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You Only Die Once– But Did You Intend It?

The Forensic Psychiatrist As Sleuth

> Doubt is not a very pleasant condition, but certainty is absurd.
>
> —*Voltaire*

Was It Really Suicide?

Vincent W. Foster, Jr.

On Tuesday, July 20, 1993, as White House Counsel Vincent W. Foster, Jr., walked out of his office in the west wing of the White House, he told his secretary to help herself to some M&M's candy left on his lunch tray. He then drove his car to Virginia, taking the George Washington Parkway to a scenic and secluded spot in Fort Marcy Park, and shot and killed himself.

In many ways, Foster was a modern version of "Richard Cory" in the poem by E.A. Robinson. As a corporate lawyer in Little Rock, Arkansas, Foster had earned professional acclaim and was earning $300,000 per year. But in Washington, D.C., at the side of the Clintons, life was different for him, and difficult. In the week before his death, he was worried about a possible congressional investigation into the White House travel office. His connection to that discredited office had been condemned by such newspapers as *The Wall Street Journal*. Foster sought the names of psychiatrists but feared that his

sessions with them might be taped. He talked to his wife about resigning and returning to Little Rock, to their former, comfortable life. On Friday, July 16, Foster confided to his sister that he was fighting depression. She gave him some names of psychiatrists to call in Washington. He attempted to reach one of the psychiatrists twice but failed to make contact.

Foster took a getaway weekend, which seemed to refresh him, because back in his White House office he appeared rejuvenated. On the day before his death, he called his family physician and obtained antidepressant medication, but to the very end, Foster exhibited few outward signs of mental distress.

Foster's death roiled Washington. He left no suicide note and had not spoken to anyone about suicide. People who knew him were gripped with utter disbelief. How could a man of such stature and apparent stability, a man whom President Clinton called "the rock of Gibraltar," have killed himself? Foster's judgment and intellect had been so respected by his White House peers that he was considered a potential Supreme Court nominee. The park officer who found Foster's body commented that his slacks were creased, his white shirt was starched, and every hair on his head was in place.

Foster's injured professionalism has been advanced as the single cause of his death, but as a forensic psychiatrist I reject that explanation as too simple. Stock ideas about suicide have no place in a true understanding of this complex subject. At best, the broadest statement that can be made about suicide is that its goal is to escape intolerable and excruciating mental pain and problems of living, considered to be solvable only by self-destruction.

The specific circumstances of every apparent suicide are unique and must be thoroughly investigated. In Foster's case, the more plausible explanation is an unrecognized and untreated psychiatric disorder. On June 30, 1994, Whitewater Special Counsel Robert Fiske, citing conclusive forensic evidence, officially determined that Foster's death was a suicide. The report describes his severe depression and symptoms of panic. Consumed by depression, he could not eat or sleep. Panic caused his heart to pound and his stomach to boil. He could not concentrate.

I have seen patients who have tolerated depression for years but who could not tolerate both depression and panic. It is one thing to feel depressed and hopeless, but life can become intolerable when one

is also constantly terrified. The combination of severe depression and debilitating panic attacks likely proved fatal for Vincent Foster. Both disorders are associated with an increased risk of suicide. It is particularly tragic because both conditions usually can be effectively and simultaneously treated with antidepressants. But it is likely that conspiracy theories will proliferate because definite answers are themselves improbable in apparent suicides.

Vincent Foster's death was quickly judged a suicide. So, too, for a time, were the deaths of two other notables, Marilyn Monroe and Robert Maxwell. On August 5, 1962, at 4:30 A.M., the Los Angeles police found Marilyn Monroe dead in her home. The cause of her death was unknown, but some considered it a suicide. On November 4, 1991, publishing tycoon Robert Maxwell's naked body was found floating in the calm waters off Grand Canary Island. Similarly, some considered Maxwell's death a suicide. But were these really suicides? Let us first examine the facts of these two deaths.

Marilyn Monroe

On that morning in 1962, Marilyn Monroe was found lying nude, face down, with a sheet pulled over her body. Her habit was to sleep naked. No suicide note was found. The night before her death, no disturbance had been heard by her neighbors, who knew her and considered her a good neighbor. On the morning after her death, an autopsy was conducted by Deputy Coroner Thomas Noguchi, M.D. Five days later, the Los Angeles coroner rendered a preliminary judgment that Monroe had died of a possible barbiturate overdose. On August 17, that judgment was amended to probable suicide. Ten days later, the coroner issued his final judgment, saying that Monroe died of acute barbiturate poisoning that followed an overdose.

The coroner's decision was based on toxicologic analysis, for no external signs of violence to the body were found. Blood analysis revealed 8 mg of chloral hydrate, a non-narcotic sedative, and 4.5 mg of pentobarbital, a sedative barbiturate. A much higher concentration (13 mg) of pentobarbital was found in the liver. It was theorized that the chloral hydrate may have interfered with the metabolizing of the pentobarbital and increased the pentobarbital's lethal potential.

