

highlighted by the absence of a significant relationship between DST results and suicide.

Second, Dr. Black overlooked our discussion of suicide in the Results and Discussion sections. In our group, there were three definite suicides and one death that was suspicious for suicide. These four cases were evenly split between the psychotic and nonpsychotic groups.

We do acknowledge, however, that the findings from our study are in contrast to those from another study that demonstrated an association between DST nonsuppression and suicide risk in patients with affective disorders (1). Prospective studies in larger numbers of subjects with psychotic and nonpsychotic depression could help tease out the complex relationships between neurobiology, clinical symptoms, and mortality.

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### Suicide Among Police Officers

TO THE EDITOR: I have several comments regarding the methods employed in the study of suicide among New York City police officers by Peter M. Marzuk, M.D., et al. (1), as well as the interpretation of the police occupational context.

This study compared police officers with the general population of New York City. While age, gender, race, and region were statistically adjusted for, an inaccurate comparison of suicide rates may have resulted. The comparison involved a healthy and psychologically tested working group (the police) with the New York general population, which included the unemployed, institutionalized, incarcerated, and mentally ill. These population groups generally experience higher suicide rates. Thus, the study compared a New York population containing segments that have high suicide rates with the police, who *should have relatively low suicide rates*. Even if this study were accurate, the fact that police officers have suicide rates equal to those of the New York population demonstrates that suicide is a problem.

The work exposures involved in policing are confounders that add considerable weight to an analysis of suicide. Incidents such as witnessing death, encountering abused children, and street combat weigh heavily as precipitants to depression, alcohol use, and suicide. The study may have better compared the police with an occupation similar in confounder weight distributions, in addition to including such confounders in the analysis to assess their impact.

While psychological testing is an important screening tool for bringing in officers suitable for police work, it does not tell the whole story. Exposure and job socialization in policing have profound impacts on officers. It was interesting that the mean age of suicide for police officers in this study was 33.5 years, an age much younger than the national norm for suicide. It was also interesting that police suicide rates were noticeably unstable, while population rates remained stable over the 20-year period. The high police suicide rate in 1994, for example, occurred during a time of citywide internal investigations into a police drug scandal.

Some researchers have stated that occupation is not on the list of suicide risk factors. While we cannot yet be certain that police work by itself is a suicide risk factor, we can state that it serves as a fertile arena for suicide precipitants, including relationship problems, culturally approved alcohol use, firearms availability, and exposure to psychologically adverse incidents. This job is part of the causal chain of suicide.

In sum, this study reflects statistics that tell us that we need to look deeper into police suicides and their root causes. While statistics such as rates per 100,000 tell us about numbers, they do not tell us about suicide risk. We may be better informed if we know the inherent risk of police suicide in both a quantitative and a contextual sense. Policing is a psychologically dangerous occupation. We still have a way to go with police suicide research, but I remain with the premise that police are at a significantly higher risk for suicide.

#### Reference

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TO THE EDITOR: In their article, Dr. Marzuk and colleagues reviewed the rate of suicide among New York City police officers and compared it with the rate of suicide among New York City residents. After adjusting for demographic differences, they found that the rate of suicide was lower among the police officers (14.9 per 100,000 person-years) than among the general population (18.3 per 100,000 person-years).

It is estimated that over 90% of the individuals who commit suicide suffer from diagnosable psychopathology, including substance abuse and dependence, mood disorders, and psychotic disorders (1, 2). New York City police officers are screened for the presence of psychiatric disorders at the time that they are hired. No doubt, some preemployment psychopathology is missed, and some officers develop addiction problems and other psychiatric disorders while working in the department. It would be interesting to know the incidence and prevalence of such disorders among police officers during the period studied.

If we assume that few of the officers who committed suicide had diagnosable preemployment psychopathology, it may not be a fair comparison to look at their rates of suicide compared with the residents of New York City generally unless the prevalence of serious psychopathology among the comparison population is accounted for. The fact that the rate of suicide among police officers is about 80% of that of the general population may speak to the enormous stresses associated with police work, and the more proper conclusion may be that being a police officer greatly increases the risk of suicide in individuals suffering from no significant preemployment psychopathology.

