The Psychological Autopsy: A Useful Tool for Determining Proximate Causation in Suicide Cases

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This overview article examines the applications of the psychological autopsy method in determining proximate causation in suicide cases. The article reviews the history of the psychological autopsy and describes its procedure and how it has proved helpful in explicating proximate causation. The five standards currently used by the courts to determine proximate causation in suicide cases are described, as are a variety of applications of the psychological autopsy method, including its application to workers' compensation cases, product liability cases, and medical malpractice cases. In particular, issues of prediction and protection are addressed. Finally, there is a discussion of an application of the psychological autopsy to criminal cases. The article concludes with a discussion of the issues raised in the use of the psychological autopsy during expert testimony and the considerations that should be addressed by an expert witness contemplating the use of the psychological autopsy method.

Until recently, suicide was treated in a number of Western societies as both immoral and culpable. According to English common law, for example, an individual who committed suicide warranted punishment for his act; his property was confiscated by the crown and a stake was driven through his heart at burial.[1] The criminality of suicide was tied to church doctrine, the belief that man's life is not his own.[2] Nineteenth century psychiatry was influenced by such religious concepts, viewing suicide as a sign of moral and mental weakness as well as a felony.[2]

Modern legal thinking, however, has moved away from blaming the person who committed suicide for his death. For instance, in 1961, all sanctions against a person who attempted or committed suicide were abolished in England.[1] This change reflected the belief that criminal law could not deter a person who wanted to commit suicide. The suicidal person was no longer viewed as a culpable person to be handled by the legal system, but rather as a troubled person to be handled

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by the mental health system.[1] That is, the person who committed suicide was considered to have a mental disorder; and, under certain conditions, was not deemed responsible for his death. Legal liability for suicidal deaths was instead shifted to those whose actions "caused" the suicide or failed to protect the potential suicide from self harm.[3]

Legal liability for suicidal deaths is still focused on the actions of others, or external forces, that have a temporal relationship to the suicide. The question that arises, however, is whether there is actually a causative relationship to the suicide. Indeed, the law demands that in order for an individual to be held liable for the suicide of another, there must be a reasonable connection between the individual's actions or omissions and the suicide. This connection is usually dealt with by the courts in terms of what is called "proximate cause" or "legal cause," with the word "proximate" derived from Francis Bacon, who, in 1630, stated: *"In jure non remota causa, sed proxima, spectatur."* ("In law, not the remote cause, but the nearest is looked to.")[4]

However, there are few concepts in the entire field of law that have called forth more disagreement and/or confusion than the concept of proximate causation.[4] Although the legal periodical output on proximate causation throughout the past century has been prodigious,[4] Prosser (1950) has noted that "proximate cause remains a tangle and a jungle, a palace of mirrors and a maze, and the very bewildering abundance of the literature defeats its own purpose and adds its smoke to the fog."[5] In general, proximate cause seems to be a concept that attempts to define, by means of many factors, when a defendant's liability will be limited, even where the fact of causation is clearly established.[4]

In fact, there seem to be at least five standards used by the courts to determine whether proximate causation exists in suicide cases. The first, the "substantial factor test," holds that an individual's conduct is a legal cause of harm if his/her conduct had a *substantial*, as opposed to negligible, effect in bringing about that harm.[4] In other words, liability will be limited to those cases in which the defendant's conduct was a *substantial factor* in producing the suicide.[1, 6] The second test, the "but for test," states that the injury would not have happened *but for* the defendant's negligence.[4] That is, recovery will be allowed if the suicide would not have occurred without the injury.[1] Although the "substantial factor test" and the "but for test" are not synonymous, they are often lumped together because, to satisfy the "substantial factor test," it must be shown that the injury would not have happened "but for" the defendant's negligence and that the negligent act was so important in bringing about the injury that reasonable people would regard it as a cause and thereby attach responsibility to it.[4] A third test of proximate causation is *foreseeability*[1, 4]; that is, recovery will be denied because the suicide was an unforeseeable consequence of a negligently inflicted injury.[1] Finally, recovery will be allowed if the decedent did not know the nature of his actions, or knew the nature of his actions but was unable to control them because of mental illness.[1] Indeed,

as Gutheil *et al.*[7] note, whether a person is *competent* (i.e., has the capacity for self-protection and the ability to give informed consent) is also considered in suicide cases.

On the issue of causation, the plaintiff has the burden of proof, and must show that it is more likely than not that the suicide resulted from the cause he posited.[4] This will depend heavily upon the opinion(s) of experts in the field of suicidology; in applying a sequence of events test, what may appear to be a cause and effect relationship may be discredited scientifically. Indeed, as Schwartz[1] has noted, courts "camouflage with the use of the talisman 'proximate cause' the difficult cause in fact question before them: how important from the psychiatric viewpoint was the defendant's act in bringing about the suicide?" In this article, we will illustrate how suicidologists can help determine proximate causation in such cases. Particular attention will be paid to the importance of a technique known as the *psychological autopsy*.

