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Examining the Use of Psychological Autopsy Interviews in a Case of Suspected Youth Suicide

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EXAMINING THE USE OF PSYCHOLOGICAL AUTOPSY INTERVIEWS

IN A CASE OF SUSPECTED YOUTH SUICIDE

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EXAMINING THE USE OF PSYCHOLOGICAL AUTOPSY INTERVIEWS

IN A CASE OF SUSPECTED YOUTH SUICIDE

This dissertation, by **Kevin (Casey) Ward**, has been approved by the committee members signed below who recommend that it be accepted by the faculty of the Antioch University Seattle at Seattle, WA in partial fulfillment of requirements for the degree of

DOCTOR OF PSYCHOLOGY

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ABSTRACT

EXAMINING THE USE OF PSYCHOLOGICAL AUTOPSY INTERVIEWS

IN A CASE OF SUSPECTED YOUTH SUICIDE

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Seattle, WA

Suicide is the thirteenth leading manner of death worldwide and eleventh in the

United States. Approximately one percent of the U. S. population dies by suicidal

means. On average, more than 30,000 people will kill themselves each year. This

qualitative research study sought to explore and describe the experiences of how

one family suffered and survived the unexpected loss of their thirteen-year-old son

suspected of dying by suicidal means and how psychological autopsies might help

survivors in dealing with this loss. Secondarily, the results also examined death

investigation practices in one county of Washington State that uses psychological

autopsies and how their use might broaden our understanding of teen suicide and

survivorship. Analysis revealed eight topical areas of death investigation pursuant

to determining the manner of death in the question of a completed suicide. From

this medical-legal forensic structure of death investigation, psychological autopsy

information was used to explore and describe in rich detail the family's experience

of the loss of their son. The implications of this study accentuated the use of

psychological autopsy information and its role in helping to facilitate the healing

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process for survivors of suicide. The electronic version of this dissertation is at

OhioLink ETD Center, www.ohiolink.edu/etd.

DEDICATION

"More than one soul dies in a suicide."

Anonymous

This dissertation is dedicated to the many who have suffered the long dark nights of the soul and the endless depths of despair due to paralyzing suicidal thoughts. It is also dedicated to the families who have survived the unexpected death of a loved one and remain haunted by the helplessness of not understanding how someone could take their own life. A completed suicide is a solitary event that reaches out and shakes our life, like throwing a rock into a pond; the ripples spread out affecting not just one household but also a community who must endure the loss.

"Each victim of suicide gives his act a personal stamp which expresses his temperament, the special conditions in which he or she is involved, and which, consequently, cannot be explained by the social and general causes of the phenomenon."

Emile Durkheim

ACKNOWLEDGMENTS

This dissertation would not have happened without the enduring love and support of my partner and soul mate, Annette Marie Wells. Without her constant love and encouragement I might have floundered and perished from this doctoral program. I am grateful and blessed to have benefited from her wisdom and patience. If the University were to award an honorary doctoral degree in spousal support, Annette would be magna cum laude. Just saying thank you is not enough nor can it fully express my gratitude. You are my sweet gig.

Many thanks to my Friday night roommates Bob Baucke, Lynnette Jones and Annie who magnanimously and with no reservations opened their home and hearts to me during the first two years of my program. They sheltered and fed me and folded me into their family. I am one lucky houseguest to have such good friends.

This research project was graciously supported by the County Coroner's Office. There are many who are trained in death investigation but none so able and compassionately as Gary Warnock, Judy Arnold, Joe West, Neoma Greenfield and Madelyn Schwartz. Their support and invitation helped me to understand the job they do and the professionalism they demonstrated when working with families and relatives who were experiencing grief and loss. I would also like to single out Madelyn Schwartz who nurtured and breathed life into this dissertation project. I am forever grateful for her willingness to share her experiences, knowledge and insights in guiding this project to fruition. It was an honor to work with her and I am blessed to call her my friend.

original dissertation chair who supervised my clinical internship and never stopped

believing that I would succeed in completing my dissertation. His encouragement

and support pulled me over the endless hurdles associated finishing a doctorate

program. He was also a mentor for learning how to conduct one's self as a

professional in the field of psychology. His compassionate and practical guidance

helped me to persevere in the face of adversity and challenged me to live larger,

think deeply and act prudently.

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Introduction

"Suicide is awful beyond expression for those who have to spend their lives with its reality. Those who are left behind in the wake of suicide are left to deal with the guilt and the anger, to sift the good memories from the bad, and to try and understand an inexplicable act" (Jamison, 1999 p. 291).

Surviving the death of a child is one of the most difficult traumas a family can experience, especially if it is a suicide. The pain and guilt felt by survivors may be different than other types of experienced grief (Clark & Goldney, 1995; Range, 1998: Jordan, 2001). Jordan (2001) asserted that suicide uniquely affects family systems differently than other deaths. In general, a traumatic death like suicide can trigger grief reactions so severe as to cause physiological changes that may endanger the health of bereaved people (Parkes, 1972; Raphael, 1983; Rando, 1985; Berardo, 1988; Stillion & McDowell, 1996; Berman, Jobes, & Silverman 2006). Family members surviving the suicide death of a child or sibling are more likely to: (1) question the meaning of the death as compared to other survivors (Silverman, Range, & Overholser, 1994-1995; Grad & Zavasnik, 1996), (2) express higher levels of guilt, blame, and responsibility (Cleiren & Diekstra, 1995; Silverman, Range, & Overholser, 1994-1995; Grad, 2003), (3) experience more feelings of rejection or abandonment along with anger toward the decedent (Silverman, Range, & Overholser, 1994-1995; Reed, 1998; Bailley, Kral, & Dunham, 1999), and, (4) negatively stigmatize themselves, resulting in a greater sense of isolation (Allen,

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Calhoun, Cann, & Tadeschi, 1993; Van Dongen, 1993) and thus become a heightened

risk for suicide themselves (Ness & Pfeffer, 1990; Fekete & Schmidtke, 1996).

Clearly, when a suicide occurs, families suffer. There is no legal mandate, nor

standardized investigation protocol, requiring family members be interviewed as

part of the death investigation process, unless they are a witness to the death. The

National Association of Medical Examiners (NAME) suggests interviewing as many

people as necessary to broaden the scope of the investigation and help to bring

clarity to the circumstances surrounding the death (National Association of Medical

Examiners, 1966-2008). From the moment a death has been discovered, through

the process of determining the cause and manner of death, investigation practices

can have an immediate and significant impact on the survivors. These death

investigations have the potential to affect the families' suffering. Therefore, it stands

to reason that coroners, as part of their death investigation can significantly

influence some aspect of the grieving process as survivors begin recovering from

their loss.

Death investigations by coroners are medical-legal in nature and are

constructed for the sole purpose of determining the manner and cause of death.

Deciding whether the death should be classified as natural, accident, suicide or a

homicide is of primary importance. One tool often employed in the investigation of

an equivocal death is called a *psychological autopsy*. Using a series of questions in an

interview format, collateral information is gathered from people who knew the

decedent. The premise is that suicide survivors may provide the clues, insights or

motivations that can account for the question of "why" someone would take their

life. Psychological autopsies attempt to gather sufficient information to reconstruct the events, understand the decedent's cognitive functioning, psychological well-being, state of physical health, spiritual beliefs and social connectedness. The investigator also hopes to build sufficient evidence to answer many of the questions suicide survivors may have about the death of their loved one. To date there is little standardized information regarding the investigative processes of the psychological autopsy or the way a death investigator conducts the interviews with families who are surviving a suicide. In general, it continues to be unclear how the administration of a psychological autopsy can help families understand and heal from teen suicide.

Although the psychological autopsy is first and foremost an investigative tool, it can also function as a first step in the healing process for survivors, especially when conducted with understanding and empathy (Maris, 1992; Stillion & McDowell, 1996; Schwartz, 1997; Maris, Berman & Silverman 2000; Berman, Jobes & Silverman, 2006). Little research exists about identifying psychological autopsies as a therapeutic tool or *postvention* method when working with suicide survivors. Shneidman (1984) defines *postvention* as consisting of "activities that reduce the aftereffects of a traumatic event in the lives of the survivors. Its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise" (p. 413). More research is needed to explore the effects of administering psychological autopsies to survivors of suicide and the impact they might have on the grief process generated by an unexpected death like suicide.

Purpose Of The Study

This qualitative research study explored and described the experiences of how one family suffered and survived the unexpected loss of their 13-year-old son suspected of dying by suicidal means. The family underwent two separate death investigations by two different deputy coroners. The first investigation followed standard death investigation protocol and ruled the manner of death as asphyxia due to ligature hanging.   However, the cause of death was suspicious and the family requested a second investigation based on information they collected from additional sources after their son's death. The second investigation used a psychological autopsy format and information was used to help determine and describe the manner of death.

This study highlighted the forensic work of deputy coroners in one county of Washington State, and examined the ways a psychological autopsy might help us understand youth suicide through the experiences of a family who lost a teenager. Using a single case study qualitative research design, attention was focused on specific areas of information that surfaced as a result of conducting a psychological autopsy, and how the autopsy broadened or limited our understanding regarding the context of a suicide death. By using psychological autopsy interviews from family and friends it was hoped that rich contextual stories would reveal subtle details and further our understanding about teen suicide. This researcher invites further dialogue regarding death investigation practices that are therapeutic in nature, as well as promotes future studies focusing on interventions that facilitate the healing process among suicide survivors.

Reviewing the Nature of the Problem

"Death by suicide is not a gentle deathbed gathering: it rips apart lives and beliefs, and it set its survivors on a prolonged and devastating journey" (Jamison, 1999; p. 295).

The prevalence of suicide has been regular and consistent since its recorded occurrence in the 1800's causing not only personal and emotional suffering for family and friends, but serious social and economic consequences for the entire community (Gray, Archilles, Keller, Tate, Haggard, Rolfs, Cazier, Workman, & McMahon, 2002). The rate of death by suicidal means has fluctuated between 10 to 15 incidents per 100, 000 persons for decades (Centers for Disease Control and Prevention (CDC), 2005). In the 1990's the suicide rate in the United States ranged from 10.7 to 12.4 per 100,000, while in the 1980's rate was 10.1 to 15.1 per 100,000 persons (CDC, 2005). (See Figure 1. Suicide Rates for Men, Women and the Nation, USA)

Suicide is the thirteenth leading manner of death worldwide and eleventh in the United States. In 2005, suicide accounted for over 33,000 deaths (CDC, 2005; Anderson, 2003). Approximately one percent of the U. S. population will kill themselves each year. On average, one person dies by suicidal means every 17 minutes. And, when one person takes their life, a chain reaction of grief can sweep across a community. Shneidman (1992) and others estimated that for each completed suicide a minimum of six people are intimately affected by this unexpected manner of death. Each survivor wondering "How could this death have

happen?" "What should we have done?" and, "Why would they do this?"(CDC, 2005;

Kochanek, Murphy, Anderson, & Scott, 2004)

Figure 1. Suicide Rates for Men, Women, and the Nation, USA, 1933-2005
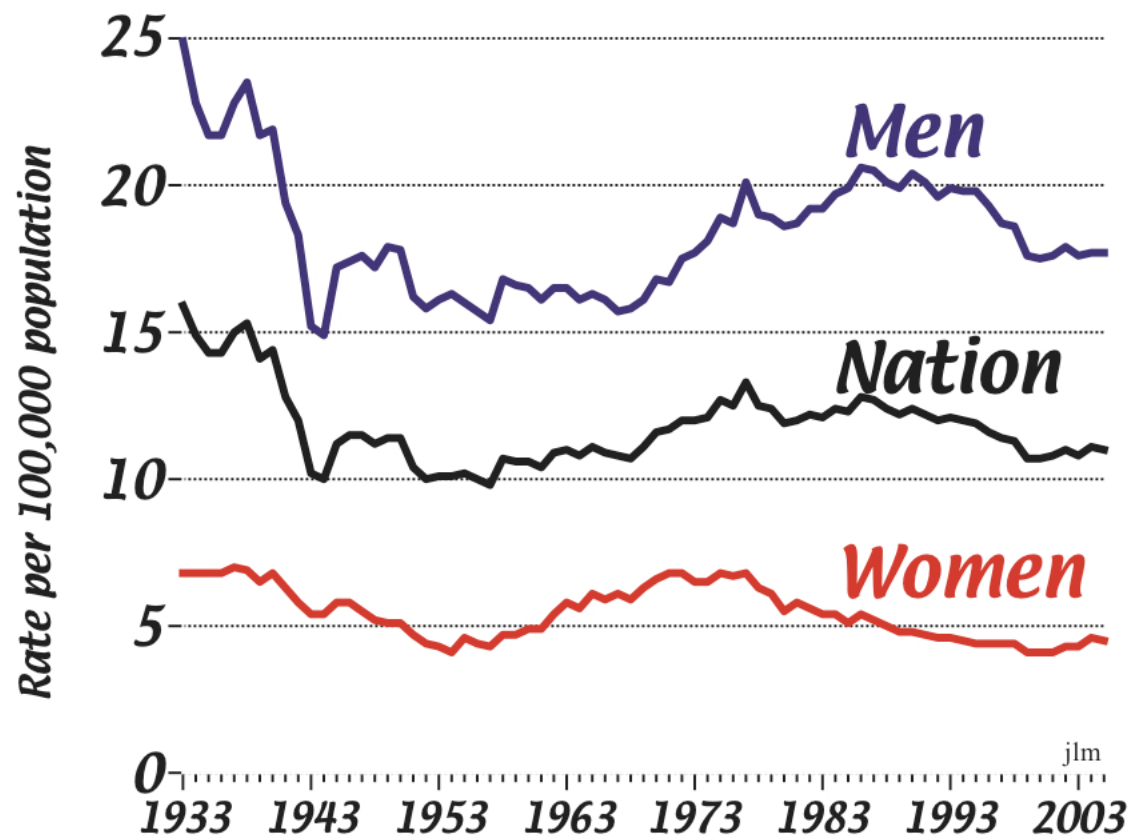
Not all suicide attempts result in death. In 2004, there were 811,000

attempted suicides in the United States recorded for all age groups, translating to

one attempt every 39 seconds (Injury Statistics Query and Reporting System

[WISQARS], 2005). This number is suspect because it is impossible to definitely

determine all suicide attempts, leaving one to speculate that the number of suicide attempts is probably significantly higher than what is actually reported.

Youth Suicide

To date, there are no definitive studies that can answer the question of, "Why do some youth kill themselves?" Suicide occurs for both young men and women, across all ethnicities and social economic class groups.

Suicide is the third leading manner of death among young people ages 15 to 24 in the United States (CDC, 2005; Anderson, & Smith, 2003). Youth are killing themselves at an alarming rate, averaging one young person every two hours and three minutes (Kochanek, et al., 2004).

Young males take their lives four times more often than females (Lubell, Swahn, Crosby, & Kegler, 2004). However, young women make three times more attempts than males in their lifetimes. Emergency room documentation suggests that for every single completed suicide, regardless of age, there will be an estimated 25 attempts (Goldsmith, Pellmar, Kleinman, & Bunney, 2002; Lubell, et al., 2004 McIntosh, 2005). Eaton, Kann, Kinchen, Ross, Hawkins, Harris, Lowry, McManus, Chyen, Shanklin, Lim, Grunbaum & Wechsler (2006) reported that in a survey of youth regarding risk behaviors over a 12-month period 16.9% of all U. S. students seriously considered attempting suicide, 13% made a specific plan, and 8.4% attempted suicide.

Young people who attempt suicide are often experiencing enormous stress, confusion and depression from situations occurring in their families, within peer

groups or at school. Many of these struggling adolescents eventually consider

suicide a "solution" to their problems. No age group is immune to the occurrence of

suicide, especially teens.

Trends in Youth Suicide

Even as our awareness regarding the signs and symptoms of youth suicide

has grown, prevention efforts and parent education programs have not stopped

young people from taking their lives (Grunbaum, Kann, Kinchen, Ross, Hawkins,

Lowry, Harris, McManus, Chyen, & Collins, 2004). The general rate of teen suicide

has continued to rise since the 1950's, with some fluctuations in the rate of

completed suicides for teens (Anderson & Smith, 2003). Between 1970 and 1994

the rate of teen deaths by suicide nearly doubled from 5.9% per 100,000 in 1970 to

11.1% in 1994 (Sadock & Sadock, 2003). The reason for this increase is unknown

and unrelated to economic, political or demographic factors (Anderson & Smith,

2003; Berman, Jobes, & Silverman, 2006). King (1997) suggests that "each suicidal

adolescent has their own unique life story, and thus, there are no predictive

equations with definitive decision-making rules for determining whether suicidal

behavior will become a completed suicide act" (p. 61).

Data from Centers for Disease Control and Prevention (2005) showed that

from 2000 to 2005 a slight decline in suicide rate occurred in adolescents ages 15 to

24. Again, the reason for this decline is unknown and occurred after a 10 year

period of steady increases in suicide rates for teens (Berman, Jobes & Silverman,

2006).

Other data from CDC (2005) noted that youth who died by suicidal means were mostly young males, 82.2%, while 17.3% were young women (Anderson & Smith, 2003). Reasons for the high male to female suicide ratio in the United States as suggested by Maris et al. (2000) include "males having higher rates of significant suicide risk factors like; alcohol abuse, access to firearms and shame at failure. In addition, males are less likely to engage in a number of protective behaviors like; seeking help, being aware of warning signs and flexible coping skills" (p. 36)

CDC (2005) also notes that the most common method of completed suicides among youth for both sexes is firearms (Shaffer & Fisher, 1981). And, findings from psychological autopsy studies suggest, "more than half the youths who complete suicide had a history of significant alcohol use problems and had made at least one attempt on their life previously, " (Maris, Berman, Silverman, 2000; p. 133).

Gender & Ethnicity

Centers for Disease Control and Prevention reported that in 2004, White males have the highest per capita rate of suicide, accounting for 23,081 deaths in the U.S. (McKeown, Garrison, Cuffe, Waller, Jackson, & Addy, 1998; CDC, 2005;). (See Figure 2. Suicide Rates by Gender and Race, USA.) In comparison, the total number of deaths in 2004 due to suicidal means among African-Americans was 2,019. Of that total, there were 1,655 African-American males and 364 African-American females who completed suicide. Other ethnic groups from the overall total of suicide deaths in 2004 included, Hispanics, accounting for 2,207 deaths; Native Americans, 404 deaths; and Asian/Pacific Islanders accounting for 765 suicidal

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deaths (CDC, 2005). (See Figure 3. Suicide Rates for Whites and Nonwhites, USA 1933-2005.)

