A REVIEW OF THE PSYCHOLOGICAL AUTOPSY

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A REVIEW OF THE PSYCHOLOGICAL AUTOPSY

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Abstract

A REVIEW OF THE PSYCHOLOGICAL AUTOPSY

Jason Free

Under the Supervision of Patricia Bromley, PhD

This paper explores the use of the psychological autopsy (PA) to examine utility and purpose of a relatively underused clinical tool. Suicidology research has been reviewed to highlight the need for future studies. The seminal work by Ebert (1987) is contrasted against the founding studies of Shneidman and the four purposes of PA (1961, 1973, and 1981). The utility of the PA is discussed in its role of examining mode of death motivations of the deceased, suicide prediction, assessment of lethality, and the therapeutic potential of such findings. Works have been examined for commonly-accepted methodology among suicidology research including structure and sources of information. Finally, the utility of the psychological autopsy is explored to propose a modernized approach that accommodates technological advances and the lack of a commonly accepted approach that is broad enough to examine all four modes of death, yet allow for the specificity of the mode of suicide.

Keywords: psychological autopsy

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Chapter One: Introduction

Within the gray area that overlaps the fields of psychology, sociology, medicine, thanatology and anthropology exists a science that is relatively unknown to mainstream society. This science is called suicidology. Suicidology is the science of suicidal behavior and suicide prevention (Maris, R., Berman, A., & Silverman, M., 2000). Suicidology is, in comparison to other scientific fields, very young. Being morbid and fairly qualitative by comparison, the science is not well researched as compared to other qualitative-heavy research such as cultural anthropology.

Within the field of suicidology is the psychological autopsy (PA). As a relatively underused clinical tool, yet one of massive utility, the psychological autopsy has become the standard for preventative purposes. The PA was developed by Shneidman and Farberow (1961) and catapulted forward by Litman, Curphey, Shneidman, Farberow, and Tabachnick (1963) with details and proposed applications. Since then, the PA has been applied in insurance claims, criminal investigations including homicide, civil litigation, research on suicidality, therapy (Sanborn & Sanborn, 1976), and aircraft crashes (Jones, 1977). The PA has also been used to examine staff behavior before a death in high-stress occupations (Neill, Benensohn, Farber, & Resnik, 1974).

Like in a traditional psychological assessment, an individual is assessed to gather evidence as to state of mind (Cantor, 2000). In this process, however, the goal is to assess the state of mind prior to an individual dying. There is usually no benefit of direct observation, but there are many other avenues of investigation available that are not available during a traditional assessment.

Statement of the Problem

Throughout the 1970s, an increasing call for a systemized method for conducting the psychological autopsy was issued (Rudestam, 1979). Instead of adapting to a particular method and bringing forth a summit to unify the approach, professionals relied on clinical experience and a subjective, eclectic approach. Shneidman (1981) proposed the most comprehensive guidelines of the early stages of the history of psychological autopsy where he listed 16 areas of the details of the death that were recommended for examination. Weisman (1974) has shown that the technique of psychological autopsy has particular utility within specific settings, such as the inpatient hospital setting. Ebert (1987) summarized the findings of multiple suicidology researchers to garner an updated 26 key arenas. Each arena was broken into sub-sections.

Despite the summary work of Ebert bringing together all psychological autopsy researchers to a single method, this was done nearly 30 years ago and has become outdated. With modern technology comes a need to address changes such as the rise of the internet and social media. Those modern innovations can serve a phenomenal purpose in the study of suicides, as there are endless routes a researcher can explore to gather data in an exploratory fashion. With scarce research existing on the topic of psychological autopsy and few researchers publishing on PA, this paper seeks to address two problems:

1) Is there a widely-accepted, systemized method for conducting the psychological autopsy?
2) Are there modern aspects to the methods for conducting a psychological autopsy which have not been addressed in existing research?

Definition of Terms

Lethality: The potential for the means chosen to commit suicide to cause death (Concise Dictionary of Modern Medicine, 2005).

Mode of death: The manner in which death came about as identified by Natural, Accidental, Suicide, or Homicide (Shneidman, 1981).

Psychological autopsy: "A procedure used to classify equivocal deaths. An equivocal death is a death in which it is not immediately clear whether a person has committed suicide or not" (Jacobs, D., & Klein-Benheim, M., 1995, p. 165).

Suicidality: The likelihood of an individual completing suicide (Concise Dictionary of Modern Medicine, 2005).

Suicidology: the science of suicidal behavior and suicide prevention (Maris, R., Berman, A., & Silverman, M., 2000).

Method of Approach

The review of literature utilized both qualitative and quantitative studies, with an emphasis on case studies, to examine existing psychological autopsy research for a systemized approach. Although it would have been preferred to examine PAs after an exhaustive review of the history of PA, there are few current studies with appropriate samples, and there is no assurance of reliability among raters from early PA studies (Werlang & Botega, 2003).

