Psychological Autopsies

Speaker 1: You are listening to a SAFLEO Sessions Podcast, a production of the National Suicide Awareness for Law Enforcement Officers Program. The SAFLEO Program is funded through grants from the Bureau of Justice Assistance, BJA, Office of Justice Programs, U.S. Department of Justice. This podcast is not meant to take the place of advice from a medical professional. If you or someone you know is experiencing a crisis, please call the Suicide and Crisis Lifeline at 988 or text the word "blue" to 741741 to reach the law enforcement officers' personal crisis text line. The points of view and opinions expressed in this podcast are those of the podcast authors and do not necessarily represent the official positions or policies of the U.S. Department of Justice. Here's your host.

Tia: Hello everybody, welcome to the SAFLEO Sessions podcast. I'm Dr. Tia White, a licensed clinical social worker, suicide preventionist and interventionist, as well as a specialist in first responder mental health and wellness. I am part of the SAFLEO team, and I am so excited to be here with Dr. Paul Nestadt and Dr. Chris Drapeau in coordination with the SPEL Lab at University of Kentucky. We're going to be talking about something really interesting and really cool today, psych autopsies. And it's kind of a new topic for this culture for law enforcement. Not a lot of people really understand or know about it. So, before we dive though, Paul, will you start and just introduce yourself briefly, what your background is?

Paul: Thanks. So, I'm a psychiatrist up at Johns Hopkins. I'm associate professor of psychiatry. I do a lot of clinical work, but in the suicide world, I'm actually the chair of the Maryland Suicide Fatality Review Committee, where we look into suicide deaths in the state of Maryland using things like psychological autopsy. My research really focuses on proximal risk factors for suicide.

Tia: Great, thanks, Paul. Chris, what about you? Tell us about yourself.

Chris: Alright, thanks, Tia. Currently, I wear a few professional hats. I'm a licensed psychologist, also adjunct research faculty at the Indiana

University Fairbanks School of Public Health, and also director of research and evaluation for the National 988 Suicide and Crisis Lifeline Network at Vibrant Emotional Health. Similar to Paul, also focused on doing suicide research and, relevant to psych autopsies, also have some experience doing local suicide investigations and serving on county/state mental health agency and statewide suicide fatality review teams.

Tia: We have such a great background here, I think, and what I hear—everybody, all of us, right? Me included, is that we care. Right? We care a lot, and we're trying to do what we can to understand suicide, understand how to prevent it, how we can offer resources to people. I think it's great. So, thanks, you guys, for being here. Let's dive in to psych autopsy. What is it? It's a great word, but what does it really mean?

Chris: That's a great question, and Dr. Edwin Shneidman really was one of the pioneers of this approach. He believed that it served a crucial purpose, that's to bring clarity to death with ambiguous or unclear intent. So, it's not clear if, for instance, was it an accident? Was it intentional? And also, it really is a thorough retrospective analysis of what the intentions of the person was or were leading up until the death. And the information that you pull to try to figure this out is often done through interviews. And usually, those are done with people who are closely acquainted with the person who died. But there's other ways of pulling in information, such as police reports, autopsies, and any circumstantial evidence that might exist. Suicide notes obviously is one that I think is a popular one that people think of, although it's only found in about a third of certified suicides. So, it's not always present and available.

Paul: That's true. And even when there is a suicide note available, there's only so much I can tell you about what the person was going through. It's really just what they were thinking of at the time of their death. And I think that's why the LAPD was interested in getting Dr. Shneidman involved, to look deeper into the suicide deaths and get a better sense of what were these suicides about? Are there things we could be doing to prevent them?

Really, when someone dies by suicide, we're left with a lot of questions. And as clinicians and as epidemiologists, as public health workers, as people in law enforcement, we need answers to these questions in order to save lives in the future and also to help the people left behind better understand what was going on. Was this a consequence of a psychiatric illness? Was this something that was

a result of something happening in the person's life—a financial crisis, a romantic crisis? And, really, psychological autopsy might be the only way that we can get closer to those answers.