Figure 2. Suicide Rates by Gender and Race, USA, 1933-2005
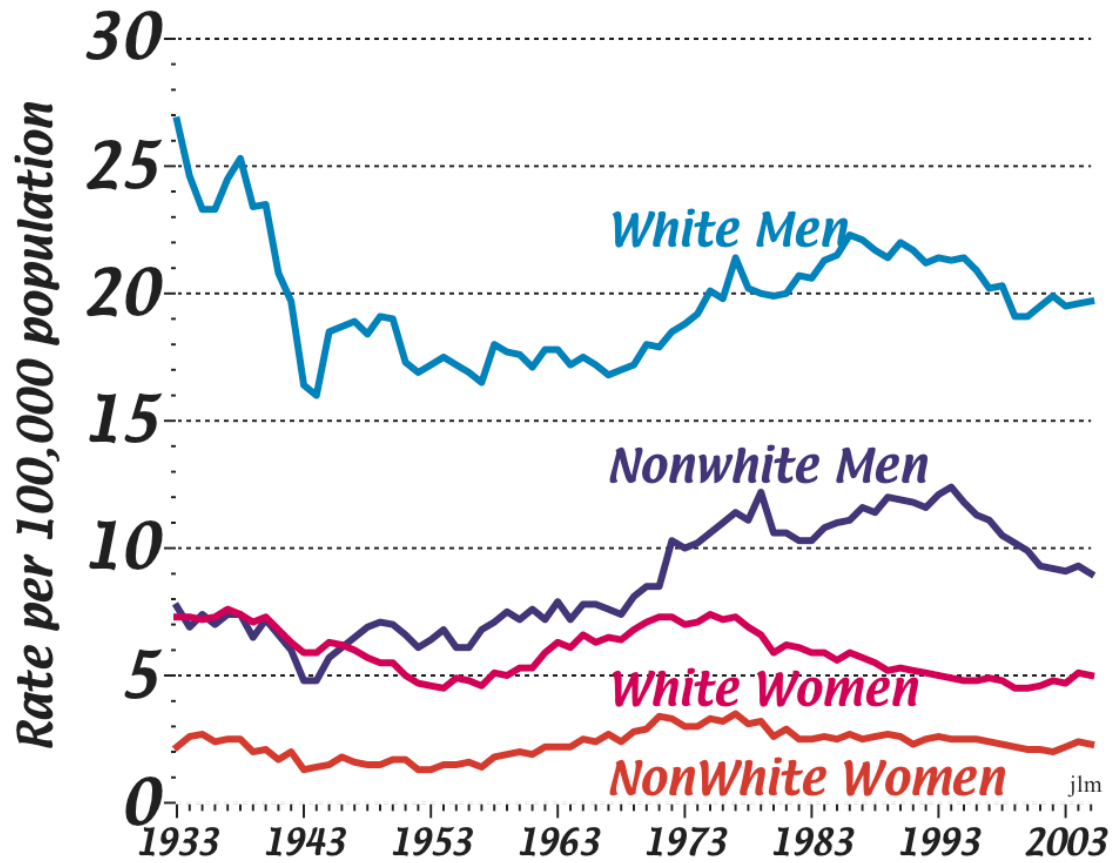
Figure 3. Suicide Rates for Whites and Nonwhites, USA, 1933-2005
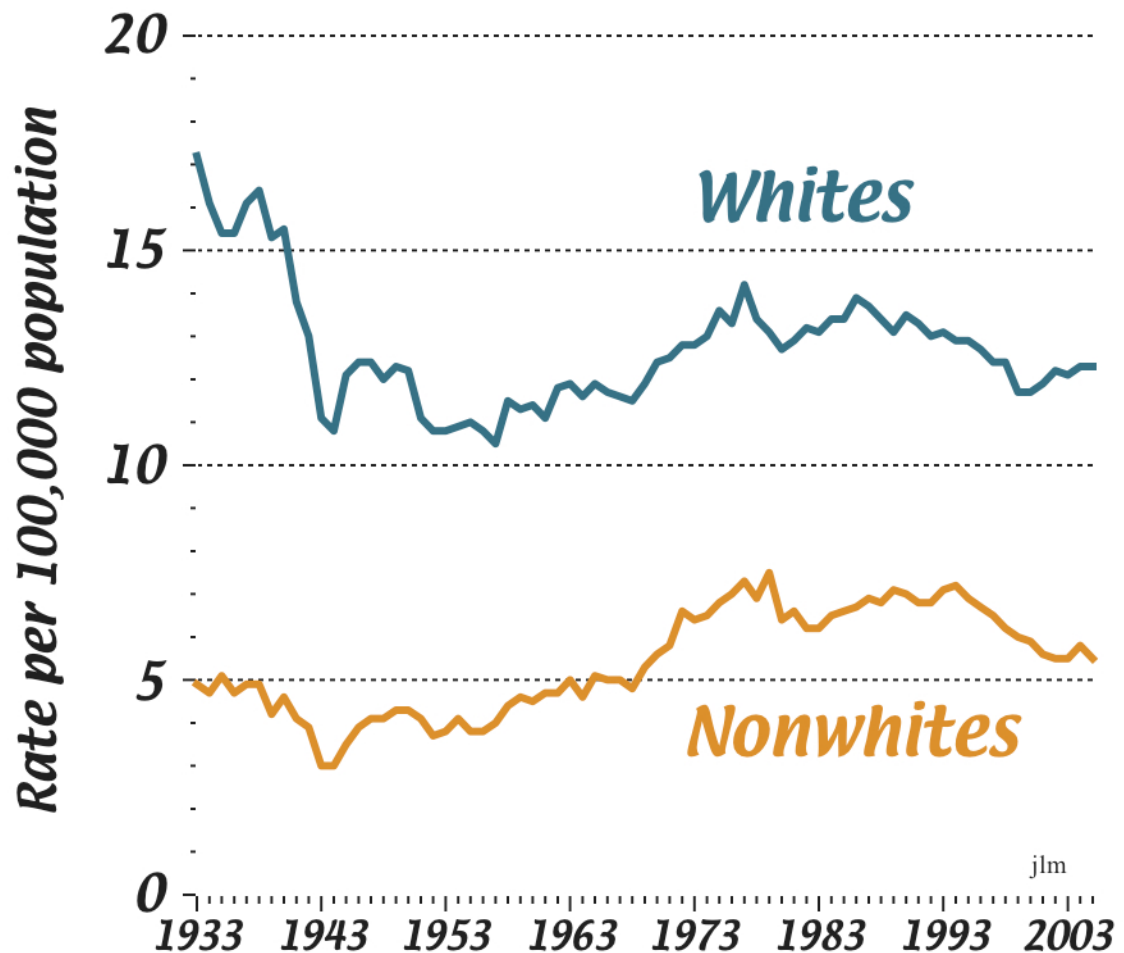
- Both Figures 2 & 3 by John L. McIntosh, Ph.D., Professor of Psychology, Indiana University South Bend, retrieved from: http://mypage.iusb.edu/~jmcintos/SuicideStats.html (all data sets, graphs and supplements may be viewed and printed and downloaded as PDF files)

Indirect Youth Suicide

The numbers do not tell the whole story. Mohler (2001) contends that the number of reported suicide deaths is imprecise and may reflect an intentional underreport. Possible reasons for this underreporting may include pressure from insurance companies, the good intentions of emergency room doctors to soften the news of suicide to a family because of religious or social stigmas attached to suicide

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deaths and medical examiners or coroners who may inadvertently misclassify the death.

Besides the intentional mis-reporting, there is the unintentional mis-categorization. Parrish & Tunkle (2005) noted, "Distinguishing covert suicides from accidents, including falls, cars crashes, and shootings, particularly in cases involving deliberate recklessness, intoxication, and drug overdoses, may be impossible to detect from current reporting sources" (p. 83). Cases of indirect suicide are also noted when youth intentionally or unintentionally provoke police officers with aggressively self-destructive behaviors coercing law enforcement to apply deadly force, referred to as "suicide by cop." Another covert or indirect suicide can occur if a youth refuses to eat or to take life-sustaining medication (Diekstra, Kienhorst, & deWilde, 1995).

Timmermans (2006) further notes, "that the search for hidden suicides may be reflected in other death classifications: single-vehicle accidents, pedestrian deaths, natural deaths, accidental poisonings, drownings and undetermined deaths" (p. 79). Cooper & Milroy (1995) suspect that the misidentification of suicide deaths are more likely to happen in specific demographic groups, namely, African Americans (Warshauer & Monk, 1978), Native Americans, women, adolescents and the elderly (Fisher, 2000; Salib, 1997). Controversy remains regarding the under reporting and mis-identification of official suicide statistics, however, researchers generally offer three reasons for possible inaccuracies in suicide determination. According to Timmermans (2006) these inaccuracies include: "...1) the equivocality of suicide; 2) legal, administrative, and procedural variations across geographic

regions; and 3) pressure from relatives who wish to avoid the stigma of suicide" (p.

80). Thus, for a variety of reasons, estimates of completed suicides are likely to be

underestimations of the actual magnitude of the problem (Parrish & Tunkle, 2005).

Suicides in Washington State

Information from national statistics indicates that for all age groups of people

who died by suicidal means, Washington State ranked 21st in 2005. In 2005

Washington State had 822 recorded deaths by suicide (McIntosh; 2005), which is 10

fewer deaths than recorded in 2004.

For Washington State adolescents ages 10-24, suicide rates declined 5.2% in

2001 (Youth Suicide Prevention Program (YSPP), 2007). From 1997 to 2001, there

were a total of 617 suicide deaths of teens between the ages of 10-24. Again like the

national statistics, young males take their lives more often than females. While,

females made twice as many attempts on their life, averaging over 3,000 as reported

by emergency hospitals records in Washington in 2001 (YSPP; 2007). Young males

on the other hand made 1,503 recorded attempts.

Figure 4. Washington State death rates – Youth 10-24 (1997-2002)
         Rates compared to U.S.
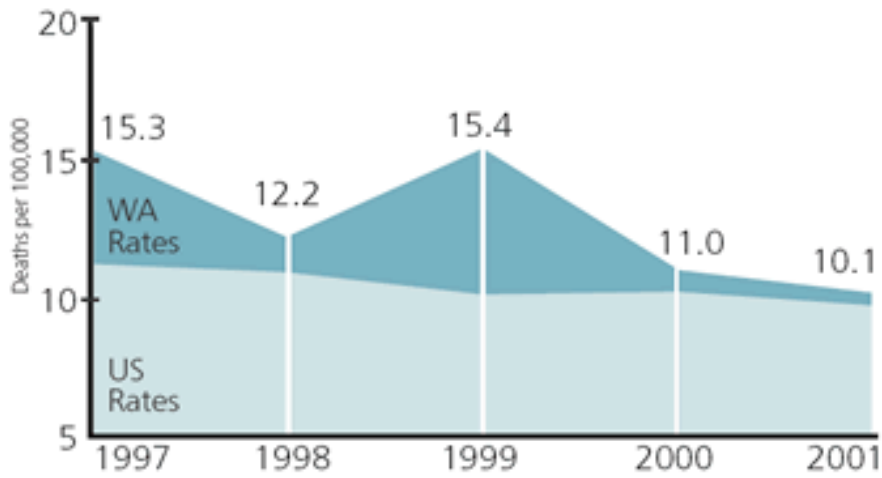
Figure 5. Number of attempted suicides by Washington State youth (1997-2002)
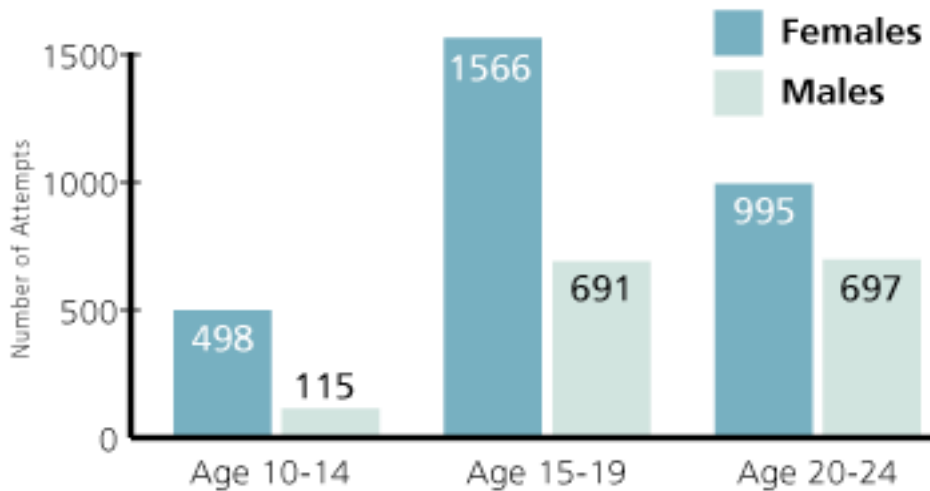
Figure 6. Males vs. Female rate of suicide
        Average Rate* per 1,000 Washington State youth (1997-2002)
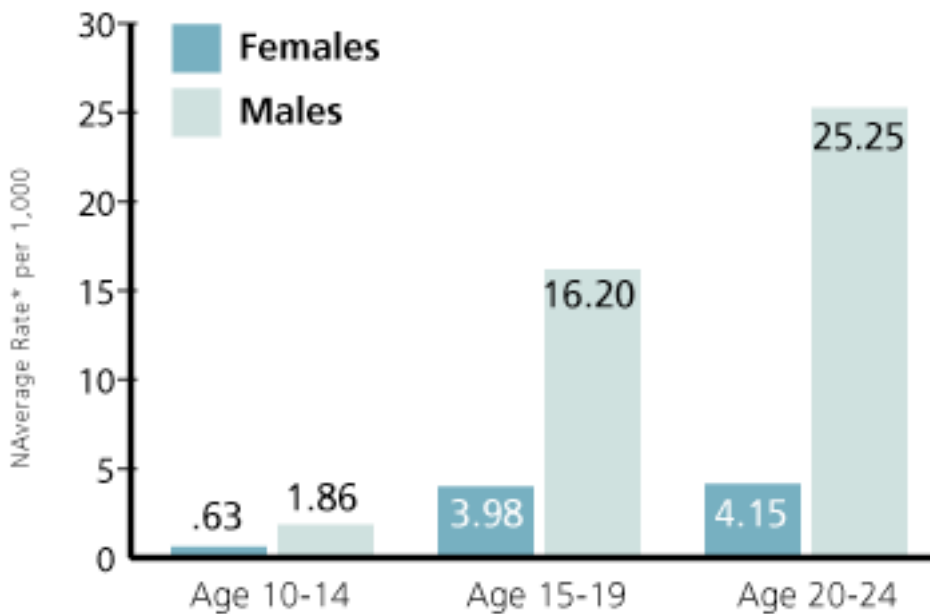
Understanding the Cause Of Suicide

"Suicide as a public health concern drives the search for causality." David Satcher, 16th Surgeon General.

The cause of suicide is unknown. Joiner (2005) observes that there is no overarching theory, which accounts for the varying degrees of individuality when someone chooses to take their life. Over 30,000 Americans a year on average will commit this singular and independent act of suicide. Not only is suicide tragic and disconcerting, it is also one of the most difficult areas to study. Research is

fundamentally limited due to the death of its subjects (Berman, Jobes, & Silverman, 2006).

However, despite not having a compelling theoretical framework for suicide, much has been learned regarding the relationships and interactive effect among risk factors, characteristics and variables found among individuals, their families, the media and cultural differences.

Suicidal behavior is convoluted and layered with multiple meanings. Some risk factors vary with age, gender and ethnic group, and may even change over time (Conwell & Brent, 1995). The risk factors for suicide frequently occur in combination with each other (Moscicki, 2001). A diagnosis of depression or other mood disorders are reported among youth who have completed suicide (Brent, Perper, Moritz, Allman, Friend, Roth, Schweers, Balach, & Baugher, 1993; Rutter & Behrendt, 2004), and often occur with alcohol and other drug use and abuse (Brent, Perper, Moritz, Baugher, Schweers, & Roth, 1994). Among the most studied variables relating to youth suicide are the influence of family (Wagner, Silverman & Martin, 2003), stressful life events (Beautrais, Joyce, & Mulder, 1997); interpersonal conflict and social isolation (Brent, Perper, Baugher, Roth, Barach, & Schweers, 1993; Lewinsohn, Rohde, & Seeley, 1994; Gould, Fisher, Parides, Flory, & Shaffer, 1996;); distortions in cognitive problem-solving (Klimes-Dougan, Free, Ronsaville, Stilwell, Welsh, & Radke-Yarrow, 1999); and faulty coping strategies (Tishler, McKenry, & Morgan, 1981).

There may also be causal links to suicide with regard to imitation and suggestibility, such as the exposure to the suicidal behavior of another person

(Harkavy-Friedman, Asnis, Boeck, & Difiore, 1987) or even to media. An example of media influence is the case of the youth who imitated the suicide of rock star Kurt Cobain. The youth killed himself on April 5th, the day Kurt Cobain ended his life with a firearm in 1994 at age 27 in Seattle, Washington (Jobes, Berman, O'Carroll, Eastgard, & Knickmeyer, 1996).

Biochemical Connection

One particular line of inquiry is the biochemistry of suicide. Postmortem analysis of body fluids, such as blood, cerebrospinal fluid and urine from individuals who have completed suicides, indicates alterations of neurotransmitters such as serotonin and norepinephrine (Arango & Mann, 1992). This suggests that people who kill themselves may have distinguishing changes in their brain chemistry and physiology (Mann, Oquendo, Underwood, & Arango, 1999). Most notably, research is studying serotonin, a neurotransmitter that inhibits self-harm. Diminished levels of serotonin are found in patients with depression, impulse control disorders, a history of violent suicide attempts and also in autopsied brains of individuals who completed suicide (Pelkonen, & Marttunen, 2003). "The outcome of such research may enable those vulnerable to attempted suicide, to be identified and appropriately treated before they harm themselves" (Leonard, 2005, p. 155).

Psychosocial Issues of Suicide

The complexity of suicide deepens further when considering the internal world of someone suffering from suicide ideation. One way to access the intra-

psychic phenomenon of the suicidal mind is by interviews with those who had attempted suicide (Corr, Nabe, & Corr, 2003). Their stories consistently described three similar intra-psychic conditions prior to their suicide attempt: 1) feelings of haplessness (*being ill fated or unlucky*), 2) a sense of helplessness, and 3) an overwhelming perception of hopelessness (p. 472).

Shneidman (1996) offered five clusters of what he calls *psychological pain* within the internal world of suicidal minds. These included: "1) thwarted love, acceptance, and belonging, 2) fractured control, predictability, and arrangement, 3) assaulted self-image and the avoidance of shame, 4) ruptured key relationships, and 5) excessive anger, rage and hostility" (p. 25).

Joiner (2005) combines the inner and outer worlds of a suicidal person for an ecological approach to the psychology of suicide. Three common elements must exist and all converge in order for someone to enter what Joiner (2005) calls a *trajectory* towards death: "1) the acquired ability to enact lethal self-injury, 2) thwarted belongingness, and 3) perceived burdensomeness" (p. 91).

Leonard (2005) stated that a conceptual framework for studying the phenomenon of suicide must include both the inter-personal and intra-personal perspective, while at the same time not ignoring the interplay of biochemical, psychosocial and environmental constituents. This array of multifaceted variables and temporal inconsistencies are all connected to the phenomenon of suicide. From the interior of the suicidal mind to the exterior world that influences suicidal perceptions, the factors are far ranging and inconclusive.

Moscicki (2001) posits that the conceptual framework for the causality of suicide must also include not only the characteristics already mentioned but variables such as: prior suicide attempts, family history of mental disorder or substance abuse, family history of suicide, family violence including physical or sexual abuse, firearms in the home, incarceration, and exposure to the suicidal behavior of others, which includes family members, peers, and even images from the media.

Variables and Risk Factors of Suicide

There is no accepted comprehensive theoretical framework for suicide because suicidal behavior is complex and layered with multiple meanings and unclear interpretations (Brent, Perper, Moritz, Allman, Friend, Roth, Schweers, Balach, & Baugher, 1993; Rutter & Behrendt, 2004). However, much has been learned regarding the interactive effect among risk factors, the relationships among suicidal characteristics and competing variables found among individuals, their families, the media and cultural or ethnic differences (Berman, Jobes & Silverman, 2006).

The most current research trends divide variables associated with the risk of suicide into either psychosocial or biochemical domains (Moscicki, 2001). This interplay between the domains of individual and his or her environment appears evident, however no single contributing characteristic is consistently associated with a suicide death. There are many environmental characteristics surrounding death by suicide. Factors range from the molecular to possible cultural triggers.

Wagner, Silverman & Martin (2003) provided a list, though not exhaustive, of characteristics and/or possible mechanisms that have been associated with completed suicides:

- Previous suicide attempts;

- Demographic variables of age, marital status and ethnicity;

- Family history of suicide, depression, bipolar disorder and alcohol abuse;

- Personal history of legal trouble as an adult and as a juvenile;

- Current and past diagnosis of depression and/or bipolar disorder;

Other indicators proposed by Brent, Perper, Moritz, Baugher, Roth, & Barach (1993); Gould, Fisher, Parides, Flory, & Shaffer (1996); and Lewinsohn, Rohde, & Seeley (1994) also appeared noteworthy. These include:

- Rage, anger, seeking revenge;

- Hopelessness;

- Withdrawing from friends, family, or society;

- Anxiety, agitation, unable to sleep, or sleeping all the time;

- Drug dependence symptoms;

- Negative life events associated with family parenting styles, physical and sexual abuse, poor coping skills;

- And, high-risk behaviors that ranged from driving recklessly to participation in extreme sports.

Furthermore, Blumenthal & Kupfer (1989) gathered the research regarding risk factors, characteristics and possible mechanisms associated with completed

suicides and derived a list of seven themes. This list is taken from Berman, Jobes & Silverman (2006; p. 116):

1. *A negative personal history.* (early life events and stressors, negative models for coping, family history of suicidality and parental psychopathology, prior self-harming behaviors).

2. *Psychopathology and significant negative personality attributes.* (symptomatology or personality characteristics defined as either Axis I or Axis II diagnosis, comorbid psychopathologies including or exacerbated by significant substance abuse).

3. *Stress.* (environmental, psychosocial affect arousing stimuli that threaten the ability to maintain self-esteem and to cope effectively).

4. *Breakdown of defenses*; *affect and behavior dysregulation.* (cognitive rigidity, irrationality, thought disturbance, loss of reality testing, heightened substance abuse, panic, heightened anxiety, disorientation, and rage).

5. *Social and interpersonal isolation and alienation.* (behavioral withdrawal, isolation and alienation from typical attachments; help-rejecting and noncompliant behavior, e.g.).

6. *Self-deprecatory ideation, dysphoria, and hopelessness.* (statements of unhappiness, pessimism, and irritability; feelings of worthlessness, uselessness; negative views of self; inability to derive pleasure or to be pleased by others; and death related and suicidal fantasies).

7. *Method availability, accessibility and knowledgeability*. (sufficient impulse toward self-destructive action or intent to die or to use self-harm for some instrumental or interpersonal gain; availability and accessibility of a weapon).

Finally, some might argue that within any population there is a group of people predisposed to killing themselves which suggests a genetic pathway to suicide (Berman, Jobes & Silverman, 2006). Currently, there is no substantiating evidence to support this premise. However, what is known and considered the most common and consistent link to suicide death is that more than 90% of people who kill themselves experience depression or another diagnosable mental or substance abuse disorder, often in combination with other mental disorders (Moscicki, 2001).

The Aftermath of Suicide: Survivorship

The community of suicide survivorship encompasses a vast and invisible population. Virtually any person who knew or cared about the decedent would be considered a member. Shneidman (1992) estimated that each suicide intimately affects at a minimum six people: a mother, father and two sets of grandparents. Thus, the 33,421 suicides in 2005 (CDC Fact Sheet, 2005; Kochanek et al., 2004), produced over 200,000 suicide survivors. Or, in one generation, from 1980 to 2005, the number of suicide survivors in the U.S. would be 4.5 million, which is 1 out of

every 65 Americans. (See Figure 7. Cumulative Number of USA Suicides &

Estimates of Survivors).