Many drug bottles were found at Monroe's bedside table, some full, others half-empty. One bottle contained antihistamines for a sinus

condition. An empty canister, dated August 3—only 2 days before her death—had previously contained twenty-five 100-mg pentobarbital capsules. There were also ten 500-mg capsules of chloral hydrate, and the remainder of a 50-capsule bottle dated July 25 and refilled on July 31st, which had been prescribed by Monroe's longtime psychiatrist, Dr. Ralph Greenson.

Dr. Greenson spoke with a suicide prevention team that the coroner had assembled to compile a psychological profile of Monroe at the time of her death. This was done so the coroner could more judiciously consider whether there had truly been a suicide. Neither Dr. Greenson nor Monroe's caretaker, Eunice Murray, believed she had deliberately taken her life. Other evidence assembled by the team showed that Monroe had not been mentally unbalanced or physically dependent on drugs. Her drug intake was considered to be light to medium. Pressed to make a decision—as one member later admitted—the team concluded that Monroe had either committed suicide or had made a suicide gesture that had turned lethal. The coroner's office was reportedly anxious to have the investigation completed, to issue a death certificate, and to put the Monroe matter behind them.

Because the controversy over her death has continued to this day, that last aim was never achieved. The haste with which the suicide investigation was conducted almost ensured that the case would, at least in the mind of the public, remain open. It has been reported that Dr. Noguchi and other forensic experts familiar with the facts at the time did not believe that Marilyn Monroe committed suicide. For example, they had learned that Monroe had made positive plans for the future. Also, the difference in drug levels in the blood and liver suggested that she had lived many hours after ingesting the pentobarbital. Further, the forensic experts cited the fact that no trace of the drugs had been found in her stomach or duodenum. To them, this meant that a lethal dose of pentobarbital could not have been taken by mouth or by injection. (An examination of the body with a magnifying glass concluded that there were no needle marks.)

In a biography of Monroe, author Donald Spoto examined carefully and rejected all the fanciful theories that contend Monroe's death was ordered because she "knew too much" about the Kennedy family. However, Spoto was convinced that her two caregivers, an attendant and Dr. Greenson, were accomplices in her death. He theorized that they could not tolerate Monroe's emerging independence and capac-

ity to achieve happiness apart from them. Spoto believed that Dr. Greenson had become so enmeshed in Monroe's life that her plan for imminent departure to a new life was an intolerable rejection of him, one that impaired his professional treatment of her. Spoto contended that the chloral hydrate enema ordered by Dr. Greenson for Monroe capriciously imperiled her. There is no evidence, however, that Dr. Greenson consciously attempted to harm Marilyn Monroe.

Was Marilyn Monroe's death a suicide, murder, or an accident? We may never know, because there was no opportunity to do a complete forensic psychiatric autopsy or postmortem evaluation drawing on how she lived her life in the days and weeks prior to her death.

Robert Maxwell

A few days before Robert Maxwell's death, he had suddenly ordered the captain of his yacht to sail for Madeira and Tenerife Island, off the northwestern coast of Africa. The captain reached Grand Canary Island and sailed around it, since Maxwell had decreed no particular course. At approximately 5 A.M. on that morning in 1991, Maxwell called the bridge to complain that his room was too cold. Then, unseen by anyone, he made his way up to the deck and either fell, jumped, or was pushed to his death. Was it suicide? An accident? Murder? Or natural causes? The answer was not an academic matter, for if it could be determined that Maxwell's death was accidental, his family could collect $36 million from his life insurance.

Maxwell had been a billionaire, the exuberant wielder of enormous power through his newspapers and other businesses, and through statesmen whom he had befriended. Given Maxwell's previously demonstrated ability to rebound from personal scandals and business disasters, suicide seemed out of character for him, although he—much more than Marilyn Monroe—seemed to have had reasons for committing suicide. Adversity had always inspired him. He seemed to crave challenges. Many who knew him, however, came to the conclusion that his death was not an accident, or by natural causes, such as cardiac arrest either before his fall into the ocean, or by the shock of the water. They believed he had committed suicide to avoid complete personal disgrace and jail that might await him upon his return to England. Outraged bankers and members of his own corporate board were scheduled to confront him about the disappearance of

corporate assets and monies from pension funds. These intimates believed that for Maxwell, who desperately sought the respect of people in high places, the humiliation that would have followed revelations about the disappearing assets would have been unbearable—and, therefore, pushed him to a shame suicide.

Some believed that Maxwell had not died at all and that the body identified by family members was that of someone else. The Spanish authorities who recovered the body refused to do a dental plate comparison. They could not use fingerprints on file because the files were too old. The autopsy that they performed was suspect because it described the corpse as having chestnut-colored hair, when Maxwell's was gray and dyed jet black. Other people—members of Maxwell's family—advanced the theory that Maxwell had been murdered by a treasonous crew member or by a frogman assassin.

What was known about Maxwell's personality gave rise to these and other theories because he was an enormously complex man of myriad contradictions, capricious behaviors, mood swings, and dark corners of mind. Some intimates thought he possessed multiple personalities; one, a former editor, believed him to have had as many as 20, each struggling with the others for control.

