

Medical-Legal Ramifications of an Autoerotic Asphyxial Death

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Attorneys, insurers, and psychiatrists frequently find themselves metaphorical bed partners. This co-tenancy can be convivial, even occasionally fruitful. Such an instance involves a case in which a man who in the process of attempting to obtain sexual gratification asphyxiated to death. A double indemnity death benefits policy was in force. The insurer refused to pay, contending that the deceased was mentally infirm and that the wording of the policy specifically excluded coverage of such a person. The beneficiary disagreed and promptly filed suit.¹

Three of the four similar cases that have reached the appellate court level (and have been reported) have held for the insurance company defendants. In each of these, the issues decided by the courts had to do with whether the death was "accidental" within the policy language and applicable law.²

In the present case, however, trial arguments focused on the term "mental infirmity," though other semantic ambiguities, as written in insurance contracts, were also at issue. The arguments in combination with a properly deployed psychiatric expert are identified as crucial factors in determining the favorable outcome.

The Syndrome

The dead man was a practitioner of a form of sexual activity variously labeled as "sexual asphyxia," "autoerotic asphyxia," "Kotzwarrism," or "hypoxyphiliac behavior."³ The behavior itself has been adequately addressed by other authors³⁻⁵ and is not the focus of this article. Briefly reviewed, it is a pattern of behavior mainly involving males who asphyxiate themselves by hanging, strangulation, suffocation, or other means, about half the fatal cases involving other forms of physical restraint (sexual bondage).³ Sometimes erotic materials are distributed about the scene in the line of vision.^{3,6} Thus prepared, the subject engages in a simultaneity of fantasizing and masturbating or may prepare himself for subsequent masturbation.³ There follows a crescendo of sexual excitement accompanied and abetted by the application of a constrictive force progressively exerted on the neck. This force apparently enhances the individual's gratification through either psychological or physiological mechanisms or some combination of both.

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Ideally, the act culminates in orgasm, but some persons accidentally asphyxiate to death either with or without the climactic experience. When death occurs it is presumably the product of mismanagement or failure of the apparatus. How many deaths occur as a result of these practices is not known. Estimates range from 50⁴ to 1,000³ such deaths per year in the United States. Occasional cases are difficult to distinguish from suicide or homicide,⁷ particularly because those who find the body sometimes alter the scene.^{3,6,7}

The Issues

The insurance policy did in fact provide for double indemnity accidental death benefits, but there was an exclusionary clause within the policy stating that benefits were not payable for "death caused or contributed to, directly or indirectly, by disease or bodily or mental infirmity, or from medical or surgical treatment therefore."

The question whether death in this instance was accidental was never really in contention. Both the investigating officers and the County Medical Examiner testified to the accidental quality, and contrary views were not seriously pressed by the defendant. The law on this point was largely against the defense because most courts draw no distinction between "accidents" and "accidental means"; hence, if one dies of any intentional act (such as autoerotic asphyxiation that unintentionally or unexpectedly produced death) his death will usually be regarded as accidental for insurance purposes.⁸

The remainder of the legal issues were fascinating. Substantive questions seemed to be: What does the term "mental infirmity" mean? Is autoerotic asphyxiation a form of mental infirmity? When practicing the act and dying thereby, is this a result of attendant risks implicit to such behavior, or is autoerotic asphyxiation not ordinarily a risky act but in this particular instance simply turned out badly? If the practice was inherently life threatening, and a preferred or exclusive mode of producing sexual excitement, are these not then the criteria for diagnosing sexual masochism,⁹ a psychosexual disorder, ergo, prima facie "mental infirmity?"

A profile of the insured was constructed from material obtained from interviews or depositions of family, friends, and co-workers. He was a hard-driving, competent, highly successful contractor in his thirties, esteemed for the quality of his work and further conspicuous by his proclivity for personally spending long hours on the job, often working seven days a week. He and his construction crews enjoyed an outstanding reputation in the state, and at the time of his death his company's services were very much in demand. New customers were coming to him all the time, and he was not only in the process of expanding his instant business but also was seeking to diversify.

The deceased's fiancée, and lover for many years, was the plaintiff in this case. She had met him in New York and joined him subsequently in

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Florida during the late 1960s. For about five years they lived together essentially as man and wife. In the mid-seventies the insured branched his company to a large city in north Florida, attracted by potential new business opportunities. She meanwhile continued to live and work in central Florida, maintaining their primary residence there. They remained in continuous contact during that interim with the intention of proximally re-establishing a common domicile. He had meanwhile taken a three bedroom apartment that he also used as his office. He kept his important personal and business papers and documents there and oftentimes several members of his crew resided with him. The apartment was thus a barracks for his crew as well as a personal residence and office for him. It was in this place that his body was found in late August 1977.