Family members left in the aftermath struggle with conflicting emotions,

accusations of blame, endless chasms of guilt and episodes of despondent grieving

(Osterweis, Solomon, & Green, 1984; Clark & Goldney, 1995). Other bereavement

reactions include anger, the perception of social stigma, and an increased risk of

physical and mental health problems (McNeil, Hatcher, & Reubin, 1988;

Wertheimer, 1991). The grief and bereavement process for parents who lose a child

is exceptionally traumatic. Wheeler (1993) explains, "…[a] child holds multiple

meanings for a parent: a connection with the past, investment in the future, and an

extension of the self" (p. 261).

Limited knowledge exists that can definitely answer whether suicide

bereavement is different than other types of bereavement (McIntosh, 1993; Cleiren

& Diekstra, 1995; Ellenbogen & Gratton, 2001). However, many clinicians and

researchers have indicated that the mourning process is different for survivors of

suicide than other manners of death, such as homicide or accident (Hauser, 1987;

Worden, 1991; Rando, 1993; Clark & Goldney, 1995; Sprange & McNeil, 1995;

Range, 1998). Jordan (2001) claims there is implicit support for the notion that

suicide affects a family system differently compared to other forms of death.

Figure 7. Cumulative Number of USA Suicides and Estimates of Survivors,
1981-2005 (last 25 years)
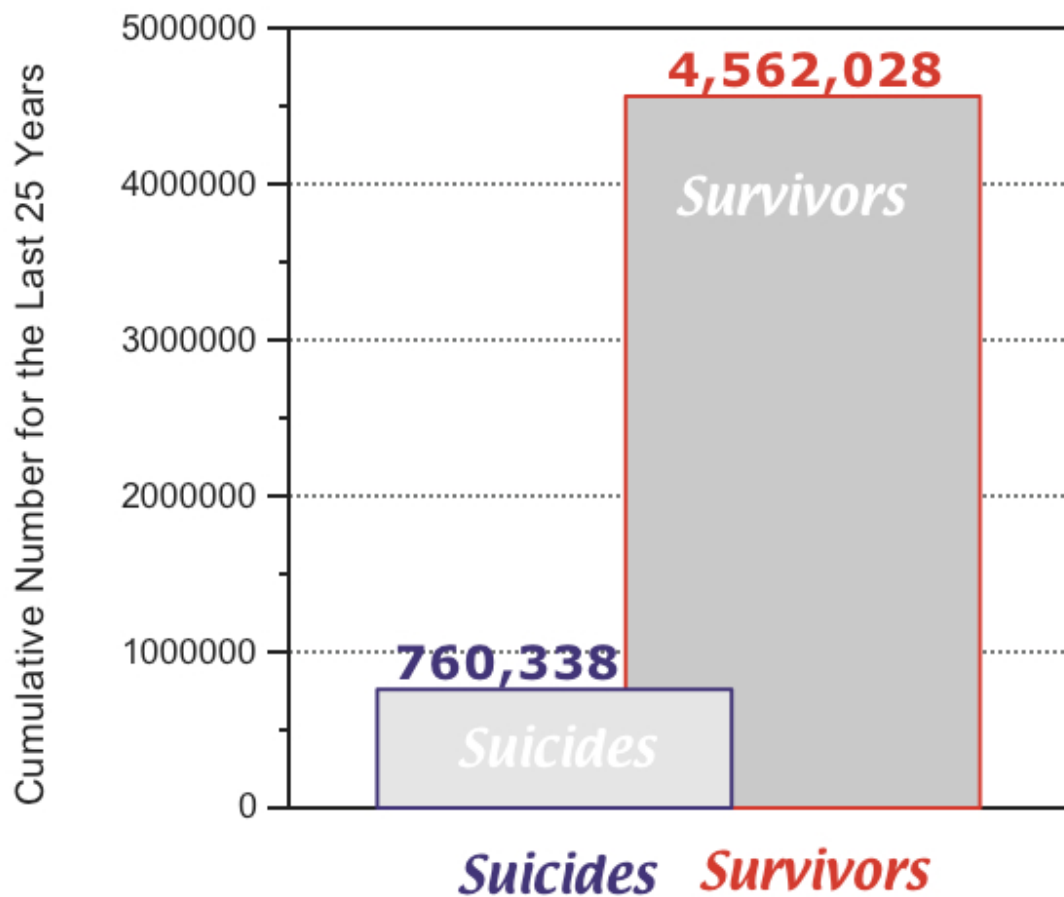
McIntosh & Hubbard (2007), in their "Survivors of Suicide Curriculum" list

five factors that make suicide grief and bereavement different than other mourning

processes. These included:

1. A completed suicide is usually sudden and unexpected. This does not

   permit survivors to prepare themselves for its occurrence.

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2. Death by suicidal means often leaves unfinished or unresolved issues with no ability to ever bring a sense of closure.

3. Death by suicidal means is often violent which may produce intensely disturbing or even intrusive images for survivors in association with their memory and thoughts about the death.

4. Suicide often occurs in systems such as family or work environments that may already be experiencing multiple stressors.

5. Death by suicidal means can compromise usual mourning rituals for survivors because of the shame, stigma and guilt associated with suicide. The family may alter their funeral plans opting for more private ceremonies, depriving survivors of the traditional support and comfort offered from normal rituals and behaviors associated with grief and bereavement.

Although there may be some similarities in bereavement, no two people will grieve in the same way, not even within the same family (Van Dongen, 1993). Grief does not follow any specific set of stages; it is highly individualistic, complicated and sometimes problematic. The experiences felt by the community of suicide survivors are personal and painful even before an official inquiry commences. When the death investigation begins, it has the potential to either exacerbate a family's distress or facilitate a sense of closure (Freckelton, 2007).

The Forensic Investigation

"The death of a loved one is often a difficult and confusing time. Family members may have to speak with doctors, nurses, fire department personnel, ambulance crews, police officers, and funeral directors, in addition to notifying family and friends. In some cases you may also speak with a representative of a Medical Examiner or Coroner's Office" (The National Association of Medical Examiners (NAME), 1999).

Definition and History

Because suicide is considered an unnatural death, the police and local medical examiner or coroner must investigate. This element of being unnatural or "suspicious" alerts the community that other victims may be claimed and more investigation is needed to assess the risk and nature of an unexplained death. Suicide is not a crime in the United States. However, homicides are sometimes made to look like suicides in order to cover real criminal activity. Law enforcement must treat the situation as a potential crime until they can establish that it was, in fact, a suicide (NAME, 1999; Baugher & Jordan, 2002). Once police arrive on the scene of the death, interagency collaboration commences between law enforcement, medical staff and the coroner or medical examiner. The investigation may continue for several days or weeks. During that time, witnesses and family members are interviewed, a forensic autopsy may or may not be conducted (regardless of family wishes) and evidence from the death scene will be sent for further lab testing and analysis.

In the process of a death investigation, suicide survivors are often caught in the multiplicity of agencies and their assigned roles. What investigators need in order to determine the cause and manner of death is not, necessarily, what survivors need in order to begin processing the loss. This is the climate under which the medical-legal death investigation often operates. According to Schwartz (2001) death investigators should have a thorough understanding of the normal responses that people have to a traumatic death. Such training and added knowledge would have the potential to significantly aid the death investigator to assist family members to better cope with the tragic loss of an unexpected death like suicide. However, not all death investigators have the same level of expertise and training nor the administrative support (Parrish 1999; Hanzlick, 2006; Timmermans, 2006).

Since the twelfth century, coroners have traditionally conducted death investigations. Their original mandate was to collect money owed to the English Crown and they were known as *crowners* or *keepers of the pleas of the crown*, (Timmermans, 2006; p. 4). Medieval coroners conducted inquests for deaths attributed to suicide and homicide. Their death investigations were instrumental in securing additional wealth and property for the king because to be guilty of suicide was considered a crime against God and king and resulted in forfeiture of the victim's estate (Hunnisett, 1961).

In the modern era, coroners are public officials who are either appointed or elected. They may or may not have medical backgrounds or training in death investigation, and often hire doctors to perform autopsies, as well as lab specialists

to conduct toxicology testing (Timmermans, 2006). Deputy Coroners are the field representatives of the Coroner Office and are responsible for investigating all deaths, especially in the event of sudden or unexpected deaths. While Medical Examiners rarely do death scene investigations or interview informants, their expertise and authority are based on inspection of the body via autopsy information. Medical Examiners are generally doctors, who will assign a crime scene investigator trained in death investigation procedures to conduct the investigative work in the field.

The Scope of a Forensic Investigation

Typically, a representative from the medical examiner or coroner's office will contact the family after a death has been confirmed. Within the scope of their duties, they notify next of kin, conduct on-scene interviews, and document pre-terminal episode history such as the medical, mental health and social variables (U.S. Dept. of Justice, 1999). No nationally standardized guidelines for death investigations exist. However, there are regional protocols and basic investigative techniques that have been developed to assist both coroners and medical examiners. One example was developed by the National Association of Medical Examiners (NAME) and it is readily available on its website at thename.org. NAME was founded to advance the professional growth of death investigators and disseminate professional and technical information for improving the investigations of violent, suspicious and unusual deaths (NAME, 2008).

Though specialized training is needed to be an effective death investigator not all investigators have the same level of expertise. Schwartz (2001) recommends additional training in the areas of grief and loss to assist death investigators in mitigating the reactions of anger, sorrow, guilt or anxiety that accompanies grief responses. Such training could significantly impact the grief process for suicide survivors. Even without specific training, investigators need to be able to provide family members or those experiencing grief the names and phone numbers of resources within their community that are competent in bereavement and grief counseling. Families who are experiencing grief and loss are subject to whatever the level of training and personal experiences of individual death investigators may have when attending to a family's bereavement.

Under the provision of state law, a coroner is directed to administer investigation protocols in accordance with their local jurisdictional death investigation system. To date, death investigation systems adhere to medical-legal forensic methodology. Evidence is collected and analyzed by board certified forensic pathologists who are guided by their training in medical science. Modern-day coroners, as noted by Timmermans (2006), are knowledgeable about the pathology of disease, injury and poisoning, as well as multiple non-medical areas more akin to law-enforcement investigative practices such as firearm inspection, ballistics, trace evidence, forensic serology and DNA technology (p. 16).

The forensic death investigation system is primarily driven by and ultimately responsible for determining the cause, manner and circumstances of a death (Hanzlick, 2006; U.S. Dept. of Justice, 1999). An investigation ends when the death

can be categorized in one of five ways: 1) Natural, 2) Accident, 3) Suicide, 4)

Homicide, or 5) Undetermined or Pending. This classification system is referred to

as the NASH/UP (Shneidman, 1980; Jobes, Berman, & Josselson, 1986; Maris,

Berman, Maltsberger, & Yufit, 1992;). The NASH/UP classification is fraught with

complexities. One example of the difficulty when categorizing the manner of death

is that a death investigator must determine the decedent's intentionality in order for

a suicide to be ruled a suicide, not an easy task if a homicide can be made to look like

a suicide or if a fatal accident appears to be homicidal. When intentionality or

circumstances cannot be determined, an investigator is faced with an equivocal

death. When this happens, the manner of death is ruled undetermined (Murphy,

1974; Pescosolido & Mendelsohn, 1986; Jobes, Casey, Berman, & Wright, 1991;

Maris et al., 1992;). Another complexity of the NASH/UP system is that causes of

death commonly overlap, such as cases where prior injury or disease may be

involved in determining the manner of death (Shneidman, 1980; Maris, 1992;).

Intentionality of Suicide

    The U. S. Centers for Disease Control and Prevention (CDC) in 1988 provided

a set of guidelines known as "Operational Criteria for Determining Suicide,"

specifically aimed at helping Medical Examiners and Coroners determine if someone

intentionally took their own life when the evidence is not conclusive. To classify a

death as a suicide, the investigator must establish that the death was self-inflicted

and intentional. This first criterion may be determined from autopsy findings,

witness reports, toxicology, and scene information. However, a person's injuries

may or may not conclusively reveal whether they were caused by the decedent or by another person. The second criterion of intentionality poses an even greater problem. Intentionality as described in the guidelines (CDC, 1988), "...can be determined explicitly from verbal or nonverbal expressions of a wish to kill oneself, or it can be inferred from implicit evidence, such as, preparations for death, signs of farewell, expressions of hopelessness or great physical pain, previous suicide attempts, precautions to avoid rescue, and serious mental disorder" (p. 774).

According to Timmermans (2006), "...in order to determine conclusively whether the deceased intended to complete a suicide, the death investigator would need to question the dead person" (p. 85). To help establish the decedent's motivation, an investigation needs to substantiate intent based on secondary evidence; the investigation follows a process of triangulating different pieces of evidence from a variety of sources. Generally, Coroners will refer to the following six sources as outlined by Timmermans (2006):

1) Eye Witness Reports – The most direct indication of a completed suicide is several independent witness reports. However, the majority of completed suicides seem to be private affairs and are only occasionally viewed by others.

2) Suicide Notes – The second most direct indication of suicides are notes left behind for the living. A note may show determination, however it is still insufficient unless backed by corroborating evidence.

3) Previous Suicide Attempts – A history of suicide attempts is a strong indication that the death was intentional. Such history is dependent on accounts from relatives.

4) Testimonials – Another good source for suicidal intent is from relatives and health care providers. However, many of these informants may have reasons to portray the death as something other than a suicide. Often, people close to the decedent are motivated to preserve a positive memory of the deceased rather than be concerned about an accurate death investigation.

5) Life Crises – Indicators may come in the form of dysfunctional relationships, or disturbances to the rhythms of life, health problems, finances, legal affairs or even worsening symptoms from inherent psychopathology.

6) Mode of dying – Intentionality can be implied by how someone dies or what they do to prevent being rescued. Timmermans (2006) notes, "Medical examiners evaluate the mechanisms of death in light of the extent to which it reflects desperation, painlessness, deadliness, aesthetics, symbolism, and cultural appropriateness" (p. 87). Even though a hanging requires a willing victim, additional evidence is required to rule out foul play.

A death investigator must be at least 51% certain the death was self-inflicted and intentional after looking at all the evidence, considering all the explanations,

and weighing all the indictors. "Imagine yourself defending the manner of death to

the decedent's relatives. If in your opinion the evidence provides a pattern that

points more than 50% to suicidal intent, and you are 51% certain, than rule it a

suicide. Your decision is neither a matter of elimination or defaulted but based on a

preponderance of evidence" (Timmerman, 2006; p. 92).

Madelyn Schwartz (personal communication, March 23, 2006) summarized

the probable care brought to determine the intentionality of suicide, "The death

certificate is a legal document, and, is the final statement regarding the deceased, so

it will cast a particular light on them and their family. It's important to treat every

case as if the reputation and survival of the Coroner's Office depends on it."

Skills of a Death Investigator

Being a death investigator takes a synthesis of skills to manage the crisis that

unfolds from a death scene. The investigator must deal with the reactions of

survivors who may be responding to an investigator's questions with shock, denial,

anger, depression, lack of concentration, poor judgment or memory difficulties.

Interviewing can be a difficult task complicated by the very nature of the

circumstances. However, both the investigator and the surviving family share a

common purpose, that is, trying to understand how and why the decedent made the

decision to suicide.

Schwartz (2001) proposed, in addition to the forensic expertise needed in

any death investigation, but especially in cases of suicide, investigators should

incorporate clinical methodologies that support a family's reaction to an unexpected

death. Suicide survivors characteristically feel higher levels of guilt, shame,

abandonment and anger (Clark & Goldney, 1995; Range, 1998; Jordan, 2001;).

Hence, a death investigator trained in clinical mental health practices could readily

focus on family systems psychology, apply crisis intervention skills and facilitate

bereavement counseling to assist survivors in the healing process. Schwartz (2001)

believes in addition to completing the prime objective, which is to determine the

cause and manner of death, a death investigator might be able to accomplish both

tasks if the investigator is clinically trained and supported by administrative policy.

The Geo-Political Organization of Forensic Investigations

        In the U.S. regardless of how a state organizes their death investigation

system, the purpose is to designate how the local government will respond in the

event of a death (Hanzlick, 2006). Death investigation systems may be established

on a statewide, regional, district, and/or at the county level. Twenty-three states

organize on a statewide basis, while the other twenty-seven states organize their

death investigation system on district, regional or countywide basis. There appears

to exist among the community of death investigators a bias that medical examiner

systems are better than coroner systems. The reasons for such bias is based on the

fact that medical examiners are required to have a higher degree of professional

knowledge in order to perform postmortem investigations. Berman, Jobes &

Silverman (2006) note that medical examiners and coroners do not have the same

level of training, education, and backgrounds. They vary in these characteristics

from one jurisdiction to another. However, others might argue that the quality of a

death investigation is not in the science of autopsies but determined by the years of experience that field investigators have in working within their jurisdictions regardless of being either a coroner or medical examiner (Timmermans, 2006).

The Three Tiered System

Washington State uses the three-tiered death investigation system with the first tier requiring the most financial resources. Counties that use the first tier hire a medical examiner. Of the thirty-nine counties in the State of Washington, six counties employ medical examiners who are board-certified forensic pathologists. The second tier, used by sixteen counties in the State of Washington, is the coroner system. Coroners are elected public officials and their role is primarily administrative. No level of medical knowledge or training in death investigation methods is required for the Coroner, who typically assigns Deputy Coroners to do death investigations (Timmermans, 2006). Coroners can hold an inquest, contract with board certified forensic pathologists to perform autopsies, and request toxicology testing (RCW 36.24.020; RCW 36.24.050; RCW 36.24.060). Under the laws of Washington State, coroners and medical examiners are mandated to investigate any death, which are sudden, unexpected, medically unattended within thirty-six hours prior to death, suspicious or violent (County Coroner's Office, 2005; RCW 36.24).

The last tier in a death investigation system is the prosecutor/coroner system, which is mostly used by counties that are not large enough to afford both positions and they are assigned to one person. In the State of Washington seventeen

smaller counties have adopted this system of having the prosecuting attorney also be the coroner.

Regardless of coroner or medical examiner system, death investigators are in the unique position of balancing the needs of grieving families with the dictates of a medical-legal death investigation. As a public health official, the death investigator's involvement with suicide survivors occurs on a spectrum from being effective and constructive at one end, to potentially detrimental and counter-therapeutic at the other.

The Psychological Autopsy: Purpose, Definition, History, and Limitations

A *psychological autopsy* is the reconstruction of the decedent's relevant life history, assembled retrospectively through interviews with the individuals who knew the decedent. It is an information-gathering tool "to achieve a better understanding of the psychological circumstances contributing to a death," (Clark & Horton-Deutsch, 1992; p. 144). Schwartz (1997) describes the goal for a psychological autopsy is to "create a multi-dimensional view" of the decedent by analyzing "all known historical data, current events, relationships, the physical and emotional health status, psychopathology, substance abuse or use, and lifestyle values of the decedent" (p. 1).

A psychological autopsy may be used to help determine the cause and manner of an equivocal death like suicide in a medical-legal death investigation (Shneidman & Farberow, 1961; Litman, Curphey, Shneidman, Farberow, & Tabachnick, 1963; Jobes, Berman, & Josselson, 1986; Brent, Pepper, Kolko, &

Zelenek, 1988; Clark & Horton-Deutsch, 1992; Maris, et al., 1992;). This is not to be

confused with a forensic medical autopsy, which is the external and internal

examination of the organs and tissues of the body to identify disease and injuries for

drawing conclusions regarding how or why a death occurred (U.S. Dept. of Justice,

1999; NAME, 1999).

The term *psychological autopsy* is thought to have first surfaced in the early

1960's from the Los Angeles Coroner's Office (Litman, et al., 1963; Maris, et al.,

1992; Maris, et al., 2000; Shneidman, 1981, 1981, 1993). A handful of psychologists

interested in the etiology of suicide were hired by the Coroner of Los Angeles to

research unexpected deaths characterized by undetermined causes. Ebert (1987)

and Rothberg (1998) noted the U. S. Army later developed psychological autopsies

for suicides to validate discharge summaries and for reporting investigation results

to families.

Earlier versions of psychological autopsies grew from therapeutic roots and

were undertaken for research purposes. Interviews were first conducted in cases of

equivocal deaths by trained behavioral scientists and clinicians (Litman, 1987;

Shneidman, 1981). Shneidman (1981) noted the process was described as "tactful

and systematic" (p. 330). The initial inquiries instructed of investigators were, "to

tread softly when talking to key persons, such as spouse, lover, parent, grown child,

friend, colleague, physician, supervisor or co-worker," (Shneidman, 1981, p. 330).

Further, investigators were encouraged to be sensitive to survivors' grief,

understanding that "their lives were forever changed" (Stillion & McDowell, 1996; p.

232).

Specifically, a psychological autopsy is a series of questions administered by a death investigator when interviewing suicide survivors. Shneidman (1981) recommends that sixteen separate categories or types of questions be explored, while Ebert (1987) proposes twenty-six categories be used to guide the administration of the psychological autopsy. (See Table 1. Comparing Psychological Autopsies)

In general, a psychological autopsy has four functions or goals (Ebert, 1987; Hawton, Appleby, Platt, Foster, Cooper, Malmberg, & Simkin, 1998; Shneidman, 1981):

1. Assist in the determination of the manner of death, using the NASH/UP classification system. Though in reality most medical examiners or coroners would not use psychological autopsies for this purpose unless there was some reason to assess risk management or to do research.