Evidence that Maxwell lived in a fantasy world of some sort was not hard to find. He had invented his background, his name, and parts of himself. Born Jan Ludwik Hock, he changed his name at various times to Leslie DuMaurier, James Maxwell, Ian Maxwell, and finally Robert Maxwell. He told people that he had been with the Czech underground in World War II, fighting the Nazis. But his tales were unsubstantiated and also at odds with the facts of the underground activity in the area of Czechoslovakia where he had lived at that time. Maxwell once refused to be interviewed by a Jewish magazine, asserting that he had joined the Church of England, but later claimed that the conversion was only a prank played on a journalist.

The most likely theory of Maxwell's death is that he killed himself because he was at a point in his life where the final identity that he had created for himself was about to be destroyed. The idea of Maxwell having multiple personality disorder also provides a theory if, in fact, Maxwell suffered from this disorder. It was not beyond possibility that because of the extreme stress of events, a murderous alter personality could have emerged and killed Maxwell. The explanation of his death could also be a lot simpler: a Spanish pathologist took note of the fact that Max-

well's stomach contained a barely digested banana and surmised that he could have slipped on a banana peel and fallen to his death.

Suicide, Accident, Murder, or Natural Death? Enter the Forensic Psychiatrist

What happened in the deaths of Vincent Foster, Marilyn Monroe, and Robert Maxwell—that despite the availability of sophisticated scientific analyses, the intent to suicide has not been definitively established but also cannot be definitively dismissed—is often true of suicides. Although most suicides are intentional, some are not, as I explain later in this chapter. What appears to be a suicide, even if unintended, may be murder. For example, preliminary results of a recent forensic examination on the exhumed body of germ warfare researcher Frank R. Olson appear to contradict government conclusions that he jumped to his death in 1953 from a Manhattan hotel after unwittingly taking LSD in a CIA experiment. This recent finding at last verified the suspicion, long held by Olson's family, that he was murdered.

Murder Masquerading as Suicide

Murder masquerading as suicide is not rare. It is less likely to occur with a public figure or celebrity, however, because close scrutiny may uncover the deception. Murder masquerading as suicide is more likely to remain unsolved when the individual murdered has a history of mental illness.

> Angela, a 36-year-old married but separated woman, was found hanging naked in her bedroom closet by her landlord. Her knees were approximately 4 inches off the floor. The police found no signs of a struggle in the apartment, and no suicide note. Angela had told friends and coworkers that she was taking a few days off to put the finishing touches on a novel she was writing. A manuscript was found on her desk. She did not have significant financial problems.
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> The body was cut down so as to preserve the knot made for the noose. Fingerprints were obtained but were inconclusive. The forensic pathologist retained by the prosecution opined in her report that the death was suspicious. She noted that suicide by hanging is not a preferred method for women. The slipknot that was used contained clumps of the deceased's hair tangled within the knot. The forensic pathologist stated that persons who hang themselves usually do so with a simple slipknot that is not intertwined with their hair. The slip-

knot is tied first and then the noose is placed over the head without entangling the hair in the knot. The rope around Angela's neck was on a horizontal plane, as if it were tightened first before any strain was applied. The forensic pathologist explained that a diagonal misplacement is more pronounced in suicides. The rope's impression on Angela's neck was not as pronounced as seen in hanging deaths. Moreover, the forensic pathologist observed that women who kill themselves do not ordinarily do so in a naked state. Furthermore, it could not be determined whether Angela sustained any trauma to her body because of advanced bodily decay. There was no evidence of a sexual assault. Blood analysis did not indicate evidence of drugs or alcohol. The pathologist concluded that Angela was murdered.

The defense's forensic pathologist's report states that it is not uncommon for hair to become entangled in a noose, that no conclusions should be drawn from the knots used, and that his experience was that women hang themselves in various states of undress. Also, the angle of the ligature was an equivocal piece of evidence. This pathologist concluded that Angela's death was a "garden-variety" suicide.

After further investigation, the police learned that Angela's husband, age 49, a retired military officer, had a police record for spousal abuse. After 10 years of marriage, Angela was planning a divorce. A year prior to her death she had obtained a protective order against her husband for stalking. Witnesses testified that Angela was afraid of being stalked again by her husband, who had once threatened to kill her. She had begun a new romantic relationship at work. Angela had told friends that her husband said that he would kill her rather than "give her up" to another man. Neighbors provided sworn statements that they had heard loud, angry voices and the sound of furniture falling over at about the time of Angela's death. One witness saw the husband's car in the parking lot and observed him entering the apartment building where Angela lived at around the time of her death. Hair samples found in Angela's apartment matched those of her husband.

The husband was questioned but denied any knowledge of Angela's death. He claimed that he had not spoken to his wife in more than a year. He stated that she had an extensive psychiatric history, and had attempted suicide on several previous occasions. His alibi was that he was out of town attending a regatta during the time his wife had died, but the alibi could not be substantiated.

Because of the suspicious circumstances, the district attorney requested a postmortem psychiatric assessment to determine the presence or absence of suicide risk factors at the time of Angela's death. Witness statements and medical and psychiatric records were obtained and reviewed. The records indicated that she had developed bulimia nervosa at age 17. The breakup of a romantic relationship had resulted in depression, superficial wrist cutting, and a brief hospitaliza-

tion at age 19. A maternal grandmother had attempted suicide during a postpartum depression. The inpatient psychiatrist had made a diagnosis of Angela as having an adjustment disorder with depression.

