

## Psychological Autopsy Semi-Structured Interview Format

The interviewer will NOT be asking these questions verbatim. Interviewers will be trained to conduct the interview in a manner that is sensitive and professional. Interviewees who do not speak English will be interviewed with the help of a translator.

Case Initials: Date of Birth: Date of Death: Age at time of death: Method used for suicide:		Interview Date: Interviewer: Interview venue:
Relationship of respondent to decedent  <input type="checkbox"/> Spouse <input type="checkbox"/> Father/Mother <input type="checkbox"/> Brother/Sister <input type="checkbox"/> Aunt/Uncle <input type="checkbox"/> Child <input type="checkbox"/> Other Relative	<input type="checkbox"/> Friend <input type="checkbox"/> Work Colleague/Employer <input type="checkbox"/> Classmate <input type="checkbox"/> Teacher <input type="checkbox"/> Other <input type="checkbox"/> Specify: _____	Any comments on respondent's cooperation/questions/reactions regarding the validity of responses:
Comments:		Time Interview Started: Time Interview Ended:

### Demographic Information of decedent

1. Place of birth (city, state, country)											
2. Tribal nation											
3. Was the decedent a US citizen	<input type="checkbox"/> Yes <input type="checkbox"/> No. Specify status in the US <input type="checkbox"/> Don't know										
4. Primary language:											
5. Gender:											
6. Race/Ethnicity	<table style="width: 100%; border: none;"> <tr> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> Asian</td> </tr> <tr> <td><input type="checkbox"/> Black</td> <td><input type="checkbox"/> Pacific Islander</td> </tr> <tr> <td><input type="checkbox"/> Hispanic</td> <td><input type="checkbox"/> Other – Please Specify _____</td> </tr> <tr> <td><input type="checkbox"/> American Indian</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Alaskan Native</td> <td><input type="checkbox"/> Don't know</td> </tr> </table>	<input type="checkbox"/> White	<input type="checkbox"/> Asian	<input type="checkbox"/> Black	<input type="checkbox"/> Pacific Islander	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other – Please Specify _____	<input type="checkbox"/> American Indian		<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Don't know
<input type="checkbox"/> White	<input type="checkbox"/> Asian										
<input type="checkbox"/> Black	<input type="checkbox"/> Pacific Islander										
<input type="checkbox"/> Hispanic	<input type="checkbox"/> Other – Please Specify _____										
<input type="checkbox"/> American Indian											
<input type="checkbox"/> Alaskan Native	<input type="checkbox"/> Don't know										

7. Education status	<input type="checkbox"/> Never attended <input type="checkbox"/> Elementary school <input type="checkbox"/> Junior high school <input type="checkbox"/> High school <input type="checkbox"/> Some college	<input type="checkbox"/> College degree <input type="checkbox"/> Graduate or professional school <input type="checkbox"/> GED <input type="checkbox"/> Other – Please Specify _____ <input type="checkbox"/> Don't know
8. Raised by	<input type="checkbox"/> Adoptive parents <input type="checkbox"/> Foster parents <input type="checkbox"/> Biological parents	<input type="checkbox"/> Other – Specify: <input type="checkbox"/> Don't know
9. If teen was a member of a minority group, did the teen have a strong/weak attachment to their cultural/ethnic traditions and identify?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Explain	
10. Marital status at the time of death  Feelings about marital status?	<input type="checkbox"/> Married <input type="checkbox"/> Living together <input type="checkbox"/> Widowed – Since when? _____	<input type="checkbox"/> Divorced - When? _____ <input type="checkbox"/> How many times? _____ <input type="checkbox"/> Separated – When? _____ <input type="checkbox"/> Never married _____

### School History

11. School status at time of death	<input type="checkbox"/> Full time <input type="checkbox"/> Part time	<input type="checkbox"/> Grade level _____
12. General school satisfaction	<input type="checkbox"/> Happy <input type="checkbox"/> Unhappy	<input type="checkbox"/> No strong feelings <input type="checkbox"/> Don't know
13. Any negative school changes in past 6 months?	<input type="checkbox"/> Suspension; Patterns of detention <input type="checkbox"/> Academic stress (big tests or projects; applying to college; failing classes)	<input type="checkbox"/> Peer issues (relationship breakup, fallout with friend, bullying, teasing) <input type="checkbox"/> Health issues <input type="checkbox"/> Family distress <input type="checkbox"/> Issues with sports/clubs

14. Did teen have any special abilities or talents?	<input type="checkbox"/> Specify:	<input type="checkbox"/> Did these create any special problems or opportunities for her/him?
15. Father present/employed	Occupation: _____	
Mother present/employed	Occupation: _____	

