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Review article

The psychological autopsy approach to studying suicide: a review of methodological issues

Keith Hawton[a,*], Louis Appleby[b], Stephen Platt[c], Tom Foster[d], Jayne Cooper[b], Aslög Malmberg[a], Sue Simkin[a]

[a]*University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX, UK*
[b]*Department of Psychiatry, Withington Hospital, West Didsbury, Manchester M20 8LR, UK*
[c]*Research Unit in Health and Behavioural Change, Department of Public Health Sciences, University of Edinburgh, Medical School, Teviot Place, Edinburgh EH8 9AG, UK*
[d]*Tyrone and Fermanagh Hospital, 1 Donaghanie Road, Omagh, Co. Tyrone, N. Ireland BT79 0NS, UK*

Abstract

The psychological autopsy approach to studying suicide is becoming an increasingly used research method. It presents considerable methodological problems. In order to assist future researchers in this field and to help readers assess reports of psychological autopsy studies the authors have reviewed these issues on the basis of their own experience and those of other workers. The areas covered include research design, identification of subjects, sources of information and the particular issues concerned with approaching relatives and other informants, choice and recruitment of controls, the difficulties of conducting psychological autopsy interviews with relatives, problems for interviewers, the selection of appropriate measures to obtain information, and achieving valid and reasonably reliable conclusions from diverse information sources.

Keywords: Psychological autopsy approach; Suicide

1. Introduction

The establishment by the Government of suicide prevention targets within The Health of the Nation strategy (Department of Health, 1992) and recent changes in the patterns of suicide have resulted in an increase in research attention to suicide in the UK. The main study methods are, first, epidemiological investigation which can identify possible risk factors, and, secondly, detailed study of individual cases in order to shed light on reasons for suicide. This paper is concerned with the latter approach to understanding suicide, which has become known as the psychological autopsy method (Schneidman, 1981). We have prepared this review on the basis of our experience of conducting psychological autopsy studies and the work of others in the field (e.g., Rudestam, 1979; Schneidman, 1981; Brent, 1989; Beskow et al., 1990; Clark and Horton-Deutsch, 1992; Henriksson et al., 1993) with the intention of establishing a consensus on key methodological

*Corresponding author

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issues to assist those who wish to use the method or appraise the increasing number of published studies.

The overall aim of psychological autopsy is to gather enough information about the circumstances of an individual's death to try to understand the reasons for the suicide. There was broad agreement in the findings of three influential early psychological autopsy studies of suicides, two conducted in the USA (Dorpat and Ripley, 1960; Robins et al., 1959) and one in the United Kingdom (Barraclough et al., 1974). Psychiatric disorder was identified in all but a small proportion of suicides (93–100%), depression being the most frequent (30–70%), then alcoholism (15–27%) and schizophrenia (2–12%). Comorbidity of disorders was common, a feature that has been emphasised in subsequent investigations (Henriksson et al., 1993; Conwell et al., 1996; Foster et al., 1997). In older suicides physical ill-health is also a risk factor (Carney et al., 1994; Henriksson et al., 1995). High frequencies of psychiatric disorder have also been found in recent studies of very young suicides, with the role of substance abuse, together with personality factors (including conduct disorder), emerging as especially important (e.g., Runeson, 1989; Marttunen et al., 1991; Brent et al., 1993; Shaffer et al., 1996). Some of these studies have also highlighted the importance of psychosocial factors whose contribution to suicide risk is clearly additional to that of psychiatric and personality disorders (e.g., Gould et al., 1996).

A variety of sources of information are used in psychological autopsy studies. These include evidence presented at inquest, medical records and information from general practitioners and hospital clinicians. The most important source, however, is interview of relatives and other informants. This is a complex research approach which is beset with considerable methodological and practical difficulties.

2. General research design

The initial research questions and hypotheses will determine the design of the study, including the areas to be focused on in interviews and the choice of controls. Particular attention should be paid to case definition. In the British Isles, suicides are frequently included in non-suicide categories of inquest verdict, especially the undetermined ('open verdict') category (Charlton et al., 1992). On the other hand, a sizeable minority of open verdicts are not suicides. A pragmatic approach is to start by including all open verdicts and, perhaps, certain accidental cases (e.g., drownings, single driver accidents) and after obtaining preliminary information (e.g., from the inquest) to review each case and judge the likelihood that the death was a suicide. Only those of moderate or high likelihood should then be included in the investigation. There is a particular difficulty in Scotland where verdicts are made in secret by the Procurator Fiscal and their release requires the consent of relatives. In Northern Ireland coroners do not bring in a verdict but produce a descriptive finding which is then interpreted and classified by experienced staff in the central registry.