2. May help to determine why a death occurred at a particular time. The timing of the death can be useful in identifying behavior that may have influenced a person's decision to complete the act of suicide (Neil, 1974).

3. Gain helpful and predictive information by identifying behavioral patterns, precipitating factors and the severity of suicidal intent. This information may be useful in treatment and prevention of future suicide occurrences.

4. Help survivors understand the precipitating circumstances surrounding the nature of the death, which may provide insight and help make sense of the suicidal act.

Table 1. **Comparing Psychological Autopsies**

	Shneidman's Guidelines		**Ebert's Guidelines**
1.	**Victim Information** • Age, address, name, marital status employment, religious practices, etc.	1.	**Alcohol History** • Family hx, binge drinking, blackouts, family or work problems, etc.
2.	**Death Information** • Where, when, method, etc.	2.	**Suicide Notes** • Content and style
3.	**Victim's History** • Medical illness, mental illness, medication, psychotherapy, prior suicide attempts, etc.	3.	**Writing** • Past writings, diary, school papers, letters, etc.
4.	**Victim's Family History** • Other family member suicides, cancers, fatal diseases, early deaths, etc.	4.	**Books** • Occult, life after death, on suicide, etc.
5.	**Victim's Personality & Lifestyle** • Depressive, gay/lesbian, etc.	5.	**Relationship Assessments** • Level of intimacy with family and friends, relationship with kids, conflicts, etc.
6.	**Victim's Typical Response to Stress** • Anger, violence, quiet, withdrawn, etc	6.	**Marital Relationships** • Quality, hx of divorces, extramarital affairs etc.
7.	**Victim's Recent Pressures or Tensions** • Upsets, pressures for the last few days to last 12 months, etc.	7.	**Mood** • Fluctuations, wt. loss, sleep disturbances, moods over the last few days, etc.
8.	**Victim's Use of Alcohol or Drugs** • Frequency, type, when last used, etc.	8.	**Presuicidal Behavior** • Giving things away, insurance policy, changes in the will, pay debts, etc.
9.	**Victim's Interpersonal Relationships** • Family, children, physicians, police, psychologists, psychiatrists, mental health professionals, etc.	9.	**Psychosocial Stressors** • Recent losses, legal, moves, relationships, work, etc.
10.	**Victim's Fantasies or Dreams** • To include premonitions, fears particularly about death, suicide, etc.	10.	**Language** • Changes in tone, content, ref. to suicide or death, etc.
11.	**Victim's Personal Changes** • Hobbies, eating, taking prescription medications, sexual patterns, other life routines, etc.	11.	**Drugs Used** • Identify, interactional effects, etc.
12.	**Victim's Life Side** • Upswings, personal plans, professional plans, success, failures, etc.	12.	**Medical History** • Symptoms, diagnoses, illnesses, etc.
13.	**Victim's Assessment Intention** • What role the victim played in his or her demise, etc.	13.	**Reflective Mental Status Exam of Deceased's Condition Before Death**
14.	**Victim's Lethality Rating** • High, medium, low, absent.	14.	**Psychological History** • Prior attempts, hospitalizations, mental illnesses, etc.
15.	**People's Reaction to Victim's Death** • Expected, unexpected, shock, etc.	15.	**Laboratory Studies** • Ballistics, powder burns, etc.
16.	**Other Comments or Special Features**	16.	**Coroner's Report**
		17.	**Motive Assessment** • Intentionality, motives, etc.
		18.	**Reconstruction of Events Occurring on the Day Before Deceased's Death**
		19.	**Assess Feelings Regarding Death as Well as Preoccupations and Fantasies**
		20.	**Death History of Family**

21.	**Family History**
	• Socioeconomic, conflicts, relationships, etc.
22.	**Employment History**
	• Number & types of jobs, problems, stresses, etc.
23.	**Educational History**
	• Special education, level, favorite subjects, suspensions, etc
24.	**Familiarity with Methods of Death**
	• Lethal drugs, knowledge or routine with weapons, etc.
25.	**Military History**
	• PTSD, assignments, promotions, etc.
26.	**Police Report**
	• Critical facts, ballistics, etc.

To date, there are no published standardized psychological autopsy protocols. The reason for this is unknown. Schwartz (2001) postulates that due to the unique circumstances associated with any suicide death, a high degree of flexibility is needed making it difficult to use one format for all situations. This reasoning would also apply with regard to the use of psychological autopsies for either research or prevention purposes. Each approach has different values and outcomes which would make it difficult to standardize one format. Whatever the reasons, the goals explicated by Shneidman (1981) have not evolved to procedures. Psychological autopsies are not universally standardized, nor are the administration of interviews consistent among professionals (Maris, Berman, Maltsberger, & Yufit, 1992; Young, 1992; Maris, Berman, & Silverman, 2000; Cavanagh, Carson, Sharpe & Lawrie, 2003; Berman, Jobes, & Silverman, 2006).

Another controversial aspect of the psychological autopsy is the difficulty in establishing inter-rater reliability (Brent, Perper, Kolko, & Zelenak, 1988; Brent 1989; Clark & Horton-Deutsch, 1992; Hawton et al., 1998).

Despite the methodological shortcomings, some experts believe the medical-legal utility of the psychological autopsy technique is clearly demonstrated, (Jobes, Berman, & Josselson, 1986; Berman et al., 2006). "Although the specific format may vary, most investigators collect data relevant to the decedent's behavior, personality, style of coping, cognitive processes, psychiatric history, and general emotional life, so a rich psychological mosaic of the decedent can be assembled" (Berman et al., 2006; p. 85).

The Psychological Autopsy as a Therapeutic Tool

From all the studies using psychological autopsies as a research tool, there are only a handful that discuss the potential therapeutic value for suicide survivors (Shneidman & Farberow, 1961; Litman et al., 1963; Sanborn & Sanborn, 1976; Jobes et. al., 1986; Stillion & McDowell, 1996; Clark & Horton-Deutsch, 1999; Maris, 1999; Maris et al., 2000; Schwartz, 1997, 2001; Berman et al., 2006). Working within the death investigation model, Schwartz (1997) contended that although the primary responsibility of the investigator is to determine cause and manner of death, assisting survivors in the wake of a suicide does not have to be an obstacle to that task. A psychological autopsy conducted for forensic purposes can incorporate many therapeutic elements such as empathetic listening, the ability to join with family members, compassionate sensitivity to multicultural issues, building trust,

debriefing and crisis interview skills, as well as knowing when to ask questions and when to listen.

Berman et al., (2006) suggested, "conducting an informal psychological autopsy with surviving family members as a means of addressing the haunting 'why' questions" (p. 349). Stillion & McDowell (1996) placed psychological autopsies in the category of *postvention* as a method of reducing the aftereffects of a traumatic event such as a suicide for survivors. Stillion & McDowell (1996) noted, "...the investigation (psychological autopsy) may help the survivors to understand better the 'why' behind the suicide," (p. 229). Lastly, but perhaps most importantly, Curphey (1961) reports that survivors have acknowledged that in a death investigation the interviews themselves have been therapeutic.

A skilled investigator can blend the medical-legal with the clinical when conducting a psychological autopsy. In this way, the unfolding of chronological data through the triangulation of multiple interviews helps establish collaborative themes, behavior patterns and diagnostic hypotheses towards the intentions of the decedent's ending actions. Discovering the "why" of suicide with the help of a psychological autopsy can diminish the guilt, shame and anger that many survivors experience. Berman et al. (2006) states, "Ultimately, in cases of suicide, developing some sense of what one did and did not do is critical to finding one's way through the survivor's struggle of feeling responsible for the death" (p. 349).

The Schwartz Retrospective Profile (SRP)

The psychological autopsy format used in this case study was the Schwartz

Retrospective Profile (SRP). The SRP was developed and compiled locally by

Madelyn Schwartz, the deputy coroner assigned to interview the decedent's family

in this case study. Though not standardized or available to other jurisdictions, the

SRP has been used in forty suicide cases over the last fifteen years (Schwartz, 2001).

The SRP is a collection of over 400 questions, the use of which requires

additional training and practice. The pre-determined questions have been gathered

over the many years of interviewing family and friends who have suffered the loss of

a love one by suicidal means. Schwartz (2001) notes that many of the questions are

open-ended and act as a guide rather than following a standardized format. This

intuitive approach allows the interviewer to skip around from one idea or tangent to

another based on the level of grief the informant might be experiencing.

Also built into the interviewing format are time outs for those who are

extremely anxious or upset. A trained interviewer on the SRP may help the

bereaved to become more grounded to the present situation by suggesting such

techniques as breathing, visualization, walking or moving about, changing locations

or encouraging self-soothing activities that will help survivors complete the

interview.

One idiosyncratic characteristic of the SRP is that it be administered in a

clinically sensitive fashion accounting for the fragile nature of survivors who are

experiencing loss. Schwartz (2001) contends that the SRP has therapeutic value

within the forensic death investigation process based on the manner in which the questions are asked and how survivors are treated during the interview.

Case Study Design

Case study research design is a qualitative approach to empirically examine contemporary events and generating theory. Soy (1997) describes case study research "as a way to bring understanding to a complex issue or event. It also excels in helping to explain an experience or add strength to what is already known through previous research" (p. 1). In addition, case studies are useful for assessing the value of a therapeutic approach, especially when relevant variables cannot be manipulated in a prospective manner (Kazdin, 1982; Stake, 1995; Yin, 2003). The case study design, according to Creswell (1998) attempts to capture a comprehensive understanding of an event under study while at the same time developing more general theoretical statements about the regularities in the observed phenomena.

Definition, History and Limitations of Case Studies

Researchers Bogdan & Biklen (2003) define a case study as "a detailed examination of one setting or single subject, or a single depository of documents, or one particular event" (p. 54). Yin (2003) defines the case study research method as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly

evident; and in which multiple sources of evidence are used" (p. 23). The strength

of case study research is the ability to incorporate a full complement of differing

data sources, such as documents, artifacts, interviews and observations (Yin, 2003).

Often a case study describes a rare or unusual condition or event but it may also be

an account of a new or classic situation. Creswell (1998) said, "a case study is an

exploration of a 'bounded system' … a program, an event, an activity, or individuals"

(p.61).

There are many types of research strategies within case study designs, such

as experimental, survey, archival analysis, and historical or individual cases

(Werner & Schoepfle, 1987; Ragin & Becker, 1992). The goal of using a single case

study approach aligns well with the aims of psychological autopsy research. A case

study can provide a richer context of an event, as well as increase the understanding

about the "why" questions of a suicide death. Creswell (2003) distinguishes single

case studies as "having the ability to examine the meaning of experiences within a

specific and unique setting, bounded in time and place, using rich contextual

materials to provide an in-depth picture from multiple sources of information," (p.

15).

However, both Stake (1994) and Yin (2003) noted that case studies are

limited both by the lack of rigor of the research methods and the potential for bias in

data collection and analyses. Additional difficulties involve the use of participant

observation as a method of data collection. Research that relies on observed

behavior is in danger of altering the results by the very act of observing it. However,

the participant-observer relationship is also an advantage that can capitalize on

greater access to groups or situations that might be more intimate with the researcher, which provide access to more revealing detail.

Despite these shortcomings, Yin (2003) suggests, "case studies have a distinctive place in evaluation research" (p. 15) and noted at least five different applications:

a) A case study design can help explain causal links in real-life interventions;

b) Case studies are an excellent choice in research to describe an intervention within a real-life, real-world context;

c) Case studies are often the design of choice for illustrating certain topics;

d) Case studies can explore situations in which interventions used have no clear, single set of outcomes, and;

e) Case studies are frequently used to study an evaluation study – meta-evaluation.

Case Study Design in the Research of Suicide

Overall, single case study designs have a long and rich history in the research of suicide. Brent, Perper, Moritz, Allman, Friend, Roth, Schweers, Balach, & Baugher, (1993) use case studies to identify notable risk factors associated with suicidal death. Brent, Perper, Moritz, Baugher, Roth, Barach, & Schweers (1993) apply case study research to relate stressful life events and psychopathology to completed suicides. Case study designs have also explored the use of firearms in adolescent suicide (Brent, Perper, Moritz, Baugher, Schweers, & Roth, 1993), studied affectively ill adolescents (Brent, Perper, Moritz, Baugher, Schweers, & Roth, 1994) and been

used to help identify familial risk factors associated with youth suicide (Brent, Perper, Moritz, Liotus, Schwears, Barach, & Roth 1994).

Specific to medical-legal or forensic investigations, case studies have been used to examine required reporting data from medical examiners and coroners (Hoberman & Garfinkel, 1988a; Jobes, Casey, Berman, & Wright, 1991; Berman, et al., 2006). In addition, psychological autopsies have been used to collected valuable and insightful data about suicide deaths (Shafii, Carrigan, Whittinghill & Derrick, 1985; Rich, Young & Fowler, 1986; Gould, Fisher, Parides, Flory, & Shaffer, 1996; Brent, Baugher, Bridge, Chen, & Beery, 1999).

Designing the Case Study Protocol

The first stage of building case study methodology is the development of the case study protocol (Yin, 2003). An efficacious case study protocol according to Yin (2003) "...is important to the researcher for three reasons: a) it acts as the primary filter in the data collection process keeping the study squarely focused on the subject of the case study, b) the framework of the protocol provides guidelines for anticipating potential snags such as identification of readership and predetermining how a case study report will be written, and c) the case study protocol provides a description of the subject or subjects and targets the direction of analysis in the research study" (p. 69).

The four general sections of a case study protocol, as recommended by Yin (2003) include:

1. *An overview of the case study project*: background information about the case and the substantive issues being investigated.

2. *Field procedures*: designated data collection procedures, description of accessing the case study site, and procedural safeguards when working in the field.

3. *Case study questions*: not just the specific questions that are to be answered from the research but the potential sources of information for answering each question. Yin (2003) notes that there are three types of questions that often define the scope of case study design. The three categories are: a) exploratory, b) descriptive, and c) explanatory. When developing case study questions, Yin (2003) offers a multi-level format, noting that the first level of questions are posed to serve as reminders regarding the information that needs to be collected and why (p. 74).

4. *A guide for the case study report and findings:* outline, format for the data and presentation of the source information.

Sources of Evidence

The case study protocol is built from an array of data, which adds significantly towards the description and augmentation of the phenomenon observed. Case study designs are strengthened when multiple sources of evidence can be obtained. Creswell (2003) and Yin (2003) recommend the following sources of evidence be used in case study research. These include:

1) Documentation (letters, agendas, written reports, administrative documents, newspaper clippings, etc.),

2) Archival records (maps, charts, lists of names, journals, calendars and telephone listings, etc.),

3) Interviews (psychological autopsy),

4) Direct observations (formal and informal in the field, on site at the Coroner Office or in the homes of the informants),

5) Participant-observation, (access to deputy coroners, trainings and conversations, etc.) and

6) Physical artifacts (photos, media materials, etc).

No single source of evidence is more advantageous than the other, however efficacious case studies use as many sources as are available. All six evidence sources were incorporated into the current research project.

Data Collection

In order to build a case study protocol to maximize overall benefits from collected evidence Yin (2003) recommends three principles of data collection to address construct validity and reliability issues (p. 97):

a) *Principle 1 – The Use of Multiple Sources of Evidence:* According to Yin (2003), a major strength in case study data collection is to use many different sources of evidence. Yin (2003) suggests, "…that by using

multiple sources the process allows the researcher to address a broader range of historical, attitudinal, and behavioral issues" (p. 98). The most important advantage in multiple evidence sources, as noted by Yin (2003), is the development of "converging lines of inquiry" (p. 98). This study used all six sources of evidence, which include documentation, archival records, interviews, direct observations, participant observations and physical artifacts.

b) *Principle 2 - Creating a Case Study Database*: The second principle has to do with the organization and documenting of the data collected for the case study. The lack of a formal database in case study design has historically been a major shortcoming of case study research. As a result researchers who use qualitative designs remain intentional and organized from the onset. Yin (2003) noted that without a case study database, raw data might not be readily available for independent inspection limiting the overall reliability of the case study. By keeping the database separate from the case study report data can be tracked more easily from each source point increasing the likelihood of reliability.

c) *Principle 3 - Maintain a Chain of Evidence:* The final principle proposed by Yin (2003) is to maintain a chain of evidence to increase the reliability of the information in the case study. This is the process of connecting the final case study results and findings to the case study database. The

objective during data analysis in this study was to work thoroughly and introspectively and allow the chronology of events to form the pairing of the collected evidence. For instance, time stamped reports from the various professionals who are called to the scene of the death, i.e. Medic One (ambulance service), law enforcement and the deputy coroner could be compared to determine how each professional viewed the events at the death scene. Further pairing of events to the collected evidence occurs by comparing the narratives of each report, which helped to establish the facts of the death as seen by each professional. In this way, patterns or groupings of contextual evidence emerged, as well as allowing for possible comparisons between the first and second death investigation. This process of explanation-building or meaning-making from the patterns highlighted significant similarities and denoted differences between the two death investigations.

As noted by Creswell (2003), the question of reliability "plays a minor role in qualitative inquiry with the exceptions of using member-checking, peer debriefing and clarification of researcher bias for examining the general stability of the study" (p. 195). In addition, another strength of case study design is developing the validity and accuracy of findings from "the perspective of the researcher, the participant, or the readers of an account" (Creswell, 2003, p. 196).

Data Analysis

Once data are collected, the process of interpreting and analyzing evidence can be challenging for case study designs. Richards (2005) suggests, "...the goal is to get up off the data and open your inquiry to wider considerations of some aspect of the process being studied" (p. 71). Yin (2003) recommends three general strategies that treat evidence fairly, produce compelling analytic conclusions and help to rule out alternative interpretations (p. 109). These strategies include:

1) *Relying on theoretical propositions*: involves the original objective of the case study to use psychological autopsy information to inform about teen suicide.

2) *Thinking about rival explanations*: the consideration of other explanations in the discovery of 'why' suicides occur, and;

3) *Developing a case description*: this is the primary emphasis of this case study, a descriptive approach to explore the meaning of using psychological autopsy information to understand suicide deaths.

Coding Procedures

Coding procedures are also an element of the case study protocol. Qualitative research endeavors to make sense of complex contextualized data from such sources as transcripts, archived records or the researcher's own bias. Themes and/or meanings surface as multiple sources of evidence are reviewed reducing data into recognized patterned categories. These categories are then coded in different ways such as by descriptions, topics or analytically (Richards, 2005). Hahn

(2008) notes that, "the goal of the coding process is to focus ideas and to organize data that exemplify concepts, categories, and themes" (p. 86). Rossman & Rallis (1998) describe coding as "the process of organizing the materials into "chunks" before bringing meaning to those "chunks,"" (p. 171). Richards (2005) remarked that, "the goal [of coding] is to learn from the data, to keep revisiting it until you understand the patterns and explanations" (p. 86).

In qualitative research each constructed category represents a place to put ideas, descriptions or concepts. The purpose of coding is to develop ideas and explore the relationships of those ideas. Richards (2005) writes, "Nodes catalogued on computer are not folders for segments of data. They are items you can move around, combine and re-sort, recoding the data coded at them, as you explore ideas" (p. 109). The data is interrogated and coded multiple times. Hierarchical catalogues emerge representing the major dimensions of the research project.

Research Methodology of the Case Study

Informed Consent

This research study was approved by Antioch University's Human Subject Research Committee to review documents from the Coroner's Office collected in the investigation regarding the suspicious death of a 13-year-old. As a part of the investigative process conducted by the County Coroner, all informants who agreed

to a psychological autopsy interview signed informed consent forms. See Appendix
D.

The Research Project

This research project came about as a result of the researcher's increasing

interest in using psychological autopsies to help families resolve discord in

equivocal deaths. With the support of Madelyn Schwartz, the Coroner's Office was

contacted about the possibility of conducting a research project into the death

investigations of the case described above. The Coroner's Office agreed to allow

access to the existing data.

Background of the Case Study Project

The following is a brief overview of how this investigative event became the

research case. Four situations converged that created the circumstances for an ideal

field study about the use of psychological autopsies in coroner investigations. The

circumstances were as follows: (1) a unique case occurred in Washington State

involving an equivocal death of a 13-year old, (2) the family of the teenager was

unresolved about the death and sought further information about it, (3) a local

deputy coroner, Madelyn Schwartz had developed a standardized approach for

conducting death investigations with a psychological autopsy, hereafter referred to

as the Schwartz Retrospective Profile (SRP), and (4) this researcher had completed

a 22-week training program with the Coroner's Office which provided information

about the case and was invited to assist in the investigation.

The focus of this case study is the analysis of documents relating to the death

of a teenager who died from ligature hanging in May of 2005. Particular to this case

was the equivocal nature of the death. The first death investigation began on May 4,

2005 and concluded on October 12, 2005. The deputy coroner who conducted the

investigation recorded the youth's death as a suicide, much to the chagrin of the

family. The family received other information after their son's death from

classmates, school officials and medical professionals. In light of this new

information, three months later, both the family and the deputy coroner came to

differing opinions as to the nature and circumstances surrounding the teen's death.

The deputy coroner reviewed further information that included additional sources

of information gathered from the decedent's home computer, a phone interview

from the principal of the decedent's middle school and several newspaper articles

highlighting a disturbing trend growing popular among middle-school-aged

students called the "choking game."

