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Exploring the Overlap: Suicidal Thoughts and Homicidal Acts Among Incarcerated Offenders

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ABSTRACT

This study explores the intersection of suicidality and homicidality through psychosocial life-history interviews with 18 people convicted of murder or manslaughter incarcerated in Minnesota. During in-depth qualitative life-history interviews about their childhood, adolescence, and adulthood, the participants revealed significant adverse childhood experiences and mental health issues. A majority of them were on the suicide spectrum before committing homicide. Hopelessness and previous suicide attempts were prevalent, highlighting the complex interplay between suicidality and violent behavior. These findings underscore the need for comprehensive mental health support and early interventions to address ACEs, suggesting that integrated care could mitigate the risk factors for both suicide and homicide. This study contributes to understanding the nuanced relationship between these behaviors among perpetrators of homicide and emphasizes the importance of holistic approaches in prevention and policymaking.

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The intersection of suicidal ideation and homicidal behavior is complex and multifaceted, necessitating a nuanced exploration to fully understand the underlying psychological, social, and situational dynamics. The present study delves into this intricate relationship by conducting in-depth qualitative life history interviews with incarcerated homicide offenders, shedding light on the often-overlooked link between prior trauma, mental illness, and suicidal tendencies leading up to their crimes. The concept that suicide and homicide may be two sides of the same coin (Bills 2017) serves as the cornerstone of our inquiry, providing a lens through which we examine the duality of inward and outward-directed aggression.

Understanding the overlap between suicide and homicide has long been a central issue in social science generally and violence research specifically. Durkheim's (1951) seminal work first noted the complex interplay between these forms of violence, observing, "Suicide sometimes coexists with homicide, sometimes they are mutually exclusive, sometimes they react under the same conditions in the same way, sometimes in opposite ways" (p. 355). Later, Henry and Short (1954) framed suicide and homicide as expressions of aggression directed inward or outward, respectively – a view echoed in Freudian psychoanalytic theory, which posits that suicide unconsciously internalizes aggression, while homicide externalizes it (Freud 2004; Palmer 1972). These frameworks emphasize the importance of exploring how suicidal ideation and attempts may precede homicidal behavior, providing a comprehensive understanding of violence as both an internal and external phenomenon.

Despite the robust theoretical groundwork, empirical studies have predominantly focused on aggregate-level analyses, examining the correlation between suicide and homicide rates across different regions or countries (Unnithan et al. 1994). These cross-sectional designs, while informative, often

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fail to capture the individual-level nuances and temporal dynamics of these behaviors. Previous research has primarily considered violence as a precursor to suicide, neglecting the potential for suicidality to serve as a precursor to violence or homicide (Conner et al. 2001; Van Dulmen et al. 2013). Notably, Van Dulmen et al. (2013) utilized longitudinal data from the National Longitudinal Study of Adolescent Health to demonstrate the bidirectional relationship between violence and suicidality from adolescence into young adulthood, highlighting the reciprocal nature of these phenomena and their stronger association among males.

The current study aims to fill a critical gap in the literature by specifically examining the role of suicidality and prior suicide attempts among homicide offenders. Through qualitative life history interviews, we seek to uncover the personal narratives and lived experiences that elucidate the pathways from suicidal ideation to homicidal actions. The paper proceeds as follows. We first review the existing literature on the relationship between suicide and homicide, synthesizing empirical findings and theoretical perspectives to examine the complex relationship between these forms of lethal violence, emphasizing the psychological, sociological, and biological dimensions. Next, we describe our methodological approach, including participant selection and data collection techniques. We then present our findings, highlighting key themes that emerged from the interviews. Finally, we discuss the implications of our results for theory, practice, and future research, offering insights into potential interventions and preventive measures to address the intertwined issues of suicidality and homicidal behavior.

Psychological perspectives

Psychology has long explored the overlap between homicidal and suicidal behaviors, with particular emphasis on shared underlying psychopathologies (Freud 2004). The overlap between suicide and homicide is most evident when perpetrators die by suicide immediately after their crimes (Nock 2014). Although this phenomenon is relatively rare in the general population of murderers in the United States, where only 4% die by suicide during their crime (Eliason 2009; Lankford 2015), it is more prevalent among mass shooters (Lankford, Silver, and Cox 2021). In a comprehensive analysis of 200 mass shooters over nearly six decades, Peterson and Densley (2021) found that a third had prior suicidal tendencies, 40% died by suicide during their act, and about 20% instigated their deaths at the hands of law enforcement. For this reason, Peterson et al. (2024) argue that mass shootings, often seen as isolated acts of violence, should be contextualized within a broader "deaths of despair" framework (Case and Deaton 2020), as perpetrators often plan these acts as a final, desperate gesture. Murder-suicide is equally common in family annihilations, the most frequent form of mass shooting (Geller, Booty, and Crifasi 2021), often involving a male perpetrator who kills his female partner and her children, typically at the point of separation (Harper and Voigt 2007).