Angela had married at age 26 after graduating from college with a master's in business administration. Because of psychological and physical abuse by her husband—a particularly violent beating—she then sought outpatient treatment. Her physical injuries included six fractured ribs and a facial fracture. Her husband was arrested, briefly jailed, and ordered to attend a treatment program for wife abusers. Angela's new psychiatrist diagnosed dysthymic disorder (chronic depression). He noted that Angela had experienced brief flurries of unbidden suicidal thoughts after being assaulted, but had no suicidal intent or plan. As a way of medicating her marital stress symptoms, she occasionally drank wine excessively. She received 3 years of psychiatric treatment, which ended 1 year before she obtained the protective order.

Further information of note came from Angela's parents, who revealed that she was about to receive a $500,000 inheritance from an aunt who had recently died. Angela and her husband knew of this bequest. Angela's husband was a secondary beneficiary of the inheritance as long as the couple remained officially married.

The estranged husband was indicted for second-degree murder, convicted, and sentenced to life in prison.

Did You Intend It?

An individual may have no intention of dying when he or she makes a suicide gesture—the sole purpose of the gesture may be as a cry for help or to bring about a desired result, in a relationship or in the external world.

Friedrich Nietzsche, in *Beyond Good and Evil*, said, "The thought of suicide is a great consolation: by means of it one gets successfully through many a bad night." For some very disturbed patients, the freedom to terminate one's own life is a fundamental solace. It is conservatively estimated that 30,000 people kill themselves each year. In fact, the actual figure is likely much higher. The World Health Organization estimates that nearly a million people around the globe take their lives each year, The same organization also estimates that 10 to 20 million people attempt suicide each year. Almost everyone has thought of suicide at one time or another, usually when seriously depressed or during a difficult personal crisis. Although there is quite a spectrum of intent among those who have contemplated suicide, often only a fine

line exists between those who think about suicide and those who actually commit it.

In my clinical experience, patients may be suicidal for just seconds, minutes, or hours. Other patients have been seriously suicidal for days, weeks, months, years, or much of their lives. Sometimes a quirk of fate makes the only difference in whether a person survives a suicide attempt. One of my patients, prior to coming to me for treatment, survived a massive overdose of pills that she took as she lay in a bathtub full of water. It was in the middle of winter. The water rapidly cooled as she lost consciousness, lowering her metabolism enough so that she survived until the next day, when she was discovered by her housekeeper. Having attempted suicide once and failed, she never again had the urge to harm herself. However, of those who do commit suicide, anywhere from 9% to 33% have made previous attempts. It is estimated that 8 to 25 suicide attempts occur for every completed suicide. Between 7% and 12% of patients who make suicide attempts commit suicide within 10 years, which means that attempted suicide is a significant risk factor for suicide.

In the United States, the statistics on suicide provide some hard facts. The rate of suicide in the general population in 2005 was 11 per 100,000 people per year. The rate has remained steady for many years. For persons with schizophrenia, mood disorders, or those who abuse alcohol or drugs, the rate soars to 180 per 100,000. In one study, the leading methods of suicide were

- Firearms, 60% (males 65%, females 40%)
- Hanging, 14% (males 15%, females 12%)
- Gaseous poisons, 10% (males 8%, females 11%)
- Solid/liquid poisons, 9% (males 6%, females 27%)
- All other methods, 7% (males 6%, females 10%)

The family and friends of suicide victims are at increased risk of suicide themselves. They are also more vulnerable to physical and psychological disorders. Suicide intent is frequently an issue in criminal cases in which it must be determined if the victim was murdered or committed suicide. In civil litigation, determination of intent is necessary to recover death benefits under insurance policies, in legal actions involving workers' compensation benefits, in malpractice claims, and when suicide is alleged to be the result of injurious actions by third parties. The most insidious tangle is in regard to insurance benefits.

Insurance companies that suspect suicide may invoke a policy's exclusionary clause to deny responsibility to pay benefits, whereas the deceased individual's estate may contend that the death was accidental and not suicide. Stakes regarding suicide intent can be as large as the $36 million riding on the cause of Robert Maxwell's death.

Why Naked Suicide?

Legend has it that when Cleopatra committed suicide by allowing the bite of an asp, she was naked. A famous painting of Cleopatra's death reveals an obvious erotic theme. Both Marilyn Monroe and Robert Maxwell were naked when discovered dead, she in her bed, he floating in the ocean. There is little mystery about Monroe's naked state, since she was known to sleep in the nude. Why Maxwell was naked when he died is a mystery, and the authorities seemed to take little note of it in their autopsy. They should have. As an expert witness in a number of suicide cases in litigation, I found that in approximately 5% of my cases, the individual committed suicide naked. Even so, attorneys and other experts in most of the cases showed little interest in the fact of the suicide's nakedness. Only in one case did it make a difference; the attorneys for the defense in a suicide malpractice case postulated that the patient was found hanging naked as the result of an autoerotic asphyxia gone wrong. The case was settled.

