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CHAPTER 6

The Psychological Autopsy

Edwin S. Shneidman, Ph.D.

It is probably best to begin by defining a psychological autopsy and its purposes, then to discuss some related theoretical background and ways of actually performing psychological autopsies. The words *psychological autopsy* themselves tell us that the procedure has to do with clarifying the nature of a death and that it focuses on the psychological aspects of the death. Two ideas, important to understanding the psychological autopsy, need to be discussed. The first is what I have called the NASH classification of deaths; the second is the idea of *equivocal* deaths.

From the beginning of this century (and with roots that can be clearly traced back to Elizabethan times), the certification and recordkeeping relating to deaths have implied that there are four *modes* of death. It needs to be said right away that the four modes of death have to be distinguished from the many *causes* of death listed in the current *International Classification of Diseases and Causes of Death* (World Health Organization 1957; National Center for Health Statistics 1967). The four modes of death are natural, accident, suicide, and homicide; the initial letters of each make up the acronym NASH. Thus, to speak of the NASH classification of death is to refer to these four traditional modes in which death is currently reported. Contemporary death certificates have a category which reads "Accident, suicide, homicide, or undetermined"; if none of these is checked, then a "natural" mode of death, as occurs in most cases, is implied.¹

It should be apparent that the cause of death stated on the certificate does not necessarily carry with it information as to the specific mode of death. For example, asphyxiation due to drowning in a swimming pool

does not automatically communicate whether the decedent struggled and drowned (accident), entered the pool with the intention of drowning himself (suicide), or was held under water until he was drowned (homicide).

It so happens that a considerable number of deaths—the estimate is between 5 and 20 percent of all deaths which need to be certified—are not clear as to the correct or appropriate mode. These unclear or uncertain deaths are called *equivocal* deaths. The ambiguity is usually between the modes of suicide or accident, although uncertainty can exist between any two or more of the four modes.

The main function of the psychological autopsy is to clarify an equivocal death and to arrive at the "correct" or accurate mode of that death. In essence, the psychological autopsy is nothing less than a thorough retrospective investigation of the *intention* of the decedent—that is, the decedent's intention relating to his being dead—where the information is obtained by interviewing individuals who knew the decedent's actions, behavior, and character well enough to report on them.

Drug-related deaths can be among the most equivocal as to the mode of death. Proper certification often necessitates knowledge of the victim over and beyond standard toxicological information, including such questions as what dosage was taken (related to the exact time of death and the time at which autopsy blood and tissue samples were taken); the decedent's weight and build; the decedent's long-term drug habits and known tolerances; the possible synergistics of other ingested materials, notably alcohol or the effects of certain combinations like hydromorphone (Dilaudid) and Methedrine; and the role of lethal action of drug overdoses, e.g., morphine sulfate (morphine) as opposed to the quicker acting diacetyl morphine (heroin).

¹See U.S. Standard Certificate of Death, appendix F.

HISTORICAL BACKGROUND

In 1662 John Graunt, a London tradesman, published a small book of "observations" on the bills of mortality that was to have great social and medical significance. By this time the weekly bills were consolidated at the end of each year, and a general bill for the year was published. Graunt separated the various bits of information contained in these annual bills and organized them into tables. When the available data on deaths were believed accurate, Graunt then focused on individual causes of death. He next turned to the subject of population estimation. Finally he constructed a mortality table, the first attempt to organize data in this manner. Of greatest significance was his success in demonstrating the regularities that can be found in medical and social phenomena when one is dealing with large numbers. Thus John Graunt demonstrated how the bills of mortality could be used to the advantage of both the physician and government (Kargon 1963).

In 1741, the science of statistics came into existence with the work of a Prussian clergyman, Johann Sussmilch, who made a systematic attempt to correlate "political arithmetic," or what we now call vital statistics. From this study came what was subsequently termed the "laws of large numbers," which permitted extended use of the bills of mortality to supply important data in Europe as well as in the American colonies. Cassedy (1969) says that Sussmilch's "exhaustive analysis of vital data from church registers . . . became the ultimate scientific demonstration of the regularity of God's demographic laws."

For many years no provisions existed anywhere in the American colonies for anything comparable to the London bills of mortality (Cassedy 1969). At first there was no necessity for detailed records since communities were small, but something better than hearsay or fading memories was needed as towns grew larger. The birth of newspapers in the British sections of America, about the year 1700, provided a means of remedying this situation. Some editors went to the trouble of obtaining information from local church and town records. They accumulated long lists to which summaries were added, which together were loosely called "bills of mortality." Issued in

a variety of publications, the bills became the earliest systematized American death certificates.

Meanwhile, back in England, "the London Bills of Mortality remained among the eternal verities for Englishmen" (Cassedy 1969). Londoners were sure to find the bills on sale in each parish each week. Bills with lists of cases of various diseases printed on the back brought twice the price of the regular bills. The American colonists had relatives or friends send copies to them: "Just as John Graunt had found the English doing, the early Americans used the bills as grist for conversation if for nothing else" (Cassedy 1969). Few in the colonies even knew of Graunt's statistical applications to the bills of mortality for years after his book was published. Not until William Douglass commented upon statistical method in his history of the British colonies in North America, published in 1751, did the colonists begin to make use of Graunt's methods.

