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The Psychiatrist's Role in Retrospective Determination of Suicide: An Uncertain Science

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ABSTRACT: Psychiatrists have made significant contributions to our understanding of the phenomenon of suicide and are generally regarded as experts in all matters relating to suicide. When a legal determination must be made as to whether an individual has died as a result of suicide or by accidental (or any other) means, psychiatrists are often called upon to proffer their expert opinion to assist the courts to resolve the matter. Two case illustrations are presented and analyzed in which psychiatrists were called upon to make such retrospective determinations of suicide. The question is raised as to whether psychiatrists may sometimes exceed the limits of their scientific expertise in making such determinations.

KEYWORDS: psychiatry, jurisprudence, suicide

Psychiatrists have made an important contribution to our understanding of the psychodynamics, psychopathology, and epidemiology of suicide [*1-3*]. In view of the fact that the number of deaths resulting from suicide, especially among the young, has escalated in recent years, perhaps the most important role for the psychiatrist in this area involves determining the degree of suicide risk in individual patients and improving the effectiveness of suicide prevention methods [*4,5*].

Although generally suicide is no longer a crime in most jurisdictions (except that one who aids another to commit suicide may be criminally liable [*6*]), there are a number of situations in which the act of suicide or threatened suicide comes to be involved with the legal process. In such situations, psychiatric expertise is often enlisted. These would include the civil commitment of the suicidal patient [*7*], the problem of murder disguised as suicide and the associated evidentiary problems [*8*], psychiatric malpractice claims [*9*], and life insurance cases involving suicide of the insured [*10*].

Sometimes there are perplexing difficulties in determining whether in fact a suicide has actually taken place. Whenever a person is found dead under such circumstances that either accident or suicide could be the cause of death, the presumption is against suicide [*11*]. Where the fact of death is established, and the evidence points equally or indifferently to accident or suicide as the cause of it, the theory of accident rather than of suicide is to be adopted [*11*].

When a legal determination must be made as to whether or not an individual has committed suicide, psychiatrists may be called upon to evaluate the relevant data and proffer an

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opinion to assist the trier of fact. Because psychiatrists are assumed to be experts on suicide, especially in the area of performing clinical evaluations of suicidal patients, it is generally accepted that they possess the requisite expertise to make such retrospective determinations of suicide.[2]

Following are two case reports in which psychiatrists were called to testify in civil lawsuits which presented a fair question of fact as to accident or suicide. The first case involved a malpractice claim against the decedent's treating psychiatrist for negligently failing to detect and prevent his patient's alleged suicide; the second case involved a life insurance company's claim that the insured had committed suicide (within the first two years of the policy's issuance), thereby releasing it from any obligation to pay out benefits under the terms of the policy.[3]

Case 1

A 55-year-old man had a 10-year history of chronic depression following a myocardial infarction. He was hospitalized briefly at the onset of his depression and thereafter received outpatient treatment over a 10-year period. During that time, his treatment consisted of psychotherapy and tricyclic antidepressants. Although his depression was refractory to treatment, it was relatively low grade and stable and he continued to work and function socially, albeit with some degree of anhedonia.

His wife, upon viewing a television show about the "miraculous cures" for depression achieved with electroshock therapy, urged that he terminate his regular psychiatric treatment and seek out an electroconvulsive (electroshock) therapy (ECT) specialist. He secured a consultation with a psychiatrist specializing in the administration of ECT and was assured that it would make him feel like "a new man" in short order. *It should be emphasized that at no time, even during the worst phase of his depression during his one and only hospitalization, had he ever been suicidal. He had never expressed suicidal ideation or made a suicidal gesture.*[4] At no point had he been delusional or exhibited other psychotic symptomatology.

After a course of seven ECT treatments administered in a psychiatric hospital setting, his depression cleared up completely and within a few weeks he was discharged from the hospital and returned to work. Over the next few months, he did not see the psychiatrist again, but did telephone him once or twice a week to complain about persistent mild memory loss. The psychiatrist told him that it was not necessary to see him. He explained that the memory problem was a typical residual side effect of ECT and was temporary in nature. The psychiatrist encouraged him to continue working and reassured him that, within a few weeks or months at most, the memory problem would clear up. This patient never expressed any suicidal ideation, delusions, or feelings of hopelessness to the psychiatrist, his wife, or anyone else.