The family who at first believed their son died as a result of a terrible

accident, in the intervening months were besieged by emails, sympathy letters and

third person reports that suggested harassment and bullying at school were the

primary triggers which precipitated their son's suicide. The deputy coroner

disagreed based on his review of the case and recanted the first official Death

Certificate adding an addendum that changed the manner of death from Suicide to

Undetermined. This corrected version on the death certificate also included several

significant conditions that contributed to the death, namely bipolar disorder and

experimentation with the choking game.

The decedent's parents were frustrated with the Death Certificate as amended on October 19, 2005 and expressed their concerns in writing to the coroner. The parents were convinced their son committed suicide due to being bullied and harassed at school. After several in-house meetings within the Coroner's office it was decided to continue the investigation and a second deputy coroner was assigned to the case. By having a second death investigation the family's concerns would be taken seriously. Though not uncommon, medical examiners and coroners will routinely re-open cases if additional evidence is deemed relevant.

The second investigation was assigned to Deputy Coroner Madelyn Schwartz, who had previously developed the Schwartz Retrospective Profile. Ms. Schwartz made the decision to use the SRP and to involve this researcher in conducting the second death investigation. Ms. Schwartz interviewed the decedent's father, a 48-year-old Caucasian male, while this researcher interviewed the mother, a 39-year-old female of Asian ancestry, his 10 year-old brother and four classmates of the decedent. Though there was more information generated from the second investigation the result remained inconclusive. The decedent's manner of death remained undetermined.

The Case Study Question

At the core of the case study protocol is the research question, "In a case of suspected teen suicide how might psychological autopsies help survivors in dealing with loss?" This line of inquiry was the over-arching filter when collecting, coding

and interpreting the evidence. Secondarily, the research study examined death investigation practices in one county of Washington State that uses psychological autopsies and how their use might broaden our understanding of teen suicide and survivorship.

Sources of Evidence Gathered for the Case Study

Multiple sources of evidence were gathered for this case study. Table 2. presents the sources of evidence, data collected and sites of data collection.

Table 2. **Sources of Evidence**

Sources of Evidence	Data Collected	Site of Collection
1. Documentation	*Letters, written reports, emails, newspaper clippings, transcripts of voice recordings, Coroner report, police incident reports, medical report, toxicology findings, medical incident report, doctor and psychiatrist reports, death certificate, corrected death certificate, psychological autopsy protocols.*	• Coroner's Office
2. Archival Records	*Personal journal records, calendars, county demographic data, County Coroner SOP manual & procedures, medical history of decedent, downloaded articles by decedent's parents from the internet pertaining to suicides, ligature hangings, poems and songs by survivors.*	• Coroner's Office
3. Interviews	*Voice recordings of case study participants, voice recordings of Deputy Coroner, telephone interview notes from doctor, school personnel, classmates of the decedent.*	• Coroner's Office • Home of case study participants
4. Direct Observations	*Visit to the home of the decedent's family, visit to the County Coroner office to access files and converse with other Deputies involved in death investigation work.*	• Coroner's Office • Home of case study participants
5. Participant-Observation	*Researcher had several roles in the study, volunteer for the Coroner's office and interviewer for the study.*	• Coroner's Office • Home of case study participants
6. Physical Artifacts	*Pictures of decedent taken by the Coroner, pictures taken by the interviewers at the 2nd investigation of decedent room & drawings made by the decedent*	• Coroner's Office • Home of case study participants

Data Analysis Overview

The first death investigation was the original source of information about the circumstances of the decedent's death. It focused on the "who, what, where and when" aspects of the death and did not investigate family or community dynamics. The second investigation started seven months after the death and provided the contextual details that were used to address the study's research question. Data analysis for this research project involved analyzing the factual data from the first death investigation, analyzing the data from the second death investigation that used psychological autopsy interviews and comparing the two in light of what was helpful to the family in resolving the loss of their son.

Data Collection of the First Death Investigation

The Coroner's Office maintains a comprehensive file for every decedent, which included the evidentiary basis for the investigation. The archival evidence was on file with the Coroner's Office from the first death investigation prior to the psychological autopsy interviews and was reviewed by the researcher. Each of the official archival documents was copied and numbered by the researcher for use in the research project. Four summary source reports were among the evidence. These included one report by the Coroner's Office, one report from law enforcement, two reports from medical personnel (the two medical reports were from Medic One and from the emergency room). Additional evidence on file included eighteen documents such as telephone notes, a toxicology report and media articles. (See Table 3. Table Contents of Field Evidence from the First Death

Investigation). In all, twenty-two documents or 45 pages of evidence were logged,

dated and entered into the case study database. Analysis of the first death

investigation was confined to review of the investigation file because the deputy

coroner who conducted the initial death investigation was not available to comment

on the investigation nor was the Coroner, who at the time of this study, had recently

retired.

Data Analysis of the First Death Investigation

  Analysis of the first investigation consisted of entering the data into a

qualitative software program called NVivo8 (QSR International Pty Ltd, 2008).

Documents were read multiple times and reflected upon through the use of

annotated notes. The researcher's emerging reactions to the data were captured in

a hand-written log. This included thoughts such as possible associations between

the data sources, possible underlying assumptions of the death investigator and the

viewpoints the researcher brought to the analysis.   The latter allowed the

researcher to become more aware of and to explore personal biases, in a process

known as *bracketing* (Richards, 2005).

  After several reviews of the data, the researcher developed a time frame.

Outlining the dates when evidence was collected brought a temporal component to

the analysis, which allowed underlying content themes to be more easily discerned.

In addition, other contextual information such as the source of the evidence and

other details specific to the investigation, were gathered into an evidentiary table

(See Table 3. Field Evidence for Initial Death Investigation)

Table 3. **Field Evidence for Initial Death Investigation**

First Death Investigation - Official Records from Coroner File

		Date
1.	Level 1. Primary Coding Categories: Pre-Psychological Autopsy	No date
2.	Decedent. Coroner's Report 2. Decedent. Coroner's Report.	05/04/05
3.	Narrative of Coroner's Report 3. Narrative of Coroner's Report.	05/04/05
4.	Narrative of Coroner's Report – Addendum 4. Narrative of Coroner's Report - Addendum.	10/12/05
5.	5. County Body View Record.	05/04/05
6.	6. County Case Notes.	05/04/05
7.	Deputy Coroner's (Lead Investigator) Notes from Dr. A., Psychiatrist 7. Case Notes from Dr. A.	No date
8.	WA State Certificate of Death 8. WA State Certificate of Death.	05/09/05
9.	WA State Certificate of Death – Corrected Copy 9. WA State Certificate of Death – Corrected Copy.	10/19/05
10.	P.D. Incident Report – Death Investigation: Juvenile 10. PD Incident Report.	05/05/05
11.	P.D. Incident Report – Death Investigation: Narrative 11. PD Narrative.	05/05/05
12.	Medic One Incident Response 12. MO Incident Response.	05/04/05
13.	WA State Toxicology Report 13. WA State Toxicology Report.	05/12/05
14.	Faxed Medical Records from Hospital 14. ER Visit 10/24/2000 (T. B. M.D).	05/05/05
15.	Hospital - Emergency Record 15. Summary of medical events when Decedent arrived at the hospital.	05/05/05
16.	Hospital – Release of Body to Morgue 16. Procedure Form.	05/05/05
17.	Hospital - Consent for Tissue Donation 17. Records	05/05/05
18.	Letter from the decedent's family to the Coroner 18. Transcribed Letter	09/12/06
19.	Letter from Coroner 19. Transcribed Coroner Letter	09/13/06
20.	Decedent's family response to the Coroner 20. Transcribed Letter	09/20/06
21.	Faxed Health Records – Archive – 21 Pharmacy Records of Deceased medications	10/20/05
22.	Faxed Health Records – Archive – 22. Historical Prescription List From age 11 was on antidepressants/antipsychotic medications	10/20/05
23.	Dear Abby Article Regarding the Choking Game	No date
24.	Medicolegal Death Investigation Guidelines Contrasted with TCCO	No date

From this initial outline, the data was reduced into categories through coding of the evidence. The researcher re-coded the datum using different classification systems. Eight categories of information that emerged from this process included:

1) Hospital Information *(H)*,

2) Forensic Information *(For)*,

3) Eye-Witness Information *(EW)*,

4) Family Information *(Fam)*,

5) Psychopathology *(Psy)*,

6) Law Enforcement *(LE)*,

7) School Information *(S)*, and

8) Research Bias/Reflections *(RB)*.

The iterative process of coding resulted in a conceptualization of the first death investigation rich in descriptive context (See Figure 8. The First Death Investigation).

Figure 8. **The First Death Investigation**
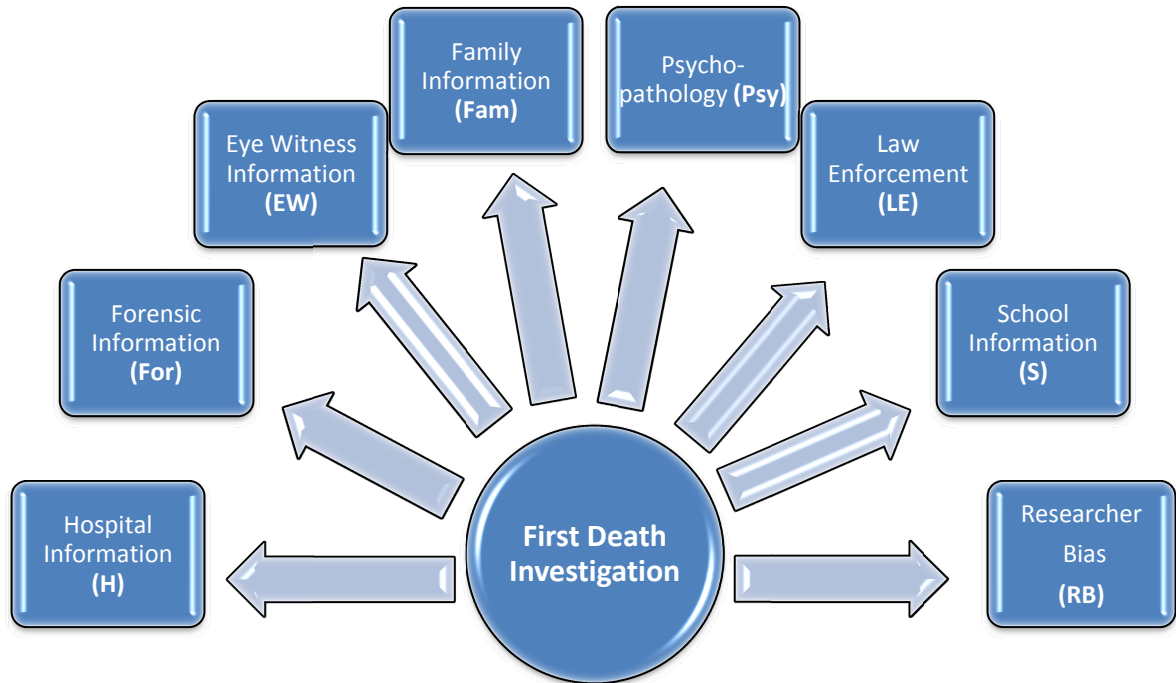
Hospital Info (H)	Forensic Info (For)	Eye Witness (EW)	Family (Fam)	Psychopathology (Psy)	Law Enforcement (LE)	School (S)	Research Bias (RB)
• EMS Report • Toxicology Report • Medication Hx • Notation of Prior Hospital Visit for Psych. Evaluation • Death Certificate	• Description of Body (Superficial) e.g. age, gender, race. • Description of Clothing • Description of EMS CPR Work on Body • Description of Injury • Description of Rigor, Livor & Temp. • Toxicology Report • Police & EMS Report • Death Certificate	• Description of Incident Scene - Police Report & EMS Notes • Description of Incident by mother as reported from Police & Coroner Interviews • Case Notes revealed interviews conducted with Fire & EMS Personnel.	• Demographic Information • Eye Witness Report • Tissue Donation • Police Report Description	• Hx of Bipolar Disorder & Depression • Hx of Tourette's Syndrome • Hx of ADHD • Played with Fire • Played at Hanging Him Self • Received Counseling • Compliant with Prescribed medications; Antidepressant & Antipsychotic	• Scene Investigator • Collection of Evidence • First Contact with Parent, Medics & Firefighters • Liasion Officer @ MS	• Media Article re: Choking Game • Interview with Middle School Principal • Comments about School Culture re: Choking Game	• Background in Mental Health • Worked in Schools • Trained as Coroner Volunteer

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Data Collection of the Second Death Investigation

The second death investigation consisted of all the data that was part of the first investigation but additionally included seven transcripted interviews from family members, friends and medical personal, notes from parents, electronic mail correspondence from community members to the family, drawings made by the decedent and other miscellaneous documentation. In total, the second investigation included twenty-three documents, 227 pages of evidence, 7 photographs and 5 drawings (See Table 4. Field Evidence for the Second Death Investigation) To view the decedent's drawings see Appendix B.

Data Analysis for the Second Death Investigation

The analysis of the data from the second investigation was conducted in the same manner as previously done with the first investigation data, resulting in Table 4. (See Table 4. Field Evidence for the Second Death Investigation)

The codes used for identifying the eight categories used in analyzing the data in the first death investigation, were used to analyze the second death investigation as well. In addition, the categories were further broken down in order to contain the expanded amount of data obtained from the second investigation. For example, eye-witness data was broken down into information about the decedent prior to his death and grief reactions from others as a result of his death. Reducing the data once more down into topic areas derived these second-level codes. Yin (2003) refers to this process as "Simple Pattern Matching - whereby the researcher looks for discernable connections among relationships, interviews, details surfacing in

similar environments and behaviors consistent over time" (p. 119). A

representation of the second death investigation is seen in Figure 9.

Table 4. **Field Evidence for the Second Death Investigation**

Second Death Investigation - Additional Evidence Collected

		Date
1.	Typed List of School & Medical Professional written by Dx Mother	No date
2.	Hand Written List of Possible Contacts by Dx Mother	No date
3.	Table of Contacts by Dx Mother with comments	No date
4.	Copy of RCW 28A.300.285 Harassment, intimidation & Bullying Policies	No date
5.	Web Article Suicidality from Antidepressant Medications	No date
6.	Ltr. From K.B.	05/05/05
7.	Email Message: From Mc (9:54 PM)	05/25/05
8.	Email Message: From Mc (9:55 PM)	05/25/05
9.	Email Message: From Mc (10:09 PM)	05/25/05
10.	Email Message: From G.C.	07/09/05
11.	Ltr. From C.O.	No date

12.	Internet Articles on Suicide collected by Dx Mother
	  In the end, we're all naked (3 pages)
	  Erotic article on hanging (4 pages)
	  Bill's Story (8 pages)
	  Jared's Story (7 pages)
	  Page with handwritten note (1 page)
		10/20/05

13.	SRP of (Mother of deceased). *C. Field Notes*	01/25/06
14.	SRP of (Father of deceased). *M. Field Notes*	01/25/06
15.	SRP of (Younger brother of deceased). *C. Field Notes*	01/25/06
16.	Copies of Dx Drawings given to Coroner by Mother (5 pages)	01/25/06

17.	Pictures of Dx room & house taken by C. W.
	  Dx room – wall opposite of bed
	  Dx room – wall over bed
	  Dx room – inside shot of door & chair
	  Dx room – inside shot of just door
	  Dx room – Bed looking down
	  Dx room – Pictures on walls in room
	  Dx room – Funeral home program use at burial
		01/25/06

18.	SRP of A. (Peer of Deceased). *C. Field Notes*	03/08/06
19.	SRP of J. (Peer of Deceased). *C. Field Notes*	03/15/06
20.	SRP of K. (Peer of Deceased). *C. Field Notes*	03/23/06
21.	M. notes from phone interview with Dr. W.	08/04/06
22.	M. notes from phone interview with Dr. H.	09/05/06
23.	Newspaper Article: "Blue Christmas' Comfort Offered" (Mother talks about death)	12/17/07

Dx=Decedent
SRP=Schwartz Retrospective Profile

Figure 9. The Second Investigation

The Second Investigation

Hospital Information
- Diagnosis & Intervention
- Bio-Chemical

Forensic Information
- Lethal Self-injury
- Thwarted Belongingness
- Perceived Burdensomeness

Eye Witness
- Grief Reactions
- Recollections Prior to Death

Family Information
- Descriptions & Relationships
- Therapeutic Responses

Psycho-pathology
- Psycho-social Factors

Law Enforcement

School Information
- Peer Relationships
- Adult/Teacher Relationships
- School Harassment

Researcher Bias
- Interviews
- Coroner Office

Analysis of Combined Data Sets

By comparing the differences and commonalities from the entire forensic investigation of this equivocal death, the addition of psychological autopsy information was analyzed to understand the influences it might have on the family. The two death investigations provided the structural framework for viewing the contextual evidence. Because not all investigations use psychological autopsy interview information, analyses concentrated specifically on the verbatim transcripts produced by the informants. From the onset, some notable differences between the two investigations emerged:

1. The investigations were conducted by different deputy coroners employing slightly different theoretical mindsets during their investigation;

2. The second investigation was conducted seven months after the first investigation had concluded;

3. The second investigator did not have access to the body of the deceased;

4. The second investigator could not examine the scene of the death;

5. The second investigator did not have the opportunity to interview the family, medical personnel or law enforcement immediately after the death;

6. The second investigation was susceptible to memory changes from the informants.

The investigative processes for both investigations were inherently the same with the exception that more information was collected from administering psychological autopsies. The six interviews gathered from family and friends constituted between 25 to 30 hours of additional evidence, not counting follow-up interviews based on the information provided by the informants.

The process of looking at the data from each investigation culminated in a narrative-based description written by the researcher about the last days of the decedent's life. Although speculative in nature the story was based on intimate information from both family members and friends of the decedent, as well as conjectures and conclusions from the professionals who were involved with the decedent. This narrative is a means for the researcher to present his view of the case, enriched by the data and supplemented by empirical insights, in real human terms. The following section, in the tradition of case study reporting presents the events leading up to the decedent's death.

Jon's Story

Due to the sensitive nature of this story all the names have been changed, the ethnicities of family members have been altered and the location of events confined to an unnamed county in the State of Washington.

May 4, 2005   Wednesday 6:30 AM

The alarm went off for the second time in Jon's room but no stirring occurred under the bed sheets until his mother, Jacinda came to his door to shout his name and tell him he had 15 minutes to dress and come down for breakfast. Jon's mother remembered, "Jon had real trouble getting up in the mornings. He didn't sleep well, sometimes getting up 3 or 4 times in the middle of the night before falling asleep either in his room or down on the living room couch." Jon stumbled out of bed and puts on a red t-shirt, beige pants and white socks. We know what Jon was wearing on Wednesday May 4th because in 13 hours a deputy coroner would be viewing his body at the hospital before releasing it to the county morgue.

Jon joined his 11-year-old brother, Thomas, for breakfast. Instead of eating the warmed waffles his mother heated up in the microwave, Jon opted for cold cereal and minimal conversation. While in the kitchen, Jacinda was reviewing the day's events reminding the boys that after picking Thomas up from school she had to run to the doctor's office before coming to get Jon. If he was paying attention, he missed the part about his mother packing for a weekend Cub Scout outing with his brother Thomas. Jacinda reported that "Jon is not a morning person, he's quiet and internal and a little grumpy." She asked Jon what he would do after she dropped

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him off at school around 7:25 AM. School wouldn't start until 8:00 AM. Jon replied, "Oh, I go back to sleep." Quizzically, Jacinda wanted to know where. Jon responded matter-of-fact, "Oh, just anywhere; the library or the cafeteria." Mother pressed, "So, how do you know when to wake up?" For the first time looking at his mother, Jon said reassuringly, "Mom, school is a noisy place, bells ring, people are loud when they go off to classes." Jacinda may have been wearing the same worried face since Jon first entered Kindergarten.

Family History

Jon was born in Eastern Washington but his parents met overseas in the Far East *(true ethnicities, names and places are confidential)*. Jon's mother explained that Jon's father, Charles, has a sister who was working for the Governmental Office as an occupational therapist in her country. When Charles's sister returned to the states she raved about the country. Charles was so impressed with his sister's description of the country and her experiences abroad that he took some time off from his job in Denver, Colorado where he worked as a lab assistant to do a tour of many Asian countries. It was on his vacation that he met Jacinda and they began a long distance romance until finally marrying a year later.

Jacinda proudly acknowledged that, "Charles's family is level-headed. My family is very emotional, and, you know, I mean, they have issues too, but my family, being Asian and all don't even acknowledge mental illness." Jacinda continued, "On both sides of our families there is a history of Bipolar Disorder. Charles had a grandmother who committed suicide and I had a brother who was hospitalized 20

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times who was probably bipolar. My brother had medication but he never took it. In Asia, these things are not recognized. It's taboo. Both of our parents, Jon's grandparents, each suffered with Depression. Charles's dad died of rare illness at age 54 and I have a sister who I think is obsessive compulsive. She is a hoarder, she'll never admit it, but, yeah, our families have issues."

Jon was described as an easy baby by both of his parents until about age three. There were no complications during pregnancy or delivery, however, Jacinda noticed, "Jon was either very quiet or very demanding. He was behind in development, you know, learning to walk, learning to potty train. I ran a licensed day care in Washington so I could tell the difference. Jon had huge temper tantrums after his brother was born that were way beyond what other normal kids would have. But, doctors are unwilling to diagnose or medicate kids that young, so we just did the best we could."