Tia: So, this is what I imagine: I hear autopsy, and I think we're being detectives, like the medical people are being detectives of what happened to a person, their body. So, we say psych autopsy, and now we're picking apart their life a little bit. We're picking apart maybe what they were experiencing emotionally and, to your guys' points, maybe some psychological issue that they may have had. And to give people peace of mind, maybe give a little closure to the family. And then, to help professionals like us that work with this all the time, maybe if we can understand this one thing about this person, maybe that can help somebody else in the future. So, we're detectives, really—that's what this is. It's a lot of detective work, right?

Chris: Absolutely. And back in 1977, Shneidman argued that really there's three central questions that a psych autopsy can address, and that's why did the individual do it in terms of their death, how did the individual die and why at that particular time, and what is the most probable manner of death for that particular situation? So, when you hear manner of death—just, really quickly, this is usually using what Edwin Shneidman has referred to as the NASHU model. So, it's a natural death, accidental, suicide, homicide, or undetermined. So, that's typically the manners of death that death investigators are trying to ascertain when doing an investigation.

Tia: I don't know what your guys' personal experience is, but I lost another officer just last week to suicide, and there's always that looming question of why and what can we do. So, it's really good for us to understand what you said, Chris, "How do we go from there?"

Paul: Well, there's a couple of different ways to go. When someone dies, one of the things that's important to do is get a sense—first off, what was the manner of death as Chris was describing? So, I think this is the part that law enforcement officers are much more familiar with. Someone dies. Well, first, let's figure out—was this a suicide or a homicide or is this an accident? And that part is much more of an investigation. It's generally a criminal investigation.

Psychological autopsy is something that happens much later, for a couple of reasons. One is for more time to have passed so the people that experienced that death, that lost their loved one, aren't re-traumatized too soon. And the other is so that there's a chance

to assemble all the information you need and who you need to be interviewing. And then instead of an investigation, I think it's so much better to think about it more as a clinical exploration because the idea is not to investigate, but to understand and inform. It's a subtle difference, but I think one that's important, especially for folks that are used to criminal investigation. Here, we're doing something a little bit different.

Tia: No, I love that. I love what you said, "clinical exploration." This is really a big deal because in police culture especially—we're fixers. We want to fix it; we want to solve it. And so, to say, "We want to understand what happened in their life, but we really aren't there to fix it." We're not there to solve it. We may never know really, but we can explore it and then use what we learn to help other people. So, I love that differentiation. It is a big deal.

Paul: Yeah, it's something scientific researchers are more used to doing. In science, it's what we would call hypothesis generating—just exploring things, not necessarily to come to a conclusion, but to come up with ideas that you can then follow up with compared to other cases and using those ideas, designed interventions, that can later be tested. But it's really, it's hypothesis generating, to put it in scientific terms.

Tia: That no conclusion piece is really hard for a lot of people, especially when it's someone that you cared about, right?

Paul: Absolutely.

Tia: And I think every officer can understand this. It's a family. They may not like them as people necessarily, but they will lay their lives down without a question for them. And so, when somebody is lost to suicide, it is felt everywhere because they're there for each other. They're there to protect each other's lives. They're there to protect each other and the communities that they live in. And so, to have no conclusion is really hard for them. But this is still important work because maybe we can help the next officer not get lost, right?

Paul: That's right. That's right.

Tia: I love that. And you had talked, Paul, a while back when we were discussing this topic—you had related it to coroners and what they do. I love that.

Paul: Yeah. Well, a coroner's job is a little bit different. Just really quick—just to define some terms here, death investigations, as folks in law enforcement generally know, are conducted by coroners or medical examiners, depending on where you're living. But the coroner or medical examiner's job is, first of all, just to determine the cause and manner of death—cause meaning this was a gunshot wound, or this was a poisoning, or this was a car accident. And then the manner of death, as Chris mentioned, from those NASHU options: natural, accident, suicide, homicide, or undetermined.

And they don't have a tremendous amount of resources. They have enough resources, hopefully, to get the job done of determining the cause and manner of death. And so, they don't have the ability, the time, or the money to go and do what a psychological autopsy does, which is extensive interviews with multiple collateral informants, a team of interviewers that then can come together; compare notes; and, as I was saying before, generate hypotheses and become at better understanding. It's just a resource issue. And so, it's something where psychological autopsy can step in for cases that require more of that understanding as opposed to solving and dig much deeper. I think it's important to distinguish.