The risk factor overlap between suicide and homicide provides further insight into their connection. Moffitt's (1993) dual neurodevelopmental pathway distinguishes between adolescent-limited offenders, whose criminal behavior typically ceases as they mature, and life-course-persistent offenders, who continue their criminal activities into adulthood. Life-course-persistent offenders exhibit both biological and environmental risk factors from an early age, including neuropsychological problems such as ADHD, disrupted attachment, maltreatment, poverty, and cognitive deficits (Carlisi et al. 2020; Dodge and Pettit 2003; Moffitt 2005). These risk factors significantly overlap with those associated with suicidality (e.g., Wenzel and Beck 2008), such as impulsivity, aggressive tendencies, adverse childhood experiences (ACEs), and violent victimization (CDC 2024). Multiple large-scale studies confirm that ACEs increase the likelihood of violence against others (delinquency, bullying, physical fighting, dating violence, and weapon carrying on school property) and violence against oneself (self-mutilation, suicidal ideation, and suicide attempts (Duke et al. 2010), with a dose-response relationship indicating greater risk of suicide attempts and completion with more ACEs (Brodsky and Stanley 2008; Choi et al. 2017; Felitti et al. 1998).

Impulsivity and anger play important roles in both aggression and suicidal behavior. Aggression can be classified into reactive aggression, driven by anger and impulsivity, and proactive aggression, which is instrumental and goal-oriented (Berkowitz 1993). Reactive aggression is traditionally seen as underlying the link between aggression and suicidal behavior. However, Conner, Swogger, and Houston (2009) found that both reactive and proactive aggression were associated with previous suicide attempts, with proactive aggression being particularly significant for men. Impulsivity, characterized by risk-taking, sensation-seeking, disinhibition, and lack of planning (Moore et al. 2022), is integral to theories of suicide (e.g., Baumeister's (1990) "escape theory") and is a core symptom of ADHD, a known risk factor for both violence and suicidality (Carlisi et al. 2020; Furczyk and Thome 2014). Additionally, trait anger is associated with increased violence and suicidal behavior (Plutchik and Van Praag 1989), as evidenced by studies linking higher trait anger with increased suicide attempts among boys (Ammerman et al. 2015; Daniel et al. 2009). The serotonin aggression hypothesis suggests that low serotonin levels in the brain are linked to impulsive aggression, influencing both suicide and homicide (da Cunha-Bang and Knudsen 2021; Nock 2014).

Depression and personality disorders are prevalent among homicide-suicide perpetrators (Liem and Nieuwbeerta 2010). These individuals frequently experience profound despair and hopelessness, mirroring the emotional states commonly associated with suicidal ideation (Eliason 2009). Beck's (1967) hopelessness theory posits that hopelessness is a key cognitive vulnerability for suicide. Longitudinal studies, such as those by Kuo, Gallo, and Eaton (2004), have confirmed that hopelessness is an independent risk factor for suicidality. Hopelessness also influences violent behavior, although it is less studied. Demetropoulos Valencia et al. (2021) found a significant positive relationship between hopelessness and youth violence, while Brezina, Tekin, and Topalli (2009) highlighted how anticipated early death, or "futurelessness," contributes to high-risk behaviors such as crime and violence (see also, Caldwell, Wiebe, and Cleveland 2006). These relationships are reciprocal; violent victimization and witnessing violence can increase adolescents' perceptions of premature mortality, leading to risky behaviors that reinforce the cycle of violence and despair (Borowsky, Ireland, and Resnick 2009; Tillyer 2015).

Psychosis has also been identified as a potential factor in both homicidal and suicidal behaviors (Peterson et al. 2022). Schizophrenia and bipolar disorder, particularly when untreated or mixed with substance use, can contribute to the risk of both self-directed and other-directed violence (Taylor and Gunn 1999). The concept of "dual harm" individuals, who exhibit tendencies toward both self-harm and aggression toward others, has gained traction in recent years, underscoring the psychological overlap between these behaviors (Slade 2019). From a familial perspective, the transmission of suicidal and aggressive behaviors is related (Brent et al. 1996).