Early one morning one of his foremen, seeking to arouse his boss for work and to share their usual cup of coffee, entered the apartment to find him dead. The circumstances were unquestionably bizarre. The insured was found suspended vertically on an upended bed enmeshed in a device consisting of ropes, pulleys, straps, and bonds of various kinds, one of which constricted his neck. The device was of such configuration as to suggest that the man had affixed himself therein, and the presence of an oleaginous substance on his unbound hand and penis suggested he had at some point been masturbating. An overturned footstool was nearby and he appeared to have fallen from same. The homicide detective investigating the matter concluded that the death was accidental and caused by asphyxia as did the medical examiner who so stated in the Certificate of Death.

The patient's fiancée was shocked by this discovery. She had never known her boyfriend to consider suicide, and for him to be found in such humiliating circumstances was totally uncharacteristic of him. She always viewed him as having a strong personality: stable but not loath to show his emotions, either tenderness, anger, or humor, as befitted a situation. He was described as intelligent, well read, and outgoing; a caring person, one inclined to become involved and concerned with the problems of others. She met him about ten years previously on a blind date. He was separated at the time and divorced the following year. They began living together shortly thereafter and had an excellent relationship through the years, with problems only by way of the deceased's near obsession with work and being successful.

Past History

He was born to a middle-class family in the northeastern United States, the middle of three children. The brother is living and well and works as a counselor. The sister is married and in good health. The parents are living, divorced, and the mother was described as being "agoraphobic." No significant medical or previous psychiatric history was disclosed. No atypical sexual interests or characteristics were ascribed to the decedent; however, he was discovered at one time to have a number of bondage-type magazines

in his possession. When his fiancée confronted him with this, he explained they had been discovered among the belongings confiscated from a tenant of his who had failed to pay his rent.

His interests were wide and ranging. He was involved in sports car racing, was a member of the SCCA, and was active in that organization as an official. He enjoyed boating, horseback riding, reading, and refinishing and rebuilding things, that is, furniture or other articles he gave as presents to business acquaintances and friends he frequently visited.

He had always been successful in his business pursuits. A licensed contractor, his favorite project was building swimming pools. He recently had begun to venture into other areas, the latest being vending machines. Partners and subordinates held him in high regard, the latter possibly influenced to some extent by such embellishments to their workday as his supplying them with a lady co-worker who provided them with sexual favors en route to and from the job in the company's van. Employees further tended to characterize him as a soft touch whenever a salary advance or loan was needed.

The Arguments

The thrust of the plaintiff's case was twofold. First, the chimerical, vague, emotive but popular term "mental infirmity" was seen as conceptually vulnerable, to be conveyed to the court as a "terminological inexactitude."¹⁰ If the term meant anything at all, it was argued, it could only apply to someone "enfeebled, in ill health, weakened, and suffering from disease." This characterization was the common essence taken from definitions appearing in a dozen dictionaries subsequently placed in evidence.

Common-law decisions were proffered in which constructions and definitions of the terms "physical infirmity" as well as "mental infirmity" were central. Mental infirmity has seldom been invoked as an exclusive defense to coverage. Cases dealing with infirmity nevertheless abound, and several of particular relevance were presented. Following this, consideration was given to the few cases in which the concept of "mental infirmity" has played a crucial role in a court's judgment.

The Physical Infirmity Cases

The paradigmatic, and certainly the most authoritative, physical infirmity case is *Silverstein v. Metropolitan Life Insurance Company*, 254 NY 81, 171 NE 914 (Ct. App. NY 1920). The insured in that case died from injuries he received after a milk can fell and struck him in the abdomen. The cause of death was peritonitis caused by a perforation at the juncture of the stomach and duodenum. At the point of perforation was found a small, benign duodenal ulcer. The evidence suggested the ulcer had weakened the visceral wall and had thus contributed in some way to the insured's death. Metropolitan refused to pay on the insurance policy because of an exclusion for "disease or bodily or mental infirmity," contending the ulcer was a

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“bodily infirmity.” Speaking through Justice Cardozo, the New York Court of Appeals rejected the infirmity defense. For a condition to be a “bodily infirmity,” the Justice reasoned, it “must be so *considerable or significant* that it would be characterized as disease or infirmity in the common speech of men.” He further noted, “a policy of insurance is not accepted with the thought that its coverage is to be restricted to an Apollo or a Hercules.” Justice Cardozo then formulated this test:

A distinction, then, is to be drawn between a morbid or abnormal condition of such quality or degree that in its natural and probable development it may be expected to be a source of mischief, in which event it may fairly be described as a disease or an infirmity, and a condition abnormal or unsound when tested by a standard of perfection, yet so remote in its potential mischief that common speech would call it not disease or infirmity, but at most a predisposing tendency (171 N.E. at 915).