Chris: I think you're making great points. And I'd like to focus on coroners because, really, this method was born from the frustrations of a coroner and medical examiner in Los Angeles County, Dr. Theodore Curphey. He was looking at a number of drug-related deaths and was feeling frustrated because he couldn't determine—were they intentional deaths or accidental? And so, he also knew at that time, back in the, I think it was the late 1950s, he knew that there was this suicide prevention center in LA County, which was the first of its kind in the country. I think at the time, it was ran by Dr. Edwin Shneidman, who we named earlier, and also Dr. Norman Farberow. And then they had a psychologist or psychiatrist join them later on—I think Robert Litman.

And he tapped them to try to help him figure out, "How can we determine whether these drug-related deaths are intentional or not?" And based on this collaboration, this is where the psychological autopsy method was created, and this term was coined by Shneidman to try to put a name on it and legitimize it.

Tia: So, Chris, can you talk more—with your background, with 988 and the different things that you deal with nationally, can you tell us a little bit more about how the psych autopsies help you guys in the work that you do or just the general population for people?

Chris: Yeah. Paul named a number of ways that this method is so important. We may not fully understand by the end of the psych autopsy, but we'll know a lot more than we did when we started. And that not only can influence the accuracy of these manner of death determinations, depending on the evidence that's found as part of the investigation, but it also provides some clues for how we might be able to help those who are living and thinking about suicide. How can we—as you mentioned earlier, Tia, how can we make sure that this doesn't impact the next officer?

And also, there's some research, not a ton, but there's some research showing that this method may also have a therapeutic effect on those who are grieving the loss of a friend, of a colleague, of a loved one who died by suicide. Because for some people, the big question on their minds following the death is, "Why did they do it?" And perhaps, "Why didn't I see it? Why didn't I notice it?" And what hopefully will be discovered, depending on the sensitivity that the autopsy is conducted in—it can shine some light on that, and then people might feel like they're giving back because by participating in the process, we're learning information that then we could integrate into prevention efforts that could make a difference.

Tia: What are your thoughts on specific things that you've learned in autopsies or that the researchers have learned in psych autopsies and the process of that information moving forward in helping other people? How's that process? Do you guys know of any examples?

Paul: Yeah, that's a really good question. There's been a couple of examples that come to mind. One of the first examples I'd ever heard about, actually—before I was conducting psychological autopsies myself, was at a meeting of the National Association of Medical Examiners where some folks from Florida were presenting on a case series they'd done investigating a bunch of suicides down in Florida and had found that a lot of the decedents had given away their pets in the days or hours leading up to their suicide. And so, based on that, something that as a suicide researcher, as a psychiatrist, I wouldn't have thought about as something to look for as a red flag, but makes a lot of sense in hindsight. So, they started to put up signs at local ASPCAs for suicide prevention hotlines, that kind of thing, based on something that could only have been gathered from really in-depth investigations of those last few days of someone's life and then putting those together as a group and seeing what was a common thread.

I think that's one example. In my own research, I do psychological autopsies in two large studies: one looking at overdose deaths to help get us a better sense of the intent, because people that die of overdose—some of it's an accident, some of it's a suicide, and usually medical examiners are stumped often. But the other one is looking at youth firearm deaths, and we use psychological autopsy to get a better sense of the pathways in which these kids get access to guns, if there's things that we could do to store guns more safely based on actual cases where that storage has failed. And we uncovered unexpected things. Of the first nine cases that I looked at, three of them, three of the young men who had died by suicide had the same odd video game behavior where—video games are popular among all kids in that generation, but they were actually killing themselves in the video game more frequently.

So, I remember one collateral informant we spoke to was the best friend of the decedent and had described his frustration because they were on a team. It was a first-person shooter type game. They were on a team together. And because this guy kept jumping in front of his friend's gun, they kept losing. That counts against him, and he was really frustrated. And then later that day, that young man died by firearm suicide, and the friend just looked back on it and remarked to himself, "Wow, I wonder if that was some kind of sign." He mentioned that to us. We started asking questions along those lines to the next few cases, and out of the first nine, three of them had had behaviors like that.