Sociological perspectives

Sociological theories contribute to understanding the situational and environmental factors that link homicide and suicide. Durkheim's seminal work on suicide highlighted the role of social integration and regulation, suggesting that social isolation and anomie can precipitate both suicidal and homicidal actions (Durkheim 1951). Contemporary studies have extended this framework, examining how social stressors, such as economic hardship, relationship breakdowns, and societal disintegration, can elevate the risk of both outcomes (Stack 2000). Notably, the concept of "fatalistic suicide," where individuals feel over-regulated by oppressive conditions, parallels scenarios of intimate partner homicide-suicide. This phenomenon is particularly evident in cases of domestic violence, where perpetrators, often overwhelmed by perceived control and powerlessness, resort to extreme violence as an escape from their circumstances (Dixon, Hamilton-Giachritsis, and Browne 2008). The interplay between societal norms, cultural context, and individual vulnerabilities forms a critical nexus for understanding these tragic events. For example, the "psychache" model posits that unbearable psychological pain is a common denominator driving individuals toward both self-destruction and outward

violence (Shneidman 1993). This model emphasizes the need for comprehensive public health interventions targeting emotional distress and coping mechanisms, but also social stressors, such as poverty and domestic violence (Vijayakumar et al. 2008).

Building on the existing literature, the current study aims to explore the interconnected themes of suicidality, impulsivity and anger, adverse childhood experiences, and hopelessness. We employ psychosocial life histories with 18 homicide perpetrators from the Twin Cities who committed their crimes between 2018 and 2022. Through in-depth life history interviews, we seek to uncover the nuanced overlap between suicidality and homicide within this group. Notably, prior suicidality and suicide attempts among general homicide offenders remain largely unexplored, highlighting the importance and novelty of our investigation. This study endeavors to fill this gap, providing a deeper understanding of the complex interplay between these behaviors.

Materials and methods

Recruitment

This qualitative study is part of a larger mixed-methods project examining over 600 homicides in Hennepin and Ramsey Counties, Minnesota, between 2018 and 2022. These counties include the state's largest cities, Minneapolis and Saint Paul. In collaboration with the Minnesota Bureau of Criminal Apprehension, we analyzed National Incident-Based Reporting System (NIBRS) records and gathered additional information from media, police reports, and trial documents to contextualize each case. These data allowed us to identify eligible participants for the qualitative component reported here.

Participants were recruited from two Minnesota Correctional Facilities-one medium-security and one maximum-security. We initially contacted all six state prisons, but only two responded. The wardens at these two facilities provided lists of eligible individuals convicted of first- and second-degree murder or manslaughter for offenses that occurred in 2020 or 2021. Eligibility was further refined based on additional criteria: individuals actively appealing their cases or deemed unfit to participate (e.g., for health or behavioral reasons) were excluded. Minnesota Department of Corrections staff then distributed a recruitment letter to potential participants. At the medium-security facility, eight out of 13 eligible participants agreed to participate. The maximum-security facility housed about 100 eligible individuals, but due to staffing limitations and the scope of the study, the warden requested we limit our sample. Therefore, we randomly selected 20 individuals from the eligible list, and 10 consented to participate. The study received approval from the Institutional Review Board (IRB) of the Minnesota Department of Corrections, ensuring ethical compliance. The principal investigators are experienced interviewers and qualitative researchers with extensive backgrounds working in prisons and with serious violent offenders, including in death penalty mitigation (BLIND).

Data were collected through open-ended, semi-structured interviews conducted over two days at each facility, with each interview, a combination of general and specific questions, lasting between 45 and 150 minutes (average of 90 minutes). Each interview began with the prompt, "Tell us about where you grew up," which helped participants feel at ease and allowed the conversation to flow naturally. From there, we inquired about their family, school, and work lives, followed by questions regarding their offending history and mental health. As the interviews progressed, we shifted focus to the circumstances surrounding the offense that led to their incarceration. Owing to prison restrictions, interviews were not audio-recorded; instead, one principal investigator interviewed while the other took detailed notes. Interviews were held in private rooms where correctional staff could observe but not hear, ensuring safety and confidentiality. Informed consent was obtained from all participants. All records were de-identified to maintain confidentiality, and consent forms were kept separate from the interview notes.

Table 1. Homicide circumstances and previous suicidality among 18 incarcerated individuals.