In calculating sample size by power analysis, account should be taken of the likely proportion of cases in which it will not be possible to obtain full information. Recent experience in the UK indicates that information from all sources, including interviews with relatives, can usually be obtained in at least 50–60% of cases. Limited information (i.e. coroners' and medical records) can be obtained in virtually all cases and can be used to answer some research questions (e.g., contact with general practitioners and other clinical services before death). It is important to check for possible bias in the interviewed sample on variables such as age, sex, marital status, verdict, and contact with mental health services. A higher positive response rate from relatives is usually obtained for subjects who were in current or recent psychiatric care at the time of death.

3. Sources of information

Depending on the area covered by the study, cases in England and Wales can be identified either through individual coroners or the Office for National Statistics, which will also supply death certificates.

3.1. Coroners

It is essential to establish a good working relationship with coroners and their officers. Experience has

shown that coroners vary greatly in their attitudes to this type of study, especially since demands on them to cooperate with such work have increased, but most coroners respond positively when the purposes of a study are fully explained. One of their major concerns will be to protect relatives. They will often require reassurance that researchers will not put undue pressure on relatives to participate in interviews. Before releasing inquest information, beyond the death information which is available to the public, they will need to be sure that the research workers can be appropriately included within the category of 'persons having a legitimate interest' in the details of each case. Coroners can often supply contact details about relatives.

3.2. General practitioners

The general practitioners of subjects are usually identified either from coroners' records or by approaching the local District Health Authority. Most GPs are willing to make available the practice records for patients who have died by suicide. Usually the records will have been returned to the FHSA but the doctor's written permission may be required before they can be released. Some FHSAs destroy records a few years after the death. General practitioners can also help researchers identify and gain access to the most appropriate informants for interview. As with coroners, GPs may advise against approaching a relative because of their concerns about the effects that an interview might have, although this may be resolved with discussion. If doctors harbour concerns about their clinical management of a patient before death this may influence their response and reassurances about how any material will be used in reports will be necessary.

3.3. Other sources

Hospital records of individuals who were in psychiatric care shortly before or at the time of death can be an invaluable source of information. Usually there is no problem in obtaining these. It can be difficult to obtain information from social services, the armed forces, police and prisons; official approval will usually be required.

3.4. Relatives and friends

A parent or partner, when these are available, will usually be the most appropriate informant. Where funding and time permit, researchers should consider approaching more than one informant (Beskow et al., 1990). For example, in the case of young suicides a sibling or friend may be able to supply important information (e.g., about drug use, interpersonal problems) which parents are not aware of. Identification of a suitable informant can sometimes be difficult if the subject lived in isolation or the individual or the family were not known to the general practitioner.

A direct initial approach by personal visit or telephone will result in higher participation but is disliked by some relatives (Runeson and Beskow, 1991). The usual initial approach to informants (and one which most ethical committees demand) will be by letter, followed by telephone discussion. The best time to approach relatives is between three months and a year after the death. This allows time for the inquest and the most traumatic part of the bereavement process to have occurred but is not beyond the time when informants will be keen to discuss the person and their death. Some workers have, however, approached relatives earlier than three months (e.g., Conwell et al., 1996). One should avoid approaching a relative close to the anniversary of the death, the birthday of the deceased, or at family occasions such as Christmas.

4. Controls

It is usually desirable to include controls, although sometimes this will not be possible because of cost or lack of a suitable control group. Selection of the most appropriate control group must be determined by the hypotheses of the study. If, for example, the study is primarily concerned with psychiatric illness and personality factors the control group may be relatively unselected. On the other hand, if social influences on suicide are the main focus of investigation it may be necessary to match the control group for the presence of psychiatric disorder. There is, however, danger of overmatching groups since this can lead to loss of ability to detect certain explanatory variables.

Sometimes a study will have more than one focus

of attention and this may necessitate the use of two control groups. For example, a study which is aimed at, first, identifying the extent to which suicide is associated with psychiatric disorder and, secondly, identifying social and other risk factors in *depressed* individuals may require both an unselected control group and one matched with a subgroup of the suicides for presence of depressive disorder.