The fact that no colonial bills were published during the 17th century may be attributed to printing priorities and especially to lack of legislative requirements. Though a printing press had begun operation in Cambridge, Massachusetts, in 1638, the next half century saw the introduction of only four more. These few presses were generally kept running at capacity turning out government documents. Though the government of each colony required the registration of all vital statistics, none of them made any provision for the information to be published. Thus the publication of anything resembling the London bills was left to private enterprise. Despite the spread of colonial newspapers and the existence of a few church bills of mortality, British publications remained the colonists' best sources of vital statistical information (Cassedy 1969).

The use of such nonstandardized death records continued into the 19th century. Recognition of the need for informed medico-legal investigation in England led to a series of reforms aimed at improving the quality of death registration. In 1836 Parliament enacted a bill requiring the recording of all deaths. Under the terms of this act, notification of the coroner was not required unless the cause of death was one included in a special cate-

gory. This system of death certification and registration was to ensure that those special deaths that came under the coroner's jurisdiction were in fact reported. The new certification system was designed to utilize the data on causes of death for statistical purposes as well as to prevent criminal practices. The medical explanation of the death was the essential information required for statistical determination. A curious aspect of the law, however, was that doctors were specifically enjoined to include no information on the mode of death on the death certificate.

The English 1836 registration act was amended in 1874 to require that personal information on the death be submitted to the registrar of the district within 5 days of its occurrence by the nearest relative of the deceased who was present at the death or in attendance during the last illness. A fine was to be levied for noncompliance. The new law also required a registered medical practitioner present during the last illness to complete a certificate stating the cause of death to the best of his knowledge and belief.

In 1893 a "Select Committee on Death Certification" of the House of Commons attempted to correct the shortcomings of the previous legislation, particularly "the carelessness and ignorance of the persons certifying, the absence of medical attendants during the last illness and the indefinite character of the disease itself" (Abbott 1901). That committee made a series of 10 recommendations, the most important of which were the following:

1. That in no case should a death be registered without production of a certificate of the cause of death signed by a registered medical practitioner or by a coroner after inquest.
2. That in each sanitary district a registered medical practitioner should be appointed as public medical certifier of the cause of death in cases in which a certificate from a medical practitioner in attendance is not forthcoming.
3. That a medical practitioner in attendance should be required personally to inspect the body before giving a certificate of death.
4. That a form of a certificate of death should

be prescribed, and that in giving a certificate a medical practitioner should be required to use such a form.

The United States Congress, trailing behind the British Parliament, enacted no standard registration act until 1903. Prior to that date, any attempts at standardization were left to the individual States.

In Massachusetts deaths were reported on sheets of paper measuring 18 by 24 inches, with approximately 40 records to a page. Information asked for (but not always provided) included date of death, date of record, name of deceased, sex, marital status, age, residence, disease or other cause of death, place of death, occupation, place of birth, and names and birthplaces of parents. These questions are generally to be found on all records of that period. The California form added only a line for the signature of the attending physician or coroner. New Jersey requested the same information but asked for a more detailed explanation of the cause of death. This was optional, however, and the space provided for it was usually left blank. The New York form, the most comprehensive of its time, also required data concerning the burial.

These early death registrations lacked many significant data: cause of death and place of death were often omitted, and no questions were asked regarding an autopsy report or the time and manner of the death, relevant information needed for statistical purposes and criminal investigation.

When the United States Census Bureau was making its preparations for the 1880 census, it decided to rely upon registration records instead of mortality enumerations, wherever possible, and made a study of State and local forms to determine where these registration records were adequate to its purpose. Wide variation was noted in the ways in which items were worded and data recorded. The study revealed the inherent disadvantages of allowing each State to enact its own registration system without guidelines provided by some central authority (Colby 1965). Therefore, with the aid of the American Public Health Association, the Census Bureau developed what may be termed a model death certificate and prescribed its use by the States,

but the use of a standard certificate for the registration of deaths was not approved by Congress until 1903.

THE DEATH CERTIFICATE

The impact of the death certificate is considerable. It holds a mirror to our mores; it reflects some of the deepest taboos; it can directly affect the fate and fortune of a family, touching both its affluence and its mental health; it can enhance or degrade the reputation of the decedent and set its stamp on his postself career. But if the impact of the death certificate is great, its limitations are of equal magnitude. *In its present form the death certificate is a badly flawed document.*

Today most States follow the format of the U.S. Standard Certificate of Death. Most relevant to our present interests is the item which reads: "Accident, suicide, homicide, or undetermined (specify)." When none of these is specified, a natural mode of death is, of course, implied. Only two States, Delaware and Virginia, have made all four modes of death explicit on the death certificate (and have included a "pending" category as well). Curiously enough, Indiana included four modes of death on the death certificate form from 1955 to 1968, but then revised the form in 1968 and now provides no item for mode of death; nor, surprisingly, does the current Massachusetts death certificate contain an accident-suicide-homicide item.

