to determine the differential prevalence of suicide and suicide-like behaviours - such as malingering and self-mutilation - in prison settings. It is hoped that future research efforts will be directed toward uncovering the prevalence and nature of self-directed violence among prison inmates.

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(1)*S.J. Morison and J.R. Weekes, unpublished raw data, 1992.*

(2)*American Psychiatric Association,* Diagnostic and Statistical Manual of Mental Disorders, *Third Edition (Washington, D.C.: American Psychiatric Association, 1987), p. 360.*

(3)*B.W. Walsh and P.M. Rosen,* Self-Mutilation: Theory, Research, and Treatment *(New York, N.Y: Guilford Press, 1988), p. 10.*

(4)*R.R. Ross and H.B. McKay,* Self-Mutilation *(Lexington, Ma.: Lexington Books, 1979).*

(5)Walsh and Rosen, Self-Mutilation: Theory, Research, and Treatment, *p.25-30.*

(6)Ibid., *p. 29-30.*