At age seven Jon was diagnosed with Attention Deficit/Hyperactivity Disorder by a psychiatrist and prescribed Ritalin to help control his behaviors. Jacinda remembered having so much faith in doctors. However she lost faith and became more cynical as Jon's behaviors worsened. Jon didn't liked to be touched, his clothes bothered him and he was constantly pulling at the fabrics. He was irritable, quick to anger, pulled at his eyelashes, made animal noises and stuttered. By third grade, he had a list of diagnoses. Jon was labeled at various times as suffering from Oppositional Defiant Disorder, Depression, General Anxiety Disorder, Pervasive Developmental Disorder and Tourette's Syndrome.

Jon's pediatrician, Dr. Hyatt, suspected Asperger's but also had concerns about adolescent schizophrenia. He commented that Tourette's was an inappropriate diagnosis. He also expressed sadness about Jon's death and was surprised that his psychiatrist didn't think Jon would have attempted suicide.

The Breaking Point

"October 2000, Jon was 10, he was taking both Ritalin and Paxil." Jacinda takes a breath, "We were visiting my folks in Southeast Asia." Charles interrupted, "This was the worst of times for Jon, the height of his illness, he would say to us, "I just want to die, I don't want to live anymore, I have this pain in my head, it hurts all the time." And, I said, Jon you're very sick right now. Your mother and I are trying our best to keep you from going further, you know, deeper into your illness." Jacinda remembered that the family was just a couple of days away before returning to the states and she gave him an Alka-Seltzer Plus for his cold. Charles continues, "It was actually Strep Throat and the doctors believed that having a virus in combination with the medications Jon was taking and the Alka-Seltzer it caused a seizure, several in fact. It took two people to hold him down. We were scared and angry. There was a huge law suit but we didn't join the class action. There was something in the Alka-Seltzer Plus, an anti-congestant or a decongestant that didn't mix well with the kinds of medications Jon was taking. It was crazy. I think he had three or four seizures during that time."

Jacinda had been waiting for an opening in her husband's restrained and slow delivery of the story. With heightened intonation, Jacinda added with energy,

"It was awful. We yanked Jon off all medications when he was at the height of his illness because nothing was working. He was un-medicated for three weeks while we waited for his psychiatrist to get back from his vacation. It was a storm waiting to … you know…, it was the lull before the storm. I remember, we had a huge crowd here [at the family home] because my cousin was getting married and I was hosting the bridal shower and in the middle of it Jon went out of control. We took him to the emergency room on the evening of the bridal shower, he tore up his room, he swore, yelled, screamed … he was possessed." Charles reached to touch Jacinda's hand, she noticed his taking her hand and he finished relating the story. "This was the breaking point. The psychiatrist began experimenting with different medications and by September of 2001, Jon's behavior began to stabilize. He was far from being normal, but he was making progress and he was managing his behavior better, so by the time he started 5th grade he was beginning to make a few friends."

Noticing several family pictures spread out on the dining room table, which were part of a picture collage displayed at Jon's funeral, Jacinda motioned to two pictures in particular: "That one is of him and me in Portland, my sister took the picture at a Subway restaurant." The picture was a portrait of mother and son staring back at the camera from the waist up. Jacinda's smile was forced, and she appeared to be trapping her son between her arms desperate to force closeness. Jon appeared uncomfortable but tolerated his mother's embrace. The shutter missed what could have been a moment of tenderness and caught instead, Jon looking to the left, head down with his face looking vacant and sad: "This was taken when he was in fourth grade. He was recovering from the horrible trauma in third grade. He was

under the chairs and under the tables, wrong medication, or when we finally found the right medication, we had to zonk him out so much just so he wouldn't tear up the house." Jacinda picked up another photograph, "He doesn't look right, because if you look at this picture, it's quite different. It was taken the Sunday before he died, April 30, 2005." This picture was a marked contrast to the first one. It was taken outside, depicting a lake in the foreground and mountains in the background. Jon was kneeling, one hand exploring the ground the other holding what looked like a piece of rock. The camera captured the instant he looked up beaming with excitement that only a discovery in nature could produce. His face looked relaxed despite a wiry body tense with energy. "We were camping on the coast when his dad took this picture. Jon loved being outdoors, it's hard being fidgety, or a perfectionist when you're outdoors."

Middle School (8:00 AM)

Jon made his way towards his first period class, which is choir. He had just come out of the library and was headed to the south hallway just off the cafeteria. It used to be one of his favorite classes, with a teacher he really liked until the "pants incident" (*to be described in next section*). There are several huddles of students breaking up and going their separate ways as they head to their respective classes. None glance his way as he passed them in the hallway. Because there are no lockers, students tote their books and materials in backpacks making even less room in the crowded halls. It is not uncommon, whether by accident or malicious intent, for a student to be knocked off their feet by making a quick turn with a fully loaded

backpack in a crowed hallway. Most 6th graders hate passing times, 7th graders have

learned to walk in groups and some 8th graders, who believe they are at the top of

the food chain, used the crowded hallways as an excuse to intimidate others and

entertain their friends. Though Jon spent much of his time trying to be invisible he

knew what it like to be bumped, goaded and teased.

The data failed to lead to a firm conclusion about whether Jon ever thought

school was a safe place. He didn't talk much about school to his friends or to his

family. His peers remembered Jon as shuffling rather than walking to class and

rarely smiled even when there were reasons to be happy, like on half-days or pre-

holiday celebrations. He was always respectful, chose his words carefully around

people he didn't know and preferred to do things on his own. Jon had a few friends

from the elementary grades who all described him as quiet, smart and skinny.

Friends knew him from birthdays, school events, swimming at the YMCA, Scout

meetings and a few home visits.

Randy knew Jon since 2nd grade. Though he only had one class with him in

7th grade he saw him occasionally at lunch and after school. Randy remembered

that, "Jon liked video games, you know, Pokémon, Super Smash Brothers and Mario

World, I think. He had a Nintendo 64, it was old style but when I went to his house

we played N64." Randy thought, "Jon was happiest when he was in 5th grade. We

both had Mr. Clark, he was a great teacher, I think Jon really liked him. I remember

he loved the class trip to Wolf Haven and our class overnight at Cispus."

Damon knew Jon from the 4th grade and remembered, "Jon liked to read. I

saw '<u>Lord of the Rings</u>' by his bed and I think Sci Fi stuff too." Damon continued,

"Jon never complained, he wasn't negative, he always looked a little bored with things. I do remember that his parents never let him use the Internet much. I think they tried to keep him in the Stone Age. Probably just to keep him docile so he wouldn't rebel or anything like that. He was a little weird, he liked to watch birds and his mother made him go to a language school, I think on weekends, so he could talk to his grandparents."

Kirk had known Jon the longest but his family had moved in and out of the school district twice and he only reconnected with Jon in 6th grade when they began hanging out again. "I used to go over to his [Jon's] house and trade Pokémon cards and play video games and stuff like that. He was probably closest to his mother and talked about his family, especially his brother Thomas. He was really family oriented." "At school I would say Jon is a loner. He didn't play sports, I think he liked math and I saw him a couple times each week during the YMCA after school program." "Jon was always friendly to me, he had a few friends I didn't know well but basically he was a solitary guy."

The middle school that Jon attended is in an upwardly mobile neighborhood with houses selling in the range between $295,000 and $650,000 in the year 2005. In general, Jon's middle school had about 700 students and the school's WASL scores were above State and National averages in all academic areas. There are three separate hallways in the school, each grade having their own wing for block classes. The school has two gyms, a weight room, a music and chorus room, a cafeteria and administrative offices located towards the entrance of the school.

Jon had been in special education since 1st grade and he continued to receive support even in the middle school, however it was called a study hall to lessen the stigma of being in a special class. As Jon became better at managing his behavior he probably didn't need what special education had to offer, but his mother liked the idea more than Jon, according to Jacinda.

The Pants Incident (one week before Jon's death)

Kirk had choir with Jon but was not in the classroom when the "pants incident" occurred. Kirk heard one version from several of his friends and later talked with Jon about it. Kirk said, "Jon normally wears a pair of sweats, a t-shirt and a sweatshirt to school. It was before class started and Mr. Wilson was not in the room, Jon stood up and a girl, I don't know her name, pulled Jon's t-shirt and said, "Jon, Jon your shirt is on fire, now it's out." Just as Jon was tucking in his shirt the bell rang and kids came in the room but all they saw was Jon's hand down his pants and people started to chuckle. One kid said Jon was "jerking off." Mr. Wilson, our choir teacher sent Jon to get some paper for the printer so he could talk to the class. He said, Ok, if you guys are going to laugh, then laugh, then we're done. I didn't laugh. It wasn't that funny, but there were, like, almost half the class was laughing."

Middle schools can be challenging for some kids as they transition between elementary and high school. Jon was a late bloomer, appeared younger than his peers, was small and skinny, and tended to keep to himself. He then suffered the ultimate in middle school humiliation, classmates rumored that he was playing with himself in class. Kirk was sympathetic, "It was hard enough on Jon being in the Alto

section, which was, I might say, not normal, because there was just a few guys in the

Alto section, maybe two and Jon was one of them. Then when Jon was in PE, some

kids gave him a hard time. I heard it. I didn't see it, but I heard it in the locker room

– a couple of guys making fun of him, "Why did you stick your hands in your pants?

Are you gay? And stuff like that."

Kirk didn't think it was a huge thing but he acknowledged it probably hurt

Jon in some ways, though you couldn't tell from Jon's somber exterior. "He mainly

just ignored it all, but that was the way Jon was, he didn't seem to care." Jon's

mother thought differently about the incident, "I think it bothered him up until the

day he died. And the choir teacher, he knew about this teasing because this teasing

wasn't just one day. Other kids heard about it and harassed him, you know on top of

everything else. I think Jon quietly suffered, he never told me about it, but he

thought about it until the day he died."

A Closer Look

Several pieces of evidence reported in the first investigation can be

understood differently about Jon's death after the post psychological autopsy

interviewing.

1) *Images from the computer.* In the first investigation, the deputy coroner

took time to view the files that the decedent had saved to the hard drive.

But it wasn't until Charles, who is a computer programmer, noticed the

same files and dug a little deeper to find photographs of people being

hung. Jacinda said, "We showed these to him [the first deputy coroner].

In Jon's assignment notebook - for history it looked like he was going to

do a paper on how criminals were punished in Europe. But then we

found another file labeled Kuwait with more pictures of public hangings."

Charles added, "The file was dated March 2005. Was he looking at ways

to kill himself?" Having heard this question, Jacinda was reminded about

another incident regarding images, "This is a sore spot between me and

my husband but he likes to watch horror videos. You know, people-chop,

chop, chop-that kind of thing. I don't watch them but I know they are

violent so I hide them away upstairs and he [Jon] found them. And when I

saw him watching it, I said, "Please Stop!" Images of horror and killing,

you know. This was in the winter time [2005]." Jacidna continued, "This

wasn't the worst of it. He researched his death so it would be final.

Charles found a site he had visited called "Ogrish," O-G-R-I-S-H. I Googled

it, thinking it must be some Middle Eastern word, a foreign word that I

don't understand, and guess where it took me? It took me to a forum on

how to kill yourself, suicide, how to hang yourself. It's a forum, and it will

tell you different steps on how to kill yourself where it's sweet and

painless or, if you want it bloody, a bloody mess. It was sickening."

2) *The dryer.* Jon went inside the dryer. Jacinda walked me to the laundry

room and showed me the front-loading dryer. She opened the door of the

dryer and said, "He climbed in there. I did not see him do it, but I know he

went in there." The laundry room sits just off the entry into the garage

before passing into the kitchen. "He went in this room, I heard him go

this way and I thought, where did Jon go? So I went to the garage and said, "Jon, Jon where are you? And I know I didn't ask him to go there to get anything, like for one of his chores. I kind of thought, where did Jon go? So I came back around this area [past the laundry room] and walked around the house and a couple of minutes later I heard the dryer. He was in there. And he knew I was looking for him, so he knew it wasn't his time, I would find him, so he got out. He tried to kill himself then. This was in February or March [2005]."

3) *The neighborhood friend*. Thomas, Jon's younger brother says, "We have two dogs. My dog's name is "Bones" and Jon's is "Ashes." Jon would have Ashes pull him on his bike. Ashes is about 65 pounds but he is a really strong dog. Sometimes Jon would get Ashes to pull Stevie. Stevie is my age and has an older sister; a grade older than Jon named Katie. We were playing out in the street, a car went by and I heard Jon say something to Katie, but not exactly, I did hear Katie say, "You're weird!" I asked Katie what Jon said and she said, "I wonder what it would be like to kill myself and throw myself in front of that car."

4) *Harassment*. Every person interviewed mentioned at least one or two incidents of Jon being bullied or teased. Jon's mother collected eight pages of names of people who had heard or saw Jon being bullied. The "pants incident" was the most significant, however, all of Jon's friends witnessed some form of harassment. Usually it was name calling, sometimes it became more physical. Jon's mother remembered, "His

clothes, a lot of them had little tears, and I could never understand why. I
don't know if he got into fights at school or if he was just rough with his
clothes. I saw bruises on his body, too, occasionally, and I know kids
bruise, but when I asked him about it, he would say no, or looked at me as
if to say, that's all I will say." Kirk remembered punching a kid for calling
Jon names. "It was in 4th grade, some kids in the popular group were
making fun of him. He [Jon] asked them to stop but they just went back to
what they were doing, then I stepped in and asked them to stop.
Someone pushed me and I pushed back."

5) *The Phone Call.* At 2:20 PM Jacinda received a phone call from Jon at
work. Her first thought, "Oh, my goodness what's up, I hope it's not an
emergency, so I was getting a little worried and then he said, "Oh, mom
that grade that I had a C-minus in, I got it up to an A-minus," and I said,
"How did you do that?" Jon said, "It was big homework that carried a lot
of weight and I forgot to put my name on it so I had a zero, then the
teacher asked me if it was my work and it pulled my grade up." I was
excited for Jon, I told him, "Excellent! Good job! We care about his
grades, you know. He knew that too." As Jacinda looked back on that
moment, she revealed that Jon never called her at work before and that
the information about his grade could have waited until he got home but
she interpreted this phone call as, "When I think about it now, I think he
was saying good-bye."

After School (5:25 PM).

Jon participated in an after school program each day, mainly because his mom's job ended each day after Jon got out of school. Jacinda had several reasons for this schedule: it gave Jon time to finish his homework, he didn't have to be home alone and she thought he might make some friends. Jacinda has always been concerned about Jon's social skills, "He doesn't make friends easily, he hated change and he's very particular about things." Jacinda remembered that today she had to run to the doctor's office and she only had time to pick up Thomas before going by the school to get Jon after her appointment. She recalled stopping to pick up some food for the boys at a Jack-in-the-Box because it was next door to her doctor's office. "As soon as Jon got in the car he started nibbling and when we got home he said, "Mom I'm still hungry, I want to cook oodles and oodles of noodles, you know, like four packages of Ramen noodles." "When we got in the house he never followed through with that, he seemed really distracted and settled for French bread and jelly, something sweet, you know." The mess he made in the kitchen was still lying all over the counters when all the emergency people showed up. "I tried to put things away before going to the hospital."

Language School (6:00 PM)

Jacinda remembered that Jon asked her for one of his CDs from the Language School that he used to attend regularly when he was younger and more sporadically when he got to middle school. She thought this was a strange request because he hadn't listened to it since February. The CD had both English and another language

translations. "Looking back on it now, I think maybe he was really struggling whether to kill himself or not. The CD he wanted to listen to was about the new year, family values and obey your parents sort of thing, be a good child, blah, blah, blah, virtues, you know."

Jacinda pulled the CD from between a stack of files and handed it to Jon. Jon hunted around for the CD player, found it but couldn't get it to work. Eventually, he walked over to the computer in the family room just off the kitchen and slid the CD into the disk drive. Jacinda was busy putting things away, cleaning up from breakfast and noticed Jon listening to the CD. Thomas let the dogs in and they were excited to welcome everyone home.

After about 20 minutes Jon abandoned his project and moved upstairs to his room to do his math homework. Charles was not home from work, Thomas was feeding/playing with the dogs and Jacinda was in the living room packing for the Boy Scout trip Thomas and she were going to attend on the weekend.

The Last Conversation (6:35 PM)

Jacinda called up to Jon to remember to take his medicine. The family lives in a spilt level home, with three bedrooms and two bathrooms upstairs. Downstairs there are two living areas, one connected to the dining room and the other connected to the kitchen. A small den sits just off the foyer entrance which opens to the stairs. Jon's bedroom is the first bedroom at the top of the stairs, on the right. When Jon came downstairs to take his medicine, Jacinda said, "Jon, let's go for a walk." He said, "No, I've got homework to do."

The Beginning of a Tragedy (6:40 PM)

Thomas and Jacinda left the house through the garage with the dogs. Jacinda said, "We went around the block, ten houses and I turned to Thomas and said, "You know, that was too short of a walk, the dogs have been cooped up all day, let's go some more." The pair went back out to the sidewalk. "I re-traced my steps two weeks later, it only took ten minutes to walk the block again. I missed him by ten minutes."

Jacinda, Thomas and the dogs came back through the front door. She walked to the closet to put her coat away and called up to Jon. When there was no answer she came upstairs and found Jon hanging from his bedroom door. He had used a blue dog leash fashioning a loop at one end to put his neck through, then draped it over his door and tied it off on the outside doorknob. His feet hung a foot and a half off the ground and his face was blue. Jacinda rushed to the body but couldn't swing him off the door. She raced into her bedroom and grabbed a pair of sewing scissors and cut him down. Once Jon was on the carpeted hallway, she loosened the leash from around his neck and began giving him mouth-to-mouth resuscitation. Seconds seemed to be hours. She dashed back into the bedroom and called 9-1-1. Thomas crept to the top of the stairs, then receded back to be with the dogs, which were acting feral and barking loudly.

Engine Number #2 pulled up to the family residence at 7: 37 PM after receiving a code 34 (Excited caller). Three crewmen jumped out and gathered their gear from the side pockets of the emergency vehicle. Thomas led them through the doorway and they rushed upstairs to note a woman doing CPR.

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Washington State Death Certificate

In box #34 on the Washington State Certificate of Death under the Cause of Death the coroner must enter the chain of events that directly caused the death. It asks for the immediate cause, then a listing of sequentially important conditions or underlying causes, and finally other significant conditions contributing to the death but not resulting in the underlying cause. For Jon, asphyxia due to ligature hanging was the cause of death. This fact was not disputed between either of the investigations. What changed were the contributing causes and the manner of death. The contributing causes went from depression and bipolar disorder to bipolar disorder and experimentation with choking game. And in box #38, "Manner of Death" was changed from suicide to undetermined.

Contextualizing Jon's Story

Coroners and Medical Examiners are the gatekeepers of death. They have the official last word on the manner of death and their notion of suicide weighs heavier than other public servants or those of relatives. By law, Coroners and Medical Examiners have been given the responsibility to detect, document and classify suicides but most will confess some suicides are not easily determined, even from the evidence. A suspicious death such as suicide needs to be positively proven to have been self-inflicted and intentional, it is never a default option. The classification of suicide is based on evidence that is inductively constructed piece-by-piece because once a coroner checks the box labeled "suicide" it is official and legally binding. Relatives who disagree have few means to appeal the verdict.

The Choking Game

During the entire investigation, Jon's manner of death was never conclusive. Initial evidence determined that Jon died by suicidal means. The investigation seriously considered that his actions reflected unintentional self-harm due to fatal accidental circumstances. However, even with abundantly more evidence from psychological autopsies, the investigation concluded that Jon's manner of death was undetermined. The reason for this range of indecision was based on speculation. In order for Jon's death to be ruled a suicide Jon's intentions or motivations would need to have been clearly reflected from his actions. In this case, they were not because both deputies investigating Jon's case wondered whether or not Jon was experimenting with the "choking game."

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Both deputies saw and talked about several media items pertaining to a party activity called the "choking game" which was circulating around the Coroner's Office at the time of Jon's death. The "choking game," is defined as self-strangulation by another person with the hands or a noose to achieve a brief euphoric state caused by cerebral hypoxia (Fields-Meyer, Sheff-Cahan, Swertlow, Perra, & Weisensee Egan, 2005; CDC, 2007; Stobbe, 2008).

One of the media articles was from a 'Dear Abby' column in a local newspaper titled, 'Choking Game Is A Dangerous Idea.' In the article several unsuspecting parents who had lost their teenagers and a school counselor, urged readers to pay attention to their kids and be curious about the internet chat rooms their children visited. In a report from the CDC (2007) titled, "Unintentional Strangulation Deaths from the "Choking Game" Among Youths Aged 6-19 Years – United States, 1995-2007," the authors estimated that between 2005 - 2007 there were 82 deaths attributed to the "choking game" occurring in 31 states. Seventy-one (or 86.6% of the 82 decedents) were male between the ages of 6 – 19 with a mean age of 13.3 (See Figure 10. Choking Game Deaths).