What follows is a review of literature that gives a summarized history of the focus of suicidology on psychological autopsy, the major proponents and their contributions to the investigative procedures, interview structure, interviewee relationships, the role of consultation, standard training and investigator background, exploration of shared elements and constellations of the approach, exploration of differing elements, and criticisms of the technique. Due to the passage of time since researchers have updated key areas of evidence, there is an exploration of the domains of inquiry that have developed due to technological changes and social media as ancillary sources of suicidal markers.

Chapter Two: Review of Related Literature

Purposes

There are four proposed purposes of PA, put forth by Shneidman (1981). The first purpose is that the psychological autopsy is performed when the mode of death is equivocal, or open to interpretation and opinion. That is to say, a medical autopsy determines "how" a person died, or the cause of death. It does not answer the question of "why" a person died, or the mode of death. Shneidman (1981), in his seminal work on psychological autopsy, described four modes of death with the acronym NASH. Those modes consisted of natural, accident, suicide, or homicide.

In conjunction with determination of mode, a secondary goal is to classify lethality of the act which led to the death in question. These classifications are categorized as unintentional, sub-intentional, and intentional. A medical autopsy may claim an event to be an accidental death or suicide, but elaboration on the behavior being reckless versus having the intent of dying from a particular act is needed. The reasoning behind classifying lethality was that the more likely that the action could be expected to end in death, the more likely the intention was suicide. Thus, lethality helps to show intent underneath the act (Bryant & Peck, 2009).

It is important to note that the second purpose of PA is to determine "why" the particular death happened at the time it did, as initially proposed by Shneidman (as cited in Ebert, 1987). Investigators are to look into common factors which precede death to see if correlating life circumstances and warning signs can be established. For instance, the timeline can be broad, starting with examining the entire life of the deceased, or it can be specific with more detail

given to events near the chronological death. Intrapsychic and interpersonal conflicts are to be focused on, with notes made on issues that may have influenced the timing.

The third purpose is simple but important: advancement of the ability to predict suicide. Shneidman (1981) proposed that is done in conjunction with assessing lethality of the individual. When looking at the individual, the motivation is the key focus of lethality. The Shneidman classifications are unintentional, sub-intentional, and intentional. The lethal intent is then grouped for research and examination of data to yield statistics of death, much of which is the mode of suicide, and further predictions on high-risk subjects.

Regarding motivation, Werlang and Botega (2003) provided a seven-step decision-making scheme for determining the presence of psychological forces, or reasons, which might have led to suicide. Those seven steps include asking if there is evidence to support reasons along the lifeline, and noting ambivalence. Once forces are identified, the researcher is to identify severe psychosocial environmental problems influencing decision-making, identify bio-psycho-social symptoms which might better explain suicide, identify personality traits which hindered coping processes, identify pre-disposing antecedents, and identify other reasons to better explain the death. For each individual sub-step, evidence is to be documented with frequency, severity, and duration of the impairment noted.

Within the seven-step semi-structured interview, there is a basic format of determining precipitants, stressors, motivation, lethality, and intentionality. Motivation would be understanding reasons to consider death across a lifetime from the subjective experiences, cognitive patterns, past conduct, personality and lifestyle. Lethality would continue Shneidman's past categorization involving the choice of method. Finally, a special consideration is given to the mental state and lucidity of the deceased. This is determined from examining the

level of planning and preparation as well as the potential objective of the action within the context of the mental state (Werlang & Botega, 2003). For example, the situation may have been mitigated by a recent relapse on heroin after seven years of successful sobriety where an abnormally large quantity of heroin was purchased compared against the dosage normally used at recreational levels.

At each stage of a decision tree, existence of evidence leads to the successive step where a "no" answer would stop the process at that step. Within Step One, the interviewer is to find immediate facts or psychological circumstances that would trigger the suicide and note the presence of ambivalence, such as spouse's infidelity and an act being intended to render one hospitalized to entice the spouse to return. Ambivalence may have been evidenced by an individual with access to a firearm simply (for example) cutting at a degree that would not have ruptured nearby arteries instead of using the firearm. Within Step Two, psychosocial environmental problems are sought that might lead to suicide such as the loss of housing when one is evicted from their home of twenty years. From Step Two until Step Six there is to be an examination of the severity, frequency, and duration of each impairment noted.

With Steps Three through Five, each finding of potential impact is to be compared against Step Six which asks for other reasons which better explain the death. Step Three examines biopsychosocial symptoms of malfunctioning which can include a lifelong struggle with recurrent Bipolar Disorder where the deceased was not using prescribed medications. Step Four examines personality traits which might making coping difficult as found in the case of a subject who was diagnosed with Borderline Personality Disorder who had a propensity to move to a new city without resources every time a relationship ended. Step Five examines family antecedents which predisposed the individual to suicide such as a family history of suicides

within every generation. A finding of the presence of factors within Steps Two through Six guides the investigator to Step Seven which affirms the presence of psychological forces and reasons along the lifetime that may have led to suicide (Werlang & Botega, 2003).