In addition to the U.S. Standard Certificate, the International Classification of Diseases and Causes of Death plays a major role in determining the way a specific death may be counted—and thus in the apparent change in causes of death statistics from decade to decade. For example, the definitions of suicides and accidents were changed in the Seventh Revision (1955) and Eighth Revision (1965) of the International Classification, and the numbers of suicides and accidents changed along with the definitions. When the Seventh Revision was put into effect for the data year 1958, the death rate for suicides increased markedly over 1957. In part, one can find the explanation in this paragraph (National Center for Health Statistics 1965a):

About 3.3 percent of the total suicide rate for 1958 as compared with that for 1957 resulted from the transfer of a number of deaths from accident to suicide. In 1958 a change was made in the interpretation of injuries where there was some doubt as to whether they were accidentally inflicted or inflicted with suicidal intent. Beginning with the Seventh Revision for data year 1958, "self-inflicted" injuries with no specification as to whether or not they were inflicted with suicidal intent and deaths from injuries, whether or not self-inflicted, with an indication that it is not known whether they were inflicted accidentally or with suicidal intent, are classified as suicides. The change was made on the assumption that the majority of such deaths are properly classified as suicide because of the reluctance of the certifier to designate a death as suicide unless evidence indicates suicidal intent beyond the shadow of a doubt. The magnitude of the comparability ratios for suicide varied considerably with means of injury, from 1.02 for suicide by firearms and explosives to 1.55 for suicide by jumping from high places.

It would seem that this redefinition led to an apparent 55 percent increase from one year to the next in suicides by jumping from high places. Even more interesting is the official observation that the death certifier would be reluctant to indicate suicide "unless evidence indicates suicidal intent beyond the shadow of a doubt." Clearly the certifier plays an important role in the process of generating mortality data. It is he who makes the subjective judgment of what constitutes conclusive evidence of the decedent's intent. The Eighth Revision (National Center for Health Statistics 1967), which made the category "Undetermined" available, introduced still further problems, apparently shifting many suicidal deaths to the Undetermined category.

What is urgently needed is an exploration and description of the current practices of certifying deaths, especially deaths by suicide. We need a uniform system that would eliminate such inconsistencies (or confirm the differential unequivocally), as for example, 10.9 deaths by suicide per 100,000 population for Idaho versus 20.2 for Wyoming. What is required is a "correctional quotient" for each reporting unit—county, State, and

Nation. Until such information is obtained, available suicide statistics are highly suspect.

At the turn of the century, an early reference book of the medical science (Abbott 1901) urged reliable death registration book-keeping and listed the following as "objects secured by a well-devised system":

1. Questions relating to property rights are often settled by a single reference to a record of death.
2. The official certificate of a death is usually required in each case of claim for life insurance.
3. Death certificates settle many disputed questions in regard to pensions.
4. They are of great value in searching for records of genealogy.
5. A death certificate frequently furnishes valuable aid in the detection of crime.
6. Each individual certificate is a contribution *causa scientiae*. Taken collectively, they are of great importance to physicians, and especially to health officers, in the study of disease, since they furnish valuable information in regard to its causes, its prevalence, and its geographical distribution.

At least three more functions for the death certificate might be added to the half-dozen listed in 1901:

7. The death certificate should reflect the type of death that is certified—brain death (a flat electroencephalographic record), somatic death (no respiration, heartbeat, reflexes), or whatever type is implied.
8. The death certificate should include space for the specification of death by legal execution, death in war or military incursions, death by police action, and others of that sort.
9. Perhaps most importantly, the death certificate should abandon the anachronistic Cartesian view of man as a passive biological vessel on which the fates work their will. Instead, it should reflect the contemporary view of man as a psycho-socio-biological organism that can, and in many cases does, play a significant role in hastening its own demise. This means that the death certificate should contain at least one item on the decedent's intention vis-a-vis his own death.

In the Western world death is given its administrative dimensions by the death certificate. It is the format and content of this document that determine and reflect the categories in terms of which death is conceptualized and death statistics reported. The ways in which deaths were described and categorized in John Graunt's day and earlier set deep precedents for ways of thinking about death, and they govern our thoughts and gut reactions to death to this day. Deaths were then assumed to fall into one of two categories: There were those that were truly adventitious—accidents, visitations of fate or fortune (called natural and accidental)—and there were those that were caused by a culprit who needed to be sought out and punished (called suicidal and homicidal deaths). In the case of suicide, the victim and the assailant were combined in the same person, and the offense was designated as a crime against oneself, a *felo-de-se*. England did not cease to classify suicide as a crime until 1961, and in the United States it remains a crime in nine States.

The historical importance of certifying the mode of death—i.e., of the coroner's function—can now be seen: It not only set a stamp of innocence or stigma upon the death, but also determined whether the decedent's estate could be claimed by his legal heirs (natural or accidental death) or by the crown or local lord (a suicide or a murder). That was certainly one important practical effect of the death certificate. The NASH categories of death were implied as early as the 16th century in English certification, and this sub-manifest administrative taxonomy of death has beguiled most men into thinking that there *really* are four kinds of death, which, of course, is not necessarily so at all.

Although it may be platitudinous to say that in each life the inevitability of death is an inexorable fact, there is nothing at all inexorable about our ways of dimensionalizing death. Conceptualizations of death are man-made and mutable; what man can make he can also clarify and change. Indeed, changes in our conceptualizations of death are constantly occurring, notwithstanding the NASH notions of death have held on for centuries after they became anachronistic. Each generation be-

comes accustomed to its own notions and thinks that these are universal and ubiquitous.