The Psychological Autopsy

Shneidman,[8] in collaboration with the Los Angeles Suicide Prevention Center and the Los Angeles Medical Examiner's Office, coined the term *psychological autopsy* to refer to a procedure used to classify equivocal deaths. An equivocal death is a death in which it is not immediately clear whether a person committed suicide or not (e.g., drug-ingestion deaths, single-car accident deaths). The psychological autopsy method entails reconstructing a biography of the deceased through psychological information gathered from personal documents; police, medical, and coroner records; and first-person accounts, either through depositions or interviews with family, friends, coworkers, school associates, and physicians.[9] One of the major contributions of psychological autopsies "has been to introduce the psychosocial context into decisions about the cause of death since examination of postmortem remains tell only what lesions the patient died *with*, not what he died *from*."[10]

Studies have shown that there are certain commonalities to suicide completers. Indeed, Roy[11] found that persons who commit suicide are likely to be unmarried, unemployed, living alone, and depressed. Clark and Horton-Deutsch[12] found that suicide completers are twice as likely to be male, almost always qualify for a psychiatric diagnosis, and more often than not communicate intent. Sanborn *et al.*[13] found that the protoypical suicidal individual is not currently employed, is experiencing acute stress and frustration in areas apart from work, and has an alcohol problem. Moreover, such risk factors for suicide have been found to vary by age group. Adolescent suicide completers often have a history of physical and sexual abuse, parental psychiatric problems, and commit suicide in the context of an acute disciplinary crisis[14, 15]; elderly suicide completers often have a history of chronic or terminal disease.[16]

Psychological autopsies review the specifics of the death and the decedent for suicide risk factors. Shneidman,[8] for example, has identified 14 areas for inquiry in psychological autopsy studies. These

areas include: (1) identifying information (e.g., age, marital status, religious practices, occupation); (2) details of the death; (3) brief outline of the victim's history (e.g., previous suicide attempts); (4) death history of the victim's family (e.g., family history of suicide, affective illness); (5) description of the personality and lifestyle of the victim; (6) the victim's typical pattern of reaction to stress, emotional upsets, and periods of disequilibrium; (7) recent stressors, tensions, or anticipations of trouble; (8) the role of alcohol and drugs in the overall lifestyle of the victim and his/her death; (9) the nature of the victim's interpersonal relationships; (10) changes in the victim's habits and routines before death (e.g., hobbies, appetite, sexual patterns, and other life routines); (11) information relating to the lifeside of the victim (e.g., upswings, successes, plans); (12) assessment of intention; (13) rating of lethality; (14) reaction of informants to the victim's death; and (15) any comments or special features of the case. A thorough psychological autopsy will also delve into factors that speak to questions of foreseeability and competency, such as the decedent's provision of false information or the use of passive coercion or emotional blackmail against others.

Over the years, psychological autopsies have shown broader applicability than simply determining the mode of death in equivocal cases.[17] They have been used as research tools to aid in the understanding and prevention of suicide and as therapeutic tools to assist survivors coping with suicide.[17] In cases of unequivocal suicide, psychological autopsies have also been used to "account for the reasons for the act or to discover what led up to it."[8] That is, they have helped determine why a person had chosen suicide, in terms of their motivation, personal philosophy, and psychodynamics, and why a person had committed suicide at a particular time. As such, psychological autopsies have proved helpful in identifying and explicating *proximate causation*, determining the role of a variety of factors in bringing about a suicidal death.

Proximate Causation

In recent years, suits have been brought against employers, product manufacturers, health-care providers, and even family members, alleging that such entities were legally responsible for suicidal deaths.[3] The following case histories illustrate the usefulness of psychological autopsies in determining liability in worker's compensation, product liability, medical malpractice, and criminal cases.

Workers' Compensation Cases Workers' compensation laws provide for the medical care and support of persons injured in the course of employment. In the past few decades, however, courts have interpreted worker's compensation laws to include the mental as well as the physical consequences of work-related injury. In fact, emotional trauma related to the job, in the absence of actual physical trauma, has been deemed sufficient for compensation under such laws. Workers with injuries incurred in work-related suicide attempts are entitled to disability benefits and appropriate treatment.[18]

Workers' compensation laws differ between states (for more detail, see Ref. 19). In Massachusetts, for example, three con-

ditions must be met for a suicide victim's estate to receive compensation under the Workers' Compensation Act.[20] First, the personal injury must have arisen out of and in the course of employment. Second, there must be a causal connection between the injury and the act of suicide. Finally, it must be proved that, due to the injury, the employee was of such *unsoundness of mind* as to make him irresponsible for the act of suicide. The last requirement is noteworthy. Indeed, as the following case illustrates, the law does not necessarily consider a suicidal act in and of itself an irrational act.

Case Example:

Mr. P. was a 55-year-old, married, white male. He worked for a bank as its chief executive officer for ten years. Mr. P. was the CEO during a period of tremendous growth and change in the banking industry. In order to respond to the growth in the banking industry, many banks decided to become publicly-owned companies and involved in commercial real estate loans.

Mr. P. was described as an extremely responsible, meticulous person, who took his work seriously. In the summer of 1986, Mr. P. suffered a ruptured aneurysm which almost resulted in his death. After this near fatal medical condition, Mr. P. made concerted efforts to spend more time with his family. Over the ensuing years, he followed up with his medical doctors in an effort to take care of himself. There was no evidence of any psychiatric or substance abuse history.