The *Silverstein* test, though somewhat general, has been followed by numerous courts including the Florida District Court of Appeals in *Commercial Travelers Mutual Accident Association of American v. Kilgore*, 201 S. 2d 486 (Fl. 2d D.C.A. 1967), in which *Kilgore*, having been injured in an automobile accident, contended that the collision was the sole cause of the spinal spasm that caused his disability. The insurer defended the suit on the ground that Kilgore had a pre-existing osteoarthritis that contributed to the disability. Summary judgment was entered for Kilgore, however, the Court of Appeals reversed, reasoning that Kilgore’s pre-existing arthritic condition obviously had a significant contributing role to his post-arthritic disease and would bar recovery if it were construed to be a “disease or infirmity.” The case was remanded to the trial court for determination of this issue. The *Silverstein* test was again the basis of the court’s affirmative decision for the plaintiff but added this additional enlightenment:

A distinction is drawn, then, between an abnormal condition that in its natural and probable development may be expected to be a source of mischief, and a condition which is abnormal when measured by a standard of perfection but which is so remote in its potential mischief that common speech would not call it disease or infirmity, but at most a predisposing tendency (201 S. 2d at 487-488).

The *Silverstein* test has been invoked and refined by numerous courts grappling with the question of whether an insured died from “physical infirmity.” The earmarks of the *Silverstein* test as developed are essentially these: First, the condition or disease in question must be so substantial and considerable, so much a “source of mischief,” in terms of the overall health and functioning of the individual, that it would be deemed a disease or infirmity in the common speech of men. Second, the disease or condition must be so well established and settled in its development or so long standing that it must be considered a chronic impairment to the health of the insured and not a temporary disorder.

The Mental Infirmity Cases

Markedly similar criteria can be discerned in the few decisions in which mental infirmity was the principal defense of the insurer; indeed, the *Silverstein* test has on occasion been explicitly relied on as authoritative. *Graves v. Penn Mutual Life Insurance Company*, 227 Fed 2d 445 (2nd Cir. 1955) (applying New York Law) is a case in point. In that case, a beneficiary sought double-indemnity benefits under an insurance policy containing exclusionary language for mental infirmity almost identical to the language in the Metropolitan policy issued the asphyxial victim in this case. The insured, Graves, had one day exhibited irrational behavior. That evening he threatened to kill his wife and others, and a police officer who attempted to intervene was assaulted. In the act of defending himself, the officer shot and killed Graves.

The insurance company conceded Graves' death was accidental but invoked the mental infirmity clause as support of its refusal of coverage. It was shown that a year before Graves was hospitalized and treated for a schizophrenic disorder and had subsequent treatment, but before the onset of this he had never been emotionally disturbed or mentally ill. The jury found in favor of the beneficiary, the insurer appealed, and the United States Court of Appeals for the Second Circuit affirmed the judgment. Citing *Silverstein* and other decisions, the court noted that the trend of authority limited the infirmity defense to diseases or conditions that were not only considerable and significant but also were relatively permanent and long-standing. The Court of Appeals found sufficient evidence in the record to sustain the jury's finding that Graves was suffering only from a temporary insanity.

The court's restriction of the mental infirmity defense to long-standing or permanent-and-debilitating mental illness is supported by authority from many jurisdictions. *Williams v. Prudential Insurance Company*, 271 Ill. App. 532 (Ct. App. Ill. 1933), a case that preceded *Graves*, is an example. In this instance, the insured was engaged in a card game in his poolroom when he suddenly became violent and irrational, breaking dishes and furniture, threatening people, and loading his rifle. A police officer, called to quell the disturbance, shot and killed the insured in attempts to subdue him. Again, the insurer invoked its policy exclusion, but the Illinois Court of Appeals affirmed the judgment in favor of the beneficiary. It was clear to the Illinois court that the insured was mentally ill at the point of his death but construed the court concept of infirmity as:

Some ailment, disorder or derangement which, in its character, is somewhat fixed and settled and does not refer to one which is slight or temporary and over in a short period of time, which, when it has been receded from, leaves the condition of body or mind as it was previous to the disability. (271 Ill. App. at 537)

A third "mental infirmity" case, *Vann v. Union Central Life Insurance Company*, involves an insured who committed suicide while insane. Under

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Colorado law, because of a so-called "suicide statute," an insurance company is precluded from denying coverage because the policy holder committed suicide. The court nevertheless found that "the death of the insured by his own hand *while insane* resulted from mental infirmity "within the meaning of the policy exclusion." Judgment in favor of the insurer was therefore affirmed. The *Vann* case has been cited by Couch's Treatise on insurance for this proposition: The purpose of mental infirmity exclusion "is not merely to make suicide a defense but to exclude coverage of all accidental deaths caused by mental illness" 10 Couch, Insurance S 41:419 at 375 (2d Ed.). Thus, when the insured is in such a serious mental condition that he or she is considered to be "insane," and he or she commits suicide or otherwise dies in an accidental manner, the infirmity exclusion effectively bars recovery.

The Use of Exclusionary Terms

The second approach addressed the misuse of exclusionary terms in insurance policies. In the last twenty years a doctrine has emerged that transcends considerations of ambiguity and uncertainty of terminology and focuses on the reasonable expectations of the insured. This doctrine has been explicated in numerous court decisions and authoritative articles and can be summarized: Exclusionary provisions of an insurance policy must be construed, even if not ambiguous in the usual sense of the term, in such a way that they honor the reasonable expectations of an applicant and his or her intended beneficiary. See, for example, *C&J Fertilizer, Inc., v. Allied Mutual Insurance Co.*, 227 NW 2d S69 (Iowa 1975), noted in Note, Georgetown LJ 64:987 (1976); *Perrine v. Prudential Ins. Co.*, 56 NJ 120, 265 A 2d 521 (1970); *Steven v. Fidelity & Gas Co.*, 58 Cal. 2d 862, 869-70, 377 P. 2d 284, 288-89 27 Col Rptr. 172, 176-77 (1962); Keeton, "Reasonable Expectations in the Second Decade," *The Forum* 12:275 (1976). Grounded in the truism that insurance contracts are essentially contracts of adhesion offered on a take-it-or-leave-it basis—and are often not even seen by the insured until they have been issued—these decisions require recovery by an insured, even though no ambiguity is present, here necessary to fulfill the insured's objectively reasonable expectations, although the policy excludes coverage of the particular loss sustained.

Kievit v. Loyal Protective Life Insurance Company, 34 NJ 475, 170 Atl. 2d 22 (1961) illustrates the application of this principle to life insurance policies. *Kievit* was hit on the head by a piece of lumber, subsequent to which he suffered body tremors that the defense physician reported as derived from pre-existing but latent Parkinson's disease activated by the blow. The New Jersey Supreme Court held the insured could recover since the pre-existing disease was dormant and unknown to the insured and was activated by an accident into the disabling condition. The court remarked:

When members of the public purchase policies of insurance they are entitled to the broad measure of protection necessary to fulfill their reason-

able expectations—where particular provisions, if read literally, would largely nullify the insurance, they will be severely restricted so as to enable fair fulfillment of the stated policy objective. (34 NJ at 482-483, 170 Atl. 2d at 26).

Applied to the present case, the reasonable-expectations doctrine mandated the term “mental infirmity” not be construed so broadly that it would operate to deprive the reasonable expectations of the insured. To do this would permit the insurer to nullify the scope of the coverage that it purported to afford by means of an overbroad definition of a “boiler plate” exclusory term “mental infirmity.”

Presentation was to the court—jury trial having been waived. The defense obtained a verification from a psychiatric witness that the term mental infirmity did, in fact, have clinical meaning.

Q How do you define “mental infirmity?”

A Well, “mental infirmity” is probably synonymous with mental disease or mental disability; and it would be any condition that substantially impairs the functioning of the individual, either in his thinking or in his behavior, to the point that his health or well-being is endangered.

And later:

Q But, standing by itself, is it a term of art (?) or simply a wastepaper basket way of describing—

A I have found it be used interchangeably with “mental disorder” and “mental disability,” “mental disease,” “mental indisposition.” It does not, in and of itself, have any golden meaning.