The fourth, and final, purpose of PA is that gathering this information may provide some sort of therapeutic gain or value to the survivors of suicide. The proposal issued by Shneidman (1981) is that discussion of actions, feelings, relationships, and attitudes gives a chance for survivors to gain a therapeutic effect by experiencing catharsis and closure. Specifically, he proposed that the interviewer must "participate in the anguish of the bereaved person" (p. 330). Further, there may be utility in recognizing signs in survivors that surpass bereavement and necessitate a referral for additional help.

The History of Psychological Autopsy

The seminal work of Shneidman.

In 1949 Dr. Edwin Shneidman, working as a clinical psychologist for the Veteran's Administration, was tasked with collecting a pair of suicide notes from the Coroner's Office when he stumbled upon an untouched Los Angeles County vault containing 721 suicide notes. Together with Dr. Norman Farberow, Shneidman began an experimental study of notes that compared them against control notes of nonsuicidal men who had been asked to pen suicide notes for a study. The two investigators conducted a blind comparison with the notes of the vault and simulated suicide notes. Shneidman hypothesized that there could be data obtained regarding psychological pain which would yield a new field of study. John Stuart Mill's Method of Difference was first used to compare the genuine notes against the controls. The field of suicidology had been created with the first official publication in *Public Health Reports* in 1956 (Shneidman, 2004).

The psychological autopsy was developed by Shneidman and Farberow (1961) and catapulted forward by Litman, et al. (1963) with details and proposed applications. Shneidman's initial proposal was that psychic pain was at the core of suicides which could be measured for a level that the suicidal individual subjectively determines unbearable. The definition was refined and narrowed from the Latin origins to meaning "the human act of self-inflicted, self-intentional cessation" (Suicide, 1968). Since then, just a few of the applications have been implemented within the realms of: insurance claims, criminal investigations including homicide, civil litigation, research on suicidality, therapy, aircraft crashes, and staff behavior involving a death.

The process advanced when psychological autopsies were conducted upon those who were formerly hospitalized. The process was given the title the *Omega Version*. The cases identify those in which hospital contact was made prior to suicide. The advent of the *Omega Version* was important because it brought in a multidisciplinary assessment of treating psychologists and psychiatrists alongside researchers' clinical interviews with family and loved ones. The psychological autopsy began to produce new information that yielded a great deal of information on suicide and led to new training and information for providers (Ebert, 1987). For instance, the PA, itself, has traditionally been conducted by behavioral scientists trained in theory, pathology, interviewing and therapeutic aspects. They have varying backgrounds, but all have some degree of forensic and criminal justice background. Each professional who conducts the process follows a standardized set of questions and areas of focus with surviving persons of importance to the deceased. The researcher then consults varying professionals to ascertain the clinical significance of common themes from interviews and aspects within writing samples.

With the advent of a new subfield of science, there is often an initial period where standardization of approach is lacking. The early phases of PA were no exception. Interviewers

were free to subjectively interpret results and imply meaning, to obtain interviews from widely varying individuals. Moreover, researchers with little-to-no clinical training in the field conducted PAs. The most important factor Shneidman adamantly pushed for, for all Pas, was a rating of lethality in the action (Shneidman, 1981), which was to be categorized as absent, low, medium, and high. The lethality scale has traditionally been a professional, yet subjective, opinion that is assigned by the examiner.

Expansion beyond the early work of Shneidman

Many factors complicated examination of the events preceding suicide. These included the increased likelihood of people in the general population committing suicide, and the difficulty of examining suicides of people whose culture was different from the treating professionals or examiners. Thus, it was difficult to identify risk factors. Weisman and Kastenbaum (1968) have shown that the technique of psychological autopsy has particular utility within specific settings, such as the hospital. Ebert (1987) cited a common example within forensic psychology when bringing the unattended death involving a gunshot wound to discussion. A noteworthy example may be to cite the question of whether such deaths are purposefully done as a suicide, are caused by someone else firing the weapon in a homicide, or are accidental such as cases of cleaning duty weapons and not noticing a loaded chamber.

Areas of focus within interviews have included those of Shneidman's Lethality domains, but with expansion into further arenas. Weisman (1967) suggested four areas of examination: final illness, premedical period, hospital course, and prehospital situation. The final illness identifies any present illnesses and patient expectations of death. The premedical period explores marital stress, premonitions and any references towards death if present. The hospital course aspect includes examining relationships with others throughout the hospital stay. The

prehospital situation includes examining the medical condition and mental status up to the time of hospitalization, including pre-admission attitudes regarding hospitalization.