Homicide Circumstance	Age at time of homicide	Previous Suicidality	Self-Reported Mental Health Diagnosis
Drove intoxicated, killed woman on street	30–39	Attempt – gun in mouth 2 years before homicide	ADHD Depression
Drove intoxicated, killed passengers	50–59	Attempt – swallowed pills 30 years before homicide	Depression
Beat elderly man to death after altercation on public transit	20–29	Attempt – stood on bridge 2 years before homicide Attempt – made noose 1 year before homicide	None reported
Killed wife and shot himself	30–39	Attempt – cut wrists 20 years before homicide Attempt – overdoses 10 years before homicide	ADHD Anxiety Depression
Killed shop owner during robbery	30–39	Attempt – drank Visine 10 years before homicide	ADHD Anxiety Learning Disorder
Arson resulting in homicide	30–39	Attempt – took pills 5 years before homicide	Bipolar Disorder
Beat baby to death	20–29	Attempt – car into lake 5 years before homicide	Anxiety PTSD Schizophrenia
Shot and killed opposing gang member	Under 18	Anticipated early death	Anxiety Depression
Fight on street that escalated to shooting	Under 18	Anticipated early death	Anxiety Depression PTSD
Shot opposing gang member, killed bystander	Under 18	Anticipated early death	ADHD Anxiety PTSD
Shot and killed opposing gang member	Under 18	Hopelessness	Depression ADHD
Shot and killed man in his car during robbery	Under 18	Hopelessness	ADHD Anxiety OCD PTSD
Shot and killed drug dealer during robbery	Under 18	Hopelessness	ADHD Depression
Traffic altercation escalated to shooting	30–39	Hopelessness	ADHD Anxiety Depression
Escalated argument in grocery store led to stabbing	50–59	None reported	None reported
Escalated argument led to shooting – claims self defense	20–29	None reported	None reported
Stabbed girlfriend to death	20–29	None reported	Schizophrenia
Stabbed brother to death during fight	20–29	None reported	Unsure which diagnosis

Participants

All 18 participants were male, because the prisons only housed male individuals. Fourteen self-identified as Black and four were White. Their ages ranged from 18 to 62 years at the time of the interview, with a mean age of 27.3 years at the time of their offenses. Geographically, the participants

were primarily from urban areas in the Twin Cities: 10 were from Minneapolis, five from St. Paul, and three from suburban areas. They were incarcerated for a wide range of homicide crimes described in Table 1.

Ten participants used a firearm, two used a knife, two used a vehicle, two used their body, and one intentionally set a fire. Six of the 18 participants had no prior criminal history. For the 12 with a criminal history, their previous convictions ranged from one to 16. Three had prior domestic violence convictions, one was previously civilly committed, and eight had previous violent convictions. Each homicide had one victim. The victims' ages ranged from 4 weeks to 75 years (Mean = 32.9 years). Four of the victims were female and 14 were male. Nine of the victims were Black, six were White, one was American Indian, one was Asian American, and one was Latino. Seven victims were strangers to the perpetrators, three were gang/group related, one was the child of the perpetrator, one was a sibling, one was a girlfriend, one was a wife, and two were acquaintances of the perpetrator.

Data analysis

Inductive thematic analysis was used to identify and analyze patterns within the interview data, emphasizing participants' narratives to uncover key themes related to their experiences and the circumstances surrounding their offenses (Braun and Clarke 2006; Clarke and Braun 2014). This process began with principal investigators thoroughly familiarizing themselves with the data through repeated review of transcribed notes. The two principal investigators independently coded the data, highlighting significant segments pertinent to the research questions. Initial codes were compared, achieving a 95% agreement rate between the principal investigators, and discussed to identify broader themes, ensuring a comprehensive analysis. Themes were refined through iterative review, ensuring consistency and coherence across the dataset. This method captured the essence of the participants' stories and lived experiences. By drawing on "narrative criminology" principles (Presser 2016), we sought to understand how participants critically constructed their life stories.

Findings

This section highlights key themes that emerged from the interviews, supported by illustrative verbatim quotes (*in italics*).

Adverse childhood experiences

Several participants had mothers who were addicted to drugs and alcohol. Participant 7 said his mom was an alcoholic. Participant 5 said his mother was addicted to meth and fentanyl, and she eventually died of a drug overdose. Participant 14 also said his mother was a drug addict.

Participant 3 described his mom as an alcoholic who was in and out of jail, "*She was never sober*." Participant 3's father was also incarcerated from when he was 6 to 14.

Other participants had incarcerated fathers. Participant 16 said his dad was "*locked u*p." Participant 8 said his dad wasn't around due to "*street stuff*," because he was in jail. Participant 10 described his immigrant mother as a "*wildflower*" who had lived a hard life. He said his mother was an alcoholic who threw wild parties every night. He said he would go down at 4 am to try to tell people that it was a school night. He described his entire childhood as parties, loud music, fighting, and violence, "*I have extreme anxiety and PTSD from it*." Participant 10 also said he didn't have a great relationship with his dad, "*my pastor filled in for that*."

Participant 14 described his mom as a "*military mom*" who was very cold and strict. His uncle made his mom a wooden spanking paddle to beat him with because her hand would get sore. Participant 11 said his mom was "*slow in the head*" because his dad pushed her down the stairs in a domestic violence situation and damaged her brain when Participant 11 was a baby. Participant 12's mom died when he was 14, from complications due to untreated diabetes.