This doesn't mean you're going to go around and hospitalize everyone who kills themselves in a video game, obviously, but it might be, if it's part of a constellation of other symptoms that clinicians might want to be aware of, that makes them pay a little bit more attention to that person because this behavior has been, if not statistically, significantly, at least in some sense, associated with these deaths. It gives us something to work with. So, it can come from, really—when you do a large, open-ended interview, like a psych autopsy, you can learn a lot of things you weren't expecting to learn.

Tia: That's really great. In SAFLEO, we go, and we teach all over the country suicide prevention to law enforcement officers, their departments, and on every level, every rank. And one of the things that we talk a lot about is, of course, very overarching in general, but those signs and warnings, the risk factors, right? All of those things, but we have to be vague because individual lives have those

unique pieces that we just can't touch on. We don't know everything about everybody's life.

One way, in working with, probably, I don't even know how many, hundreds and hundreds of people over the years of individuals that were suicidal, I've just learned how to identify suicide. The way I've defined it as a very overwhelmed person that didn't have the coping skills, that exceeded their ability to cope. And so, I always say overwhelmed, flooded, and didn't know what to do, and that was the choice they made.

But this is really helpful because it's more specific, like what you're talking about. These are these little tangible things. It's nice that I can generalize it. It's nice that I can talk to the long list of risk factors, but when you're talking about these more specific things, I might perk up a little bit, right? Like, "Oh wait, pets." That is something I know I can look at, because who doesn't talk about their pets?

Paul: Absolutely. And when we think about risk factors as clinicians or as epidemiologists, most of the risk factors that we know are really chronic risk factors. We know people are at much higher risk of suicide if they're male or white, if they're divorced, if they have substance use problems, if they suffer from depression, if they have a family history of suicide—long list of these chronic risk factors that don't really narrow down either the people themselves or when they might be at most risk. And psychological autopsy is unique in that it looks at those proximal risk factors, what was going on in those few days before death, because that is where we want to target our intervention. We don't want to go around taking everyone that has a list of chronic risk factors and forcing them into treatment or something like that or locking them up until unknown time.

But if we know, "Okay, this is going to be a high-risk period." We're seeing a dynamic change in their risk factors, we're seeing an increase in this behavior, a decrease in that, they're isolating more, giving away a dog, video game behavior—whatever it is that helps us really target interventions. And that understanding of proximal factors comes from no other investigation. It's also notable that suicide as a spectrum of behaviors is often thought of as this gradient—that there's suicidal ideation, people thinking about suicide; there's people that make suicide attempts as if they're a small portion of the ideators; and then there's people who die in those attempts as if they're a small portion of the attempers. But in reality, the people who have suicidal thoughts and even who make

suicide attempts are very different in many ways from people who die by suicide, even epidemiologically.

Well, for instance, just looking at sex, women tend to attempt suicide three or four times more often than men, but men die by suicide at four times the rate of women. Eighty percent of suicide deaths in the U.S. are men—similarly for age groups, race. And so, because of that, we would ideally study—instead of interviewing people who have chronic suicidality to understand suicide, it might be more helpful to interview people who have died by suicide, but of course, they've passed away and can't be interviewed. Psychological autopsy is our best proxy for that, of getting a sense of what was going on for this person who actually died by suicide. Most people who died by suicide have never had an attempt before. Most people who died from suicide have actually never seen mental health care before. And so, that's a population we know so little about and can only get through this methodology.

Tia: I'm curious—Paul, Chris, do you guys know, psych autopsy in itself is usually after somebody's passed away, right? It says died by suicide, but there are many that have attempted and survived or it failed. And do you guys ever include those individuals in a psych autopsy research project? Is that a thing? Because they could give you lots of insight that an individual that is not living can't, right?

Chris: Oh, along similar lines, Paul, say in terms of psychological autopsy, I'm not aware of any that have—given that it's typically focused on the death itself. But as Paul was mentioning, yeah, there's a number of studies that have incorporated the perspectives and experiences of people who've survived suicide attempts. There's been a greater focus on people with lived experience, so people who have survived suicidal crises or attempts, as mentioned earlier, and trying to incorporate them into research projects to try to get that unique perspective, making sure that that's captured based on the research that is being utilized. So yeah, Paul, I don't know if you had more to build off of from there, but similar thoughts.