Mr. P. was under stress at work. Several of the loans that occurred during his tenure were nonperforming. The person responsible for handling the loans was asked to leave the bank. There was concern about the management of the bank. However, as the chief executive officer, Mr. P. was appropriately concerned. In an effort to respond to the problems at the bank, Mr. P. made organizational changes.

In his private life, Mrs. P. reports that her husband was able to maintain his usual activities. He was nominated to be president of the boating club in the summer of 1988. She did not report any changes in his eating or sleeping habits. There was no evidence of loss of energy or difficulty concentrating.

As events began to unfold, there was a critical meeting held at the end of September, 1988. At that meeting, there was concern expressed about the management of the bank, which upset Mr. P. He was noted to be subdued during and following the meeting. Mr. P.'s secretary, for example, reported that Mr. P. "looked somber and gloomy" but he "picked up several days later." He kept appointments and continued to carry out his duties at work. Unbeknownst to his secretary, Mr. P. cleaned out his desk at the end of the work day on October 12 and told her that he would be "in by 1:00 P.M." In retrospect, she found this quite unusual.

On the day of his suicide, Mr. P. had breakfast with his wife, dressed in his usual meticulous dress, and drove the car pool to work. Mr. P. then returned to his home, knowing that his wife would not be at home, and hung himself. Mr. P. had written a suicide note. In this note, he described his concern for his family and fear that their wealth would be eroded. He viewed his suicide as a solution to the problem.

In this case, there did not appear to be a recoverable proximate cause connection between the employee's injury and his act of suicide. That is, there was no demonstrable proof that Mr. P. was of such "unsoundness of mind" that he, himself, should not be deemed responsible for his suicide. For instance, the psychological autopsy did not reveal that the stress that Mr. P. experienced at work produced a clinical depression. Despite descriptions of Mr. P. being distraught and concerned, Mr. P.'s emotional reactions did not appear to reach clinical significance. The description of Mr. P.'s mood and behavior by his wife and business associates did not indicate the presence of sufficient symptomatology to satisfy the criteria for depression as described in the DSM-III-R.[21] Further-

more, a person who is depressed will frequently neglect his physical health, or present to physicians with vague somatic complaints. The medical records demonstrated that Mr. P. was attentive to his health in the months preceding his suicide and there were no descriptions of soft symptomatology.

Furthermore, neither Mr. P.'s wife, secretary, nor business associates noted cognitive impairment or loss of contact with reality. Mr. P. appeared concerned that his position was in jeopardy as a result of the problems at the bank. This was not an unrealistic perception given that there was a possible recommendation that he would be moved from an operational position to become chairman of the board.

Thus, the psychological autopsy of Mr. P. revealed that he was not of unsound mind at the time of his death. He was not suffering from depression, schizophrenia, or alcoholism and, in fact, was not found to have any diagnosable mental disorder. The fact that Mr. P. did not have a psychiatric or substance abuse history is unusual, insofar as research has shown that as many as 90 percent of suicide completers will suffer from some form of mental disorder.[14] Miles,[22] for example, found that half of persons who commit suicide are depressives, one-fifth to one-fourth are chronic alcoholics, and a significant but smaller number are schizophrenics.

Moreover, the psychological autopsy suggested that a vulnerability in Mr. P.'s personality was the proximate cause of his suicide. Although less than 15 percent of suicide completers leave notes, such notes "can have a great deal of meaning under certain circumstances, specifically when they are put in the context of the detailed life history of the individual who wrote the note and committed the act."[23] In analyzing Mr. P.'s suicide note, it appeared that Mr. P. viewed his ability to provide for his family's wealth as a major source of his self-esteem. It is not uncommon for men to base their self-esteem on their work or their ability to provide for their family. Mr. P. had a self-perception, a self-image, that did not allow him to be embarassed and suffer the shame of his failure, and this aspect of his personality did not seem to be caused by the changes and stress he experienced at work.[24]

The judge dismissed the claim, based on the fact that lay and medical testimony did not show a recoverable proximate cause relationship between the disability/suicide and the employment. According to the judge, Mr. P. committed suicide because he:

> . . . set a careful goal in life for himself; a goal which he attained. The goal of being a successful businessman and president of a bank crumbled and his life was over. Mr. P. was always in proud control of his life and ultimately, with dignity, his death. It would be a disservice to the memory of Mr. P. to place the blame for his death on others. Mr. P. was so concerned with responsibility that he probably perceived that the bank's troubles were a failure for which he was responsible. A man that affected by the importance of personal accountability would not be likely to shift the responsibility for any of his actions, including those surrounding his death, to others.[20]

Product Liability Cases Those who produce products for human use have a legal responsibility to ensure the safety of the product's user.[3] In light of this, suits have been brought against pharmaceutical

houses claiming that the medication they produced caused suicidal deaths.[3, 25] Suits have also been brought against recording and television broadcasting companies alleging that the songs or movies they produced precipitated suicidal deaths.[3]

Take, for example, the following product liability case. A 39-year-old man received a severe electrical shock when he used a drill he had recently purchased at a neighborhood hardware store. He was admitted to a local hospital in a coma with a diagnosis of post-electrocution syndrome. This diagnosis was based on presenting symptomatology of confusion, depression, and memory loss. Approximately five weeks after the electrocution incident, this man committed suicide by overdosing on a medication that had been prescribed for his wife. The issue to be resolved in this case was whether or not a defect in the drill led to the electrocution incident, the subsequent depression, and ultimately the suicide. That is, could it be stated with a reasonable degree of medical certainty that the suicide resulted from the electrocution incident?