Curphey (1968) proposed arenas that rely upon medical autopsy results. Medical autopsy results are to be examined for toxicology tests as well as the history of psychiatric issues. Other factors worth noting include recent losses suffered by the deceased, changes in habits or patterns, and morbid thought. Morbid thought was of interest because examiners believed that the greatest indicator of future suicide and attempts was past history. Yet, in a recommendation not often repeated throughout literature, Curphey believed that the scene of death, prior to the act, was particularly pertinent to be viewed by the researcher for significance.

Additional research has added areas to the early foundations. The work of Ungerleider (1971, cited in Ebert, 1987) recommended examination of educational achievement, substance use and abuse, and job history. Neill, et al. (1974) added assessment areas including: review of medical notes; interviewing friends, family and hospital staff; documenting events preceding suicide (with stronger focus as time moved closer to the death); investigating to uncover social history and psychological history; and finding those who had awareness of the feelings of the patient. Finally, further aspects of the deceased's medical records and any pertinent military records were to be examined, consistent with advances in thinking regarding modern medical science (Selkin & Loya, 1979).

Areas not yet addressed as the protocols for psychological autopsy were developing, but which were later recommended by Shneidman (1981), included the lifestyle of the deceased, personal history, interpersonal problems, relationships including romantic, and personality. All records received should be reviewed and documented. This shift in thinking increased Shneidman's recommendations to 16 categories along with the lethality rating.

Potential Sources of Information

The arenas

Ebert (1987) suggested one of the most comprehensive methods of data review involving foundational research. The areas pertinent to researcher focus would include the 16 Shneidman arenas and lethality domains, Weisman's four areas of study, Neill's five arenas, Curphey's seven arenas, Underleider's two arenas, the medical records expansion and military records research of Selkin & Loy. Records, along with the results of interviews conducted by the researcher, yield a decision on psychopathology from the interviewer. The decisions are to be reviewed by consultants who are skilled in psychological autopsy, who review the records along with a clinical vignette (Shneidman, 2004).

Psychological autopsies typically involve the researcher interviewing as many informants who were familiar with aspects of the decedent's life as possible. The researcher would examine aspects that could yield data from a variety of categories within the individual's life (Shneidman, 2004). Each informant is asked about the deceased individual from various psychosocial guidelines, using a semi-structured interview format which is based on the comprehensive areas of data review recommended by Ebert (1987). The format includes opportunities to interview regarding factors which are idiosyncratic to the situation. These might include aspects which are unique among vocations and cultures. Data is to be collected for possible future use. Such data might include information that pertains to the stressors of a profession, such as physician or police officer. It would also include cultural relevance such as the stigma of not talking about hardships within a migrant community or the role of a female within the household, as viewed in her religious denomination.

The first constellation of information traditionally obtained by the researcher is the history of the deceased. The alcohol history is first. This includes family use and levels that were regularly ingested, as well as evidence of binge drinking, blackouts, and driving under the influence. Alcohol-related offenses, employment problems, and family problems are examples of noteworthy findings. Blood alcohol levels at the time of death are to be obtained (Ungerleider, 1971). The same historical information is obtained regarding other drugs, whether prescribed or non-prescribed, where an overall pattern of use throughout the life of the deceased must be illustrated (Ebert, 1987).

The employment history is a major focus within the psychological autopsy. Interviews include co-workers and supervisors (Ebert, 1987). Any significant flags, including reprimand, yearly reviews, and change in duty, are noted. Other important variables might be high-risk work, specialized duties and applications for duties, recognitions and merit (or lack thereof), conflicts, requests for transfer, and applying for jobs with different employers. With Shneidman's (1981) suggestions on lifestyle and personality characteristics as a basis, an interpersonal style will be sketched out.

Education and military histories are obtained, including DD214s, letters of reprimand, Article 15 actions, court-martial proceedings, discharge records, medals and awards of merit, and number of assignments and transfers (Selkin & Loya, 1979). Evidence of deployment in combat zones for trauma, transfer to bases, and job ratings are noted. An assessment of educational level, success and grades, and plans for future education or professional trainings documented are included in the Education and Military section (Ebert, 1987).

Family history, including the history of each identified member and their relationship, are explored. Shneidman (1981) suggested that the family history should include the socioeconomic

status, family medical and psychological history, and notation of conflicts that had occurred throughout the lifetime of the deceased with particular focus on the events occurring shortly before the death. Family history also includes those members' death histories, with a listing of causes of death and notations on suicides. Relationships are explored from every role, including interviewing close friends, intimate sexual and romantic partners, acquaintances, family members (with special preference given to the immediate family), other relatives, and those who had a falling out with the deceased. Levels of intimacy must be reconstructed on the basis of discussions and verifying evidence. Each interviewee is examined for a reaction to the victim's death, relationship with the children of the deceased, and any evidence of behavioral patterns with the deceased. .