From the time of John Graunt and his mortuary tables in the 17th century, through the work of Cullen in the 18th century and William Farr in the 19th century, the adoption of the Bertillon International List of Causes of Death in 1893, and the International Conference for the Eighth Revision of the International Classification of Diseases as recently as 1965 (National Center for Health Statistics 1965*b*), the classification of causes of death has constantly been broadening in scope. The changes are characterized primarily by attempts to reflect additions to knowledge, particularly those contributed by new professions as they have developed—anesthesiology, pathology, bacteriology, immunology, and advances in obstetrics, surgery, and most recently, the behavioral sciences.

PURPOSES OF THE PSYCHOLOGICAL AUTOPSY

As long as deaths are classified solely in terms of the four NASH categories, it is immediately apparent that some deaths will, so to speak, fall between the cracks, and our familiar problem of equivocal death will continue to place obstacles in our path to understanding human beings and their dying. Many of these obstacles can be cleared away by reconstructing, primarily through interviews with the survivors, the role that the deceased played in hastening or effecting his own death. This procedure is called "psychological autopsy," and initially its main purpose was to clarify situations in which the mode of death was not immediately clear.

The origin of the psychological autopsy grew out of the frustration of the Los Angeles County Chief Medical Examiner-Coroner, Theodore J. Curphey, M.D., at the time of the reorganization of that office in 1958. Despite his efforts, which were combined with those of toxicologists and nonmedical investigators, he was faced with a number of drug deaths for which he was unable to certify the mode on the basis of collected evidence. As a result he invited Norman Farberow, Ph.D., and me, then Co-Directors of the Los Angeles Suicide

Prevention Center, to assist him in a joint study of these equivocal cases, and it was this effort—a multidisciplinary approach involving behavioral scientists—which led to my coining the term "psychological autopsy."² (Curphey 1961, 1967; Litman et al. 1963; Shneidman and Farberow 1961; Shneidman 1969, 1973).

In the last few years, especially with the interesting and valuable work of Litman et al. (1963), Weisman and Kastenbaum (1968), and Weisman (1974), the term "psychological autopsy" has come to have other, slightly different meanings. At present there are at least three distinct questions that the psychological autopsy can help to answer:

1. *Why did the individual do it?* When the mode of death is, by all reasonable measures, clear and unequivocal—suicide, for example—the psychological autopsy can serve to account for the reasons for the act or to discover what led to it. Why did Ernest Hemingway "have to" shoot himself (Hotchner 1966)? Why did former Secretary of Defense James Forrestal kill himself (Rogow 1963)? We can read a widow's explicit account of how she helped her husband, dying of cancer, cut open his veins in Lael Tucker Wertebaker's *Death of a Man* (1957). Some people can understand such an act; others cannot. But even those who believe they understand cannot know whether their reasons are the same as those of the cancer victim or his wife. What were their reasons? In this type of psychological autopsy, as in the following type, the mode of death is clear, but the reasons for the manner of dying remain puzzling, even mysterious. The psychological autopsy is no less than a reconstruction of the motivations, philosophy, psychodynamics, and existential crises of the decedent.

2. *How did the individual die, and when—that is, why at that particular time?* When a death, usually a natural death, is protracted,

²On the lighter side: From the viewpoint of his colleagues, Dr. Curphey became suspect as to his professional ancestry by virtue of his extending the autopsy procedure to include behavioral scientists. He has told me that around that time he was asked whether he was a psychiatric pathologist or a pathological psychiatrist.

the individual dying gradually over a period of time, the psychological autopsy helps to illumine the sociopsychological reasons why he died at that time. This type of psychological autopsy is illustrated by the following brief case from Weisman and Kastenbaum (1968):

An 85-year-old man had suffered with chronic bronchitis and emphysema for many years but was alert and active otherwise. He had eagerly anticipated going to his son's home for Thanksgiving and when the day arrived he was dressed and ready, but no one came for him. He became more concerned as the hours went by. He asked the nurse about messages, but there were none, and he finally realized that he would have to spend the holiday at the hospital. After this disappointment the patient kept more and more to himself, offered little and accepted only minimal care. Within a few weeks he was dead.

The implication here is that the patient's disappointment and his resignation to it were not unrelated to his sudden downhill course and his death soon afterward, i.e., if his son had come to take him out for Thanksgiving, the old man would have lived considerably longer than he did. This man's death like some others—voodoo deaths, unexplained deaths under anesthesia, and "self-fulfilling prophecy" deaths, for example—must be considered subintentioned. There can be little doubt that often some connection exists between the psychology of the individual and the time of his death (Shneidman 1963).

There is, of course, a wide spectrum of applicability of this concept. When a person has been literally scared to death by his belief in the power of voodoo, the role of the victim's psychological state seems fairly obvious; and it is difficult to believe that there was no psychological connection between the fatal stroke of Mrs. Loree Bailey, owner of the Lorraine Motel in Memphis, and the assassination of Martin Luther King, Jr., at the motel 3 hours earlier. But in many other cases any relationship between the individual's psychological state and the time of his death seems difficult or impossible to establish.

As an example of the problems raised by this concept, consider the following case, reported in the *New York Times* of June 26, 1968:

WIDOW, 104, DIES IN COTTAGE
SHE ENTERED AS 1887 BRIDE

Mrs. John Charles Dalrymple, 104 years old, died here [Randolph Township, N.J.] yesterday in the cottage to which she came as a bride in 1887.