A psychological autopsy revealed that the man had been in excellent health premortem. Before the electrocution incident, he was, by all accounts, a vigorous, healthy, muscular individual; he jogged regularly and had no prior psychiatric history including psychotherapy, depressive symptomatology, or suicide attempts. Following the accident, however, the man was found to be "different." He was forgetful, disoriented, fatigued, and had nightmares. His affect was noted to be flat, he was disinterested in his usual activities, and had symptoms consistent with clinical depression. As a result, he was started on an antidepressant medication by his family physician.

Thus, the psychological autopsy portrayed a proximate cause relationship between the electrocution and the suicide. Specifically, the psychological autopsy found that the man should not be held responsible for the suicide because of interceding brain damage and depression. The electrocution incident led to depression, and suicide is associated with depression. These formulations from the psychological autopsy were corroborated by research indicating that brain damage can lead to, as well as exacerbate, clinical depression.[26] One of the challenges that arose during the deposition was whether or not suicide was foreseeable as a consequence of the injury. Although suicide, in and of itself, was not foreseeable in this particular case, the opinion was offered that there was a continuous chain of events from the electrocution incident to depression to suicide.

Medical Malpractice Cases Between 1972 and 1983, 20 percent of claims filed against psychiatrists covered by the American Psychiatric Association's professional liability insurance were attributable to attempted or completed suicide by patients.[27] Between 1984 and 1994, 30 percent of claims filed against psychiatrists covered by the American Psychiatric Association's professional liability insurance were attributable to attempted or completed suicide by patients.[28] It should be noted, however, that the number of lawsuits against psychiatrists for patient suicides may not have increased by a full 50 percent in the past 10 years. Indeed,

the number of sexual misconduct cases filed against psychiatrists appears to have decreased substantially during the same time period.[28]

Nevertheless, patient suicide clearly accounts for a significant number of lawsuits against psychiatrists and other mental health professionals. Such lawsuits have been placed in three categories. First, mental health professionals may be sued by surviving family members for not providing adequate care, or for not arranging adequate supervision, when a hospitalized patient commits or attempts suicide. Second, mental health professionals may be sued by surviving family members for negligent discharge decisions when a recently released patient commits or attempts suicide. Finally, mental health professionals may be sued by surviving family members when an outpatient commits or attempts suicide for failure to assess and treat appropriately.[27]

In general, however, mental health professionals will only be held liable for the suicide of a patient if it is determined: (1) that they should have predicted that the patient was likely to harm him/herself; and (2) that they did not take adequate steps to protect the patient in light of the degree of risk.[27] The key words, as you will see below, appear to be *reasonable, anticipated, foreseeable, preventable,* and *controllable.*[18, 29, 30]

Case Example:

A 45-year old woman with a long history of prior suicide attempts consulted a psychiatrist requesting medication management. The psychiatrist took a comprehensive history, ordered relevant blood tests, and appropriately adjusted medication. After a period of time, the patient began to complain of side effects and an increase in symptomatology. The psychiatrist made changes in the medication. Following the changes in the medication, however, the patient made a nonlethal suicide attempt.

The psychiatrist reevaluated the patient with accompanying blood tests and recommended hospitalization. The patient refused to be hospitalized. During the subsequent sessions, the patient acknowledged her long-term preoccupation with dying, but specifically denied current suicidal ideation. The patient requested that the psychiatrist not contact family members, indicating that they were aware of her suicide attempt. In the interim, the patient had returned to work.

On the morning of the patient's suicide, she had had her blood drawn for a lithium level as per doctor's instructions. The claims against the psychiatrist included inappropriate medication management and failure to hospitalize. Although there was a temporal relationship between the medication changes and the suicide attempt, the expert witness demonstrated that there was no proximate causation. The jury ruled in favor of the defendant doctor.