Paul: No, just that it is. That has been the main thrust of suicide research is interviewing people who have lived experience because it's a much easier type of research to do. There's many more people who have attempted suicide than have completed suicide, and of course, they can be interviewed directly. Those are very useful studies, but I feel like it leaves a gap in the people who have died by suicide, just keeping in mind that they can be a very different population in a lot of ways.

Tia: Interesting.

Paul: It's worth pointing out that attempting suicide is a major chronic risk factor for suicide in the future. I think it's one of our best predictors, but even as our best predictor, it's a very poor predictor. The vast majority of people who've attempted suicide do not go on to die by suicide. There's been a lot of studies where they look at large swaths of people who have made very serious attempts and followed them for a long time.

I think a lot about a study of the Golden Gate Bridge. And there was a study that was done in the seventies, Dr. Seid and his team, that looked at 515 people who had attempted suicide from that bridge. This is usually a very high lethality attempt. About 1% of people will survive the fall, or you can be pulled off by the police and survive that way. They followed 515 people that had made that attempt for a period of 26 years, so very long follow up, and found that of those 500 some people, less than 5% of them ever went on to die by suicide.

So, these are people that have made very serious attempts, but it speaks to the impulsivity of suicide and the importance of the lethality of means, frankly. But I think something to take home is that most people who attempt are not going to keep attempting until they die. Some people will. In that study, 5% of people did, but the majority, 95% really do keep on surviving, and that's important to know.

Chris: Tia, if I could add, I think the survival aspect is key, and it's tempting to want to describe surviving a suicide attempt as a failure. Well, you failed at attempting suicide. But really, I wonder if the question could be asked, "Why didn't you die? What led to you surviving this?" Because there could be important information there that also could inform prevention efforts into the future, but also helping people understand that it's not a failure if you survive. And in some cases, people have talked about how not following through on those thoughts and attempting was one of the best decisions they've made in their life.

There are a number of anecdotes where people have said, "I'm living a life I never thought I ever could, and that wouldn't be possible if I would've died from that attempt." And so, I'm really grateful that Paul brought up that study, just echoing the number of people who did attempt and survive didn't do it again. So, there's a transformative effect. I don't know if you want to call it post-

traumatic growth, but there is some research suggesting that yes, people who survive a suicide attempt can experience this post-traumatic growth, similar to those who've been bereaved.

Tia: Paul, when you were talking about the study, how many of them are thriving now where they struggled before, right? I mean, it's really important.

This is really helpful for the law enforcement community, what you guys were just talking about, because so many don't understand suicide at all. We're talking about how clinicians are still trying to understand it, but then the police community especially—it is not talked about. It's more commonly just brushed under the rug, and agencies don't address it directly. And so, there is a belief out there that if an officer has attempted, that they will continue to attempt. And it is unfortunate because it alienates that individual when they're trying to recover and trying to thrive in life, and they're treated as if they will try that again. And so, I'm really glad that you guys brought up that up. So, thank you for clarifying that.

One thought here is, "How is this going to help an agency?" Understanding what a psych autopsy is and the process of it, what is an agency going to do with that information, like a police department? Why should they even care about this? What do you guys think?

Chris: Yeah, law enforcement—they clearly have an important public service, yet very traumatizing jobs based on what they have to experience day-in and day-out. This method, if employed within a law enforcement agency and if fully supported by administration, can be therapeutic for the reasons we described earlier. When a fellow officer dies by suicide and people are able to participate in an interview process to share what they think contributed to that, and then learning what the recommendations of that autopsy are as a result of their participation can be very healing. It could be also—it could show them the purpose of participating because they see action coming from using this tool. And so, that's one area.

Also, I would caution though that it may backfire. If you look to institute this method in your agency, but there isn't administrative support, it just may look like it's something that you're going through the motions and doing, and it actually may dissuade officers from participating because they may be asking, "Well, what's the point if nothing's going to come from this?" So, there's a number of things, I think, for agencies to consider, but I think that what you said earlier,

Tia, is that there is this culture of, "We have each other's back." It doesn't matter how we feel about each other as colleagues, we have each other's back. And you could look at the psychological autopsy approach as a way to further solidify that attitude within that culture, is that we're doing this investigation to figure out what led to this and what can we do about it to look out for those who are still with us.