Her husband brought her in a sleigh to the house, which she was to leave next week to make way for the new Morris County Community College. . . .

The main question here, as in Weisman and Kastenbaum's case of the old man who was left alone on Thanksgiving, is: Might even this person have lived at least a little longer had she not suffered the psychologically traumatic threat of being dispossessed from the home where she had lived for 81 years? Or does the question in this particular case tax one's commonsense credulity?

3. *What is the most probable mode of death?* This was the question to which the psychological autopsy was initially addressed. When cause of death can be clearly established but mode of death is equivocal, the purpose of the psychological autopsy is to establish the mode of death with as great a degree of accuracy as possible. Here are three simplified examples:

Cause of death: asphyxiation due to drowning. A woman found in her swimming pool. Question as to correct mode: Did she "drown" (accident), or was it intentional (suicide)?

Cause of death: multiple crushing injuries. A man found dead at the foot of a tall building. Question as to correct mode: Did he fall (accident), jump (suicide), or was he pushed or thrown (homicide)?

Cause of death: barbiturate intoxication due to overdose. A woman found in her bed. Question as to correct mode: Would she be surprised to know that she was dead (accident), or is this what she had planned (suicide)?

The typical coroner's office, whether headed by a medical examiner or by a lay coroner, is more likely to be accurate in its certification of natural and accidental deaths than of those deaths that might be suicides. Curphey says, "A major reason for this, of course, is that both the pathologist and the lay investigator lack sufficient training in the field of human behavior to be able to esti-

mate with any fair degree of accuracy the mental processes of the victim likely to lead to suicidal death. It is here that the social scientists, with their special skills in human behavior, can offer us much valuable assistance" (Curphey 1961).

The professional personnel who constitute a "death investigation team" obviously should hold no brief for one particular mode of death over any other. In essence, the members of the death investigation team interview persons who knew the deceased—and attempt to reconstruct his lifestyle, focusing particularly on the period just prior to his death. If the information they receive contains any clues pointing to suicide, their especially attuned ears will recognize them. They listen for any overt or covert communications that might illuminate the decedent's role (if any) in his own demise. They then make a reasoned extrapolation of the victim's intention and behavior over the days and minutes preceding his death, using all the information they have obtained.

CONDUCTING THE PSYCHOLOGICAL AUTOPSY

How is a psychological autopsy performed? It is done by talking to some key persons—spouse, lover, parent, grown child, friend, colleague, physician, supervisor, coworker—who knew the decedent. The "talking to" is done gently, a mixture of conversation, interview, emotional support, general questions, and a good deal of listening. I always telephone and then go out to the home. After rapport is established, a good general opening question might be: "Please tell me, what was he (she) like?" Sometimes clothes and material possessions are looked at, photographs shown, and even diaries and correspondence shared. (On one occasion, the widow showed me her late husband's suicide note which she had hidden from the police!—rather changing the equivocal nature of the death.)

In general, I do not have a fixed outline in mind while conducting a psychological autopsy, but, inasmuch as outlines have been requested from time to time, one is presented below with the dual cautions that it should

not be followed slavishly and that the investigator should be ever mindful that he may be asking questions that are very painful to people in an obvious grief-laden situation. The person who conducts a psychological autopsy should participate, as far as he is genuinely able, in the anguish of the bereaved person and should always do his work with the mental health of the survivors in mind.

Here, then, are some categories that might be included in a psychological autopsy (Shneidman 1969):

1. Information identifying victim (name, age, address, marital status, religious practices, occupation, and other details)
2. Details of the death (including the cause or method and other pertinent details)
3. Brief outline of victim's history (siblings, marriage, medical illnesses, medical treatment, psychotherapy, suicide attempts)
4. Death history of victim's family (suicides, cancer, other fatal illnesses, ages at death, and other details)
5. Description of the personality and lifestyle of the victim
6. Victim's typical patterns of reaction to stress, emotional upsets, and periods of disequilibrium
7. Any recent—from last few days to last 12 months—upsets, pressures, tensions, or anticipations of trouble
8. Role of alcohol or drugs in (a) overall lifestyle of victim, and (b) his death
9. Nature of victim's interpersonal relationships (including those with physicians)
10. Fantasies, dreams, thoughts, premonitions, or fears of victim relating to death, accident, or suicide
11. *Changes* in the victim before death (of habits, hobbies, eating, sexual patterns, and other life routines)
12. Information relating to the "life side" of victim (upswings, successes, plans)
13. Assessment of intention, i.e., role of the victim in his own demise
14. Rating of lethality (described in the final section of this chapter)
15. Reaction of informants to victim's death
16. Comments, special features, etc.

In conducting the interviews during a psychological autopsy, it is often best to ask

open-ended questions that permit the respondent to associate to relevant details without being made painfully aware of the specific interests of the questioner. As an example: I might be very interested in knowing whether or not there was a change (specifically, a recent sharp decline) in the decedent's eating habits. Rather than ask directly, "Did his appetite drop recently?" a question almost calculated to elicit a defensive response, I have asked a more general question such as, "Did he have any favorite foods?" Obviously, my interest is not to learn what foods he preferred. Not atypically, the respondent will tell me what the decedent's favorite foods were and then go on to talk about recent changes in his eating habits—"Nothing I fixed for him seemed to please him"—and even proceed to relate other recent changes, such as changing patterns in social or sexual or recreational habits, changes which diagnostically would seem to be related to a dysphoric person, not inconsistent with a suicidal or subintentioned death.