### Occupation and Employment

16. Employment status at time of death	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Retired	<input type="checkbox"/> Unemployed <input type="checkbox"/> Self employed
17. Occupation	<input type="checkbox"/> Laborer <input type="checkbox"/> Agriculture <input type="checkbox"/> Professional <input type="checkbox"/> Service industry <input type="checkbox"/> Government	<input type="checkbox"/> Homemaker <input type="checkbox"/> Subsistence <input type="checkbox"/> Railroad <input type="checkbox"/> Other – Specify: <input type="checkbox"/> Don't know
18. Tenure at last job	<input type="checkbox"/> Less than one year <input type="checkbox"/> 1 – 5 years <input type="checkbox"/> 10 - 20 years	<input type="checkbox"/> 20 – 30 years <input type="checkbox"/> 30 years or more <input type="checkbox"/> Don't know
19. Job satisfaction	<input type="checkbox"/> Happy <input type="checkbox"/> Unhappy	<input type="checkbox"/> No strong feelings <input type="checkbox"/> Don't know
20. Any major negative job change in past 6 months	<input type="checkbox"/> Fired or Laid off <input type="checkbox"/> Demoted <input type="checkbox"/> Pay cut <input type="checkbox"/> Seasonal	<input type="checkbox"/> Health issues <input type="checkbox"/> Other – Specify: <input type="checkbox"/> None <input type="checkbox"/> Don't know
21. Main source of income	<input type="checkbox"/> Job <input type="checkbox"/> Savings/Retirement <input type="checkbox"/> Public Assistance <input type="checkbox"/> Social Security <input type="checkbox"/> Spouse	<input type="checkbox"/> Parents <input type="checkbox"/> Other family members <input type="checkbox"/> Friends <input type="checkbox"/> Other – Please Specify _____ <input type="checkbox"/> Don't know
22. Financial situation	<input type="checkbox"/> No financial pressure <input type="checkbox"/> Lived paycheck to paycheck <input type="checkbox"/> Other Specify:	<input type="checkbox"/> Significant Debt <input type="checkbox"/> Don't Know

## Religion/Spirituality

23. Religion/Spirituality	
24. Was he/she active in his/her spirituality?	<input type="checkbox"/> Very active <input type="checkbox"/> Somewhat active <input type="checkbox"/> Not active <input type="checkbox"/> Don't know
25. Family expectations for spirituality Practice	<input type="checkbox"/> Expected <input type="checkbox"/> Optional <input type="checkbox"/> Other – Specify: <input type="checkbox"/> Don't know
26. Attended spirituality services	<input type="checkbox"/> Daily <input type="checkbox"/> Once/week <input type="checkbox"/> Monthly <input type="checkbox"/> Rarely <input type="checkbox"/> Don't know
27. Change in participation in spirituality activities over past year	<input type="checkbox"/> Increase <input type="checkbox"/> Decrease <input type="checkbox"/> Remained the same <input type="checkbox"/> Don't know

## Suicidal Desire / Symptoms

28. Symptoms or behaviors in weeks preceding death (check all that apply)	<input type="checkbox"/> Appeared sad, tearful, or moody <input type="checkbox"/> Displayed symptoms of depression. Describe: <input type="checkbox"/> Expressed suicidal ideation or thoughts of dying. Describe: <input type="checkbox"/> Appeared to have made a change for the better <input type="checkbox"/> Appeared anxious, or complained of anxiety or panic attacks <input type="checkbox"/> Appeared agitated <input type="checkbox"/> Behaved impulsively <input type="checkbox"/> Displayed uncontrolled rage or aggressive behavior <input type="checkbox"/> Demonstrated constricted thinking or “tunnel vision” <input type="checkbox"/> Disclosed feelings of guilt or shame <input type="checkbox"/> Appeared confused, disoriented, or psychotic <input type="checkbox"/> Expressed feelings of hopelessness, helplessness, or worthlessness <input type="checkbox"/> Showed an inflated sense of self or signs of magical thinking <input type="checkbox"/> Engaged in excessive risk-taking behaviors <input type="checkbox"/> Preparations for own death (e.g. updating will, insurance policies) <input type="checkbox"/> Expressed wish to reunite with a deceased one or to be reborn
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29. Mental Status: Did decedent exhibit any of these in the last year of life?	<input type="checkbox"/> Impaired memory <input type="checkbox"/> Poor comprehension <input type="checkbox"/> Poor judgment <input type="checkbox"/> Hallucinations or delusions <input type="checkbox"/> Difficulty recognizing friends or family members
30. Precipitants to death (Check all that apply)	<input type="checkbox"/> Significant loss(es) – relationships, job, finances, prestige, self-concept, family member, moving, anything else important to deceased individual <input type="checkbox"/> Disruption of a primary relationship (real or perceived) <input type="checkbox"/> Legal troubles <input type="checkbox"/> Difficulties with police <input type="checkbox"/> Traumatic event <input type="checkbox"/> Significant life changes (negative as well as positive) <input type="checkbox"/> Suicide or suicide attempt by family member or loved one <input type="checkbox"/> Anniversary of a significant loss <input type="checkbox"/> Exposure to suicide of another (e.g. celebrity) through media or personal acquaintance