Tia: This is really heartwarming for me because they care so much and they want to do something. Because, like I said, the culture is fixers. They're out there in the community taking care of it, and after suicide, they feel so helpless. They don't know what to do. And so, this is—taking the information or participating in a psych autopsy, it's something that they can do, they can tangibly do. They can take the information and apply it.

Paul: That's absolutely true. When we're going through someone's last few days or weeks, we start to notice systems level points of intervention that could be implemented that might prevent deaths like this in the future, really only by looking at what that person went through, where they touched parts of the system that could have intervened. Can we learn how to do that?

I think it's also important as you go through—I just want to point this out, as we go through learning about missed points of intervention, to remind the people being interviewed that suicides are very, very hard to predict. I'm a psychiatrist that studies suicide, and I can interview a patient and have no idea what their risk level is. We're really bad at predicting suicide. And so, in the course of those interviews, it's always important to talk to those collateral informants who are often loved ones and friends to point out that they didn't miss something that they shouldn't have missed. That's the instinct, right? The idea is people that are left behind by a suicide often find themselves questioning every interaction they had with that person those last few days. "What didn't I do that I should have done?" And it's not an accurate view of what suicide is. Suicide can be very impulsive. It's very easy to hide, suicidality, even if it is there during those conversations.

And that's one of the reasons that these interviews can be cathartic, not just in giving the survivors a chance to talk about what they've gone through and perform a helpful role, but also to reassure them, coming from people who are experts in suicide by virtue of being psych autopsy interviewers, that there wasn't some reason to feel guilt, that this was something that happened as a consequence of

usually a psychiatric illness or other things going on in that person's life that had very little, if anything, to do with the person they were talking to.

Tia: I think it's really comforting to hear a clinician, a psychiatrist, say, "We're really bad predictors. I could be talking to you all day every day for ten years and still not have a clue that that was something that you were going to do."

Paul: That's absolutely the case. Yeah.

Tia: Yeah.

Paul: It's frustrating because I guess if anyone has the training to predict this, it would be people with lots of clinical experience, but there's been studies that have shown we are very bad at it. This is something that's very hard to predict, and part of it's because even though suicide is a relatively common cause of death, it's generally most years in the top 10 causes of death, it's the second leading cause of death for Americans under 35, it's still relatively rare in the context of all the people alive. Only about 14 for a 100,000 Americans die by suicide each year. So, it's a low frequency event, so predicting it is incredibly hard. It's like trying to predict a lightning strike or something like that. And I try to remind survivors of that.

Tia: Well, and this is important—in law enforcement culture, they're also very good, most of them, at hiding things, and it's a job necessity. I found this as a social worker working in the communities that I worked in. Nobody knew I was married, and nobody knew I had kids, and there was a reason for that. It's because I was protecting my family from individuals that I did not want them to be exposed to. So, we get very good professionally at hiding things and living almost a second life. So, add that component to what you're talking about, and it's very, very, even more difficult to know if somebody is going to do that or not.

Paul: Absolutely.

Tia: Chris, you mentioned if they participate in an autopsy, if their agency—is this something that my agency, I work with a lot of agencies, if they're interested in this, how do they reach out and say, "Hey, this might be good." Who do they talk to? Or is it even open to public? How does this work?

Chris: Yeah, there are some national organizations that provide training if you want to do psychological autopsy. Sometimes it's called retrospective fatality analysis. So, there are trainings out there that they can take a look at and go through. There's also certifications if they want to be formally certified as well. I can tell you there are researchers who have created their own protocols building off of what Shneidman and colleagues created back in the early 1960s. So, there's a number of protocols that exist out there, but there's also an interest in trying to create a more standardized approach to psychological autopsy.

Tia: Oh, thank you so much. Okay, so we have also this fantastic thing that police do in that they just try to do things themselves, without training. Would you guys recommend that they just try to do this on their own? Or who would you recommend they consult with before doing this if they can't get the training? Because sometimes budget's an issue, right? So, what would you recommend in that case?