The marital or domestic partnership relationships are explored in detail, as they often reveal some of the most intimate details within a PA. Included in the interview notes are notations of any significant problems that may have increased tension or depression. Any potential extramarital relationships are explored, and the overall quality of the relationship is assessed. In this category, a discussion ensues about the work / life of the deceased to determine if the spouse or domestic partner had an extensive knowledge of the work of the deceased, and how they perceived any behavioral changes or boundary concerns relating to the deceased's work-related issues (Neill et al., 1974). Work-related issues may arise from interpersonal conflicts, perceived slights or being passed over for promotions, a sudden lack of productivity, carelessness and a drop in the quality of work output, or a sudden change of interactions among colleagues. An example may be a police officer who has always kept a policy of not discussing home life on the job and not discussing the job at home who finds himself at a critical time without supports when life obligations add pressure. If the officer were to have a spouse that has

left them for someone else and then be required to go to a high-stress job without an outlet to allow others to help, they may face residual effects of the boundaries and situation if they had not received proper counseling.

The gathering of the individual's medical history information takes place with interviews from practitioners, if possible. Curphey (1968) and Neill, et al. (1974) proposed that notation is to be made regarding any unusual illnesses or diagnoses. Examination of any illness should take place, along with a review of the course of the illness, from the prehospital situation to the final illness. Illnesses that may have been terminal should be given extensive coverage (Weisman, 1974).

The psychological history of the deceased shall be gathered, with special attention given to examining past psychological testing. An example may be that in law enforcement, many departments administer pre-employment tests, conditional hire tests, and other measures of aptitude and suitability that may be of use in PA research. Notation is made of any previous suicide attempts. Reasons for seeking treatment via therapy or pharmacological intervention should be explored, and, if possible, clinicians should be interviewed. Evidence of any diagnoses and mood fluctuations, with special attention given to depression and bipolar disorder, is to be documented along with a history of any hospitalizations. Impulsive behavior at any point in the history is to be noted. It is particularly relevant to connect impulsivity to the employment history section (Shneidman, 1981).

After completion of work history data retrieval, a reflective Mental Status Exam of the deceased's overall mental status before death is to be attempted (Ebert, 1987). It should be noted if there were any changes in attire, or any violations of company dress code or grooming policies. Weight loss and appetite changes, sexual drive changes, and evidence of sleep

disturbances are noted, along with any other somatic symptoms. Focus in this area relies heavily on family, friends, co-workers and those who were closest to the deceased in the days preceding death. Each interviewee is questioned as to any knowledge of the decedent's feelings, regarding death and preoccupations or fantasies of death (Shneidman, 2004).

Ebert's suggested format of Ebert promoted an examination of suicide notes, books and writings in three different sections. However, there needs to be an expansion while researching the writings of the deceased because of the change in times since the initial proposal of examining hand-written notes. Examination of emails, blogs, text messages, messenger apps, and other social media should be included. Suicide notes should be examined for content and style, but a handwriting expert should also be consulted to examine any potential discrepancies in handwriting detail to ensure the deceased was the likely author. Special attention should be given to materials written regarding suicide, life after death, death, and the occult (Ebert, 1987).

Shneidman (1981) proposed special psychosocial stressors and presuicidal behavior that are to be a major theme in interviews. Co-workers and supervisors are asked if there are any other known suicides in the area. Relationship changes, legal and financial problems, moves to new locations, and losses ranging from deaths to loss of a job are explored. Interviews also assess whether each informant is aware of the decedent putting affairs in order, if there were any payments to insurance or on debts, any changes to living wills, and any new end-of-life orders, or renewed involvement with loved ones. Language can be examined to identify references to suicide and scrutinized to note changes in behavioral patterns (Shneidman, 2004).

Official reports are examined at length. Those include any pathology reports, with focus given to significant factors and anomalies, toxicology and drug screen results, description of physical functioning and health at the time of death, and identification of poisons (Curphey,

1968; Neill, et al., 1974). Laboratory studies, if involved, are noted, with attention to ballistics and powder burns or incongruent areas of residue. Police reports are copied, with attention regarding whether the investigation was conducted by an outside agency, and what the relationships of the investigators were to the deceased.

Finally, the death itself is explored. The deceased is assessed for extensive knowledge of methods of death beyond what should be expected based on their history or training (Shneidman, 1981). Belongings may be explored for anomalies including possessing more weapons than expected from their lifestyle, including noting the number of weapons, types, and whether those weapons included firearms in particular areas of the residence and, if firearms, whether they were loaded (Shneidman, 2004).

Curphey (1968) proposed a reconstruction of the events that occurred on the day before the deceased's death, documented chronologically. A step-by-step chart of the movements, activities, calls for service, and photography of any scene are explored for relevant details. Belongings collected by the medical examiner or deputies are examined, including lethal drugs. Critical factors, including photographs of the scene, should yield a description of the area, method, level of detail put into the act, and anomalies (Ebert, 1987). When all information is obtained, and all interview subjects have been assessed, the final piece comes in the form of a Motive Assessment as suggested by Shneidman (1981). The assessment, often in the form of a chart, will not only detail the determined motive but the possible reasons that the subject could have committed suicide, regardless of determined motive, and the possible reasons for a homicide, regardless of determined motive.