In relation to a barbiturate death³ where the mode of death is equivocal (between suicide and accident), it might be callous to ask the next of kin, "Did your husband (wife) have a history of taking barbiturates?" A more respectful and productive question might be, "Did he (she) take occasional medication to help him (her) sleep at night?" If the response to this question is in the affirmative, one might then ask if the respondent knows the name of the medication or even the shape and color of the medication. If one determines that the deceased in fact had a history of taking sleeping medication, one might then ask if the decedent was accustomed to having some occasional alcoholic beverages prior to going to sleep. If these facts can be brought into the open, it may well be that one can then establish the quantity of the medication and alcohol content that the decedent was taking immediately prior to his death. The general method of questioning is one of "successive approaches," wherein the respondent's willingness to answer one question gives a permission to ask the next one.

³I am grateful to Dr. Michael S. Backenheimer of the National Institute of Drug Abuse for the suggestions contained in this paragraph.

That is the general way that one would inquire, if it were relevant, into, say, drug patterns of behavior. Where suicide or homicide is a possible mode of death, it is rather important to know whether or not the decedent was "into" drugs, an habitual user, or a dealer, on what terms he was with his dealer, etc.

FUNCTIONS OF THE PSYCHOLOGICAL AUTOPSY

The questions should be as detailed (and lines of inquiry pursued) only as they bear on clarifying the mode of death. All else would seem to be extraneous. And to do this depends, of course, on having established rapport with the respondent.

The results of these interviewing procedures are then discussed with the chief medical examiner or coroner. Because it is his responsibility to indicate (or amend) the mode of death, all available psychological information should be included in the total data at his disposal. Since a sizable percentage of deaths are equivocal as to mode precisely because these psychological factors are unknown, medical examiners and coroners throughout the country are robbing themselves of important information when they fail to employ the special skills of the behavioral scientists in cases of equivocal deaths. The skills of behavioral scientists should be employed in the same way as the skills of biochemists, toxicologists, histologists, microscopists, and other physical scientists. The time has long since passed when we could enjoy the luxury of disregarding the basic teachings of 20th century psychodynamic psychology and psychiatry. Certification procedures (and the death certificates on which they are recorded) should reflect the role of the decedent in his own demise, and in equivocal cases this cannot be done without a psychological autopsy.

The retrospective analysis of deaths not only serves to increase the accuracy of certification (which is in the best interests of the overall mental health concerns of the community), but also has the heuristic function of providing the serious investigator with clues that he may then use to assess lethal intent in living persons.

And there is still another function that the psychological autopsy serves: In working with the bereaved survivors to elicit data relative to appropriate certification, a skillful and empathic investigator is able to conduct the interviews in such a way that they are of actual therapeutic value to the survivors. A psychological autopsy should never be conducted so that any aspect of it is iatrogenic. Commenting on this important mental health function of the psychological autopsy, Curphey (1961) has stated:

The members of the death investigation team, because of their special skills, are alert in their interviews with survivors to evidences of extreme guilt, serious depression, and the need for special help in formulating plans for solving specific problems such as caring for children whose parents committed suicide. Since we noted this phenomenon, the coroner's office has, in some few cases, referred distraught survivors of suicide victims to members of the team specifically for supportive interviews even when the suicidal mode of death was not in doubt.

This therapeutic work with the survivor-victims of a dire event is called *postvention* and has been presented in some detail elsewhere (Shneidman 1967, 1971, 1973).

A large university hospital in the east (which has asked not to be identified, but to which I am appropriately beholden) conducts what they call "psychiatric inquests" on those (rare) occasions when a patient commits suicide or makes a serious suicide attempt. A staff psychiatrist, emphasizing the therapeutic aspects of the psychological autopsy procedure, stated that "the inquest is a kind of postvention, designed primarily for the benefit of a shocked and grieving staff." He stated further that, for them, there are essentially three main purposes of such a procedure: "(1) To review with those responsible for the patient, the status of the patient prior to the act, and to determine what course of clinical management would more likely have led to its anticipation and prevention; (2) To facilitate expression of feeling appropriate to the event on the part of staff members; and (3) To determine whether dissemination of the results of the inquest would serve an educational purpose, and arrange for this (e.g., Grand Rounds) when appropriate." Further, he states that

these meetings "should be small enough to exclude those interested primarily in the sensational aspects of the event in question, and should include only those whose presence would serve one of the above purposes."

Following, reprinted with permission, are verbatim reports (except for a few minor changes to disguise identity) of two psychiatric inquests from that university hospital setting.