#### References

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TO THE EDITOR: On the basis of the limited data available, Dr. Marzuk et al. concluded that the suicide rate of police officers may be lower than the suicide rate of the New York City population. However, there are several concerns about the study. Since death certificates were used, it is likely that the number of police suicides was underreported. Although the authors adjusted for accidental deaths and undetermined deaths (potential suicides), the graph does not include this information. In addition, some reported police homicides may actually be suicides. A suicidal officer may expose himself or herself to a life-threatening situation that also allows an opportunity to spare peers and family the aftermath of a suicide. The entire New York City population, which includes some who are jobless, have significant legal histories, or who have severe mental illness or personality disorders, is not an appropriate comparison group. These factors all increase the risk of suicide. In addition, most officers live outside the city, which decreases their risk of suicide.

Violanti and colleagues (1) compared police officers to other municipal workers and reported that the officers had a higher suicide rate and lower homicide and accidental death rates. An analysis of reported deaths in municipal workers demonstrated that police suicides (including likely suicides such as gunshot wounds to the head or drowning) were more likely to be reported than nonsuicides (2). In a department of about 40,000 officers with about five to six reported suicides per year, reclassifying just two missed suicides per year would raise the reported rate from 15 in 100,000 to 20 in 100,000, higher than the rate in the New York City population.

A New York City Police Department employment screening includes administration of a psychological interview, an MMPI, a California Personality Inventory, and a Cornell Index and the gathering of prior legal history, work history, and relationship history. Many high-risk candidates (e.g., with psychotic symptoms, severe mood disorder, poor work history, severe personality disorder, or extensive legal history, each of which is a risk factor for suicide) are not hired. If similar people were excluded from the New York City comparison group, the city's suicide rate would be much lower than reported. If the city population was "adjusted" to be more comparable to police officers, we are confident that the police department's suicide rate would be significantly higher than the appropriate comparison group.

We are concerned that the results presented may negatively affect police officers. Fears of stigmatization, job loss, or perceptions of personal weakness already are barriers that officers must overcome. If they are led to believe that suicide is not a problem for law enforcement personnel, they may see their own suicidal ideation as a personal weakness or failure and become less likely to seek assistance.

## References

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TO THE EDITOR: Suicide among the police has been described as an epidemic (1). It is claimed that the suicide rate of law enforcement personnel is between two and three times that of the general population (2). Repetitive citations may have given the impression that the suicide rate among the police is appreciably greater than that for other occupational groups. However, research on police suicide has yielded widely varying rates, ranging from 5.8 suicides per 100,000 police officers per year in London to 203.7 per 100,000 per year in Wyoming (3). Perhaps the greatest challenge is the lack of empirical, reliable evidence on police suicides (1). Hence, the study by Dr. Marzuk et al. of the New York City police was most welcome. They stated that "with one exception...studies have shown police suicide rates to be lower than those of the general population" (p. 2070). This is not correct. We published what we believe to be the first systematic review of suicide among police in which strict methodological inclusion criteria were applied to the original studies (3). We identified 41 original studies, 20 of which fulfilled the inclusion criteria. All studies were from North America (13 studies), Europe (six studies), and Australia (one study). The results showed that some studies found elevated suicide rates among police officers; others showed an average or low rate of suicide. However, the rates varied widely and were inconsistent and inconclusive, especially because of methodological shortcomings. Most studies have been conducted in limited specific police populations, particularly in the United States. Local and regional variations in suicide can affect the rates of police suicide. Moreover, the reason for studying police suicide in a specific region may be due to a local "epidemic" of suicide in a subgroup. This may lead to publication bias. However, our review identified three nationwide studies of suicide in police from France (4), Germany (5), and England and Wales (6). These studies do not suggest an increased suicide rate in police (4–6), which is in accord with the results of Dr. Marzuk et al. However, we agree with the authors that these findings do not imply that suicide is not a problem among police officers.

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