Ethical Considerations, Criticisms, Reliability and Validity

Though Ebert's summary work brought all PA researchers together in a single method, it has become greatly outdated. Moreover, there is a lack of quantitative analysis among findings, limiting psychological autopsy research to case studies and qualitative routes of data collection. However, Suicidology has come a long way in utilizing PA research to offer predictive factors which often go into the warning signs of suicidal behavior (Ji-Won, 2016).

Because of the imprecise nature of the PA, with it being subject to unreliable reports, subjective interpretations from researchers, and the problems that stem from a retrospective nature, Botega and Werlang (2003) have addressed the use of semi-structured interviews within the psychological autopsy. Validity and reliability concerns may be addressed by a second interviewer performing an independent assessment, a second assessment occurring at a later point in time, or by structuring the interview so that it is administered to more reporters.

Additionally, instruments and methods used have become outdated and newer findings and tools have not been systematically included or applied (Vasudeva Murthy, 2010). Though Ebert (1987) used the Holmes and Rahe Scale (Holmes & Rahe, 1967) factors in examining psychosocial stressors and risk of illness, that scale was already outdated, as the findings used were from 1978. Further the scale is limited in that differing stressors affect individuals differently.

Summary

Shneidman pioneered an entirely new subfield to help us understand human self-destruction. He articulated the four purposes of conducting the Psychological Autopsy and elaborated on how it should be conducted. He proposed an initial 16 arenas for investigation, devised the Lethality Rating, and established the standard four purposes for which every PA is conducted. Combining

with the four areas of study proposed by Weisman involving Final Illness, the avenues of Neill et al., Curphey, and Selkin and Vaya were tied together in a broad protocol that was recapped in a concise protocol review by Ebert.

Since the inception of Shneidman's initial methodology, the ancillary materials have grown past the initial subject and personal contact interviews to shed new light on individuals' deaths. Yet those methods have not seemingly adapted at the rate at which technology and communications have grown. Despite the initial focus and history of the field coming out of the suicide note itself, there has not been a modern focus on methods of communicating final thoughts through means outside of handwriting. Despite an initial qualitative focus on case studies, a relatively low amount of data-driven, objective works have emerged.

Chapter Three: Conclusions and Recommendations

Conclusions

The psychological autopsy, largely used to gather what we do know about suicidal behavior and often giving closure to loved ones and the public, has great utility, yet has quietly slipped from mainstream use. The strong suit of the PA lies in the details, giving qualitative data to case studies. Yet, the weakness is inherently in the subjective nature of the reviewers' professional opinions. Despite methods to relieve the burden of subjectivity on part of the PA investigator by incorporating consultations, uniformity remains elusive.

Finally, despite the enormously detailed summarization on the part of Ebert (1987), not much literature has come forth attempting to modernize the sources of information to accommodate for the digital age and changing dynamic of human relationships and communication that have been brought out by the advent of the internet and smart phones, tablets, and other modes. In addition to the devices used for communicating, the means have not been explored with respect to data collection. The PA remains one of the most fascinating and potentially detailed tools for shedding light on the uniquely human behavior of ending one's own life. It is imperative, however, that researchers attend trainings and seminars and attempt to reach consensus on modernized methods. As the 1960s opened up the study of suicide, procedures were unofficially adopted by nearly every prominent researcher within the field. Yet, despite several well-written literature reviews in more recent years, there has been no uniform consensus on protocol that has emerged.

Recommendations

With modern technology comes a need to address changes, such as the rise of the internet and social media as well as electronic filing of records. Those modern innovations can serve a

phenomenal purpose in the study of suicides, as there are endless routes a researcher can explore to gather data in an exploratory fashion. It is here that a question presents itself: Are there more modern, systemic barriers to treatment of mental health that could be identified via psychological autopsy? According to the work of Moskos, Olson, Halbern, and Keller (2005) on PA among adolescents, special attention should be paid to the electronic and social media communication with those who are closest to the deceased. The appendix expands on the work of Ebert, to include updated areas.

Modern studies of psychological autopsy, specifically the process, are scarce. Hardly any research has focused on suicide within samples of professionals, despite controversial statistics to warrant the need. If researchers are to identify any relationships between occupational hazards and suicidal ideation, there has to be more in-depth research into the occupation and the qualities of it that are associated with suicide. Many of the factors that were not well understood during the times of psychological autopsy are now well-researched. This includes, as an example, the research on Post-Traumatic Stress, occupational burnout, genetics, addiction, and the interplay among social media, just to name a select few.

