Suicide of a 27-Year-Old White Male: A Psychological Autopsy Case Study

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The purpose of this case study is to examine the suicide of a 27-year-old white male who died of a gunshot wound. Because this event occurred in 2008, we feel it necessary to relay the statistics of suicide among the decedent's demographic and of the suicide method for the period surrounding that time. We will also provide the rates of suicide in the U.S. in and around the time of the subject's death.

In the year of the decedent's death, 2008, suicide was the second leading cause of death for the case study demographic of non-Latino white males, ages 24-34 in the United States (18.5% of all deaths in the age group) (Centers for Disease Control and Prevention [CDC], 2019). A study by Anestis, Khazem, and Anestis (2017) revealed that one is more likely to die of suicide by firearm if one (1) is male, (2) has never attempted suicide before, and (3) does not secure owned firearms. Gun deaths comprised 50.6 percent of all suicides in the U.S. in 2008 and 49.1 percent in 2016 — the leading method of suicide in our study demographic (CDC, 2019).

Methods

The authors are both certified as psychological autopsy investigators (PAIs) by the American Association of Suicidology. The PAI assigned to this case used standardized psychological autopsy (PA) protocol and procedures for this investigation. This consisted of a review and analysis of medical records, personal papers, journal entries, social media posts, the medical examiner report, the police report, and four semi-structured interviews of those with a close relationship to the decedent. All interviewees gave written consent to share the anonymized findings publicly.

Case Presentation

The decedent was a 27-year-old Caucasian male who died in October of 2008 by a self-inflicted gunshot wound. The subject's death occurred in his bedroom of his home that he shared with one roommate and, frequently, his roommate's girlfriend. The roommate's girlfriend was home at the time of his death. However, it is unclear if the roommate was home at the time of death; he went out in the middle of the night as required by his on-call job. The roommate discovered the decedent dead in the decedent's bedroom after growing impatient with the television volume in the subject's room being too loud for too long.

The decedent lived as a healthy person experiencing common ailments such as chicken pox, pneumonia, and asthma during his early childhood and adolescent years. During his adult years, he experienced frequent heartburn, an episode of venereal warts, neck pain, a rash, and pharyngitis. In the months leading up to his death, the decedent experienced extremely high cholesterol and significant weight gain. According to the autopsy, at the time of death the decedent had advanced coronary disease. There is a significant history of mental health concerns, substance use, and suicide ideations and attempts in the decedent's family. There was evidence of mental health issues, suicidal ideation, and substance use of the decedent. The decedent did have alcohol in his system at the time of his death and was above the legal threshold for intoxication. In April 2007, the first mental health issues were noted in the decedent's medical record. The decedent reported to his primary care physician (PCP) that his anxiety (with panic attacks) had worsened over the past years. The decedent noted that panic attacks occurred four times per day lasting one hour. Depression and anxiety disorder were diagnosed in this visit. An antidepressant (Celexa) and anxiolytic (Xanax) were prescribed. The patient's PHQ-9 during this visit noted severe depression, thoughts of suicide nearly every day, and it being extremely difficult to carry out daily functioning. In November 2007, the decedent presented to his PCP and reported that his medication was no longer working. In July 2008, the decedent presented to his doctor for anxiety. The patient reported that his medication was working well, and his PHQ-9 score indicated moderate depression.

The PHQ-9 Patient Depression Questionnaire was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues using an educational grant from Pfizer Inc. The self-administered instrument is commonly used in primary care settings and was administered to the decedent on multiple occasions. This PHQ-9 includes nine items on a four-point scale ranging from "not at all" to "nearly every day." Following the nine items is an additional question regarding the impact of these symptoms on the person's daily life.

In April 2007, the decedent had a score of 27 and noted that it was extremely difficult to progress through daily life. After this visit, the PCP noted that the patient was "not currently suicidal" and had "passing thoughts of harming himself." Medication was prescribed, and the patient was to return in two weeks if the problem worsened. Item No. 9 on the PHQ-9 states, "Thoughts that you would be better off dead, or of hurting yourself." The decedent marked "nearly every day" on this item. In July 2008, the decedent had a score of 14 and noted that it was somewhat difficult in his daily life. The PCP noted that the patient was, "not currently suicidal" and had "passing thoughts of harming himself."

Multiple informants reported the decedent was a "jokester" and the "life of the party." The decedent had many strong relationships with friends and family, especially his mother. He had a long-term romantic heterosexual relationship at the time of his death and had several heterosexual romantic relationships throughout his life.

The decedent had a history of steady employment as a chef. In the months leading up to his death, he had decided on a career change and had gone back to school to become a law enforcement officer. There is evidence of financial stress, reckless spending, and moderate debt belonging to the decedent.

The decedent's family found a piece of paper with a list of types of guns that the decedent was collecting. The decedent's roommate told the responding police offers that the decedent had purchased five guns within the three months prior to his death. Three days prior to the decedent's death, a family member gave him a gun safe and was concerned about his recent gun purchases and level of alcohol consumption. The decedent jokingly commented, "Don't you trust me? Do you think I'm going to hurt myself with the guns?"

Suicide Risk

Table 1. contains a list of suicide indicators developed by the American Association of Suicidology ([AAS], 2013). These indicators, with the support of the evidence found during the investigation, drive the determination of intent on the part of the decedent. The weight of the indicator is a subjective measure developed by Timothy Heap, co-founder of the Strub Caulkins Center for Suicide Research. This measure is not evidence-based, but rather helps the PAI place the indicators in an order of severity.