Another important consideration is whether living or dead controls should be used. Again this will be determined by the hypotheses to be tested. For example, investigation of risk factors associated with suicide within a specific diagnostic group will require use of living controls whereas dead controls will be necessary for a study of the needs of relatives bereaved by suicide. Ideally, third party informants should be used for obtaining information on controls so that one is comparing like with like. However, living controls have been unwilling for their relatives or friends to be interviewed (Beskow et al., 1990). The resulting control group is then subject to bias, which is difficult to assess.

Psychological autopsy interviews using informants for controls can also have negative consequence for families (Beskow et al., 1990). For example, the interviews may highlight current problems (e.g., psychiatric disorder and interpersonal difficulties). Difficulties over confidentiality are likely to arise. In practice, the response rate from informants for controls is often less than that from informants for suicides. The potential biases resulting from this are difficult to ascertain as little or no information will be available about the characteristics of controls where informants refuse to participate.

5. Interviews

The interview with relatives and other informants will usually take place at the informant's home or a neutral setting such as the GP's surgery. Timing of interviews is important as they may take between two and five hours to complete. Relatives need to be forewarned of this.

Studies have differed in the method of interview. Use of an interview schedule provides structure to the interview and ensures all areas are covered, but it is important to be flexible and adjust to the psychological needs of the informant. As in clinical interviews each area of enquiry should begin with open-ended questions before moving on to closed questions. One should start the interview by asking about the circumstances of the death before collecting background information as the former will usually be uppermost in relatives' minds. Excessive note-taking should be avoided; tape-recording the interview is acceptable to most informants (Beskow et al., 1991) and allows the interview to flow more freely.

The integrity of the deceased should be respected. Informants should feel free not to discuss sensitive issues, and be allowed to stop at any time without feeling guilty. It is important to be aware that not all relatives will view the death as a suicide; their views should be respected. Interviews should be paced, with breaks to alleviate tiredness. The interviewer should try to end the interview on a positive note, stressing how helpful the informant has been.

5.1. Impact of interviews on relatives and other informants

Detailed enquiry about deceased relatives and friends may uncover or evoke emotional reactions in informants. These include distress, anger and guilt. Suicidal ideas are also sometimes revealed. There is evidence that in spite of such emotional responses psychological autopsy interviews are not generally regarded as detrimental by informants, in fact usually the reverse. Thus Åsgård and Carlsson-Bergström (1991) found that most informants reported having benefitted from the interview, which has also been our experience. Some informants have commented that the interview provided them with their first opportunity to discuss the death in detail. If an informant becomes very distressed at the time of an interview, the interviewer should ascertain whether support is available, such as through the general practitioner. Offering to contact the general practitioner on behalf of an informant will sometimes be appropriate, especially if significant depression and/or suicidal ideation are identified. Some of the present authors have offered a bereavement information pack to relatives and other informants, irrespective of whether they have agreed to be interviewed. This pack, which has now been published by the Royal College of Psychiatrists (Hill et al., 1997),

includes details of common experiences people have during bereavement by suicide, sources of support and useful reading. Some relatives find books on bereavement helpful, especially *A Special Scar* by Wertheimer (1991).

Psychological autopsy interviews can raise important ethical issues which interviewers need to be aware of. For example, asking specific questions about treatments received by the deceased can lead to questions on the part of the informant about what treatments the deceased *should* have received. Unless such responses are handled carefully there is a risk that informants might themselves feel guilty about not having ensured that such care was provided and, or, angry towards healthcare agencies for not having arranged this care.

5.2. Interviewers

Most studies have used psychiatrists or psychologists as interviewers; some have used social workers or nursing staff. Where psychiatric and social data are being collected joint interviews by a psychiatrically experienced interviewer and a scientist with experience of qualitative research methods may be advantageous but might not be to the liking of some relatives. The interviewer should have experience of clinical or in-depth social science interviewing, and the ability to empathise without becoming too emotionally involved with the subject.

Interviewers may find it difficult to cope emotionally with this type of work, particularly at first. Regular debriefing sessions with a skilled supervisor are advised.