Most naked suicides are fraught with psychological meaning, if that meaning can be divined. The professional literature has little data on the topic. Most information is anecdotal, coming from individuals who have attempted suicide naked, but survived. The reasons given reflect highly individual psychodynamics in each instance. I have asked a number of experienced psychiatrists for their interpretation of naked suicide. Many spontaneously recited Job 1:21: "Naked came I out of my mother's womb, and naked shall I return." Other psychiatrists postulated that naked suicide symbolizes a new beginning, a rebirth and cleansing or a sloughing off of an intolerable world. Naked suicide challenges the forensic psychiatrist's sleuthing abilities.

Mysterious Deaths: The Psychological Autopsy

The psychological autopsy originated in 1958, from the Los Angeles Suicide Prevention Center, to assist the Los Angeles County Medical Examiner's Office in distinguishing drug overdoses from suicides. The

basic principles for performing the psychological autopsy were established, as was its goal: the psychological autopsy is a procedure that assists in the classification of equivocal deaths, where the manner of death is unclear. A lack of standardization of the psychological autopsy procedures is a significant limitation on the practice, raising admissibility issues in criminal and civil cases.

Forensic psychiatrists are experts who understand the pertinent legal issues as they apply to psychiatric cases before the court. They translate psychiatric principles into the language of intent as it is defined by the legal system. Forensic psychiatry is a recognized subspecialty of psychiatry, and specialists can earn board certification. Years ago, forensic psychiatrists were known primarily for their work with criminals. Today, they also consult on a wide variety of administrative, legislative, and civil law matters, some of them involving suicide.

The forensic psychiatrist is frequently called upon in insurance litigation to evaluate suicide intent, sometimes by the plaintiff—the estate that is bringing the suit—and sometimes by the defendant—the insurance company. Although, as Oliver Wendell Holmes once observed, "Even a dog knows the difference between being tripped over and being kicked," the forensic psychiatrist's job in establishing suicide intent can be a complex, daunting task. The basic problem comes from the fact that psychiatry and law have views that differ in trying to understand the conundrum of suicide intent. Psychiatric theories of behavior tend to be deterministic; that is, they say that the individual contends with psychological forces that are often beyond his or her control. On the other hand, legal theories are based on the belief that humans have free will—that they are not deterministic. In evaluating suicide intent, therefore, the forensic psychiatrist must keep both understandings in mind, adapt psychiatric principles to the legal framework, and perform what is, in essence, a psychological autopsy.

The *intentional injury exclusion* of insurance policies is designed to prevent enrichment for immoral or illegal acts that have been performed by a *competent* individual. Competency itself is vague and complicated. When is someone competent, and when not? It is necessary in individual suicide cases to determine whether the victim intended to end his or her life. Approximately 90% to 95% of all those who commit suicide are suffering from a mental disorder. In a given case, did the individual understand that the self-destructive act would end his or her physical existence or was he or she not able to understand that?

One factor affecting the legal definition of *intent* is the presumption against suicide that is maintained in many jurisdictions. This presumption is a legal restatement of the common belief that the instinct for self-preservation in a rational person renders suicide improbable. This, of course, is not always true. So-called rational suicides occur, for example, among individuals who have terminal illnesses.

In elderly persons or persons suffering from chronic or terminal illnesses, deciding when a contemplated suicide is rational can be a very tricky business. I have been asked to assess elderly persons who were refusing food, water, and essential medications. In a number of instances, the elderly person's caretaker assumed that the patient had decided that he or she has lived long enough and has made a rational decision to die. Yet a majority of these persons were depressed and, in reality, were committing silent suicide. Their response to antidepressant medications was often rapid and gratifying.

Evidence of intent is generally derived from two basic sources. The first is from the persons who knew the individual's behavior and desires for some time prior to the moment of death—such as family members, friends, neighbors, coworkers, and treating physicians. The second source is forensic, and is provided by experts and based on the development of all relevant information about the individual at or around the time of death. In an insurance claim contest, this latter information will be given by forensic psychiatrists, who attempt to determine the *most likely* psychological reason or cause for the insured person's death.

In doing our forensic psychiatric work in an equivocal suicide case, we attempt to reach a detailed understanding of the deceased person's life because the way a person lived has a bearing on how and why he or she died. The key to the establishment of intent, then, depends on the establishment of motive. What could have been the reasons for wanting to die, that is, to have an intent to commit suicide? A terminally ill patient who refuses further medical treatment may seem to be, but is not necessarily, committing suicide. He or she may not intend to die, but rather, to live free of useless, burdensome, or painful medical treatments. Especially in regard to the elderly and chronically ill, the forensic psychiatrist must distinguish between suicide and the desire not to prolong the process of dying. Suicide notes may establish a motive, but such notes are found in only about one-third of all cases.