Participant 5 was raised by his dad owing to his mom's drug addiction. However, his dad was also addicted to meth, and they were frequently homeless. Participant 5 said that CPS took him for the first time at age 6. His dad and mom's dad were driving around drunk, and he was in the back seat. He was in and out of foster care the rest of his childhood, "*It's weird to live with complete strangers*."

Participant 6 was also primarily raised by his dad, who was 19 when he started caring for him on his own when he was six months old. He described an afternoon when he had to strip down to his underwear on the couch. Participant 6 thought he would get beat, but his dad laid out a rod, a gun, a belt and a bible. He said the belt wasn't working, so he would switch to the gun if he needed to.

Participant 15 was born addicted to heroin. He was in foster care from ages 5 to 11 at 7 or 8 different homes, he estimated. He said, "*Foster care was horrible*." One foster mom burned him with a curling iron, made him "*do sexual stuff to her*," and locked him in the basement. Later, as a teenager, his mom got clean from drugs, and he was living with her and his stepfather. "*I was doing good for a year, but then my stepdad was killed. They say it was suicide but that doesn't make sense*." He remembers it was raining. "*I've never seen so much blood. It was everywhere, like a horror movie. His guts were out*."

Four participants experienced homelessness during their childhood. Participant 1's mom passed away when he was going into sixth grade after an overdose of medication. He lived with his grandmother briefly, but then she passed away from cancer when he was 15. After his mom and grandmother died, we would "*sleep outside*" or in a shelter. He would rob people a couple of times a week to get money for food and clothes.

Participant 4 said money was a struggle in their house growing up. They were homeless a couple of times and stayed in a shelter. Participant 5 said his family was homeless when he was 8 or 9. They lived at his mom's ex-boyfriend's house, then his dad's sister. Eventually, they lived in a shelter, but he was violent with a staff member, so they were kicked out.

Participant 7 said his family struggled financially when he was young and there was rarely food in the house. When he was 8, they were homeless for 2 years and lived in a shelter, "*It was a place to rest your head, but that was about it."*

Many participants grew up in neighborhoods plagued by violence. Participant 1 described his neighborhood as dangerous and violent, "*people dying, wild stuff*." He was threatened with guns growing up, shot at, and watched people get shot. Eventually, two of his best friends got killed in shootouts. He has two other family members incarcerated for murder – his cousin is serving 40 years, and his little brother is serving life.

Participant 17 said growing up in the projects he was exposed to "*drugs, guns, people dying*. Participant 4 said he was 12 years old when he first saw someone get shot. Participant 3 said he had personally been involved in 30–40 shootings in his neighborhood. Participant 7 had been in shootings about 10 times – shootouts or drive-bys with rival gangs. Participant 8 stated, "*The problem? It was my environment. It was "negativ*e." He later said, "*I never liked doing street stuff, but that's all I know. Violence, that's all you seeing*." Participant 15 said he was "*around violence*" a lot – in his foster homes, in the streets. "*I seen a lot of stuff no kids should see*."

Early behavior problems and criminal justice involvement

Almost all the participants mentioned early behavioral problems in elementary school. Participant 1 had to switch schools frequently because of fighting in elementary school. Participant 4 described himself as disobedient, adding "*I was suspended and expelled from a lot of schools."* Participant 5 said he got bullied in school. He was always getting in trouble and his dad would have to come and pick him up, which resulted in his dad losing his job.

Participant 7 only started attending school in third grade. He missed kindergarten through second grade, so he misbehaved to save face: "*I didn't want to be embarrassed*," he said. He described biting his teachers and needing to be restrained. Participant 8 described his elementary school kicking him out at seven years old, *"I kneed a kid in the face, broke his nose*." Participant 12 also got kicked out of elementary school for fighting, adding "*I really didn't get school. I didn't understand anything*."

Participant 13 was also kicked out of elementary school and sent to an alternative school, "*If you fought there, they locked you inside rooms*." Participant 14 said he had dyslexia and was bullied, "*It made me go crazy*." He was kicked out of at least three elementary schools. Participant 16 also said he was bullied because he was short, so he was constantly fighting. Participant 17 said he fought a lot in elementary school as well: "*I never started them, just reacted*."

A majority of participants also described criminal justice involvement from a young age. Participant 3 was 11 the first time he went to jail and was already carrying a gun regularly at that time. He went to juvenile detention again twice for shootings and robberies. Participant 5 started committing crimes at age 6. He described stealing mail and breaking into houses to steal Lego sets. Participant 8's criminal career started at 10 years old, and at the age of 12, he was arrested for a home invasion. Participant 15 was arrested for the first time at 12, which is when he started selling drugs and carrying a gun. Participant 15 also started selling drugs at age 12. By age 14, he was involved in a carjacking where he hit a pregnant woman over the head with a bottle.