6. Information that can be obtained in psychological autopsy studies

A list of areas that can be covered is shown in Table 1. Some areas of data collection present particular problems in psychological autopsy studies:

6.1. Assessment of psychiatric disorder

This should be tied into existing diagnostic systems, usually ICD or DSM. The schedule which is used should have a relatively brief screening section with cut-offs for each diagnostic area in order to keep the interview as short as possible. Particular problems arise in assessing symptoms such as guilt, pessimism or thoughts of suicide since the informant may not have knowledge of these. This means that strict adherence to diagnostic criteria requiring a certain number of symptoms and signs may underestimate the prevalence of psychiatric disorder in a sample. We suggest making psychiatric diagnoses which seem clinically likely given information about the subject's behaviour and manner. For example, where clear depressive delusions are elicited but only

Table 1
Potential areas which might be investigated in psychological autopsy studies

Details of death (including, for example, circumstances, access to method, premeditation)
Family background, including history of psychiatric disorder and suicidal behaviour
Childhood, adolescence, education
Relationships: partner, family, friends
Social support and isolation
Housing
Legal problems
Occupation and employment
Physical health
Psychiatric disorder
Psychiatric history
Personality disorder and characteristics
Exposure to suicidal behaviour
Religious commitment
Life events
Contact with clinical services and other helping agencies prior to death
Relatives' response to the death

three other depressive symptoms (e.g., weight loss, early morning waking, and psychomotor retardation) a diagnosis of severe depressive episode with psychotic symptoms (ICD 10) might be reached, provided no other diagnosis (e.g., schizophrenia) is likely.

6.2. Assessment of personality disorder

This presents particular difficulties in this type of study. Some informants find this aspect of interviews the most distressing because the focus tends to be on negative characteristics of the deceased. Again it is best to use a schedule which has brief screening sections with cut-offs. We have found both the Personality Assessment Schedule (Tyrer et al., 1988) and the Structured Assessment of Personality (Mann et al., 1981) to be useful instruments.

A variety of specific personality and behavioural characteristics have been linked to risk of suicidal behaviour and may repay study in psychological autopsy investigations. Those for which measures are available include, for example, impulsivity (Plutchik and van Praag, 1986), aggression (Brown et al., 1979, 1982) and hostility (Buss and Durkee, 1957).

6.3. Assessment of life events and problems

Assessing life events is likely to be difficult because relatives may have little idea of the impact of events on the individual and the degree of causal independence of events from other phenomena such as psychiatric disorder. A pragmatic approach may have to be adopted whereby only major events are assessed (Brugha and Cragg, 1990) and degree of independence of events is largely ignored.

A useful means of determining psychosocial factors associated with suicide is to identify particular '*problems*' faced by the deceased prior to death. This necessitates the use of consensus or independent ratings on the basis of all available information. Ratings can be made of, first, whether a particular problem (e.g., relationship difficulties, unemployment) was present, and, secondly, whether it was judged to have contributed directly to the suicide.

We recommend that researchers try to establish the chronological sequence of events and development of psychopathology, rather than simply their occurrence. This will provide far more information on pathways to suicide and the suicidal process, and help identify possible prevention strategies.

7. Achieving valid and reliable ratings

Two important problems may affect the validity and reliability of information obtained through interviews with relatives and friends. The first is *recall bias*. Because of the complex nature of both bereavement following suicide and memory for emotion-laden events and relationships, the recall of information about a close relative or friend may be distorted. There may be selective recall of certain aspects (e.g., positive characteristics) and selective forgetting of others (e.g., negative characteristics), or vice versa. Secondly, information may be *unreliable* for other reasons, including the informant being unaware of certain factors (e.g., parents may not be aware of problems such as drug taking, concerns about sexual orientation and relationship difficulties), and deliberate withholding of information, especially that which may cast the dead individual in a bad light.

What can be done to reduce the extent of these problems? Interviewing more than one informant will increase the extent of information that can be obtained and its reliability, but this will greatly increase the cost of the research. The approach we have adopted is to assimilate information from several sources, including informants and official records, and then make ratings on the basis of what seems most likely to be correct in the context of the overall history, the nature of the relationship between informants and the deceased, and on commonsense grounds.

As a minimum, information on each case, particularly on psychiatric diagnoses, should be reviewed by other members of the research team and consensus reached. Completely independent review of interviews is ideal but extremely time consuming. Key items (e.g., psychiatric disorder, problems that may have caused the suicide) might be given a probability rating (e.g., 'definite', 'probable' or 'possible') on the basis of how confident the researchers are about their presence or absence. This will allow less reliable information to be omitted if necessary.