To reconstruct the psychological life of an individual who is suspected of having committed suicide is to perform a psychological

autopsy. In systemic risk assessment, forensic psychiatrists thoroughly examine the person's lifestyle, circumstances, and the feelings, thoughts, and behaviors that existed during the days and weeks prior to death. This permits a better understanding of the psychological events of those last weeks and the circumstances that might have contributed to the death, considering both suicide risk and protective factors. Table 9–1 is a conceptual model of suicide risk assessment used in assessing suicidal patients and in determining whether a person committed suicide or died of other causes. Other models of suicide risk assessment are available, but none have been tested for reliability and validity.

In a psychological autopsy, what we look for are ways to evaluate the ability of the deceased to *conceive*, *plan*, and *execute* suicide, and to evaluate that within the legal concept of *intent*. A failure in any one of these three basic phases of mental functioning may indicate that the deceased lacked the mental capacity to intend suicide. However, the presence of ability to conceive, plan, and execute suicide does not necessarily ensure that the deceased had sufficient mental capacity to intend suicide. For example, one could conceive and plan violent acts with the greatest diligence and execute them with remarkable elegance, and still be mentally deranged by delusions and thereby be considered as lacking the mental capacity to fully intend a violent act. In some jurisdictions, the presence in the deceased of serious mental illness may negate any finding of intent. In other jurisdictions, even if the person has been totally psychotic, he or she can still be determined to have had suicide intent. If the psychotic individual did not understand what he or she was doing, would that mean intent was absent? For example, was there intent to die if a person on LSD was convinced that he or she could fly off a building and not be harmed? In that instance, I would conclude that the intent was not to commit suicide.

Complex and nuanced medical-psychiatric issues are often present in determining intent to commit suicide. The psychiatrist who only treats patients, or who seldom thinks along the lines necessary for forensic evaluation, has a tendency to overidentify with the family of the bereaved and give a judgment that favors the family over the insurer. Forensic psychiatrists, trained in clearly separating the treatment component from the role of evaluator, are more able to minimize or to avoid emotionally biased conclusions in litigation.

It is important to evaluate the person's state of mind in relation to the legal question at hand, for example, to evaluate intent to commit

TABLE 9–1. Systematic suicide risk assessment: a conceptual model

Assessment factors[a]	Risk	Protective
Individual		
Distinctive clinical features (prodrome)		
Religious beliefs		
Reasons for living		
Clinical		
Current attempt (lethality)		
Therapeutic alliance		
Treatment adherence		
Treatment benefit		
Suicidal ideation		
Suicidal intent		
Suicide plan		
Hopelessness		
Prior attempts (lethality)		
Panic attacks		
Psychic anxiety		
Loss of pleasure and interest		
Alcohol/drug abuse		
Depressive turmoil (mixed states)		
Diminished concentration		
Global insomnia		
Psychiatric diagnoses (Axis I and Axis II)		
Symptom severity		
Comorbidity		
Recent discharge from psychiatric hospital		
Impulsivity		
Agitation (akathisia)		
Physical illness		
Family history of mental illness (suicide)		
Childhood sexual/physical abuse		
Mental competency		

(continued)

TABLE 9–1. Systematic suicide risk assessment: a conceptual model *(continued)*

Assessment factors[a]	Risk	Protective
Interpersonal relations		
Work or school		
Family		
Spouse or partner		
Children		
Situational		
Living circumstances		
Employment or school status		
Financial status		
Availability of guns		
Managed care setting		
Demographic		
Age		
Gender		
Marital status		
Race		
Overall risk ratings[b]		

[a]Rate risk and protective factors present as low (L), moderate (M), high (H), nonfactor (0), or range (e.g., L–M, M–H).
[b]Judge overall suicide risk as low, moderate, high, or a range of risk.

Source. Adapted from Simon and Hales 2006. Used with permission.

suicide as defined in the insurance policy signed by the deceased and by the laws of the jurisdiction. The legal context evaluates *motive*, *intent*, and *act* in regard to a particular happening. In clinical psychiatric contexts, it is *conception*, *planning*, and *execution* that must be assessed, and the two sets of notions are only roughly similar. Here, as in other clinical-legal contexts, an imperfect fit exists between psychiatry and the law.

Conception (Motive)

How, when, and why the idea of attempting or completing suicide arises in a person must be critically analyzed, especially in a court case.

Was it a sudden and impulsive act, or was it planned in considerable detail? Was the suicide committed in a fit of rage or during a bout of drunkenness? Was the suicide the outgrowth of depression or schizophrenia? Can one find evidence of a plan to commit suicide, say, in the fact that an individual was mired in financial problems and might hope by death to provide for his or her family through insurance death benefits? Consider the following case:

> A 57-year-old chairman of the board of a once successful manufacturing company, which he had built up through years of hard work, is facing difficult choices. Business reverses and intense competition have brought on a crisis. Banks are demanding payments on loans that are overdue and are refusing to refinance those loans. The chairman sinks his personal fortune into the company in the fight to keep it afloat. He takes a substantial cut in his own salary. His wife of 28 years is worried, because in all that time, she has never seen him so upset. He seems "panicked" about their personal finances.
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> The couple's three children are in college, and he wants to keep them there. He himself never had the benefit of a college education. He cannot bear the thought that if the financial situation continues to worsen, he might not be able to pay the balance of their tuitions. He hints to his wife and friends that he has a plan to improve his financial situation. At work, he seems to function without difficulty. He does not seek out a mental health professional, nor does he seem to coworkers to be depressed.
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> One morning, the chairman works until 11 A.M. and then departs in his car for a meeting in another part of town. The weather is clear. En route to that meeting, and traveling at 80 miles per hour, his car strikes a bridge abutment. He dies instantly in the crash.
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> Police examination of the scene reveals no skid marks from his car. No other vehicles were involved in the crash. It could not be established that there were any pre-crash mechanical problems with his car. An autopsy finds equivocal evidence that he had had an acute heart attack. No suicide note is found. The death certificate states that the cause of death is natural. The workers' compensation insurance carrier, however, conducts its own investigation and concludes that the death was a suicide. It refuses to pay out on his policy.
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> The forensic psychiatrist retained by the family of the deceased, and charged with the task of performing a psychological autopsy, does not automatically accept the death certificate finding, nor does she reject it. Death certificates frequently do not address the matter of suicidal intent or lack of it. The death certificate is a document whose purpose is to provide vital statistical data. It is not based on the totality of evidence that may later become available. The forensic psychiatrist

cannot simply accept the postmortem finding of a possible heart attack either, because it is not in keeping with the weight of the other evidence. For instance, it was discovered that shortly before his death, the deceased had put all of his affairs in order.

The forensic psychiatrist's examination of the chairman's life reveals a man who was very disciplined and who rarely acted impulsively. He led a quiet life, had conservative habits and tastes. No history of alcohol abuse, drug abuse, or gambling was present. Family, financial stability, and occupational success and gratification are no longer protective factors against suicide.

The workers' compensation law in the deceased's state reads that the insurer could refuse to pay compensation "if the injury or death resulted from the person's intent to injure or kill himself." The forensic psychiatrist concludes that despite the absence of evidence of a mental disorder such as depression or psychosis, the preponderance of the available evidence (more likely than not) showed that the chairman had intended to kill himself, in a suicide staged as an accident, to provide financially for his family. The chairman's *conception* or *motive* for killing himself was likely the result of his declining financial status and the perception that further decline would produce dire consequences for his family. His *plan* was to cause his death through a staged accident and thereby enable his family to cash in on his large insurance policy. *Execution* of the plan of suicide was carried out by crashing the car into the bridge. The three conditions required to find intent to suicide were thus met. The forensic psychiatrist presented her findings to the family. They discharged her and decided to seek another expert opinion.

In the matter of conception or motive, there are suicides that are not motivated or not intended. Some people who suffer from brain disorders may be considered unable to conceive or to have a motive for suicide, but they occasionally randomly or impulsively kill themselves—or others. Trauma to the head or drug and alcohol intoxication can cause acute brain dysfunction accompanied by the unleashing of violence. The resulting acts, even when directed against the impaired person, may not meet the legal criteria for intent to commit suicide, in part because it is so obvious that the other two conditions, planning and execution, have not been met.

Certain "suicides" are also just as clearly not intended, although they involve no physical brain disorder. For example, a person may plan a suicide gesture. The motivation may show the intent is only a cry for help or the desire to manipulate a situation or another person, but, through miscalculation, the suicide gesture may result in death.

Miscalculations also occur in other kinds of death that initially may appear to be suicides, such as in autoerotic asphyxia. This is an attempt by young men to enhance sexual pleasure by decreasing the flow of oxygen to the brain. If miscalculated, it can result in death by hanging, even though the real motive was only to produce a heightened sexual experience while masturbating.

Planning (Intent)

One can conceive the idea of suicide but fail in the intent or planning of it. Persons driven by impulse, by psychosis that produces a break with reality, or by intoxicants may have lost the ability to plan a violent act, even though they have thought about it for some time. The event may still happen, however, even if it is not actually planned. Intoxicants may destabilize the person and prematurely precipitate a violent act. For example, consider this case:

> A 33-year-old minor league baseball player harbors a grudge against a former major league coach. The player has often been heard by other players to threaten physical harm to that coach, who he feels has thwarted the player's major league career. One evening, while intoxicated with alcohol and cocaine, he takes a baseball bat and bludgeons to death a different person, the coach of an opposing minor league team, and then fatally shoots himself.
>
> Citing the intentional-injury clause of the player's team liability insurance, the carrier disallows payment to the deceased coach's family. Litigation follows. The forensic psychiatrist conducts interviews with players from both teams, which reveal that the murdered coach was liked and admired by the player who killed him. Postmortem blood analysis of the player reveals the presence of cocaine and a blood alcohol level of 0.23 (intoxicated).
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> In this case, forensic psychiatric analysis reached the conclusion that the player's toxic mental state, brought on by cocaine and alcohol, had caused the release of a violent act against an unintended victim. This indicated the inability to plan. The murder-suicide, then, was unintended; it was, instead, an impulsive act.

Another case illustrates a different cause for failure of intent:

> A 28-year-old depressed, devoutly religious woman, a week after the birth of her first child, awakes to intense command auditory hallucinations. She writes a note to her husband: "God commanded me this morning to bring myself and the baby to Him immediately. God said

> we will not die but live forever. I must obey God. I know you will understand." Leaving the note for her husband, she gathers their child in her arms and jumps from the 18th-story apartment.