The Issue of Prediction First, the law demands *reasonable* care in *foreseeable* situations. The difficulties in predicting suicide and other types of dangerous behavior have been widely touted.[31] For example, although there are certain commonalities among suicidal individuals, it is difficult at any given time to differentiate those at acute risk of suicide from those at long-term risk. In fact, a history of previous suicide attempts in not necessarily a reliable guide.[27, 32] Indeed, 90 percent of individuals who attempt suicide do not go on to complete it.[33]

Because of high error rates in prediction of future dangerousness, many courts have held that mental health professionals should not be held liable for the suicide of a patient if their treatment decision, albeit wrong, was not arrived at carelessly or

thoughtlessly and was based on sufficient information. Psychological autopsies, which include a thorough review of the medical record in conjunction with other material, can help determine whether the mental health professional had, in fact, made a careful assessment of the situation. For instance, if the psychological autopsy reveals that the treating professional failed to conduct a proper mental status examination, failed to consult another practitioner when indicated, failed to meet with family members, or failed to obtain important information from available sources (e.g., history of prior suicide attempts, access to a firearm), there is a greater likelihood of a court imposing liability.[27]

The Issue of Protection The law also demands that mental health professionals take certain steps to safeguard individuals at acute risk of suicide. As Litman[18] has noted, "the best precaution against suicide in or outside of a hospital is the presence of other people." Under certain clinical conditions, hospitalized patients may warrant constant supervision. Although hospitals continue to improve the physical plant, trying to make it as safe as possible, no unit is suicide proof. In addition, in determining when it is safe to discharge a patient who previously had been suicidal from a hospital, a careful assessment of such factors as the current level of suicide risk, the level of social support available outside the institution, and the extent of improvement in the patient's illness must be undertaken.[27] Although it is more challenging for the therapist to manage the suicidal outpatient than the suicidal inpatient, there are treatment responses that can be used. For instance, the threat of suicide in outpatients may be responded to by increasing the frequency of sessions, focusing the therapy on the elimination of suicidal urges, and prescribing medication and/or hospitalization.[27]

In recent years, there has been a strong emphasis on the civil rights of psychiatric patients. Indeed, the trend in psychiatry has been to remove the prison-like features of mental hospitals by abolishing restraints and encouraging patient responsibility.[18] However, as Litman[18] has noted, the problem with such a trend is that "[p]sychiatrists find themselves responsible for suicidal patients in psychiatric settings which have been deliberately designed to give the patients maximum freedom of action as part of the therapeutic milieu." Although suicide in general or psychiatric hospital settings account for only four percent of the total number of suicides,[34] more than one-third of hospital suicides result in lawsuits.[18]

In addition, in the treatment of suicidal patients, there exists a delicate balance between providing clinical treatment, which involves certain risks, and applying protective, less therapeutic measures.[35] For instance, while such measures as increasing observation, placing a patient in seclusion, and using physical or chemical restraints can reduce the risk of suicide in hospital settings, they can also prolong the patient's illness, delay discharge, and increase the risk of suicide at some later time.[27] In addition, a number of outpatients have committed suicide by overdosing on the very medication the psychiatrist had prescribed to treat their depression and suicidal urges.

As a result, the courts have tended to find negligence only in cases in which the choice of intervention or manner of supervision was *unreasonable* given the circumstances.[35] The particular burden in such cases is not only how one substantiates and documents "a standard of care," but how one demonstrates that if the proper standard had been adhered to the suicide may have been prevented. Psychological autopsies, in the hands of experienced suicidologists, can help to determine whether the standard of care had indeed been met. The risk of liability tends to be greatest when the plaintiff produces experts who testify that the therapist did not exercise reasonable care, or did not follow his usual practices in caring for a patient at risk of suicide and cannot explain the deviation.[27]

Criminal Cases Family members have also been held liable for the suicide of "loved" ones. In a 1987 criminal case in Florida, for example, a mother was accused of contributing to the suicide of her daughter. The case was precedent setting in that it was the first time that a psychological autopsy had been used by the prosecution in a criminal case and that a mother had been convicted of contributing to the suicide of her daughter. The case received a great deal of media attention not only because it was precedent setting, but also because the details of the case were salacious in nature (for a more detailed description of this case, see Ref. 17).

Case Example:

Tina was the middle of three children. Her parents divorced when she was three. Tina had little contact with her biological father, who had moved to California. Her mother remarried a man who was known to be a transvestite and ultimately had a sex change operation. The second marriage did not last long. Shortly thereafter, Tina's mother remarried for a third time.

Tina manifested her difficulties at the age of 13 when she made a suicide attempt. She took approximately seventy pills and called a friend who subsequently called the police. She was admitted to a pediatric unit at a local hospital, where she stayed three days. She was seen in consultation by psychiatrist who deferred diagnosis, recommending family treatment which the mother subsequently refused. Her friends were later to testify at depositions that the basis for the suicide attempt was that Tina's mother had called Tina a "slut."

The turmoil in Tina's life began to escalate and during the fall of 1984, Tina dropped out of school. Tina had been an A student, but her grades had plummeted in recent months. In the ensuing six months, tension mounted at home. In the summer of 1985, Tina and her brothers attempted to run away from home. Their attempts were unsuccessful and they were brought back by the police. Three days following one runaway incident, Tina called the police because she and her mother were fighting. When the police arrived at the scene they felt it was best to have Tina stay at a friends for the night. The police offered intervention to Tina and her mother. The mother, however, became angry, claiming that the police always sided with her daughter. The mother refused follow-up, and Tina did not call the police again for assistance.

A week after this incident in August 1985, the mother's current husband called the police stating that he was frightened of his wife's violence after he had asked for a divorce. The police investigated and confiscated a handgun owned by the mother. On that occasion, the police asked Tina if she would like to spend the night away from home. Tina replied to the police officer: "No, she'll be over it by then." What struck the police officer reporting this incident was that someone had "just threatened her with a gun and it was an ordinary thing to her." The apparent reason for nonchalance was that the mother frequently terrorized Tina with a gun, holding it to her head with the trigger cocked.