Researchers should be aware that absence of information about specific items (e.g., a recent GP visit or presence of certain symptoms) does not necessarily mean that these did not occur or were not present.

Further work on assessing the validity and reliability of information obtained in psychological autopsy interviews is required. A partial check on validity would be to interview living subjects, preferably ones with a range of severity of psychosocial problems, and then for another interviewer to conduct such interviews with relatives. The extent of agreement between the information obtained from the two sources could then be checked. There is evidence that reliability of scores regarding personality as assessed by the Personality Assessment Schedule used in this way are satisfactory (Brothwell et al., 1992). Of course such an approach would not control for bias caused by the death of the subjects. Reliability could be investigated by conducting psychological autopsy interviews with two informants (e.g., with parents separately) and checking the degree of agreement between the information from each. However, pooling information from all available sources is likely to result in the most valid and reliable findings.

8. Conclusions

The psychological autopsy method of research is a valuable means of expanding our understanding of the factors that contribute to suicide and identifying potential preventive strategies. This intensive approach can also help ensure the correct interpretation of results of epidemiological investigations. But, as we have emphasised, psychological autopsy has its limitations and is associated with considerable problems. Careful planning can improve the reliability and value of this approach.

In recent years several psychological autopsy studies have taken place, both of general samples of suicides and of specific subgroups (e.g., the very young). As the pattern of suicide changes over time there will be a need for new general studies, since earlier findings will become less relevant. There is also a need for work focused on particular subgroups, such as high-risk occupational groups and psychiatric patients, and on the role of personality dimensions. This approach also allows study of the suicidal process (Runeson et al., 1996), especially the sequence of events and experiences which lead to death. Identifying the components of this process is likely to provide the most valuable information for determining potentially effective strategies for preventing suicide.

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References

Åsgård, U., Carlsson-Bergström, M., 1991. Interviews with survivors of suicides: Procedures and follow-up of interview subjects. Crisis 12, 21–33.

Barraclough, B., Bunch, J., Nelson, B., Sainsbury, P., 1974. A hundred cases of suicide: Clinical aspects. Br. J. Psychiatry 12, 355–373.

Beskow, J., Runeson, B., Åsgård, U., 1990. Psychological autopsies: Methods and ethics. Suicide Life-Threat. Behav. 20, 307–323.

Beskow, J., Runeson, B., Åsgård, U., 1991. Ethical aspects of psychological autopsy. Acta Psychiatr. Scand. 84, 482–487.

Brent, D.A., 1989. The psychological autopsy: Methodological considerations for the study of adolescent suicide. Suicide Life-Threat. Behav. 19, 43–57.

Brent, D.A., Perper, J.A., Moritz, G., Allman, C., Friend, A., Roth, C., Schweers, J., Balach, L., Baugher, M., 1993. Psychiatric risk factors for adolescent suicide: A case-control study. J. Am. Acad. Child Adolesc. Psychiatry 32, 521–529.

Brothwell, J., Casey, P.R., Tyrer, P., 1992. Who gives the most reliable account of a psychiatric patient's personality? Ir. J. Psychol. Med. 9, 90–93.

Brown, G.L., Goodwin, F.K., Ballenger, J.C., Goyer, P.F., Major, L.F., 1979. Aggression in humans correlates with cerebrospinal fluid amine metabolites. Psychiatry Res. 1, 131–139.

Brown, G.L., Ebert, M.H., Goyer, P.F., Jimerson, D.C., Klein,

W.J., Bunney, W.E., Goodwin, F.K., 1982. Aggression, suicide, and serotonin: Relationships to CSF amine metabolites. Am. J. Psychiatry 139, 741–746.

Brugha, T., Cragg, D., 1990. The list of threatening experiences: The reliability and validity of a brief life events questionnaire. Acta Psychiatr. Scand. 82, 77–81.

Buss, A.H., Durkee, A., 1957. An inventory for assessing different kinds of hostility. J. Consult. Psychol. 21, 343–348.

Carney, S.S., Rich, C.L., Burke, P.A., Fowler, R.C., 1994. Suicide over 60: The San Diego study. J. Am. Geriatr. Soc. 42, 174–180.