**Physical Health**

31. Any major health problems during his/her life	<input type="checkbox"/> Yes – Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
32. Seeing a doctor for any health problem in 6 months prior to death?	<input type="checkbox"/> Yes – Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

**Emotional Reactivity**

33. Over the course of his/her life, how many time did decedent:	Never	Once	Few times	Many times	Too many times	Don't know
a. Throw a temper tantrum – screaming, slamming doors?						
b. Get into a physical fight with people						
c. Get into verbal arguments with people						
d. Deliberately hit another person or animal						
e. Have discipline problems resulting in suspensions or expulsions						

f. Have fights with bosses or supervisors that led to reprimands, demotions, or firing from job						
g. Have difficulties with police that resulted in a warning, arrest, or conviction for a misdemeanor or felony						
h. Do something that caused someone to complain to the police or to other family members						

**Lifestyle/Character**

34. Would you describe the decedent as a perfectionist?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
35. Would you describe the decedent as rigid or very strict?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
36. Safety belt use during the last year of life	<input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never <input type="checkbox"/> Didn't ride or drive in last year <input type="checkbox"/> Don't know
37. Compared with most drivers, did the decedent drive	<input type="checkbox"/> A lot faster <input type="checkbox"/> A little faster <input type="checkbox"/> About the same speed <input type="checkbox"/> A little slower <input type="checkbox"/> A lot slower <input type="checkbox"/> Don't know
38. Any motor vehicle accidents in year prior to decedent's death?	Describe:
39. Smoking behavior at time of death	<input type="checkbox"/> Yes – Specify how many packs each day: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
40. Duration of smoking behavior	<input type="checkbox"/> 0-4 years <input type="checkbox"/> 5-9 years <input type="checkbox"/> 10-14 years <input type="checkbox"/> 15 years or more <input type="checkbox"/> Don't know
41. Was decedent trying to quit smoking at time of death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know

42. Did decedent ride a motorcycle, ATV, or snow mobile?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
43. Did decedent ever crash while riding a motorcycle, ATV, or snow mobile?	<input type="checkbox"/> Yes – Specify when, how many times: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
44. Did decedent wear helmet while riding ATV, snow mobile, or motorcycle?	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Most of the time <input type="checkbox"/> Always <input type="checkbox"/> Don't know
45. In the last 30 days of life, how often did decedent drive a car when he/she had been drinking alcohol	<input type="checkbox"/> Never <input type="checkbox"/> Once <input type="checkbox"/> 2 - 4 times <input type="checkbox"/> 5 or more times <input type="checkbox"/> Don't know
46. Would you describe the decedent as impulsive?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
47. Gambling behavior	<input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Often <input type="checkbox"/> Don't know

### Suicidal Capability / Psychiatric History

48. Prior suicidal attempts	<input type="checkbox"/> Yes – Describe each attempt: (Method, date of attempt, any medical attention or hospitalization): _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
49. Hospitalization in psychiatric setting	<input type="checkbox"/> Yes – Describe where, when, diagnosis: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

### Substance Abuse

50. Did he/she ever drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> If yes: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other – Specify:
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51. Binge drinking in the month prior to death	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
52. History of drinking problem	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
53. History of drug use (non-medication)	<input type="checkbox"/> Yes – Specify which drugs: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
54. History of “accidental overdose”	<input type="checkbox"/> Yes – Specify when, which drug: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
55. Under influence of alcohol or other drug at time of death	<input type="checkbox"/> Yes – Specify which drug: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
56. History of blackouts after drinking	<input type="checkbox"/> Yes Describe how often: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
57. History of arrests due to drinking or drug abuse	<input type="checkbox"/> Yes Specify when, which drug, how often: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

### Family History

58. Raised by either biological parent	<input type="checkbox"/> Yes Specify: Both parents or Single parent, Mother or Father <input type="checkbox"/> No <input type="checkbox"/> Don't know
59. Family birth order	<input type="checkbox"/> Only child <input type="checkbox"/> First born <input type="checkbox"/> Second born <input type="checkbox"/> Third born <input type="checkbox"/> Fourth born <input type="checkbox"/> Other – Specify: <input type="checkbox"/> Multiple birth – Specify: <input type="checkbox"/> Don't know
60. Number of biological siblings	Don't know
61. Number of siblings dead	Don't know
62. Manner of sibling death	



Sibling	Natural	Accident	Suicide	Homicide	Undetermined	Other
#1						
#2						
#3						
#4						