In September of 1985, Tina's mother separated from her husband, ultimately to divorce for the third time. Chaos seemed to reign following the divorce. Tina's two brothers were in and out of the house. In January 1986, Tina's mother "allowed" Tina to work at a topless nightclub. The mother obtained the grandfather's notary public stamp and forged Tina's birth certificate so that Tina could work. The mother, filled with admiration, drove her daughter to work. She took from Tina's earnings $200 a week for rent and $100 a week for driving her daughter to and from work. The actual rent for the apartment was $465 per month.

Tina did well at her new job. The mother "allowed" her to work at a second club starting in March of 1986. Tina told her friends how she wanted to stop working, but felt she could not do anything about it. She secretly started to accumulate money. At this point in time, the brothers were away from home and Tina and her mother were alone, fighting constantly.

On the day of her death, Tina and her mother got into a violent argument about Tina's work. This was reported by Tina's brother who witnessed the argument. Even though Tina was making a lot of money and enjoyed the dancing, she found the work humiliating. Tina had pleaded with her mother to let her stop dancing at the nightclubs. After the mother left that day, Tina called her friend to learn whether it would be possible to live with her. She told her friend that she had $2000 for a car and thus could move in. The friend stated that her mother was afraid of Tina's mother. She knew that Tina's mother would come after her, that the police would become involved, and that Tina would have to be sent back home. Her friend reluctantly and sadly told Tina, "I'm sorry you can't stay with us." A half hour later, on March 24th, 1986, Tina shot herself with a .357 magnum.

The question that the psychological autopsy was used to answer was whether the abuse from Tina's mother was a significant contributory factor in her suicide. The question in this case was not whether the abusive relationship was the *sole cause* of the daughter's suicide, but rather whether it was a *significant contributory factor*. This is an important distinction. As Havens[36] eloquently wrote: "Suicide is the final common pathway of diverse circumstances, of an interdependent network rather than an isolated cause, a knot of circumstances tightening around a single time and place, with the result, sign, symptom, or act."

A psychological autopsy is a retrospective analysis of a person's life, focusing on the antecedents to suicide. Psychological autopsies generate a list of contributing factors, with some factors more relevant than others. In the hands of experienced suicidologists, psychological autopsies can help sort out the substantial causes of suicide from the "screen" or "trigger" causes.[1] In this case, for example, the psychological autopsy revealed that aggravated child abuse by the mother (which included such atrocities as forcing her daughter to dance nude, subjecting her daughter to verbal abuse, and failing to seek treatment for her daughter following an earlier suicide attempt) was a significant contributory factor in Tina's suicide.[17]

That is, our reconstruction of Tina's life based on a review of all available material indicated that had it not been for this young girl being the victim of an exploitive relationship with her mother and feeling powerless and hopeless, she would not have committed suicide at the particular time she did. The trial jury as well as the appellate court agreed, and found Tina's mother guilty of charges of forgery, procuring the sexual performance of a child, and child abuse.[37] She was sentenced to one year in prison for forgery; two years of house arrest for procuring

the sexual performance of a minor; and three years of probation on the condition that she continue to receive outpatient therapy at a mental health clinic for aggravated child abuse (i.e., for driving her teenager to suicide by forcing her to dance nude in a nightclub).

It should be noted, however, that this was not the first case to convict someone for the mental anguish that leads to suicide. In a 1932 legal case, *Stephenson v. State*, the Indiana Supreme Court upheld a murder conviction for a man who kidnapped a woman acquaintance, attempted to rape her, and failed to seek immediate attention for her when she took poison. The woman died after the defendant took her home.[38] The case presented here, however, was precedent setting to the extent that it was the first time that a mother was convicted of contributing to the suicide of her daughter.

In fact, because this was the first time that child abuse charges had been brought against a parent after a child's suicide, some feared that this case would set a precedent for inquiry into the family life of teens who commit suicide. *The Washington Post* even quoted one individual as stating: "The Florida ruling smacks of medieval church law, whereby family surivors were treated as accessories to both a sin and a crime."[39] However, the case presented here was a special case. This woman had clearly abused her daughter, and one of the consequences of that abuse was suicide. Tina's mother exploited her sexually, creating an environment that made her feel her only worth was the amount of money she was bringing in from dancing. Tina lived in an extremely poor psychological environment, filled with humiliation and abuse, and felt that there was no way out of this environment aside from suicide. Although there is always the possibility that there will be inappropriate applications of this precedent, it is hoped that the outcome of this case will serve not to blame the victims, but rather to direct much needed attention toward the rights of children.[17]

Issues Raised

The use of psychological autopsies in legal cases, however, is not without controversy. First, it has been argued that the psychological autopsy fails to meet the *Frye* test (whereby it is necessary to show that evidence is widely accepted within a field of specialty) or new standards for expert testimony under *Daubert*. It has also been aruged that the psychological autopsy procedure when applied to legal cases raises isues of admissability because it is prepared in anticipation of litigation, is based on third party information, and usually excludes direct examination of the subject in question. Furthermore, it has been argued that the psychological autopsy is unnecessary, overly prejudicial, and based on hearsay elements.[40] This section will discuss each of these issues in turn.