Anger and mental illness

Several participants mentioned having anger issues. Participant 1 said he was "*a problem child*" with "*anger issues*." Participant 3 said that he was very angry as a teenager. Participant 8 said he gets so angry that he "*blacks out*." Participant 8 said he started fighting "*out of the womb*." Participant 12 said it was hard to make him angry, but when he did get angry, "*I would explode*." Participant 15 described himself as "*very angry*" and distrustful. Participant 16 said that ever since he was a kid, "*I would black out. Anger would take over. I've got real anger problems*."

Out of the 18 participants, 15 discussed prior mental health diagnoses, including depression, anxiety, ADHD, and PTSD (Table 1). Eleven of them reported a combination of these conditions. Participant narratives revealed the profound impact of these diagnoses on their lives:

One participant shared, "*I can't sleep*" (Participant 1), while another mentioned seeing a psychologist for depression at the time of their crime. Another participant took Prozac for anxiety at age 12 after being assessed at a juvenile detention facility. One individual, diagnosed in fifth grade with ADHD and depression, noted that therapy helped them learn to think before acting. Participant 5 described a complex array of diagnoses, stating, "*I was diagnosed with FASD, PTSD, ADHD, OCD, ODD, anxiety, attachment disorder, and trust issues*."

Participants frequently mentioned ADHD and anxiety. One participant diagnosed with ADHD, PTSD, and anxiety said, "*I see a therapist now and take A LOT of meds. It helps with my anxiety*" (Participant 7). At an alternative school, another was diagnosed with ADD, ADHD, and ODD, though their mother refused medication, opting for therapy at age nine. Another participant admitted, "*I'm impulsive. I've had anxiety forever, also ADD and depression*" (Participant 9). Some reported taking medication in prison but not outside, and one had experienced hallucinations. Medication histories included treatments like Ritalin, Adderall, and Wellbutrin for ADHD and Xanax for anxiety, in some cases dating back to as young as 4 years old. An additional participant, unsure of his exact diagnosis, said, "*You can ask my mom, she knows*" (Participant 16).

Three participants described being diagnosed with long-term serious and persistent mental illness. Participant 17 was diagnosed with bipolar disorder after a suicide attempt led to hospitalization. He vividly described his manic episodes: "*I don't sleep, can't sit still; it would last for a few days up to a week*." He likened mania to a "*super rollercoaster ride*" and believed his father also had bipolar disorder. He was convicted of setting a house on fire, resulting in a fatality, but did not describe being in a manic or depressed state during the incident.

Participant 12, diagnosed with schizophrenia, admitted, "*I don't know what schizophrenia is*." His experiences included multiple hospitalizations in psychiatric facilities for "*trippin out*," which he described as feeling like "*the world is against you*" and feeling watched and followed. These episodes began in elementary school, where teachers would take him on walks to calm him down. He mentioned slow brain development and had been hospitalized twice for competency restoration,

once for this murder and once for a previous crime. Convicted of stabbing his girlfriend to death, Participant 12 stated he "*was trippin out*."

Participant 18 had been diagnosed with PTSD, anxiety, and schizophrenia. During a required mental health assessment on probation as a teenager, he was diagnosed with schizophrenia, a condition his father also has. He described hearing voices and seeing shadows, which led to self-harm behaviors such as hitting, cutting, and stabbing himself out of frustration. Participant 18, originally from a country where mental illness is heavily stigmatized, explained, "*If you are mentally ill, you are just crazy*." Convicted of beating his newborn baby to death, he reported being in a psychotic episode at the time, driven by voices commanding him to act.

Hopelessness and Suicidality

Seven participants answered "yes" when asked if they had ever attempted suicide before the homicide crime for which they were presently incarcerated (Table 1). Suicide was attempted anywhere from one year to 30 years before committing homicide. Perpetrators with previous suicide attempts tended to be older. Participant 2 attempted suicide around age 18 after getting into a fistfight with his stepfather. He was living alone in an apartment at the time and took 200 Advil. A friend found him, and he went to the hospital to have his stomach pumped. Participant 10 described driving to a bridge and standing on the edge for a long time but changing his mind. Another time, he made a noose in jail, but a corrections officer found it before he could use it.

Participant 13 attempted suicide two years before his homicide. He described feeling, "*What's the point of everything?*" His two young kids were at his house that day. He got high in the garage and realized he couldn't afford Christmas presents for his children. He asked his mom to come over, told his kids that he loved them, took a gun that he had stolen from his ex-girlfriend, went to the garage, and cocked the gun in his mouth. His mom suddenly walked in and made him stop. She took him to the store to buy Christmas presents. That same participant described being put on the suicidal unit after he committed this homicide, *"My whole life was going to shit. I just wanted to be dead*." He was hitting himself in the head with anything he could find while on the unit.