One night, the patient and his wife watched the movie "A Star is Born" on television. At the end of the movie, James Mason, playing a movie star who feels that he is "washed up," commits suicide by walking into the ocean and drowning himself. He supposedly does so to cease being a burden upon his wife in the movie, played by Judy Garland. After watching the

[2]For example, in California, Schneidman and his colleagues at the Los Angeles Suicide Prevention Center devised a method known as the "psychological autopsy." A death investigation team endeavors to reconstruct the victim's life circumstances, medical history, state of mind preceding his demise, previous suicide attempts, and substance abuse, among other factors. This method is sometimes used to supplement the routine police investigation and medical postmortem, when a case is provisionally classified as "accident-suicide undetermined" [*12,3*].

[3]Most life insurance policies contain a provision to the effect that the company will not be liable in the event of suicide occurring within two years from the date of issuance of the policy [*10*].

[4]ECT may be the indicated treatment for a depression refractory to antidepressants, even where suicidal risk is absent. The absence of a history of suicidal ideation or attempts does support the contention of the defense expert, that is, thereby one of the important predictive indices for suicidal risk is lacking.

movie, the patient expressed no suicidal ideation nor made any comments that would have indicated that he took the movie personally in any way. The next morning, he left for work, but never arrived at his job. Ten days later, his body washed up near Coney Island Beach; he was dead from drowning. The New York City Medical Examiner classifies all deaths in one of four categories: natural causes, accident, homicide, or suicide. Based on the patient's past history of depression (albeit never suicidal in nature), his death was classified as a suicide. Note that the patient had a history of cardiac disease, that he had a cardiac pacemaker, and that, when the body was discovered, both his wallet and watch were missing. There had been no suicide note.[5]

The plaintiff (the decedent's wife) brought a malpractice lawsuit against the psychiatrist, claiming that he had negligently failed to prevent the suicide. The contention was that the psychiatrist should have taken the patient's complaints about his persistent memory loss more seriously, should have responded by seeing the patient in his office face-to-face and monitored him more closely. Had he done so, it was argued, he would have been able to detect the risk of suicide and prevent it from happening. The psychiatric expert who testified at trial for the plaintiff opined that the death was definitely the result of suicide. He stated that viewing the movie had exacerbated the patient's own feelings of despair, and, in a pathological identification with the James Mason character, he had set out the next day to drown himself. He stated that had his psychiatrist been seeing him on a regular basis, his suicidal tendencies would have been readily observed and checked.

A psychiatrist retained by the defendant psychiatrist testified that, in his opinion, it was unlikely that death had resulted from suicide. After evaluating all of the patient's psychiatric records dating back ten years, he concluded that there was no indication that the patient fit the typical profile of a suicide. He enumerated various parameters used to assess a high risk for suicide, for example, history of previous attempts, psychosis, being single, living alone, occupational status, history of depression or suicide in the family, related physical health problems, age, alcoholism, and so forth. He found that the patient possessed few of the specific risk factors associated with a high risk for suicide. (He was a male over fifty years of age with a history of depression; aside from that, he lacked any history of prior attempts or of any suicidal ideation, had never been psychotic, was married and lived with his wife, was gainfully employed, was in good health, and was not a heavy drinker.) Most of the characteristics that are held to be indicia of a high suicide risk were absent in this patient. Furthermore, the expert testified that there were a number of signs pointing to a good recovery after the ECT: a remission of depressive symptomatology, a return to work, and a complete absence of any suicidal ideation. He concluded that it seemed unlikely to him that death had resulted from suicide. He viewed the temporal relationship between the patient's watching the movie and his own death by drowning as a mere coincidence, albeit a highly dramatic one. The patient's heart disease and the missing wallet and watch led him to speculate that the cause of death might have been due to an accident (the patient wanted to walk near the water after watching the movie, had a cardiac arrhythmia, and fell into the water and drowned) or even a homicide (during a robbery, the patient suffered a cardiac arrhythmia, fell into the water and drowned). He further testified that, even if one were to assume that the death had resulted from suicide, the risk of suicide had not been reasonably foreseeable under the circumstances, and therefore the defendant psychiatrist had not been negligent in his management of the case. The jury disagreed and awarded the plaintiff $600 000.00 in damages. The case is currently on appeal.