The other media item was from People Magazine that had published an article in August 2005, which quoted a Temple University psychologist as saying, "A growing number of doctors and officials are alerting parents and children to the dangers of this game, but warning signs can be subtle. Until recently most coroners concluded that kids found dead from self-strangulation were suicides. Now many medical examiners suspect many such deaths are accidents related to the game. The evidence looks exactly the same" (Fields-Meyer, Sheff-Cahan, Swertlow, Perra,

Weisensee Egan, 2005; p. 142). Ms. Schwartz reported that after reading those

articles and reviewing the initial evidence from the first investigation she thought

there might be a connection between Jon's death and the "choking game." She

admitted that what caught her attention were the subtle signs printed from the

sidebar of the article as a result of playing the choking game. These included:

- Red or blood shot eyes.

- Marks on a child's neck.

- Complaints of headaches or dizziness.

- Cuts and bruises that may have resulted from a child getting dizzy and
  falling.

- Objects such as belts, ropes, towels, the string for a youth's sweatshirt or
  plastic bags that are misplaced or misused (tied to a doorknob or high
  shelf, for instance).

In the end, even after school officials admitted that many middle school

students were experimenting with the "choking game," Ms. Schwartz could not say

beyond a reasonable doubt that Jon's death was directly related to his engaging in

this activity.

Figure 10. Choking Game Deaths: Age distribution of youths aged 6-19 years
comparing choking game deaths with that of suicides by
hanging/suffocation during 1995-2007.
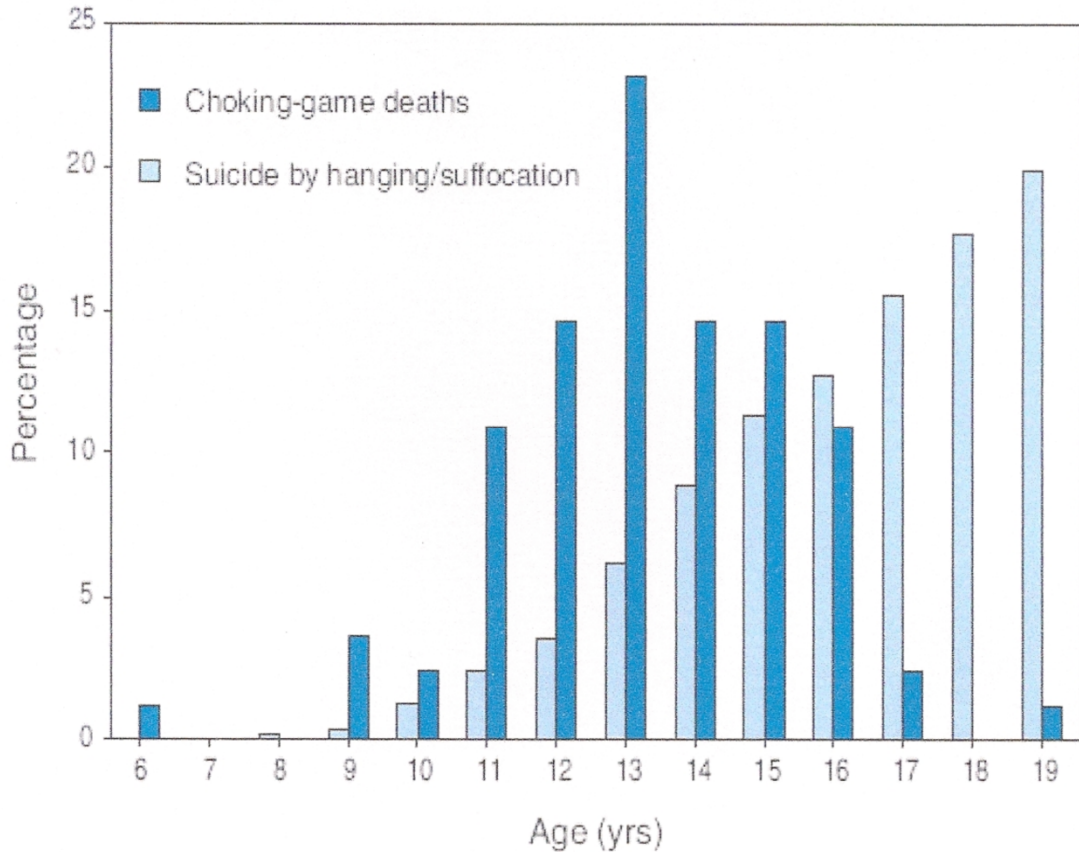
Conflict of Interests

The objectives of a death investigation can often collide with the needs of the

family. "Families seek answers to their questions as to how the death could have

occurred. They also require details of the lost time before death in order to

compose the last stages of the deceased's biography and to map that narrative onto

their own continuing biographies. In contrast, the coroner seeks closure. With an eye to a future existence without the deceased, bereaved people look for explanations, understanding and even compassion, but not necessarily closure" (Hallam, Hockey and Howarth, 1999, p. 95). Madelyn Schwartz (personal communication, March 23, 2006) notes it is difficult to follow investigative leads when family and friends are experiencing the grief and loss process. "All of us in the Coroner's Office assume from the onset of an investigation, that those closest to the deceased are concerned more about preserving the best possible memories of their love one, than about the accuracy of our investigation." It makes sense why survivors often misunderstand the investigation process and have described some deputy coroners as "dispassionate" or "uncaring."

Schwartz (2001) has argued the SRP was developed to assist survivors find meaning and closure. In this way there may be less conflict between family members who want their questions answered and a deputy coroner whose job it is to determine the cause and manner of death. More information is needed when addressing the survivors in equivocal deaths, like Jon's. The question of "why" may be less haunting to survivors if the death can be processed with more details, which allows those who are grieving a chance to assimilate a reasoned conclusion to the loss. During the debriefing, survivors are offered information and resources for understanding the nature of the death and the death's impact on them as individuals and on their family system as a whole. However, specialized training is needed in order to effectively conduct a psychological autopsy interview. According to Schwartz (2001), "In the hands of a skilled investigator, the psychological autopsy is

not only a research tool, but it can become an educational as well as a healing

experience for family members and others touched by the death" (p. 3).

Though Jon's case remains undetermined and Jon's parents have stated their

frustration with the outcome of the second investigation, the continued process of

extracting information in a compassionate manner had some benefits for the family.

Ms. Swartz (personal communication, March 23, 2006) suggested two benefits in

which the investigation may have assisted the family based on feedback from the

family: 1) the parents stated their appreciation of having a follow-up investigation

conducted by the Coroner's Office, and 2) the parents stated their appreciation of

having the opportunity to tell more of Jon's story after hearing from many of Jon's

classmates.

Results

The goal of this descriptive case study was to explore and describe the experiences of how one family suffered and survived the unexpected loss of their 13-year-old son suspected of dying by suicidal means. In addition, this research examined the use of psychological autopsy information for assisting the family with the loss of their son. The family underwent two separate death investigations by two different deputy coroners. The second investigation used psychological autopsy information. This research study examined the data that emerged from the Coroner's report and compared it to the data from conducting psychological autopsy interviews. This comparison suggested ways in which the use of psychological autopsies might have benefited this family in the suspicious death of their son.

Briefly, eight areas of benefit were identified which coincided with the eight categories of the death investigation process with the exception of law enforcement. These included: 1) Family, 2) School, 3) Medical, 4) Psychopathology, 5) Forensic, 6) Eye Witness, 7) Researcher Bias, and 8) Corollary Benefits. For each area of benefit one of five types of benefit for the family was also identified. These included benefits that were discovered, revealed, confirmed, suggested or validated from the research. (See Table 5. How Psychological Autopsies Helped The Family In This Case Study, for a summary of results)

Family and School Information

The benefits of conducting psychological autopsies to family and friends can be seen in the differences that emerged between the two death investigations. Each

difference notes an expansion of information in the investigation process. Thus, potentially assisting the Coroner in the determination of manner of death, as well as providing more information for the family to facilitate a better understanding of the death. One such difference between the two death investigations was in the categories of Family and School Information. The Schwartz Retrospective Profile (SRP), gathered additional information about Jon's family and his school environment. In the Family Domain, latent indicators of suicidal patterns emerged that were not clear from initial contact with the family. Psychological autopsy interviews discovered the following: a history of psychopathology; prior suicides and attempted suicides by other family members; and a description of pervasive self-harming behaviors displayed by Jon that could be interpreted as suicidal motivations.

In the School Domain, information emerged suggesting a back-story of harassment towards Jon, which appeared insidious and pervasive. The most notable example of harassment for Jon was the "pants incident," which occurred in his choir class. According to several of his peers, this incident was humiliating and spurred rumors that Jon was "playing with himself." Again, the evidence is presumptive and none of the informants who knew Jon could confirm whether this incident led to Jon contemplating self-injury.

Another benefit from the information gathered by psychological autopsies was the additional insight into environmental factors surrounding this case. Looking closer at the interview transcripts from Jon's family, school, and medical background, multiple risk factors linked to suicide causality surfaced. For Jon,

interviews with family indicated long-term suffering and pervasive mood dysregulation, early childhood seizures and at least one hospitalization due to "acting out" behavior. The evidence also amplified Jon's connections to negative life experiences, such as parents and doctors descriptions of his low self-esteem, on-going difficulty with social skills, difficulty communicating with others regarding his needs, bouts of depression, exposure to parenting styles that could be seen as constrictive or over-protective and frequent episodes of Jon's poor problem-solving and coping strategies when dealing with his stress or anxiety.

However, what could not be determined, even with additional information from the psychological autopsies, was whether Jon's intentions were suicidal in nature. The evidence from family and peers suggested a compilation of nagging risk factors, which contributed to Jon's deteriorating life circumstances. Some of Jon's psychosocial difficulties were noted in the first investigation and became more apparent through psychological autopsy interviews in the second investigation.

Medical and Psychopathology Factors

Further analyses also indicated that the two death investigations differed within the categories of Medical and Forensic Information. Psychological autopsy interviewing supplied more contextual details about Jon's medical diagnostic history including the differences of opinion between Jon's psychiatrist and his pediatrician. Ms. Schwartz noted in a follow-up interview with Jon's pediatrician, that Jon's pediatrician did not agree with the psychiatrist's diagnosis of Tourette's syndrome or that Jon might be suffering from Asperger's. Jon's pediatrician

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speculated that due to the varying diagnostic labels, Jon's family might have been confused regarding Jon's medication regime. Jon's mother reported that in an attempt to reduce Jon's symptoms of stress and anxiety she would experiment with his medications. Though Jon's mother admitted adjusting Jon's medications she said she only wanted Jon to be "less depressed and more like a normal boy."

Psychological autopsy information indicated that Jon was not "normal" as compared to his peers. Jon's family physician diagnosed Jon with Bipolar Disorder suggesting the existence of a bio-chemical disability. Family and friends confirm that Jon had difficulty in making decisions, was impulsive and did not always apply good common sense to his situations. Jon also had difficulties managing his emotions, using effective communication and applying self-soothing skills to quiet his distress. As a result, Jon had at least one hospitalization for behavioral outbursts, needed special education at school and developed few peer friendships.

Forensic Information Expanded

Within the Domain of Forensic Information, two topics were expanded when comparing the two death investigations. The first topic expanded speculation regarding prior self-injury and a possible clue towards intentionality. Jon's mother surmised that her son hid in the clothes dryer with the intention of killing himself. However, other members of the family could not confirm this event.

Other incidents that did imply Jon's intentions, which could be confirmed and collaborated was Jon's visits to internet sites about hangings and to a website describing how to kill one's self. In addition, Jon's younger brother, Thomas

remembered hearing a comment Jon made to the neighbor, saying, "he wondered

what it would feel like to step in front of a speeding car." Any of the above events

when taken out of context could be interpreted as normal adolescent angst

behavior. The multiple sources of evidence from multiple environments suggested

that a pattern of suicidal acting out might have been present.

The second area of expanded investigation centered on Jon's internal world

or how he might have been experiencing his life according to family and friends.

Joiner's (2005) theory about looking at suicide from an ecological position could be

applied in Jon's case. Jon's circumstances provide the three pivotal elements toward

for completed suicide:

1) *An ability to enact lethal self-injury*. (Jon may have experimented with the

   choking game and according to his mother's perception tried to kill

   himself in the dryer).

2) *Thwarted belongingness*. (Jon experienced chronic school harassment,

   had few friends and participated in few social groups).

3) *Perceived burdensomeness*. (Jon reported feeling different from others,

   saying that, " ...he didn't feel like himself and wished he were dead").

Despite the additional information, it remained unclear whether Jon was on a

trajectory towards a completed suicide as would be suggested by Joiner's (2005)

research or if Jon died as a result of a terrible accident.

Generally, when there is a substantial amount of information in a death

investigation then a death investigator has a better chance for determining both the

cause and manner of death. More information allows for the possibility of making meaning out of the decedent's behavior. However, even with the addition of psychological autopsies providing more detail from more sources, the definitive answer regarding Jon's manner of death remains undetermined.

Grief Reactions

Another kind of information generated by a psychological autopsy, which is generally not available in a forensic death investigation is a community reaction to the death. Evidence in the Eye Witness area revealed two areas of interest: 1) grief reactions from classmates; and 2) recollections prior to death which changed over time. When someone dies, their death will impact others. The reactions of grief by others are important in the investigation process. It was evident from the psychological autopsy information that Jon's death had a wide-spread effect on his classmates which in turn affected Jon's family and their perception of his death. In the beginning, Jon's parents believed his death was an accident and not by suicidal means. However, once the news of Jon's death reached the middle school he attended, Jon's parents reconstructed another version of his death based on his classmate's reactions. Through post funeral correspondence, the family became aware of harassment incidents endured by their son. Several examples read by Jon's parents came from letters and emails received after the funeral. One peer wrote, "Jon seemed very nice. I wish I had taken the opportunity to know him better. Some people made fun of him and talked about him behind his back. I wish I would have done something more but I had no idea it would get so serious. Tons of people at

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school were crying, even some teachers..."Another student emailed, "I feel guilty for never giving Jon a smile, turning away from him. I'm sure he was great. We are all grieving in our own ways, many girls are busy talking to the counselor, mostly everyone is crying."

Madelyn Schwartz, deputy coroner who supervised the second investigation commented, "Being bullied or teased, as harmful as that is, may have contributed to Jon's fatal behavior, but the last incident in an equivocal death is not always the smoking gun which points to the cause. In my opinion, psychological autopsy information can tease out more evidence to help lead us to the truth, especially if informants are treated compassionately. But finding the real truth, if we'll ever know the real truth, is about reassembling all the pieces in the puzzle of a person's life. At it's best, a psychological autopsy can provide a clearer picture of what may have happened that led to a person's death" (personal communication, March 23, 2006).

Another important element in the investigation process is watching for perturbations over time in the recollection of events after a death. Several occurrences happened in Jon's school because of his death. A letter went out to the parents regarding information about the "choking game" and the school walls became decorated with posters urging students to report bullying and harassment. The Coroner's Office considered follow-up interviews with school staff but at the time of the second investigation, tensions were high between the school district and Jon's parents, who were now threatening to sue the school district.

During the interviews with Jon's parents they appeared noticeably angry and grieving. Over time, their perception of Jon's actions prior to his death were affected by shocked and grieving classmates. Jordan (2001) asserted that equivocal deaths such as suicide affect family systems differently then other manners of death. Even after interviewing Jon's family no insight was revealed regarding their underlying conflicted motives towards pressuring the Coroner's Office to change Jon's manner of death. School administrators told Ms. Schwartz that school staff could not be interviewed due to the possibility of litigation. In an attempt to forgo any ill will between the fractured parties the second investigation concentrated on interview evidence from family and friends only. A liaison officer from the middle school was contacted but no additional insights regarding Jon's death emerged. The phone interview corroborated student grief reactions. The middle school responded by sending out a parent letter regarding Jon's death, as well as providing information to school staff about the choking game. Additionally, administrators asked the staff to encourage students to report incidents of harassment.

Emotional and Nonverbal Reactions

The benefit of conducting a psychological autopsy becomes most evident in regards to the emotional reaction of persons who knew the decedent. From the researcher-participant perspective, an immeasurable sense of relief appeared from the informants as they shared their story. Many remarked that they experienced some comfort in being given permission to relate more details regarding their

relationship with Jon. Their cathartic transition was evidenced by a noticeable sigh

or some other nonverbal indication of stress reduction at the end of each interview.

Another element revealed in psychological autopsy interviewing was the

inconsolable pain associated when one member of the family is diagnosed with a

mental illness. Jon was diagnosed with Bipolar Disorder. This type of mental illness

does not reflect the personal hardships affecting the inflicted or their families.

Jon parents were constantly on alert and at times felt hopelessly inadequate

in helping Jon cope with his illness. Information from psychological autopsy

interviewing captured the despair and denial of Jon's parents as they coped with his

mental illness. They tried adjusting his medication; his diet, structured his routines

around sleep and activities and sought help from professionals. Information from

psychological autopsy interviews documented the family's journey from trusting

doctors and teacher's suggestions to becoming more cynical and practical when

dealing with Jon's behaviors, irritability and moods. Psychological autopsy

information in this case study provided a rich context for understanding the family's

struggle.

Researcher Bias

In addressing researcher bias, each interview contained palatable emotions

that moved and affected this researcher's sense of empathy and compassion. The

nature of face-to-face interactions created a powerful relationship, which according

to this researcher, helped to create an empathetic and supportive environment.

Being with another person instead of just reading a transcript from an interview

provided an opportunity and the space for the informant to share more details about the deceased. Psychological autopsy information in a death investigation is clearly indicated when the goal is to assist in the determination of decedent intentionality. Though in Jon's case, the addition of psychological autopsy information did not generate a preponderance of evidence to indicate whether Jon died by suicidal means or by accident. However, it did illuminate the delicate balance between intimacy with the family and maintaining the necessary detachment and objectivity required in a medical-legal investigation. Such a balance was observed while interviewing both parents and touring Jon's room, which was being maintained in the same state as the night Jon died. The answers to the interviewer from both parents became more subdued, more reflective and less spontaneous and direct.

Department Validation

Another possible benefit in doing psychological autopsies, which is corollary to the question of how psychological autopsies help families, is how might psychological autopsy interviewing, in cases of suspected suicide, help the Coroner's Office? The answer is two-fold. By deciding to follow up with psychological autopsy interviews, the Coroner Office addressed not only the concerns of the family but validated the department's investigative process. Though the family expressed their disappointment in the outcome of the investigation because the results did not change the manner of death for their son they did state their appreciation of having additional information and an opportunity to share more of their story about Jon.

In addition, the Coroner Office by having overlapping investigations with two different deputy coroners confirmed the consistency and efficacious manner in which the department conducts death investigations. There is also the possibility that the public image of the Coroner Office was improved by demonstrating their compassionate response to the family by doing more investigation work.

It should be noted that using psychological autopsies in death investigations do not result in the unequivocal determination of the manner of death. The interviews are a way of eliciting additional facts of the death, to help establish the chronology of those facts, to infer motivations of the decedent by family and friends, to provide additional observations of the reactions of survivors and to gather collective themes that might give additional clues into the intentions of the decedent prior to their death. The investigation process of suspicious deaths like suicide is a complicated affair requiring good professional judgment and the collegial review of ambiguous outcomes.

Summarizing Table

The following summary of benefits depicted in Table 5 summarizes the type of benefit for each area within the scope of the death investigation indicating how psychological autopsies helped the family in this case study.

Table 5.   **How Psychological Autopsies Helped The Family In This Case Study**

Area of Benefit	Type of Benefit	Example
Family	Discovered	Suicidal patterns within the family hx.
	Revealed	Appreciation for a follow-up investigation & opportunity to tell more of Jon's story.
School	Revealed	Back story of harassment; special education; isolation; few peer friendships.
Medical	Revealed	Hospitalization; disagreement between psychiatrist & pediatrician.
Psychopathology	Confirmed	Dx of BPD; bio-chemical connection; medication management issues; account for symptomology.
Forensic	Discovered	Prior self-injury events – mother's perception-dryer; neighbor rpt; computer sites.
	Suggested	Theoretical implications – Joiner (2005); a) lethal self-injury, b) thwarted belongingness, c) perceived burdensominess.
Eye Witness	Revealed	Individual – Grief reactions from classmates Community – Grief reactions from school administrators; bullying posters; information to parents about the "choking game."
Researcher Bias	Revealed	Cathartic reactions; family's perceived pain associated with mental illness; palatable emotions during interview; sense of a supportive & empathetic environments for the interview.
Corollary	Validated	Addressed family issue for more information; validated the county's investigative process between deputies; improved public image.

Limitation of Current Research

A limitation of this research was using only one idiosyncratic case, which was both unique and typical, but offers no ability for establishing trustworthiness due to the small sample size. Furthermore, because the sample size was small there is no way to establish the probability that the data is representative of larger populations. However, according to Yin (2003) "case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes" (p.10).

What this research did was bring an abundant amount of evidence to assist in the understanding of a very complex issue through the real-life experiences of a family who suffered the loss of their son. This qualitative case study used a single case, which highlighted previous research findings through emphasizing rich contextual details and the underlying multi-layered relationships. Wolcott (1994) recommended, "In depth, rather than in breadth, [referring to the number of cases needed for quality research] we realize the promise of qualitative research" (p. 184).

The most significant limitation of this study involved researcher bias. No matter how rigorous the research design, case studies cannot be completely objective. Such bias is inherent and rather than guard against it, a researcher must strive to make judgments, stated insights and interpretive thinking as transparent as possible. In this single case study the researcher strived to present adequate evidence from the data and link conclusions directly to the data.