Defense experts were further able to establish a diagnosis and clarify its chronicity and linkage with the cause of death.

Q Now, I understand—that you have reached an opinion on the cause of Mr. R’s death. What is that opinion?

A It is my opinion that his death was due to or the product of a long-standing masochistic—sodomasochistic—bondage—sexual perversion, which is a well-known and defined psychiatric disease entity and is found in the *Diagnostic and Statistical Manual*, both the old version and the new version that is about to come out. And that this disease is known to be, by the literature, as a long-standing type disease, not something that comes on over a short period of time but it usually develops in, at the latest, late childhood and before the teen-age years, and is a long-standing infirmity.

Q Is that opinion given within a reasonable degree of medical or psychiatric certainty?

A Yes.

Contrasting views were offered by the plaintiff’s experts.

The Witness: Yes. The term is not in the psychiatric glossary I have here. Let me put it this way. Dorland’s defines infirmity as “(1) a

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feeble or weak state of the body or mind; (2) a disease or condition producing weakness." To me, in trying to interpret from my medical training and experience and use it in this definition also, I would think that this means a disease or condition implying a feeble or weak state that was chronic and was an impairment of normal functioning.

And:

Q Could you give us your definition of the term "mental disorder?"

A To me, mental disorder would be a case in which a person's affect (A-F-F-E-C-T), thinking, or behavior were disturbed in such a way that it would regularly cause subjective distress or regularly be associated with generalized impairment in social effectiveness; that is, love, relationships, friends, and work.

At this juncture the plaintiff de-emphasized the role of the psychiatric witness as a semanticist and sought to establish what other parameters (in addition to a diagnosis) a mental health professional should consider in rendering judgments in such issues.

A Well, with the reasonable—I think I can say with a reasonable—degree of medical certainty that he did not suffer from a mental infirmity as I have defined it.

Q And would you tell us briefly your reasons for reaching that conclusion?

A Well, I found in the history that was available to me that Mr. R had had some normal relationships with women and they tended to last a reasonable amount of time; for instance, his marriage and his relationship with Miss N. There was evidence that he had and could make friendships and had some—at the time of his death he had what I consider a very reasonable work record, was productive; he was able to re-create and enjoy himself. He did not seem to be addicted to any drugs or any other substance, and there was no evidence in my questioning or investigation involving any psychotic or neurotic mental processes, brain damage, or epilepsy.

The plaintiff contended that simply to have a diagnosable mental disorder does not necessarily render one infirm. In this instance the deceased's history even suggested a preponderance of the characteristics of health as set forth by Alport,¹¹ Appel,¹² and Jahoda¹³ and summarized by one witness:

Common features in these depictions of the mature or healthy individual are such things as being self-accepting and warm in relating to others, having realistic perceptions of the self in the world and the capability of becoming problem centered or losing one's self in their work. The healthy individual has a unifying philosophy of life, a sense of direction, and purpose and an ability to extend himself to others and to other spheres beyond those of his own self-interest. Such persons can function in a reasonably

independent manner, are self-reliant, capable of self-direction and have the ability to do the job and take responsibility, be persistent, and get along and work with others. They have the ability to re-create, to show empathy and manifest humor, to cope with stress and attain physical, psychological, and social potentials. Such persons are able to make and obtain friendships, maintain positive attitudes toward themselves, grow, develop, and actualize. They are future oriented, and investments in living are important considerations. They have the ability to integrate and unify their outlook on life. There is a resistance to stress, perception and reality, and the capability of environmental mastery including the ability to love, work, and play.''

The defense either viewed this as irrelevant or had not done their homework.

Q I'm just looking for the bounds of what you know about Mr. R's life generally as opposed to the specific event which caused his death. So far we have found out from you that he had a girlfriend and that he died in the presence of certain erotic materials. Is there anything else that you know of Mr. R's work or his social outlets or anything—driving ability—almost anything that makes up the entire individual? Do you have any other knowledge of him as a whole person?

A I don't immediately recall anything. Possibly if you remind me of some facts I can tell you whether I have been told those facts.

Q Well, for example, was he self-employed or did he work for someone else?

A I don't recall offhand.