Chris: So, Tia, I think it's deceptive, right? It probably sounds simple, the way we're describing it to do it. However, one thing, going back to Schneidman—he was very clear about the need for sensitivity. And I think having a clinical background, part of your training is how to interview people around sensitive topics and to do it in a way that allows them to feel safe and comfortable sharing that information. And that's a critical component of these autopsies, because if people don't feel safe opening up to you, they're not going to share everything with you. So, building rapport is a key aspect of the process.

I also want to point out, if going on your favorite search engine doesn't do enough to locate resources, please look into who your local or state suicide prevention leader might be, within local or state government, as they may have information. They may be trained themselves, may be able to guide you in where to look next.

Tia: Oh, that's great. No, that's really good. I'm thinking about these other situations that police engage in, that it's the same thing. They need the professionals to help create the safe space to have those sensitive conversations. A lot of officers or agencies do something called a critical incident stress debrief, and it's the same thing. They can go very badly when somebody is not trained to facilitate, but they can also be very healing when they have somebody there that knows how to manage those because you're talking about a critical

incident that really affected people deeply. So, it's that same idea. That's the way I'm associating it.

Let's just wrap up. You guys have been fantastic. I truly appreciate all your thoughts. Do you have any final thoughts, any final nuggets for anyone listening out there about our psych autopsy conversation?

Paul: Yeah, I think if there's one thing to sum this up—it's important for law enforcement agencies to be aware of this methodology of psychological autopsy because it's a really useful method to accomplish a couple of goals. One is to identify missed points of intervention, to develop good prevention measures in the future. It's also a good way to help target post-vention. In the context of interviewing people, the agencies can get a better sense of who is struggling the most and who might need additional resources. That's another reason that it's important that clinicians are doing these interviews, to identify that need and make referrals when needed. That's something that you never want to be missed in the course of psychological autopsies, but this is a really great methodology. It's something that comes from law enforcement originally, as Chris said, from the LAPD, and is something that continues to be a very useful tool in dealing with suicide and preventing future suicides.

Tia: Oh, that's amazing. Thank you, Paul. Yeah, Chris?

Chris: Yeah. Oh, thanks, Tia. Building off of what Paul said, I think it's also important to have, I guess, a perspective focused on continuous evaluation of the process. And I would encourage any agencies that are utilizing this method to ask their officers, "How is this going for you? What concerns do you have about the process?" Almost doing a psychological autopsy on the psychological autopsy to try to uncover, "How can we make it better? How can we make it easier for you to participate and share what you're thinking? What are you afraid of happening? Should you open up?"

Because one thing we do know, as Paul has mentioned, he's talked about the difficulty with predicting suicide risk. We also know there's research that suggests that suicide risk might run in social networks. And so, if you have people who are close to the person who died, it's feasible that they also may be thinking about suicide. And one particular point that I'd like to make is to pay attention to anniversaries around the loss of a fellow officer, as that may be very difficult times for folks and could be high risk times as well. But then again, going back to Paul's point, it's really hard to know for sure.

But if you're thinking about all these ancillary things that could be influencing how the psychological autopsy goes in terms of helping your agency, I think it's really important to have that continuous evaluation perspective so that you're paying attention to any factors that you haven't even thought of that might be impacting the quality of the process.

Tia: I love that. Thanks, Chris. It's like an AAR, right? An after-action review of our psych autopsy process. And Paul, to your point, that post-vention, that is something that agencies are craving, like, "How do we do better? How do we do different?"

You guys, thank you again—so much appreciate your insight. This has been a fascinating conversation, I think really helpful for a lot of people as they learn more about what is available out there, and researchers and clinicians are trying to help them and have their back. And for more information on this topic, other officer wellness topics, please go to the SAFLEO.org. You can search under Officer Suicide Post-Event Response Guide. That will get you a lot of really good information from our researchers and the experts. A healthy officer is a safer officer. Until next time, stay safe and be well.

Speaker 1: The SAFLEO Program is dedicated to providing training, technical assistance, and resources to law enforcement agencies, staff, and families, to raise awareness, smash the stigma, and reduce and prevent law enforcement suicide. For additional information regarding the SAFLEO Program, please find us on social media and visit SAFLEO.org, that's S-A-F-L-E-O.org.

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