Case 1. A 32-year-old male graduate student took his life by drug overdose. He had first been hospitalized in 1974 for treatment of strychnine poisoning and was discharged eight days later with a diagnosis of cyclothymic personality. He was readmitted late the same year with depression and paranoid delusions, both of which cleared rapidly on Triavil (a combination of the major tranquilizer—antipsychotic agent perphenazine—and the tricyclic antidepressant amitriptyline), was discharged after a two-week hospitalization and was followed in the outpatient clinic by a resident who had undertaken his care only one week before the discharge date. Gradual improvement was reported, although the absence of the supervisor (who was aware of the suicide risk and would have questioned termination of treatment) leaves the reported improvement open to question. Two months later the patient said that he had discontinued his medications because they slowed him down and that he was confident about his work, feeling well, and would not try suicide again. He was discharged from outpatient treatment at his request, with the assurance that he could call back if he needed further help. He did not contact the clinic again, but three days before his death called his faculty advisor, made accusations against a fellow graduate student and requested a departmental inquiry. He was advised to go on a vacation but went instead to another city, where it was reported that he spent two days praying in a chapel, returned to his boarding house, ate supper and took a fatal drug overdose. Those commenting on the case stressed the questionable aspects of taking at face value the statements of the patient which led to his discharge from the clinic. Furthermore, the patient sent out danger signals in his last call to his faculty advisor.

Case 2. An 18-year-old male patient spent three months on the Child Psychiatry Service two years prior to committing suicide. He had been evaluated for a mild aortic stenosis about which he and his family were greatly concerned. During his first

admission, he showed fragmentation, loose associations, grimacing, and bizarre movements. Within three months of treatment with haloperidol (a major tranquilizer with antipsychotic properties), milieu therapy and psychotherapy he improved enough for discharge to outpatient treatment. Haloperidol was discontinued three weeks prior to his discharge from the hospital. He was carried as an outpatient for six months. About a month prior to readmission looseness of associations and paranoid ideation recurred, and he was reported by his family to have wandered nude out of his house. His school performance declined, and he said he had strange thoughts and could not trust anyone. He refused to take the haloperidol which was again prescribed for him. Upon readmission to the hospital he appeared disorganized, suspicious, and regressed. Two months later he had improved sufficiently to warrant a reduction of the haloperidol which he had been given since admission, but he again regressed and was placed on higher doses of haloperidol by a staff supervisor. His bizarre behavior, open sexual advances to staff and patients, and age combined to necessitate a transfer to a ward where he could be more appropriately managed. There it was reported that he accepted seclusion when required, seemed to respond to medications, but was in general withdrawn and regressed. He was angry at his therapist, who had informed him of his departure some months hence, and on the day of his suicide made known a desire to cut off his penis. Later that day he struck an attendant, spent some time in seclusion, and shortly after his release from seclusion left the ward undetected and went to the tenth floor where, finding an unguarded window, he jumped to his death. After the event it was revealed in a patient meeting that he had informed another patient of his intention and had given away his radio. The discussion pointed out the strong suicide potential of young disturbed males, the risks of multiple therapists and multiple absences, the hazards of disagreement about diagnosis, prognosis, and treatment method.

SUICIDE STATISTICS: SOME QUESTIONS

In relation to suicide statistics in the United States, we know that accurate figures do not now exist. There is widespread confusion and considerable difference of interpretation as to how to classify deaths. For example, what is considered suicide in one locality is often

reported as accidental death in another. The factors that determine decisions of coroners and medical examiners must be made clearly visible as attempts are made to develop criteria for gathering vital baseline data in the area of suicide.

There is an urgent need to explore and describe present practices of reporting suicides and the degree of consistency or inconsistency of such reporting in the United States. Until such information is obtained, it will be impossible to interpret the available statistics. The coroners and medical examiners are the keys to the meaningful reporting of statistics on suicide.

It is believed that it is of the highest priority that an investigation be focused around the following questions directly related to this problem:

1. What percentage of all deaths are autopsied?
2. Who, at present, are the certifying officials, officers, or agencies? Are these medical examiners, physicians in the community, sheriffs, coroners? How are they selected? how trained?
3. What are the present official criteria given to certifying officials in various jurisdictions to guide them in reporting a death as suicide?
4. What are the present actual practices of certifying officials in reporting suicidal deaths? To what extent are these practices consistent with or different from the official criteria?
5. By what actual processes do the certifying officials arrive at the decision to list a death as suicide?
6. How often are autopsies performed? Who determines when an autopsy is to be performed? Are the services of a toxicologist and biochemist available?
7. What percentage of deaths are seen as equivocal, or undetermined, or as a combination of two or more modes (for example, accident-suicide, undetermined)?
8. What are the criteria for special procedures in an equivocal death?
9. How much of the total investigation of a death is dependent upon the police reports? What is the relationship of the coroner's investigation to the local police department?
10. When, if ever, are behavioral or social

scientists involved in the total investigatory procedure of a death?

11. What percentage of certifying officials in the United States are medically trained? Does medical training significantly influence the way in which deaths are reported?

From data dealing with these questions, based on appropriate sampling from regions and taking into account rural-urban differences, size of municipalities, etc., appropriate agencies could then address themselves to a number of important general questions, including the following:

- What local, State, regional, or other differences emerge in the practices of reporting the various modes of death?
- What are the general implications from the data for the accuracy of present death statistics, especially the statistics for each separate mode?
- What suggestions can be made for improvement in conceptualization, practice, and training which point toward more accurate and meaningful reporting?