Critique

It had been difficult throughout to predict the outcome. From the defense standpoint a simple progression of reasoning seemed to be the crucial ingredient for a favorable finding. Competent experts had diagnosed the insured and attested that his condition was categorically subsumed by the general term used in the contested clause of the policy. The defense correctly noted that despite other differences of opinion, all the experts connoted "infirmity" or "disorder" with chronicity. Proof that the bizarre behavior leading to the insured's death was recurrent and chronic, not sporadic, seemed to them evident not only from the expert testimony but also from the physical evidence that eyebolts, which were part of the bondage trappings, had been permanently affixed to the bed frame. As death would likely not have occurred except in the context of the patient's (chronic) mental infirmity, and there being a clearly stated exclusion to this end in the policy, the insurer in line with the *Vann* case felt no obligation to pay.

"Soft" factors seemed to favor the defendant—the taboo nature of the subject, the bizarre circumstances of death—points not left unattended in

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the presentation to a conservative court.

The medical testimony elicited by deposition and at the trial, to the extent that it intended to define mental infirmity, was viewed guardedly by the plaintiff. It was conceded that medical experts are qualified to give medical opinions and define technical terms but not to give opinions on linguistics or to authoritatively define terms of ordinary meaning. It was pointed out particularly that in this instance the contract did not indicate that the term in question was intended to be used in a technical or particular sense. (See generally 18 Fl. J. Ins. 405 (1971).)

To the plaintiff the plausibility of the psychiatrists lay in their expertise as clinicians and their verisimilitude therein derived to a large extent from the sum of notes on which they based their clinical judgments. The contention was that any valid conceptualizing of an individual as mentally ill (or well) required the inclusion and proper weighting of a number of variables. This is not so simplistic as to be accomplished by merely labeling a person and drawing inferences therefrom as the defense had attempted to do.

An incidental question, the ethical virtue of diagnosing someone in the absence of having personally examined him, was broached.

Q So it is your testimony that you are unable to attach any particular—can I say “percentage”—any particular share or importance to the need for a face-to-face interview?

A Oh, yes, I made it very clear that I think that it is all important where you have a living individual. I think in the case of having to render some postmortem opinion, that is, of course, impossible, and so it is considered legally valid in the courts, and also ethical, to render an opinion based on what evidence you have.

On October 15, 1979 the verdict was returned: “After consideration of all testimony of witnesses, exhibits received in evidence, memorandums of law and arguments of counsel, the court finds for the plaintiff.” An appeal was not filed and the policy’s double indemnity cash benefit of \$50,000 was paid.

The trial regrettably pitted expert against expert. Herein the cynic finds reassurance that no two psychiatrists can agree on anything; the detractor, that testimony can be bought; the skeptic, that the legitimacy of psychiatry presenting itself as a unified body of knowledge is doubtful.

It is hypothesized that were one to critically analyze cases in which oppositional psychiatric testimony appeared, one would find in the majority of such instances, the disparate views were not so much a product of flaws intrinsic to the discipline or of the cupidity of its practitioners but, rather, as in this case, related to philosophical and procedural issues.

Though testimony is the showcase of our court work, the integrity and effectiveness of the expert presupposes his or her pretrial investiture in the following:

1. Obtaining familiarity with relevant research material related to the problem in contention.

2. Assimilating all available clinical data on the case on issue.

3. Devoting sufficient time in pretrial conferences with attorneys not only to clarify issues on which his or her testimony bears but also to reaffirm to himself or herself that the position he or she supports is scientifically valid.

As to the role of the psychiatrist as a definer of words, the position of the plaintiff, though perhaps tactically correct, in this instance might be argued otherwise. Inspection is the technique of the scientist and, indeed, holds a time-honored place in the practice of medicine. What can be measured, assayed, and objectified is of the essence. Denotative words are cherished, and those frequently used become our jargon. In addition to inspection, the psychiatrist by nature of his or her work must depend on the process of introspection both in formulating diagnoses and implementing treatment. By that on-going, self-examination of thought and sensory experience does the psychiatrist better serve the patient. The words used to formulate perceptions, thus derived, and to communicate them to patients, colleagues, or courts are more often *common* than technical in character. Perhaps thus we are more expert in the area of linguistics than the plaintiff would acknowledge. Psychiatry and the law combined, for instance, in this case when the following definition was proposed to the court:

Mental infirmity is a substantial and significant disease or disorder so disabling as to give ordinary people the impression that the individual is mentally feeble, frail, ill or insane. This condition must be long standing permanent, fixed and settled and not ephemeral or temporary in character.

As our science evolves, still will our terminology improve. Meanwhile, psychiatrists must attempt to provide whatever denotative legitimacy is possible to common terms that are his or her daily fare but that also have ramifications in areas afield.

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