Participant 14 cut his wrists after his grandma died when he was 16 years old. His mom found him and took him to the hospital. He had other overdose attempts after that, including after a close friend of his died. He took six fentanyl pills that day. He remembers feeling, "*I'm ready to fucking die*." Participant 15 was hospitalized in a psychiatric facility for attempting suicide by drinking Visine. He said he was "*feeling dark*" and "*my stomach was pumped for three days*."

Participant 17 described feeling depressed in his 20s and took "*baby aspirins*" to overdose. He ended up hospitalized in a psychiatric facility for several weeks. He took pills again in his 30s after his girlfriend broke up with him, but not enough to need hospitalization.

Participant 18 described driving his car into a lake at age 19 attempting to die by suicide. Participant 8 said he started to feel like "*life was nothing*," "*life was empty*." He was "*stressed and depressed. I was just lost*." Participant 9, when asked if he ever attempted suicide, said that he was never suicidal but would get a feeling of "*just being over it*."

At the same time, in addition to the seven participants with previous suicide attempts, an additional three participants anticipated dying early when asked about how they imagined their future before their crime. Participant 1 reported, "*I didn't think I'd survive for the future*." Participant 3 said "*Did I have plans for the future at any point? Hell no. I would die or go to jail*." Participant 7, when asked if ever thought about where he would be at 25, said, "*Either dead or in prison. You can't leave that life. All of our lifespans were real short*." Participant 14 said he "*knew his life would end with death or being locked up and he was prepared for that*." All three respondents perpetrated homicide before their 18th birthday.

Another four participants described feeling hopeless and like nothing mattered anymore in the period leading up to their crime, though not explicitly suicidal. Participant 4 said he felt that way after his best friend was killed at the age of 15, having grown up together, he felt angry at the world. Participant 5 described the hopelessness and chaos of his life when he was 15 years old, "*I would crash at people's houses and dig through cars all night. I never went to school. I started heavy drug use and*

everything became a blur." The crimes committed by perpetrators who anticipated early death and felt hopeless were more impulsive and part of a broader criminal lifestyle (i.e., gang membership, robbery).

Discussion

Building on research that has traditionally treated homicide and suicide as distinct phenomena, our findings illuminate the nuanced intersections between these behaviors. Using psychosocial life histories from 18 homicide perpetrators in Minnesota – a unique qualitative sample – we examined how themes of suicidality and violence converge within this group. Our findings revealed patterns of prior suicide attempts and pervasive hopelessness that frequently preceded participants' violent acts. Approximately half of the sample attempted suicide before committing homicide, with some making multiple attempts. Additionally, seven participants, most of whom were younger, exhibited a sense of "futurelessness," anticipating a short life or expressing profound hopelessness.

Despite the established role of mental health struggles, impulsivity, and futurelessness as risk factors for violence, prior suicidality among homicide offenders remains underexplored – a critical gap that this study begins to address. By examining suicidality in the context of homicide, we offer insight into how a trajectory shaped by early adversity, mental health challenges, and limited future orientation can culminate in violence. This study suggests that rather than existing as mutually exclusive behaviors, suicidality and homicidality can share underlying psychological and social roots. Indeed, the boundary between self-directed and outward-directed violence may blur under intense emotional strain, highlighting the need for integrated approaches to understanding and preventing both forms of violence.

Limitations

This study has several limitations. The small sample size and focus on the specific geographical area in the Twin Cities may limit the generalizability of the findings. The participant narratives are also retrospective accounts, which could be influenced by their current circumstances and perceptions, perhaps shaped by experiences and interventions in prison. Self-report data can be unreliable, however in this study the narratives were cross-referenced with official case files, court transcripts, media reports, and police reports. Future qualitative research should aim to include larger and more diverse samples to validate these findings and explore the life histories of those with similar risk factors for violence and suicidality who did not end up committing homicide. Longitudinal studies could also provide a more comprehensive understanding of how suicidality and violence interplay throughout development.

Mental illness

Nearly all the participants in this study had prior mental health diagnoses. However, it can be difficult to disentangle the role these diagnoses played in both their crime and prior suicide attempts and hopelessness. Many symptoms of mental illnesses are traits that motivate violence for individuals both with and without a specific diagnosis. For example, irritability and hopelessness are symptoms of depression that may contribute to both violence and suicidality for perpetrators with or without a diagnosed serious mental illness. Impulsivity, a symptom of bipolar disorder, is a trait that influences violence and suicidality among people both with and without a mental health diagnosis (Krueger et al. 2007). It's easier to examine the role of psychosis because delusions and hallucinations tend to be specific to a serious mental illness, and it is easier to conceptualize how these symptoms can directly motivate violence, through command hallucinations for example (McNiel, Eisner, and Binder 2000; Peterson et al. 2014). Only two of the 18 participants in this study described psychosis motivating their homicide, which is consistent with previous research (Peterson et al. 2014).