Recommendation for Future Research

Research regarding the use of psychological autopsy information to evaluate medical-legal death investigation practices or to determine whether psychological autopsies have a therapeutic effect for survivors of suicide has not been sufficiently explored. One recommendation is to encourage thoughtful collaborations between deputy coroners doing death investigations and local mental health therapists who specialize in grief and loss issues. The services of these two professional groups are a natural fit. Such collaboration might develop specific protocols or strategies that could benefit the Coroner's Office investigative team and ultimately facilitate the healing for survivors experiencing an unexpected death.

The next research step for discovering whether a psychological autopsy has a therapeutic effect would be to schedule follow-up interviews with informants who have already participated in an interview. The goal would be to survey their experiences and measure the effect it had on their bereavement and grief processes. Future research should focus on whether there are any therapeutic effects in survivors who have been interviewed by death investigators that used the Schwartz Retrospective Profile (SRP).

Another, but controversial topic for psychological autopsy implementation would be to conduct research on the timing of the interview. Typically, most psychological autopsies are administered weeks, sometimes months after the death, which increases the likelihood that any information recalled would be biased or reconstructed to put the deceased in a positive light. The best time as advocated by Schwartz (1997) "...is at the time of notification, provided the interview is handled

with sensitivity and the family member is not alone" (p. 2). There are many in the field of death investigation, who would consider this recommendation disrespectful and even unethical. Schwartz (1997) urges that, "Attention to the sensitivity and compassion of the investigator often sets the stage for later cooperation and assistance from informants for follow-up interviews or additional queries" (p. 3). The role of a death investigator should be more fully explored to include strategies that not only benefit death investigation practices but also facilitate the healing experience for survivors touched by death.

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APPENDIX A

Schwartz Retrospective Profile

For more information and/or training of the Schwartz Retrospective Profile, please contact:
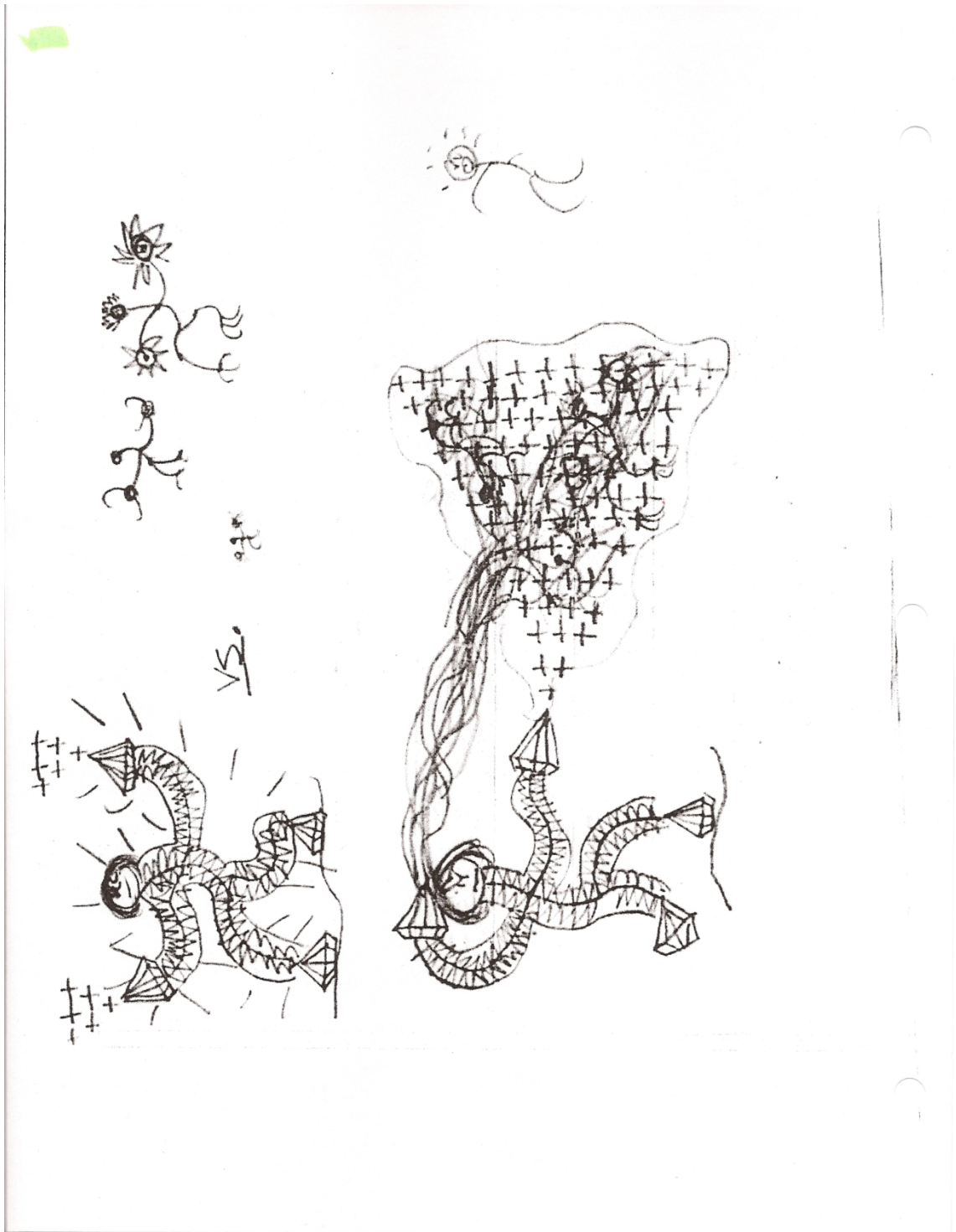

Madelyn Schwartz, M.A., A.B.S.
heartworkcc@aol.com

APPENDIX B

Drawings and Pictures

Picture 1.   Decedent's Drawing
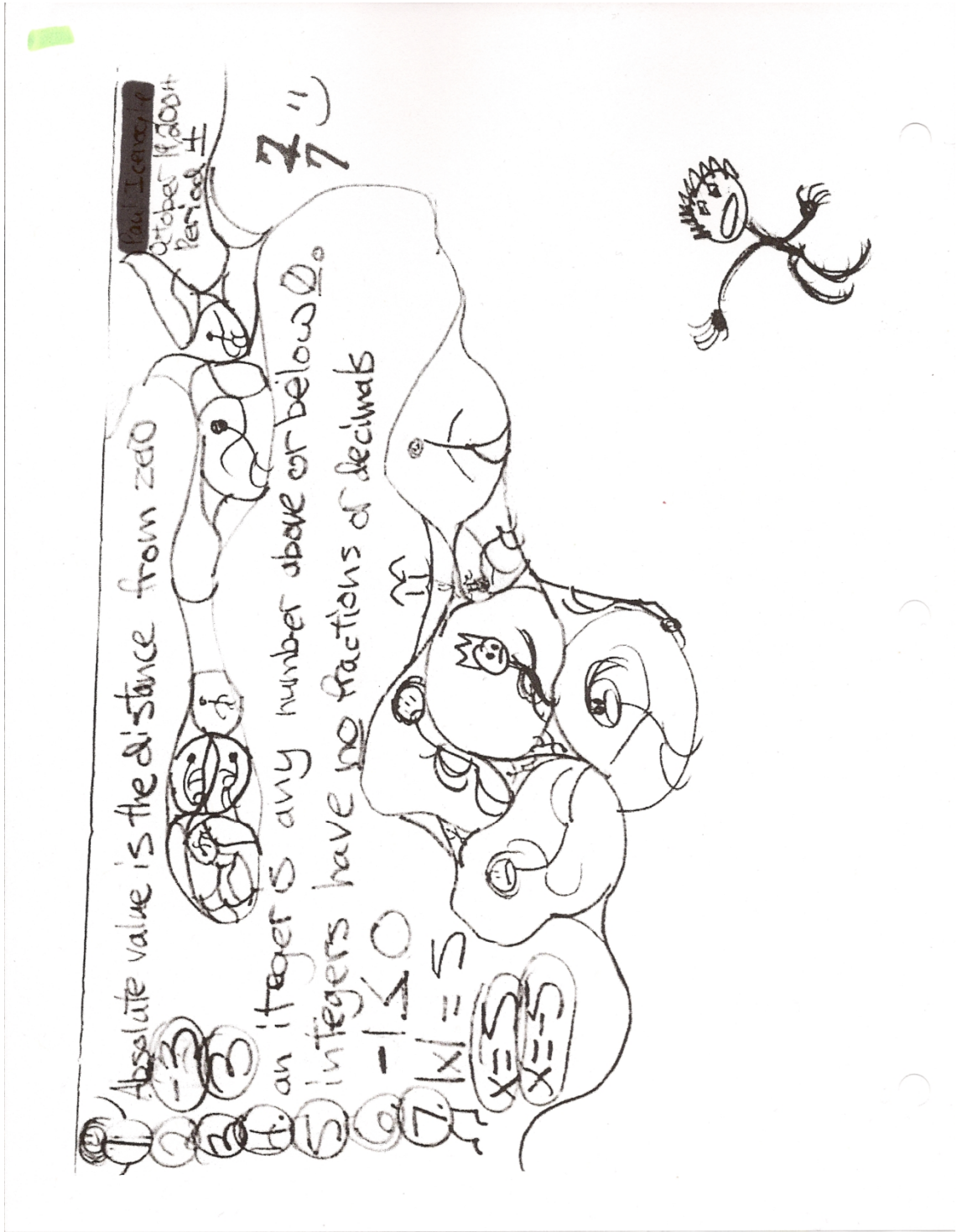
Picture 2.   Decedent's Drawing

Picture 3.   Decedent's Drawing

APPENDIX C

Medical, Law Enforcement and Coroner Reports

Medic One Report (7:39 PM)

Symptoms (S): 13 y/o male c/c respiratory arrest. Pt's. mother left home for n/s minutes and returned home to find pt. hanging from a dog leash tied around his neck and slung over a door. She cut him down and called 911 and attempted CPR. Mother states pt. has a hx of bipolar disorder, uncertain of events leading up to hanging.

Observations (O): Pt. found on floor, unconscious, unresponsive, pulseless, apneic, obvious rope burn around his neck, emesis (*vomit*) in airway. No other signs of trauma. Pupils fixed – 4mm. pt's blood on neck or anywhere.

Assessment (A): Respiratory and cardiac arrest due to hanging.

Plan (P): Assess, start CPR/ACLS (*resuscitative protocol*) algo rhythms. Monitor – asystole (*cardiac standstill; no cardiac output*). ETT (*endotracheal tube*) placed, 6.0. (*refer to the size of the tube*) confirmed with endtidal CO2 (*Carbon Dioxide*) auscultation, visualization I.V. Medications: I.V. for a total of Epi (*Epinephrine*) 1mg x 7, Abapine 1mg x 3, Sodium Bicarb 50mcg x 2. Sequence time below. Attempted pacing without capture. Patient had episodes of PEA (*pulseless electrical activity*) that lasted 10 seconds to 5 minutes. Call to Hospital, Dr. F. requested transport if patient maintained PEA. Patient received a total of 1400 cc NS IV. Returned to asystole upon arrival @ Hospital. Dr. F pronounced patient and stopped efforts @ 2024 (8:24 PM). Chaplain notified and made contact with family.

Incident Classification: Death Investigation Case Number: 2005-00000

The caller had reportedly started CPR. Fire Department (FD) had been dispatched to the residence. On arrival I saw that FD was on scene. Engine two and it's crew, Jeff Strong, A. J. Lennard and Bob Watson, along with Medics, Donny Majors and Vickie Anders, were inside the residence treating the victim. I made contact with Jacinda C. upstairs. She was standing outside of the bedroom where the victim was being treated. I asked her to walk downstairs where I obtained some basic information. Jacinda told me that she had spoke to her son just before she went on her walk. She tried to get him to go but he didn't want to. She left and was gone for approximately 20 minutes. When she returned home she changed and called to her son but got no response. She went upstairs and found him hanging from his bedroom door. Jacinda said one end of a leash had been placed over the doorknob while the rest of it had been thrown up and over the door. Her son was hanging from a loop that had been created at the other end. She said his face was blue in color and he was not breathing. She used some scissors to cut him down and called 911. After making the 911 call she started CPR and continued until medics arrived. Jacinda told me that her son had been diagnosed as Bipolar. She said he had been taking his medications and hadn't indicated a desire to harm himself.

Officer Nelson arrived and waited with Jacinda until her husband and a chaplain arrived.

I returned upstairs and was advised by Medics that it was unlikely that the boy would survive. He was transported from the residence to hospital for additional treatment. I checked the room and recovered a blue colored leash that had been cut in two. It was on the floor near the bedroom floor. I located a pair of scissors on the floor near the door as well. I checked the room but did not locate any other items of evidence. I did not locate a suicide note. I then photographed the bedroom and it's contents.

There did not appear to be any signs of a disturbance in the room.

I cleared the residence and drove to Hospital for follow-up. I made contact with emergency room staff and the attending doctor. They advised that the victim was deceased and that they had called the time of death just prior to my arrival. I checked the victim and noted injury to his neck. The injury was consistent with the shape and texture of the leash that I had recovered from the room. I photographed the injuries from both sides and the front. There were no other visible injuries on his arms and legs to indicate a defensive struggle.

The Coroner's Office was notified.

I cleared Hospital after notifying Sgt. Johnson of the victims passing. I returned to the main station where I entered the scissors, leash and memory card into evidence. Open.

Officer Name/Number: (Perkins, P.) #0000   Unit: 0A16   Date: 05/05/2005
Approved By Number: (Johnson, J) #1000

CORONER'S REPORT: *Narrative* – Jon C.

13 YEAR-OLD MALE FOUND HANGED FROM DOORKNOB, HISTORY OF BIPOLAR DISEASE

On 05/04/05 at 2040h, a call was received from Hospital ER regarding the death of 13 year-old JON C. It was reported Mr. C. was transported via medics from his residence after he was found hanging from a doorknob. Due to the circumstances surrounding the death, a scene response was deemed necessary.

Examination of the decedent was conducted at the Hospital Emergency Room. Examination revealed a young male with Asian features lying supine on a hospital gurney. He was clad in beige pants, white socks, white briefs and a red & grey T-shirt that was cut by medics. An intravenous catheter was noted in the left arm. Numerous cardiac monitoring pads were noted on all four quadrants of the trunk. An intubation tube was noted protruding from the mouth of the decedent. A 2" linear abrasion was noted on the skin at the right scapula. A ½" wide, ¼" deep furrow was noted on the front of the neck beginning below the left ear beneath the jaw and extending across the anterior surface of the throat to below the right ear and terminating near the back of the neck. The face appeared slightly congested with pinpoint petechial hemorrhages noted inside both eyelids. The decedent was warm to the touch. Pronouncement of rigor was limited to the jaw. Mottled purple livor was noted on the forearms and hands. Unfixed purple livor was noted on the back and was appropriate to the supine position. Blood was drawn for toxicology testing. The descendent was photographed, diagrammed, fingerprinted and released to the hospital morgue for tissue donation as authorized by the parents.

According to mother, Jacinda C., she spoke with her son just before going for a walk. She said she tried to get him to come along but he didn't want to. Mrs. C. said she was gone for about 20 minutes. When she returned home she changed clothes and called to her son but got no response. She said she then went upstairs and found him hanging from his bedroom door. Mrs. C. said one end of a leash had been placed over the doorknob while the rest of it was up and over the door. She said Jon was hanging from a loop that had been created at the other end. She said Jon was not breathing. Mrs. C. said she used scissors to cut him down and called 911. Jacinda said her son suffered from Bipolar Disease and has been taking medication for it for several years. During a phone interview on 05/05/05, Jacinda mentioned that Jon "played" at hanging himself. Jacinda did not feel Jon fully understood the consequences of such play. She also stated Jon played with fire in the

past and a visit to the Fire Station was instrumental in stopping this type of activity. Jacinda had no suspicions that anyone would want to harm Jon.

Initial toxicology results were negative. Follow-up toxicology results received on 06/17/05 indicated therapeutic levels of carbamazephine. According to mother, Jacinda C., Jon took his medication approximately a half and hour prior to his discovery.

According to P.D. Officer P. Perkins, examination of the residence revealed no indication of any disturbance and no notes of suicide intent were discovered. Officer Perkins said medics at the scene indicated to him that it was unlikely Jon would survive but transported him to St. Peter Hospital for further treatment. Officer Perkins stated he recovered the leash and submitted it to the police evidence locker.

According to Dr. A., Jon was diagnosed with Tourette's syndrome and Bipolar Disorder and was prescribed Wellbutrin, Fluoxetine and Integritol. Dr. A. said he last saw Jon in March 2005. He said Jon gave no indication of depression or wanting to do him self harm. Dr. A. appeared genuinely surprised at being notified of Jon's death.

According to medical records, Jon was seen at Hospital on 10/24/2000 for a psychological evaluation following an outburst at home. At the time of this examination, he was being prescribed paroxetine and Ritalin for Tourett's, bipolar disease and ADHD.

Based on examination of the decedent, and information provided by family, medical personnel and law enforcement, the cause of death is attributed to asphyxia due to ligature hanging with depression and bipolar disease as significantly contributing conditions. The manner of death is determined to be SUICIDE.

CORONER REPORT – NARRATIVE ADDENDUM

10/12/2005 Addendum: New information regarding the phenomena known as "the choking game" was considered regarding this case. Although this type of game is not new, it has recently come to light as of September 2005 in recent media articles involving middle school-aged children. A call to Middle School Principal, Ms. Smith revealed the "choking game" was being practiced in that school but was not known to teachers and counselors at the time. Ms. Smith said she was made aware of two past incidents involving 6th graders where the sweatshirt hood cord was actually used as a ligature to achieve unconsciousness. Ms. Smith said the staff has mobilized and addressed the dangers involved in this type of game.

Jacinda C. was contacted. She stated that twice she had found Jon "playing" at hanging himself in the general manner as stated above.

Based on the new information regarding the "choking game," there is a possibility that Jon C. was experimenting with asphyxiation and may not have fully understood the possible outcome. Therefore, the manner of death is changed from *SUICIDE* to *UNDETERMINED*. The death certificate was adjusted to reflect this change through an Affidavit of Correction.

APPENDIX D

County Coroner Informed Consent Form

Informed Consent

Description of the Interview Protocol:
As part of the County Coroner Department's on-going goal to improve and become more effective in death investigation techniques, deputies are piloting a standardized interview protocol, which will later be analyzed to determine its effectiveness in equivocal cases, like accidents, suicides or homicides. Madelyn Schwartz, deputy coroner for County for the last 16 years, has developed an extensive retrospective profile interview format (SRP) with the intent of not only helping to establish the mode of death but an intense examination of the psychosocial factors to tease out the intentionality and possible motivations of the decedent.

Your participation will involve answering questions about the decedent from your personal perspective to the best of your abilities. The protocol is designed to facilitate an objective and nonjudgmental approach for remembering details about the decedent. The interview generally lasts anywhere from 1 to 3 hours depending on your relationship to the decedent; you will be encouraged to attend to your physical and mental health needs, like taking breaks, stopping for food, or attending to emotional needs. If for any reason you would like to terminate the interview you may do so at any time.

Risks and Discomforts:
There may be some discomfort associated with the interview process in that your responses to the interview questions may trigger a range of emotions from sadness, anger, confusion, or laughter. All are normal and natural reactions to a painful and unfortunate event. Again, please feel free to ask for what you need in order to address your physical and mental health needs. Each interviewer has a telephone list of local counselors and therapists who specialize in bereavement and grief and would assist in arranging an appointment for you if requested.

Potential Benefits:
Many participants who agreed to be interviewed have reported a "sense of relief," or described the interview as an opportunity to "piece some of the pieces of the puzzle together." Your participation will also be contributing to a growing body of data that will help to standardize and improve the death investigation process.

Protection of Confidentiality:
As with any investigation done through the Coroner's Department, your responses to today's interview are private and confidential. If this particular case is used for future training or research, all the information you share will be disguised so as to protect your identity and the identity of any persons, place or situations depicted in the interview.

Alternative Recording Procedures:
The interview you are voluntarily participating in may be recorded by the interviewer in a number of ways that is most comfortable and preferable to you. You will have the choice of having the interview video taped, recorded with auditory tape or hand-written notes taken by the interviewer during the interview.

Voluntary Participation:

Your participation in the interview process is considered voluntary. You may choose not to participate and you may withdraw your consent to participate at any time.

Contact Information:
If you have any questions or concerns regarding your participation in the interview process as well as any questions or concerns you might have about the interviewer, please contact Madelyn Schwartz at the County Coroner's office. The phone number is…. You will be given a business card from the interviewer if you should need to contact the Coroner's office.

CONSENT

I have read the above statement and have been fully advised of the procedures to be used in this project. I have been given sufficient opportunity to ask any questions, I had concerning the procedures and possible risks involved. I understand the potential risks involved and I assume them voluntarily. I likewise understand that I can withdraw from the study at any time without being subjected to reproach. I may also ask for a summary of the results of this study.

Signature _____   Date _____
       Participant

Print Name _____

If under the age of 18 the signature below indicates that you are making a decision to have your child participate in this study. Your signature indicates that you have read (or been read) the information provided above and decided to allow your child to participate.

Signature _____   Date _____
    Parent and/or Guardian and/or Authorized Representative

Print Name _____

* If requested, you may have a copy of this signed consent form.