Case 2

A 50-year-old divorced woman art gallery owner had a history of chronic anxiety, hypochondriasis, and unstable interpersonal relationships. For a brief period of time, she had

[5]No suicide note is left in 85% of cases.

received supportive psychotherapy. She frequently consulted various specialists about vague and nonspecific physical complaints. She constantly worried about cancer and feared that her doctors were failing to arrive at an accurate diagnosis or were keeping something from her. These concerns and fears would come to the fore at times of emotional stress and then recede. One psychiatrist had diagnosed her as a borderline personality disorder.

At times, she abused prescribed minor tranquillizers and sleeping medications. At no time had she been diagnosed as suffering from an affective disorder or from schizophrenia. She had no history of suicidal ideation or gestures.

After the death of a close male friend (who died of cancer), she became intensely worried about her own health. She entered a hospital for a series of gastrointestinal diagnostic tests, convinced that she had cancer of the colon. A few days after discharge from the hospital, she was found dead in her apartment. She had consumed a fatal overdose of barbiturates and was found lying in a full bathtub, wearing her nightgown and robe.

A note was found which read in relevant part as follows:

> Darling,
> Live. Go to law school, Harvard or wherever. Live in Cambridge. It is a beautiful appropriate setting and you may well build a life that is good there . . . My body is failing me. My spirit and love are a part of you and you will have these always . . . I love you. No tears. No remorse. No looking back. I am with you always.
> [signed] Mommy

A life insurance policy named the daughter as sole beneficiary. The insurer refused to pay under the terms of the policy, which relieved the insurer of any liability if the insured committed suicide within the first two years of the policy. The daughter commenced a lawsuit to recover for her mother's death, claiming that her mother's death had resulted from an accident and not from suicide.

There is a legal presumption against suicide [*11*]. The effect of such a presumption is to place the burden of proof upon the one interposing the defense of suicide (that is, the insurance company) to establish the fact of suicide by a preponderance of the evidence (that is, to prove that it is more likely than not that death resulted from suicide) [*11*].

In this case, the psychiatric expert retained by the defendant insurance company testified that in his opinion the deceased had been depressed and despondent, had taken an overdose of barbiturates (confirmed to be the cause of death by autopsy), and had left a note which was unequivocably a suicide note. He enumerated a number of indicia of a high suicide risk that were present in her case, for example, her depression, her age, her poor health (such as she believed it to be), her living alone and her divorced status, her history of substance abuse, and so on.

A psychiatric expert retained by the plaintiff (the daughter of the deceased) maintained that there was doubt as to the fact that a suicide had actually caused death. He enumerated a number of predictors of suicide that were lacking in this case, for example, a lack of any prior diagnosis of affective disorder or schizophrenia, no history of prior suicidal ideation or gestures, no family history of affective disorders or suicide, her occupational status, her attachment to her daughter, and so on. He testified that he could not make a definite diagnosis of suicide because there was substantial doubt in his mind that it was intentional in nature. In view of her history, he speculated that the alleged suicide note may well have been a "farewell" message to her daughter in the event that she died of cancer (she erroneously believed that she had cancer and might die at any time).

As to the actual cause of death, the psychiatric expert referred to the phenomenon of "drug automatism" as a cause of pseudosuicide [*13*]. Drug automatism, or serial consumption of hypnotic drugs, refers to a mechanism that may account for some incidents erroneously identified as suicides [*14*]. This mechanism has been described as follows: the individual has been under great stress and takes a capsule or two to get to sleep. In his overwrought

state, the medication has little effect. He becomes too restless to wait for the desired effect and takes a few more capsules, gradually entering a semi-confusional state. He is no longer able to act purposively and may go so far as to consume the entire bottle. Such an unintentional serial consumption of a hypnotic medication leading to a fatal intoxication would be better classified as an accidental overdose or a pseudosuicide rather than as an intentional act of suicide.

The jury returned a verdict in favor of the plaintiff in the amount of $100 000.00, the full amount of the life insurance policy. This verdict was set aside on appeal and a new trial was ordered. At the second trial, the jury again returned a verdict for the plaintiff, which is again being appealed.