Suicide spectrum

Suicide is frequently viewed along a spectrum (Bersia et al. 2022), with van Heeringen (2002) proposing a pyramid structure to conceptualize its varying stages. At the top of this pyramid are individuals who die by suicide, followed by those who engage in nonfatal attempts. Below them is a larger group of individuals who experience recurrent suicidal ideation or have concrete plans. At the base of the pyramid is the largest group: individuals in the general population who have experienced suicidal thoughts at some point in their lives.

While "futurelessness" or an anticipated early death has been recognized as a risk factor for violence (Brezina, Tekin, and Topalli 2009), it has not been fully integrated into the suicide spectrum or pyramid. In a recent survey, Goodwill (2023) examined 264 Black young adults who reported suicidal thoughts within the past two weeks, identifying hopelessness about the future as their most common reason for considering suicide. The findings presented here suggest that recognizing futurelessness as part of the suicide spectrum – and as a critical intervention point – represents an essential direction for future research, not least because it could help differentiate those with transient suicidal thoughts from individuals whose despair is intensified by a pervasive sense of limited prospects. This distinction could be critical, identifying a group potentially at higher risk for both self-directed and outwardly directed violence. To deepen understanding, moreover, future studies could employ longitudinal methods to track how futurelessness evolves over time and across stages of suicidal ideation and behavior. Such studies could reveal patterns in how futurelessness intensifies or diminishes based on life circumstances, identifying key intervention points for preventing progression to more severe suicidal behaviors.

Relationships

Several participants highlighted major turning points that marked the onset of their trajectories toward violence, often triggered by the loss of influential figures who had provided emotional support and stability. These losses included the death of a mother (participants 1 and 12), stepfather (participant 15), or the departure of supportive figures like a godfather (participant 5) or pastor (participant 10). Consistent with this, previous research has shown that secure attachment and positive relationships, particularly with parents or mentors, can serve as powerful protective factors, buffering against both violent and self-destructive behaviors even when other risk factors are present (Lösel and Farrington 2012). FitzGerald et al. (2017) found that positive relationships with adults were negatively associated with suicide attempts among 2,794 American Indian and Alaskan Native high school students, for example, highlighting the importance of adult support across cultural contexts. Similarly, school bonding has emerged as a significant protective factor, promoting nonviolent outcomes and reducing suicide risk, with a meta-analysis of 16 studies confirming that school connectedness is associated with lower reports of suicidal thoughts and behaviors, even among high-risk youth (Marraccini and Brier 2017).

Relatedly, the Benevolent Childhood Experiences (BCEs) scale offers an innovative way to measure the impact of positive early-life experiences that may counterbalance the effects of adverse childhood events. Developed by Narayan et al. (2018), this tool assesses key factors like having a caregiver who fosters a sense of safety, positive friendships, meaningful beliefs, and supportive adult relationships, including teachers and neighbors. By focusing on benevolent experiences rather than solely on trauma, the BCE scale broadens the scope for understanding resilience in the face of risk. The scale's emphasis on emotional safety, social support, and meaningful adult connections aligns closely with evidence that positive relationships can mitigate the risks of violence and suicidality, making it a promising tool for future research.

More research is warranted to understand the nuanced role that these protective relationships play, particularly in high-risk individuals who have experienced significant loss. Longitudinal studies could provide insights into how supportive relationships buffer against negative outcomes over time, and

how their absence might accelerate pathways to violence or self-harm. Additionally, research on interventions targeting relationship-building – such as mentoring programs or initiatives to strengthen school connections – could identify practical strategies to reduce violence and suicidality. Exploring how benevolent childhood experiences interact with adverse events to influence both suicidal and violent behaviors could inform comprehensive prevention efforts and interventions that leverage positive relationships and social connectedness as central components of resilience.

Conclusions

While violence has been studied as a precursor to suicide, suicide attempts have not been examined as a precursor to homicide. Nearly all participants in this study fell somewhere along the suicide spectrum before committing homicide, although the timing varied for each individual. This novel finding highlights the significant overlap between suicidality and violence, and how they both may be connected to trauma, mental health, hopelessness, and futurelessness. Additional research is needed that focuses on larger samples and longitudinal designs. These findings have important implications for how violence and suicide risk are assessed, and potential new avenues for prevention and intervention of both suicidality and violence.

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