TABLE 1. RISK FACTOR ASSESSMENT

Weight Legend (Subjective assessment)
☐ Indicator has no or minimal impact | ☐ Indicator has moderate impact | ■ Indicator has high impact

INDICATOR	WT.	INVESTIGATOR COMMENTS
Ideation (communicated thoughts of suicide)	■	In his journal, the decedent wrote about not wanting to wake up and wanting to die. He also wrote that the "real hell is life." One family member noted an incident where they thought something might have been going on, but the decedent noted that he was "fine." Another family member explained that the decedent shared his suicidal thoughts, but he noted that there was never a plan. In 2007, decedent noted having thoughts of suicide "nearly every day" on the PHQ-9 at his doctor's office. Additionally, he responded that the issues noted were making it "extremely difficult" to execute daily functioning. Yet, doctor noted, "not currently suicidal, has had passing thoughts of hurting himself with panic attacks but nothing where he would act on it." According to one informant, the decedent had a visit from his deceased sister-in-law who died by suicide. During this visit, the decedent asked her how it was there, and she said, "not bad." Suicide thoughts, behaviors, and mental health diagnoses are evident in multiple members of the decedent's family of origin. This suggests that a genetic factor may exist.
Substance Use (increased or excessive)	■	From an early age (teen years), the decedent consumed alcohol on a regular basis. Arrest for minor consumption of alcohol and his family noted having an intervention regarding the decedent's alcohol consumption at the age of 17. The decedent noted in his journal that he drank alcohol to deal with all his problems. Alcohol use increased as he got older. He began to binge drink and drink to cope with social situations and go to sleep at night. Informants discussed the decedent using marijuana as a young adult. Decedent smoked cigarettes on off and throughout his life. Decedent seen smoking the day of his death. Decedent also used chewing tobacco, and it was present in his mouth at the time of his death. The day after the decedent's death, the family discovered an overflowing trashcan of empty beer cans.

INDICATOR	WT.	INVESTIGATOR COMMENTS
Purposelessness (no reason for living)	■	The decedent did not graduate high school, and this may have been evidence of purposelessness. The decedent noted in his journal that his dream was to be a history teacher, but he would never be able to do this due to his social anxiety.
Anxiety (agitation, unable to sleep or sleeping all the time)	■	The decedent had a history of anxiety, including social anxiety, anxiety related to flying, and panic attacks. The decedent was on multiple medications throughout his life for his anxiety and was under treatment by a physician. Multiple informants noted that the decedent had trouble sleeping and frequently drank alcohol to the point that he would pass out to fall asleep. Throughout his adult years, medical records indicate frequent sleep problems.
Feeling trapped (like there's no way out)	□	There is no evidence to support that the decedent felt trapped in his life.
Hopelessness	■	Decedent may have experienced hopelessness regarding "fitting in" and feeling accepted. The decedent noted in his journal that he was hopeless and that he would never find a medication that would help him.
Withdrawal/Social isolation	□	The decedent lived with social anxiety, but there was no evidence to support the notion that the decedent was withdrawing any more than normal leading up to the time of his death. Decedent known to engage frequent in social situations with family and friends. He continued to attend social gatherings and work up until the time of his death.
Anger/Rage/ Expressions of wanting revenge	□	Did not often express anger, even in situations in which it might be expected. This is indicative of holding emotions in, which may result in anger that is more expressive when composure is lost.
Recklessness/ excessive risk-taking	■	The decedent exhibited reckless behavior in several areas. He owned a motorcycle ("crotch rocket") and a Jeep, both of which he drove at high speeds. He also had a history of making large purchases that his cash flow did not support (house, motorcycle, Jeep). The history of genital warts indicates the decedent may have had multiple risky and unprotected sexual relationships.
Mood Changes	□	Normally displayed a steady mood.

Discussion

The manner of the decedent's death was ruled a suicide by the medical examiner in consultation with the law enforcement investigation. Based on the evidence presented during the psychological autopsy investigation, it is the evidence-based opinion of the PAIs that the most likely manner of death is suicide and is consistent with the findings of law enforcement and the medical examiner.

There are many factors and facets of this case that led up to the perfect storm causing the suicide of the subject. Consistent with Reason's (2000) Swiss cheese model of error prevention, if a factor or situation could have been recognized and acted on, the suicide may have been prevented (see Table 1). Of course, hindsight bias is problematic, so action based on one item still may not have been sufficient to prevent the death.

The PA revealed that six of ten known suicide risk factors were present before the subject died. Among these were ideation, substance use, purposelessness, anxiety, hopelessness, and recklessness. Additionally, the family history of mental health problems was well documented, and a ready access and familiarity with firearms was present. Of particular concern are the PHQ-9 results.

It is the clinical opinion of PAI Miskowiec that there is inconsistency in the interpretation of the PHQ-9 that could have been better addressed. Of course, it is not known what actually happened in these PCP visits versus what was documented. In the end, additional training on how to properly discuss suicide in primary care visits and best practices for PHQ-9 administration may be beneficial. Best practice for asking about suicide is to ask openly and directly about it. Guidelines for administering the PHQ-9 note that item No. 9 measures the presence and duration of suicidal ideation, yet the word "suicide" is not used in the question itself.

Author Biographies:

Chris Caulkins, Ed.D., MPH, M.A. is the executive director of the Strub Caulkins Center for Suicide Research and has researched, presented, and published on suicide at a state, national, and international level. Chris is a practicing paramedic and emergency medical services educator with over 25 years of experience responding to 911 calls for suicidal ideation, attempts, and — sadly — deaths. Chris became a suicidologist after the suicide death of his wife, which intensified after the suicide of his brother and ten EMS colleagues. For over 14 years, Chris has run a peer support group for those bereaved by suicide. Chris sits on subcommittees of the Minnesota Suicide Prevention Program and the National Action Alliance on Suicide Prevention. Chris co-chairs the Lived-Experience Special Interest Group of the International Association for Suicide Prevention. He can be contacted at c.caulkins@suicideresearch.org

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