Forensic psychiatric examination reveals that the woman had a stable personality prior to the birth of the child, but that a severe psychotic depression emerged after childbirth. The suicide note clearly indicates an acute postpartum psychosis. Having a newborn child was not a protective factor against suicide in this instance, as it is in many others. The psychiatrist reports to the court that in this instance, the planning phase of suicide was nonexistent because the woman heard the auditory hallucinations that compelled her to act immediately. Such command hallucinations can be extremely powerful psychotic symptoms that can force action in the here and now. Another factor that affects the psychiatrist's understanding of the case is that women who intend suicide often do not use a method of suicide that will leave them disfigured. They choose a method that does not involve smashing themselves on the ground. This testimony is challenged by the opposing expert as not having any scientific merit. The court rules that the deceased did not intend suicide because when she jumped, she did not want or expect to die.

Execution (Act)

An individual may be able to conceive and to plan a violent act, but the way in which the violence is manifested may indicate impairment of the individual's capacity to execute. Unintentional death, bizarre actions, and the inability to delay or to control behavior are strong indicators of the presence of severe psychiatric disorder. Consider the following case:

> A divorced rancher squanders his inheritance, runs into financial difficulties, and is in danger of losing his ranch. His older brother, by contrast, has invested his portion of the inheritance wisely and has accumulated considerable wealth. The two have had a falling out. The wealthy brother refuses to lend money to the rancher brother. The rancher conceives the idea of killing the brother's beloved wife and then shooting himself. This is no idle fantasy, for the rancher has been in frequent fights throughout his life and has a reputation for violence.
>
> The rancher waits until the brother is out of town on business and sets out to do the deed. He drinks three martinis before he goes. He

also leaves a note detailing his intentions. The note contains rambling comments about past grievances against the brother but also mentions "the good times" with him. The rancher hopes that he will change his mind about killing the sister-in-law before he arrives at her home. On his way to kill his sister-in-law, the rancher is involved in a minor automobile accident. An altercation develops. The rancher shoots and kills the other driver, and then kills himself.

The estate of the slain driver brings a claim against the rancher's excess liability insurance policy. This policy contains an exclusionary provision, which denies coverage for bodily injury or property damage "intentionally" caused by, or at the direction of, the insured.

The forensic psychiatrist interviews friends, acquaintances, and employees of the deceased rancher. He also culls the available records. The rancher's history of intense envy and ambivalent feelings toward his brother are revealed, as are his spendthrift and impulsive-spending ways. School, military, and police records demonstrate years of alcohol intoxication and fights. His blood-alcohol content at the time of death was 0.15 (intoxicated). Few, if any, protective factors against suicide existed, especially abstinence from alcohol.

The psychiatrist concludes that the rancher had the mental capacity to conceive and plan a violent act but lacked the capacity to execute the plan in the way that he had intended. As the rancher drove to his sister-in-law's house, the psychiatrist testified, his envy and rage were so great that the minor accident and altercation in which he was involved, combined with the alcohol that he had ingested, ignited the violence prematurely toward an unintended victim and himself.

The court decides to apply a narrow view of intent and makes a determination that the murder-suicide was the result of the altercation that came out of the accident. The court ruled that the rancher had known that he was firing a gun at the other driver and had wished to bring about a fatal result. The ambivalent feelings expressed in the note, the court opined, meant that the deceased might have changed his mind about his original target. The court's decision, therefore, was to uphold the injury exclusion clause of the policy and to deny payment to the family of the deceased driver of the second car.

Is Every Suicide a Murder?

As the various cases in this chapter make clear, the forensic psychiatrist's role in the retrospective assessment of lethal acts is a difficult and arduous task. It is also one in which the psychiatrist's judgment is not the final word. The law is pragmatic. It only requires testimony of "reasonable medical certainty," but reaching any sort of certainty is often hard to do. The evidence is often conflicting, and it is up to the

court to decide what weight to give to each part of it. Moreover, the legal determination of whether a suicide occurred may depend heavily on criteria of intent applied by the courts. Ultimately, psychological interpretation of the web of facts and fantasy surrounding a mysterious death is an art based on a science, and art is a subjective undertaking. It is left to the courts to make the legal determination of suicide, accident, or murder.

In the world of the psychiatrist, distinctions are not and cannot be clear-cut. Violent rage reactions can change direction in a second. A person's murderous rage that erupts against someone else may, at the very last moment, be turned upon himself. Conversely, at the last second, a person who intends suicide may turn murderous rage outward and kill someone else. Or both things may happen: after committing a murder, and as part of the same violent act, the murderer may turn the same murderous impulse against himself or herself.

Many years ago, Karl Menninger, the famous American psychoanalyst, observed that almost every suicide is a murder. The recognition that murderous rage can go either way—directed outward or inward—is critically important in assessing the last mental stage in suicide and in murder. Suicide is often attempted or completed among a welter of unclear, confusing, and ambivalent feelings. In fact, only one thing about suicide is clear: the intent to kill oneself is hardly ever absolute.