Does Not Meet Standards for Expert Testimony Prior to 1993, the landmark case defining limits on expert testimony was the case of *Frye v. United States*. This 1932 landmark case, which incidentally was without Supreme Court solemnization, allowed opinion testimony from those generally accepted in the scientific community. The ruling stated that "the

thing from which the deduction is made must be sufficiently established to have gained general acceptance in the particular field in which it belongs."[31] As noted above, some have questioned whether the psychological autopsy procedure meets the *Frye* test.

For example, in the aforementioned case, Tina's mother appealed her conviction, arguing primarily that the psychological autopsy is an unreliable technique that is not generally accepted in the field of psychiatry and, as a result, should not have been admitted as evidence in a criminal trial. On December 13, 1989, however, the appellate court ruled to uphold the conviction on the basis that there was no merit to these arguments. In particular, the judge ruled that there was no distinction between the psychiatrist's expert opinion in this case and the admission of the psychiatrist's expert opinion to establish the defendant's sanity at the time of committing an offense or to prove the competency of an individual at the time of executing a will.[37] Dregne,[41] in a note for the *Arizona Law Review*, similarly concluded that the psychological autopsy was a reliable and accurate technique meeting admissibility requirements under *Frye*.

However, on June 28, 1993, the U.S. Supreme Court changed the federal standard for expert testimony in their ruling in the case of *Daubert v. Merrell Dow Pharmaceuticals, Inc.* The major change initiated by *Daubert* was to establish a gatekeeping role for trial judges, requiring them to make a preliminary assessment of expert testimony. In particular, the judge must assess four aspects of expert testimony: (1) the qualifications of the expert; (2) the reliability of the expert testimony; (3) the helpfulness of the testimony; and (4) the prejudicial effect of the testimony. Furthermore, when expert testimony is scientific in nature, *Daubert* gives guidance on how to determine reliability.[42]

It should be noted that *Daubert* is actually a more liberal standard than *Frye*, and that any testimony previously admissable under the *Frye* standard should be admissable under *Daubert*. Indeed, as Davis[42] writes, *Daubert* differs from *Frye* in that "the lack of general acceptance will not in itself prevent the evidence from being admitted but will require a more in depth inquiry upon which to base reliability (p. 1317)." Put another way, the ruling easily admits scientific evidence based on general acceptance, but can also admit testimony that has not yet gained general acceptance if supported by other factors (e.g., testability, peer review or publication, rate of error, and known standards).[42] Moreover, for borderline scientific evidence, Justice Blackmun "definitely favors admitting the evidence and then deciding the case based on sufficiency, determined by presentation of opposing experts and evidence and by flushing out problems with the expert testimony by cross-examination (p. 1320)."[42] This ruling should bode well for the admission of the psychological autopsy technique in future cases.

Dealing with a Deceased Subject

Psychological autopsies have been used to reconstruct the state of mind of the deceased by examining school, hospital, and employment records; police incident reports; and custody disputes; and by reading pretrial depositions taken of family,

friends, and coworkers. It has been argued that in reconstructing a suicidal individual's mental state, suicidologists must conduct face-to-face interviews with everyone who knew the suicide victim, including the suicide victim him/herself. That is, how can someone know the state of mind of someone one has never met? It should be noted, however, that although one can never know with 100 percent certainty what is going on in someone's mind, the mind of suicidal individuals has certain consistencies and, furthermore, the certainty for medical expert testimony is based upon a reasonable degree of medical certainty or "more than likely." Shneidman,[43] for example, lists 10 commonalities to suicide, including such factors as hopelessness-helplessness, frustrated psychological needs, ambivalence, and the constriction of thought that leads one to see no options. Iga[44] has identified three elements common to all suicide cases: (1) a discrepancy between one's ego ideal and self-concept; (2) rigid social conditions; and (3) a lack of alternative means from which to choose for problem solving or tension reduction. The psychological autopsy helps to gain insight into the relationship among goals, means, conditions, social interaction, and personality of the individual concerned.[44]

Like Iga, Menninger[45] also theorized a triadic model for suicide: (1) the wish to kill (revenge); (2) the wish to be killed (guilt); and (3) the wish to die (escape). In the aforementioned case, for example, Tina had feelings of murderous rage and revenge toward her mother, which she expressed symbolically in her use of her mother's gun to kill herself. Tina also felt degraded by nude dancing, and the guilt associated with this likely intensified her self-destructive impulses. In addition, Tina felt trapped. She ultimately felt forced to participate in nude dancing to bring home money to support her mother, whom she resented supporting. People always look for avenues to escape pain, and in Tina's case, the way out was suicide.