Discussion

Suicidology as a scientific endeavor is of relatively recent origin. Durkheim's classic *Suicide: A Study in Sociology* [*15*] was published in 1897, Freud's *Mourning and Melancholia* [*16*] in 1917. Psychiatrists, along with psychologists, social scientists, and others, have made substantial contributions to our understanding of suicide and our efforts to deal with it within a rational therapeutic framework [*2,17,18*]. From a legal standpoint, it is sometimes critically important to make an unequivocal determination that suicide was or was not the actual cause of death. Sometimes, psychiatrists may be called upon to evaluate the available clinical and historical data to testify as to whether, in their opinion, death resulted from suicide. Such retrospective determinations of suicide are but a further example of the everexpanding role of the forensic psychiatrist, involving matters that seem rather arcane and far removed from the consulting room and the couch [*19,20*].

Some have questioned whether the actual expertise of forensic psychiatrists has kept pace with the increasing demands on them imposed by the legal system [*21,22*]. As a profession, we have become more concerned about the ethical and scientific limits of psychiatric knowledge and expertise [*23,24*]. Can psychiatrists make a meaningful contribution to the scientific detection of suicide? Proponents of such a role believe that psychiatrists and other mental health professionals have more expertise than anyone else in regard to suicide and are best equipped to assist the courts when such a question requires final resolution. Others are less sanguine that psychiatrists can provide much in the way of scientific clarity when they depart from their traditional role. Stone contends that "[t]he hubris in psychiatry has come from passing it off as scientific certainty or claiming that we know things beyond a reasonable doubt" [*24*, p. 66]. By exceeding the limits of scientific expertise and adopting a partisan role in the adversary system, he contends that psychiatrists attempt to put forward the best possible case for their side at the expense of scientific candor. In the two case illustrations presented here, there is some evidence that the psychiatric testimony may indeed have been unduly biased and speculative, falling short of acceptable standards of scientific reliability. For example, in the first case, both the plaintiff's expert and the defendant's expert appear to have slanted their conclusions in the direction of what Stone has called the "partisan truth" [*24*, p. 72]. The plaintiff's expert stated that had the treating psychiatrist been seeing the patient on a regular basis, his suicidal tendencies would have been readily observed and checked, that is, that the psychiatrist thereby would have been able to detect the risk of suicide and prevent it from happening. Such a conclusion is at best speculative. The defendant's psychiatrist concluded that there was *no indication* that the patient fit the typical profile of a suicide. A more candid conclusion would have been that although the patient fit the suicide profile poorly, nonetheless because he was over 50 and had a history of depression, the possibility of suicide was not all that remote, merely not easily predictable.

In the second case, the psychiatric expert retained by the plaintiff failed to note that many suicidologists reject the concept of drug automatism to the extent that a fatal dose is con-

sumed [25]. Furthermore, he did not give sufficient weight to the number of indicia of a high suicide risk that were present, including a diagnosis of borderline personality disorder (a condition in which impulsive suicide gestures occur not infrequently). Furthermore, it seems rather farfetched, under the circumstances, to have maintained that the note was a *farewell* message, rather than a suicide note. The history and the timing were in keeping with a suicide, whether or not it was considered imminent at the time. (This case, where juries twice found for the plaintiff, appears to support the proposition that often a jury's decision fails to comport with "scientific truth" at all, but rather may be based on other diverse considerations, such as the credibility of the expert witnesses, the consistency of the expert testimony with the jurors' personal view of the world, or, last but not least, lawyer theatrics [26].)

Conclusion

I have discussed the role of the psychiatrist in making retrospective determinations of suicide within a forensic science context and presented two case illustrations. In these cases, the role of the psychiatrist appears to be part detective, part clinician, part actuary, part Sherlock Holmes, and part advocate. As I emphasized in an earlier article:

> [j]ust as Freud cautioned against "wild analysis" as a reckless and blind misuse of psychoanalysis, so must the forensic psychiatrist avoid introducing any testimony based on incomplete, inadequate, or questionable methods of clinical evaluation in order to aid the legal process in reaching more informed and intelligent decisions [19, p. 1240].

Although the law requires a final determination as to whether or not a suicide actually took place in such cases, the question is raised as to whether psychiatrists may sometimes exceed the limits of their scientific expertise in making such determinations.[6] Indeed, the psychiatrists's role in such retrospective determinations of suicide appears to be an uncertain science at best, except in the most obvious cases.