A consideration not given in early PA research was that of HIPAA and confidentiality limits. With today's PA research, there may be a slowed process, yet one that needs to be addressed for collecting ancillary materials and even interviews. Proper consent and releases of information will be required for all parties involved in interviews. With a "Public Records Inquest", department files may be retrieved from former employers, medical examiners, pharmacy databases or modern state controlled-substance databases, records bureaus. Releases of information and death certificates must be obtained for medical and psychological records, with preference given to electronic records. In lieu of death certificates and endorsements for record

collections from families, facilities will need to receive requests for redacted copies which are devoid of identifying information, pursuant to their research support policies.

Writings should include any hard copies, but also explore the material or electronic diaries. Alternative methods of leaving notes, giving warnings, and communicating thoughts have developed aside from the devices themselves. An exhaustive search should be explored to include but not be limited to any electronic means of storing and retrieving information or communicating to others or the public. This search might include USB drives, social networking pages which are ever evolving but currently include public wall posts and messenger applications, texts, media searches and web browsing, video blogs, and e-book or journal histories. The communications to family, friends, co-workers and acquaintances should be scrutinized with any potential phone records located for all lines and electronic mail addresses that may have belonged to the deceased. Those communications are not just another mode of communicating distress or suicidal thoughts, but also avenues to observe changes in patterns which include public postings on social media for topics such as morbid content. An Information Technology specialist in fragmentation should be consulted, if necessary.

With the advent of new technology has come about, distance interviewing is now possible. This opens the research up to entirely new realms of reporting sources. Included in the newer realms of reporting sources are the varying categories of relationships that have become more accepted and researched. This includes the prospect of emotional relationships without a physical component (e.g., a strictly online friendship), or Lesbian-Gay-Bisexual-Transgender-Queer relationships. This could reveal evidence of sexual preference and gender identity.

APPENDIX

APPENDIX

Suggested Modifications of Ebert's Protocol for Psychological Autopsy

Psychological Autopsy Guidelines (Ebert, 1987)
Red = Areas of possible expansion
**Obtain Release of Information / consent forms from necessary persons
**Submit public records inquest where appropriate
*Denote limitations (such as HIPAA)

1. Alcohol History
    a. Collect family history
    b. Research ingested regularly
    c. Research evidence of binge drinking
    d. Research evidence of blackouts (known from friends, family, acquaintances)
    e. Research evidence of driving under the influence of alcohol
    f. Research evidence of alcohol-related offenses
    g. Research evidence of family problems (alcohol related)
    h. Research evidence of work difficulties connected to alcohol
    i. Research evidence of blood level (BAL) g / l at time of death

2. Suicide Notes
    a. Examine content
    b. Examine style
    c. Have handwriting expert review writing style

3. Writing
    a. Review any past writing by the deceased
    b. Peruse any diary of the deceased
    *Examine emails / USBs & digital storage / Blogs & videos / text messages / messenger services / forums & chat rooms, social networking walls and social media
    c. Examine school papers for topics of essays or term papers
    d. Read letters to friends, family, co-workers, acquaintances

4. Books *Online journals, e-books
    a. Examine books of the deceased
        i. Look for books on the occult, life after death, death
        ii. Look for actual books on suicide
    b. Assess books checked out of local libraries *online stores / followed-pages & web browser history

5. Relationship Assessments
    a. Interview people who knew deceased including:
        i. Close friends
        ii. Close intimate heterosexual or homosexual companions
        iii. Acquaintances
        iv. Mother, father, siblings

v. Co-workers and supervisors
vi. Other relatives
vii. Physicians and / or mental health professionals
viii. Teachers

b. Construct level of intimacy on the basis of discussions with "close" friends
c. Assess people's reactions to the victim's death
d. Secure a history of marriages and divorces *Physical and emotional affairs as well
e. Examine relationship with children
f. Look for anger directed to particular people

6. Marital Relationship *Expand to domestic / unionized / partnerships
    a. Note any significant problems that may have made the deceased person depressed
    b. Look for history of extramarital relationships
    c. Assess the overall quality of the relationship

7. Mood
    a. Identify mood fluctuations
    b. Look for symptoms of depression:
        i. Weight loss
        ii. References to depression
        iii. Problems with memory
        iv. Fatigue
        v. Sleep disturbances
        vi. Withdrawal
        vii. Decreased libido
        viii. Appetite and / or taste changes
        ix. Constipation and diarrhea
    c. Look for mood indicators during last few days:
        i. Interview friends and family
        ii. Interview anyone surrounding the deceased

8. Psychosocial Stressors (note and chart importance on Holmes & Rathe Scale factors)
    a. Recent loss: deaths of people or pets
    b. Relationship separations: divorce, breakups of significant relationships
    c. Loss of job
    d. Legal and financial problems
    e. Demotion, promotion and so on
    f. Reaction to stressors
    g. Move to a new location *Evidence of career burnout

9. Presuicidal Behavior
    a. Giving away important possessions
    b. Paying up insurance policies
    c. Payment of debts
    d. Arrangements for children and pets
    e. Sudden order in deceased's life
    f. Change or initial creation of a will