Charlton, J., Kelly, S., Dunnell, K., Evans, B., Jenkins, R., Wallis, R., 1992. Trends in suicide deaths in England and Wales. Popul. Trends 69, 10–16.

Clark, D.C., Horton-Deutsch, S.L., 1992. Assessment in absentia: The value of the psychological autopsy method for studying antecedents of suicide and predicting future suicides. In: Maris, R.W., Berman, A.L., Maltsberger, J.T., Yufit, R.I. (Eds.), Assessment and Prediction of Suicide. Guilford, New York, pp. 144–182.

Conwell, Y., Duberstein, R.R., Cox, C., Herrmann, J.H., Forbes, N.T., Caine, E.D., 1996. Relationships of age and axis I diagnosis in victims of completed suicide: A psychological autopsy study. Am. J. Psychiatry 153, 1001–1008.

Department of Health, 1992. The Health of the Nation: A Strategy for Health in England. HMSO, London.

Dorpat, T.L., Ripley, H.S., 1960. A study of suicide in the Seattle area. Compr. Psychiatry 1, 349–359.

Foster, T., Gillespie, K., McClelland, R., 1997. Mental disorders and suicide in Northern Ireland. Br. J. Psychiatry 170, 447–452.

Gould, M.S., Fisher, P., Parides, M., Flory, M., Shaffer, D., 1996. Psychosocial risk factors of child and adolescent completed suicide. Arch. Gen. Psychiatry 53, 1155–1162.

Henriksson, M.M., Aro, H.M., Marttunen, M.J., Heikkinen, M.E., Isometsä, E.T., Kuoppasalmi, K.I., Lönnqvist, J.K., 1993. Mental disorders and comorbidity in suicide. Am. J. Psychiatry 150, 935–940.

Henriksson, M.M., Marttunen, M.J., Isometsä, E.T., Heikkinen, M.E., Aro, H.M., Kuoppasalmi, K.I., Lönnqvist, J.K., 1995. Mental disorders in elderly suicide. Int. Psychogeriatr. 7, 275–286.

Hill, K., Hawton, K., Malmberg, A., Simkin, S., 1997. Bereavement Information Pack: For those Bereaved by Suicide or other Sudden Death. Royal College of Psychiatrists, London. Gaskell Press.

Mann, A.H., Jenkins, R., Cutting, J.C., Cowen, P.J., 1981. The development and use of a standardised assessment of abnormal personality. Psychol. Med. 11, 839–847.

Marttunen, M.J., Aro, H.M., Henriksson, M.M., Lönnqvist, J.K., 1991. Mental disorders in adolescent suicide. Arch. Gen. Psychiatry 45, 834–839.

Plutchik, R., van Praag, H.M., 1986. The measurement of suicidality, aggressivity and impulsivity. Clinical Neuropharmacology, Vol. 9, Suppl. 4. Raven Press, New York.

Robins, E., Murphy, G.E., Wilkinson, R.H., Gassner, S., Kayes, J., 1959. Some clinical considerations in the prevention of suicide based on a study of 134 successful suicides. Am. J. Public Health 49, 888–889.

Rudestam, K.E., 1979. Some notes on conducting a psychological autopsy. Suicide Life-Threat. Behav. 9, 141–144.

Runeson, B., 1989. Mental disorder in youth suicide: DSM-III-R axes I and II. Acta Psychiatr. Scand. 79, 490–497.

Runeson, B., Beskow, J., 1991. Reactions of survivors of suicide victims to interviews. Acta Psychiatr. Scand. 83, 169–173.

Runeson, B.S., Beskow, J., Waern, M., 1996. The suicidal process in suicides among young people. Acta Psychiatr. Scand. 93, 35–42.

Schneidman, E.S., 1981. The psychological autopsy. Suicide Life-Threat. Behav. 11, 325–340.

Shaffer, D., Gould, M.S., Fisher, P., Trautman, P., Moreau, D., Kleinman, M., Flory, M., 1996. Psychiatric diagnosis in child and adolescent suicide. Arch. Gen. Psychiatry 53, 339–348.

Tyrer, P., Alexander, J., Ferguson, B., 1988. Personality Assessment Schedule (PAS). In: Tyrer, P. (Ed.), Personality Disorder: Diagnosis, Management and Course. Butterworth/Wright, London, pp. 140–167.

Wertheimer, A., 1991. A Special Scar: The Experiences of People Bereaved by Suicide. Routledge, London.