References

[1] Menninger, K., *Man Against Himself*, Harcourt, Brace, New York, 1938.
[2] Stengel, E., *Suicide and Attempted Suicide*, Penguin Books, London, 1964.
[3] Choron, J., *Suicide*, Scribner's, New York, 1972.
[4] Shader, R., Assessment of Suicide Risk," in *Manual of Psychiatric Therapeutics*, R. Shader, Ed., Little, Brown and Company, Boston, 1975.
[5] Motto, J. A., Heilbron, D. C., and Juster, R. P., "Development of a Clinical Instrument to Estimate Suicide Risk," *American Journal of Psychiatry*, Vol. 142, No. 6, June 1985, pp. 680–686.
[6] Barry, J. V., "Suicide and the Law," *Melbourne University Law Review*, Vol. 5, No. 1, 1965.
[7] Szasz, T., "The Ethics of Suicide," *Antioch Review*, Vol. 7, No. 17, 1971.
[8] Lonsdorf, R., "Legal Aspects of Suicide," in *Suicidal Behaviors*, H. L. P. Resnik, Ed., Little, Brown and Company, Boston, 1968.
[9] Dawidoff, D., *The Malpractice of Psychiatrists*, Charles C Thomas, Springfield, IL, 1973, pp. 56–58.
[10] *Strasberg v. Equitable Life Assurance Society of United States*, 117 N.Y.S.2d 236 (1952).
[11] *Kent v. New England Mutual Life Insurance Company*, 277 N.Y.S.2d 788, 792 (1966).
[12] Curphey, T. J., "The Psychological Autopsy," *Bulletin of Suicidology*, July 1968.
[13] Jansson, B., "Drug Automatism as a Cause of Pseudo Suicide," *Postgraduate Medicine*, Vol. 30, 1961, p. A-34.
[14] Ettlinger, R. W. and Flordh, P., "Attempted Suicide: Experience of 500 Cases at a General Hospital," *Acta Psychiatrica et Neurologica Scandinavia*, Supplement, Vol. 103, 1955, pp. 1–45.
[15] Durkheim, D., *Suicide*, 2nd ed., Free Press, Glencoe, IL, 1951.
[16] Freud, S., "Mourning and Melancholia," in *Complete Psychological Works of Sigmund Freud*, Vol. 14, J. Strachey, Ed. and translator, Hogarth Press, London, 1961.

[6]The associated ethical dimension of this question is beyond the scope of this paper. For an excellent discussion of the ethical problems inherent in such determinations, see Alan Stone's chapter "The Ethics of Forensic Psychiatry: A View from the Ivory Tower" [24].

[17] Comer, J., "Black Suicide: A Hidden Urban Crisis," *Urban Health*, Vol. 2, 1973, pp. 41-43.
[18] Hendin, H., *Suicide and Scandinavia*, Grune and Stratton, New York, 1964.
[19] Goldstein, R. L., "Credibility and Incredibility: The Psychiatric Examination of the Complaining Witness," *American Journal of Psychiatry*, Vol. 137, No. 10, 1980, pp. 1238-1240.
[20] Goldstein, R. L., "Sanctum Sanctorum: The Psychiatrist's Role in Posttrial Competency Examination of Jurors," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 13, No. 2, 1985, pp. 191-196.
[21] Stone, A. A., "Comment on Goldstein's Posttrial Competency Examination of Jurors," *Bulletin of the American Academy of Psychiatry and the Law*, Vol. 13, No. 2, 1985, pp. 197-199.
[22] Perr, I. N., "The Insanity Defense: The Case for Abolition," *Hospital and Community Psychiatry*, Vol. 36, 1985, pp. 51-53.
[23] Rappeport, J., "Ethics and Forensic Psychiatry," in *Psychiatric Ethics*, S. Bloch and P. Chodoff, Eds., Oxford University Press, Oxford, 1981, pp. 255-276.
[24] Stone, A. A., "The Ethics of Forensic Psychiatry: A View from the Ivory Tower," in *Law, Psychiatry, and Morality*, A. A. Stone, Ed. American Psychiatric Press, Washington, DC, 1984, pp. 57-75.
[25] Dorpat, T. L., "Drug Automatism, Barbiturate Poisoning and Suicide Behavior," *Archives of General Psychiatry*, Vol. 31, 1974, pp. 216-220.
[26] Goldstein, R. L., "The Twilight Zone Between Scientific Certainty and Legal Sufficiency: Should a Jury Determine the Causation of Schizophrenia?," *Bulletin of the American Academy of Psychiatry and the Law*, in press.

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