10. Language
    a. Identify any specific references to suicide (deceased may have stated, "Have a party in remembrance of me," or "You won't have to worry about me anymore")

b. Note any changes in language before suicide
c. Analyze language (tapes, recollections of conversations, writing) for morbid content

11. Drugs Used *and Prescribed
    a. Identify all drugs used by deceased
    b. Assess interactional effects of legal and illegal drugs in use
       *Consult pharmacist / pharmacologist / psychiatrist

12. Medical History
    a. Review complete medical history
    b. Note any unusual symptoms or diagnoses
    c. Note any terminal illnesses or diagnoses
       *Consult medical expert

13. Reflective Mental Status Exam of Deceased's Condition Before Death
    a. Orientation
    b. Memory
    c. Attention
    d. Concentration
    e. Mood and affect
    f. Hallucinations or delusions
    g. Cognition, IQ
    h. Language
    i. Judgment
       *Appearance
       *Speech
       *Thought content
       *Knowledge Base
       *Reliability of Information

14. Psychological History
    a. Look for previous suicide attempts (type, method)
       *Examine previous plans
       *Examine lethality of previous attempts
    b. Assess reason for treatment if involved in therapy
    c. Research evidence of depression, manic depression (bipolar disorder)
    d. Research past psychiatric hospitalizations
       *Research partial-inpatient / intensive outpatient treatment
       *Research detoxification / substance abuse hospitalizations
    e. Examine diagnoses
    f. Examine evidence of impulsive behavior
    g. Examine any recent or past psychological tests

15. Laboratory Studies
    a. Examine ballistics
       *All forensic and materials science (blood-spatter pattern analysis, chemical recognition, DNA, defensive wound pattern, etc.)
    b. Evaluate powder burns on hands and body

16. Coroner's Report
    a. Conduct complete drug screen
    b. Identify poisons
    c. Read for detailed description of physical functioning / health of deceased at time of death

17. Motive Assessment
    a. Make a chart divided four ways: Murder, Suicide, Accident, and Natural, recording data to support each as it is uncovered.

b. Report the possible reasons for suicide
c. Report the possible reasons the subject could have been murdered (identify enemies, illicit activities)
*Note who stood to gain anything from death

18. Reconstruction of Events Occurring on the Day Before Deceased's Death
    a. Make a step-by-step chart of subject's movements and activities
    b. Form a chronological history of the victim that immediately preceded death
    *Visit scene and / or view photos to observe significance of surroundings
    **Consider significance of location

19. Assess Feelings Regarding Death as Well as Preoccupations and Fantasies

20. Military History
    a. Look for evidence of difficulty adjusting such as letters of counseling (LOC), letters of reprimand (LOR), Article 15 Action (A15), or court-martial proceedings [Note: A15 is a form of nonjudicial punishment for offenses not serious enough to warrant a court-martial and include repeated lateness, driving under the influence of alcohol, sleeping on duty, or negligence on duty. Punishment from an A15 can include reduction in rank, fines, or removal from duty].
    b. Attempt to secure job ratings (airman promotion rating and officer effectiveness rating)
    *Adapt to service branch and rank system, add similar section if civilian emergency responder
    c. Look for decorations or awards
    d. Notice whether deceased was in a combat zone at any time
    e. Look for evidence of posttraumatic stress disorder in Vietnam Veterans
    *Change to all conflicts, including domestic relief actions such Hurricane Katrina & 9/11, rioting, flooding due to expanded understanding of PTSD and nature of Ebert's work as military
    f. Determine the number of assignments and which were at the request of the victim
    *Note discharge type and post-separation adjustment

21. Death History of Family
    a. Examine history for suicide by other family members
    b. List immediate deceased family members and their mode of death

22. Family History
    a. Identify family members and relationships with deceased
    b. Examine the socioeconomic status of family
    c. Identify any conflicts that occurred before death of the victim

23. Employment History
    *Tailor to profession / line of work

a. Identify number and types of jobs (high-risk work may indicate the presence of subintention behavior for quite some time)
b. Look for repetitive problems
c. Assess whether any problems existed before death (e.g., co-worker conflict, failure to progress as planned)
d. Note any disciplinary action

24. Educational History
    a. Assess educational level
    b. Identify any problems with teachers or subjects
    c. Note special interests or topics (e.g., in particular, look for special interests in death)

25. Familiarity with Methods of Deaths
    a. Examine belongings for guns, knives (e.g., the deceased may have had five or six loaded weapons around his or her house regularly)
    b. Look for lethal drugs
    c. Note deceased's interest and knowledge in weapons

26. Police Report
    a. Critical facts will be obtained by review of the police investigation

*Of critical importance are the death investigation file and any prior police reports with the subject involved

    b. Pay special attention to ballistics data

*Expand to all forensics
*Incorporate studying witness statements
*Consult with expert, if possible

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