Moreover, from a clinical point of view, psychological autopsies of suicide victims with whom the person conducting the psychological autopsy has had no prior contact removes the vagueness of the interpersonal relationship between the mental health professional and the examinee. As such, psychological autopsies in some ways are more objective and less controversial than the analysis of living patients.[40] However, an ideal addition to the psychological autopsy would be to call to the stand (in the trial) the mental health professional who saw the patient in the days or weeks preceding suicide and to incorporate his/her opinions into the psychological autopsy. In most cases of completed suicide, however, the decedent has not had contact with a mental health professional in the period immediately preceding his/her death, and the decedent is no longer available to be interviewed. Indeed, as Clark and Fawcett[33] report, half or more of all persons who die by suicide have never seen a mental health professional in their lives. Thus, suicidologists are forced to rely on retrospective techniques to reconstruct the mind of the deceased.

The Retrospective Nature of the Instrument The retrospective nature of the psychological autopsy is an additional

methodological issue. The mood associated with bereavement at the time of the interview as well as the time lag between the death and the interviews are two factors hypothesized to influence the quality of the information reported.[17] For instance, researchers have expressed concern that informants could either exaggerate the presence of psychiatric symptomatology because of guilt or, alternatively, minimize the victim's psychiatric problems because of idealization. Brent,[46] however, did not find an association between time lag and parental reporting of psychiatric symptomatology in the suicide victim within a range of two to six months. Brent *et al.*[47] also did not find that having an affective disorder at the time of the interview had an impact on the information given during the interview.

Based on Documentary Evidence It has also been argued that experts should not base their opinions on police reports and other forms of documentary evidence. For instance, police reports are often incomplete as sources of information, perhaps because the police are primarily interested in determining whether a homicide was committed. Litman,[17] one of the pioneers of the psychological autopsy technique, however, does not believe that basing psychological autopsies on documentary evidence is unusual or alarming. For example, police reports and other sources of information compiled shortly after a death often are more helpful than personal interviews conducted months after the fact, when witnesses have had a change to forget, and conceivably alter or embellish, the facts.[17] Moreover, in evaluating a possible suicide, it is highly desirable to have a police report describing the scene of death (including the position of the body) and to have evidence gathered at the scene (e.g., weapons, pills, poisons, and notes).[18]

In addition, it has been argued that psychological autopsy studies should not rely on depositions; inasmuch as they are elicited in the context of an adversarial examination, the expert is unfamiliar with the interviewing skills of the deposer, and informants are not interviewed in a standardized fashion and, as a result, cannot be compared against previous psychological autopsy studies.[12] Clark and Horton-Deutsch,[12] for example, advise that the expert should undertake "a preliminary case review together with the opposing legal parties to identify all knowledgeable informants and then undertake structured interviews with identified informants independent of the deposition process." Although this process may be ideal, it will be difficult to invoke in practice given today's legal system. In addition, researchers have consistently pointed out that the main problem in conducting psychological autopsy studies is in obtaining cooperation for interviews from friends and family of the suicide victim.[48,49]

We do not agree that a psychological autopsy necessitates direct interviewing of relevant parties. In cases in which direct interviews are not conducted, some care must be taken to ensure that information obtained for the psychological autopsy is reliable. Deikel[50] detailed the procedures he employed to increase the reliability of the psychological autopsy of Lenny Bruce, which included excluding opinions and reactions of individuals not

acquainted with the comedian, excluding sensational and extreme information, ensuring that facts had been verified by an alternate source, and including only material written before the comedian's death in August, 1966. It should be noted, however, that in legal cases it is not up to the psychiatric expert to determine whether the information has a basis in fact. That is up to the state to prove, for the defense to rebut, and the jury to decide. The expert's role is not to question the charges, but to question and then determine, within the limit of his/her expertise, the mind of the suicidal victim.[17]

Conclusion

Suicide is a multidimensional phenomenon, literally defined as "a crime against oneself."[51] For many years, suicide was associated with crime and with its theological partner, sin.[51] Although the stigma attached to suicide has persisted, the recent trend has been to view suicide less as a sin and crime, and more as an unfortunate consequence of mental illness and social disorganization.[18] Indeed, persons who commit suicide in England and the United States are no longer penalized. Research has also indicated that only 10 percent of persons who commit suicide do not suffer from some form of major mental illness.[14]

Blame still appears to be an issue in suicide. For example, the responsibility for suicidal deaths has shifted to persons deemed in a position to cause a suicide, either by specific acts on their part or by neglecting their duty to protect the suicide victim from self-harm. Such persons include employers, product manufacturers, health care providers, and even family members. In general, it is recognized that there are multiple factors in assigning responsibility for a suicide, including but not limited to current psychiatric illness, personality disturbance, biological factors, family history, medical illness, and psychosocial stressors.[15, 52, 53] Psychological autopsies, conducted by experienced suicidologists, can help the judge and jury determine which factors are most pertinent to the particular case.

However, the use of psychological autopsies is not without controversy. For example, as Shaffer[15] has noted, information from psychological autopsies will often be incomplete, being limited to only what the informant has observed. In addition, informants may be ignorant in such areas as undetected legal activities or insensitive to subjective mental states such as depression or anxiety.[15] However, despite such limitations, the psychological autopsy is often the best method available to study the detailed characteristics of suicide victims and, as such, will play an important role in legal litigation surrounding suicides.

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