63. Has decedent's mother, father, or caregiver died	Yes No Don't know
64. Manner of parents'/caregivers' death	
63. Has decedent's mother, father, or caregiver died	Yes No Don't know
64. Manner of parents'/ caregivers' death	

Parent	Natural	Accident	Suicide	Homicide	Un-determined	Other
Mother						
Father						
Care-giver 1						
Care-giver 2						

65. Family history of suicide	<input type="checkbox"/> Yes – Specify how many, who, method <input type="checkbox"/> No <input type="checkbox"/> Don't Know
66. Family history of mental illness	<input type="checkbox"/> Yes – Specify who, diagnosis <input type="checkbox"/> No <input type="checkbox"/> Don't Know

## Firearm History

67. Did the decedent have access to or own a firearm?	<input type="checkbox"/> Yes - Specify when obtained: <input type="checkbox"/> No <input type="checkbox"/> Don't know
68. Were any guns kept in or around decedent's home in the year prior to his/her death?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
69. What types of guns did decedent have access to? (Check all that apply)	<input type="checkbox"/> Handgun <input type="checkbox"/> Shotgun <input type="checkbox"/> Rifle <input type="checkbox"/> Other – Specify: <input type="checkbox"/> Don't know
70. Were the guns kept locked up?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
71. Did the firearms have a locking mechanism such as a trigger lock?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
72. Did the decedent have access to ammunition for the firearm?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
73. How familiar was decedent with firearms?	<input type="checkbox"/> Very familiar <input type="checkbox"/> Somewhat familiar <input type="checkbox"/> Not familiar at all <input type="checkbox"/> Don't know

## Suicidal Intent / Method of death

74. Would decedent have had knowledge and/or capability of assessing the degree of lethality of such an act?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
75. Distance of railroad from decedent's residence	
76. Presence of barriers to access train tracks	<input type="checkbox"/> Yes – Specify kind of barrier <input type="checkbox"/> No
77. Was suicide rehearsed or planned	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
78. Did decedent give any opportunity to be rescued	<input type="checkbox"/> Yes – Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

79. Did decedent have any relationship to the site of death?	<input type="checkbox"/> Yes – Specify: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know
80. Did decedent leave a suicide note?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
81. Did decedent tell anyone that he was going to commit suicide?	<input type="checkbox"/> Yes – Specify whom: _____ <input type="checkbox"/> No <input type="checkbox"/> Don't know

### Buffers/Connectedness

### Access to Care

82. Received counseling in last year	<input type="checkbox"/> Yes. From whom? <input type="checkbox"/> No <input type="checkbox"/> Don't know	
83. Seen a therapist in last year	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> If yes, <input type="checkbox"/> Psychologist <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Social worker <input type="checkbox"/> School counselor <input type="checkbox"/> Other – Specify:
84. In therapy at the time of death	<input type="checkbox"/> Yes <input type="checkbox"/> No – Stopped when?	<input type="checkbox"/> Don't know _____
85. Receiving needed mental health care	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	<input type="checkbox"/> If no, why? <input type="checkbox"/> Didn't believe in counseling or seeking help <input type="checkbox"/> Difficulty finding or getting into a facility <input type="checkbox"/> Difficulty finding or getting treatment <input type="checkbox"/> Problems getting help at home <input type="checkbox"/> Problems paying bills <input type="checkbox"/> Problems with transportation <input type="checkbox"/> No insurance coverage <input type="checkbox"/> Did not want help <input type="checkbox"/> Other – Specify: <input type="checkbox"/> Don't know
86. Did you seek help for deceased individual	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**Access to Medications**

87. Any prescription medications used	<input type="checkbox"/> Yes – Specify which medications, dosage? <input type="checkbox"/> No <input type="checkbox"/> Don't know
88. Medications taken regularly	<input type="checkbox"/> Took as prescribed      Frequently missed doses <input type="checkbox"/> Occasionally missed doses      Don't know
89. Medications covered by insurance	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
90. Trouble paying for medications	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
91. Ease of obtaining medications	<input type="checkbox"/> Easy <input type="checkbox"/> Other – Specify <input type="checkbox"/> Difficult <input type="checkbox"/> Don't know

**Social Supports/Attachments**

92. Number of close friends or relatives to talk freely to	
93. Who could decedent count on to help him/her feel better when under pressure?	<input type="checkbox"/> No one <input type="checkbox"/> Relationship
94. Did decedent have a confidante?	<input type="checkbox"/> Yes. Specify: <input type="checkbox"/> No <input type="checkbox"/> Don't know
95. Who accepted the decedent totally (best and worst points)	<input type="checkbox"/> No one <input type="checkbox"/> Relationship
96. Who would help with daily chores if decedent was sick	<input type="checkbox"/> No one <input type="checkbox"/> Relationship