SUGGESTIONS FOR THE CONCEPTUAL IMPROVEMENT OF THE DEATH CERTIFICATE

The current NASH classification of death grew out of a 17th century way of thinking about man (as a biological vessel who was subject to whims of fate) and tended to leave man himself out of his own death. Twentieth century psychology and psychiatry have attempted to put man—conscious and unconscious—back into his own life, including the way in which he dies. The NASH classification of modes of death is not only apsychological but it tends to emphasize relatively unimportant details. For example, it is essentially a matter of indifference to a human being whether a light fixture above him falls and he is invaded by a lethal chandelier (accidental mode), or someone about him coughs and he is invaded by a lethal virus (natural mode), or someone shoots a gun at him and he is invaded by a lethal bullet (homicidal mode), if the fact is that he does not wish (intention) any of these events to occur.

In order to avoid the inadequacies of this conceptual confusion, it has been proposed that all human deaths be classified among three types: intentioned, subintentioned, and unintentioned (Shneidman 1963, 1973).

An *intentioned* death is any death in which the decedent plays a direct, conscious role in effecting his own demise. On the other hand, an *unintentioned* death is any death, whatever its determined cause or apparent NASH mode, in which the decedent plays no effective role in effecting his own demise—where death is due entirely to independent physical trauma from without, or to nonpsychologically laden biological failure from within.

But most importantly—and, in a fashion I believe to be characteristic of a sizable percentage of all deaths—*subintentioned* deaths are deaths in which the decedent plays some partial, covert, or unconscious role in hastening his own demise. The objective evidences of the presence of these roles lie in such behavioral manifestations as, for example, poor judgment, excessive risk-taking, abuse of alcohol, misuse of drugs, neglect of self, self-destructive style of life, disregard of prescribed life-saving medical regimen, and so on, where the individual fosters, facilitates, exacerbates, or hastens the process of his dying.

That individuals may play an unconscious role in their own failures and act inimically to their own best welfare and even hasten their own deaths seems to be well documented in the psychoanalytic and general clinical practice. This concept of subintentioned death is similar, in some ways, to Karl Menninger's concepts of chronic, focal, and organic suicide (1938). Menninger's ideas relate to self-defeating ways of continuing to live, whereas the notion of subintentioned cessation is a description of a way of stopping the process of living. Included in this subintention category would be many patterns of mismanagement and brink-of-death living which result in death. In terms of the traditional classification of modes of death (natural, accident, homicide, and suicide), some instances of all four types can be subsumed under this category, depending on the particular details of each case.

Confusion also discolors and obfuscates our thinking in the field of suicide. Currently there is much overattention paid to the cate-

gories of attempted, threatened, and committed suicide. These categories are confusing because they do not tell us with what intensity the impulse was felt or the deed was done. One can attempt to attempt, attempt to commit, or attempt to feign, and so on. One can threaten or attempt suicide at any level of intensity. What is needed is a dimension which cuts across these labels and permits us to evaluate the individual's drive to self-imposed death. We propose a dimension called *lethality*, defined as the probability of a specific individual's killing himself (i.e., ending up dead) in the immediate future (today, tomorrow, the next day—not next month). A measure of the lethality of any individual can be made at any given time. When we say that individual is "suicidal" we mean to convey the idea that he is experiencing an acute exacerbation (or heightening) of his lethality. All suicide attempts, suicide threats, and committed suicides should be rated for their lethality. The rule of thumb would be that beyond a certain point one must be wary of the danger of explosion into overt behavior.

What is suggested is that, *in addition* to the present NASH classification, each death certificate contain a new supplementary item which reflects the individual's lethality intent. This item might be labeled *Imputed Lethality* (recognizing its inferential character) and would consist of four terms, one of which would then be checked. The terms are: *High*, *Medium*, *Low*, *Absent*, and would be defined as follows.

High lethality. The decedent definitely wanted to die; the decedent played a direct conscious role in his own death; the death was due primarily to the decedent's openly conscious wish or desire to be dead, or to his (her) actions in carrying out that wish (e.g., jumping rather than falling or being pushed from a high place; he shot himself to death; he deliberately interrupted or refused life-saving procedures or medical regimen).

Medium lethality. The decedent played an important role in effecting or hastening his own death. Death was due in some part to actions of the decedent in which he played some partial, covert, or unconscious role in hastening his own demise. The evidences for this lie in the decedent's behaviors, such as his carelessness, foolhardiness, neglect of self,

imprudence, poor judgment, provoking others, disregard of prescribed life-saving medical regimen, active resignation to death, mismanagement of drugs, abuse of alcohol, "tempting fate," "asking for trouble," etc., where the decedent himself seemed to have fostered, facilitated, or hastened the process of his dying, or the date of his death.

Low lethality. The decedent played some small but not insignificant role in effecting or hastening his own demise. The same as medium above, but to a much less degree.

Absent lethality. The decedent played no role in effecting his own death. The death was due entirely to assault from outside the body (in a situation where the decedent played no role in causing this to happen), or death was due entirely to failure within the body (in a decedent who wished to continue to live).

The item on the certificate might look like this:

IMPUTED LETHALITY: (Check One)
 High Medium Low Absent
 (See Instructions)

The reasons for advocating the suggestion are as follows: First, this classification permits reflection of the role that the dead individual played in his own dying, in hastening his own death; the ways in which he might have participated in his own death, etc. Next, it is more fair. At present, individuals of higher social status who commit suicide are more likely to be assigned the mode of accidental or natural death than are individuals of lower social status who no more evidently commit suicide. If the term is to have any meaning at all, it should be fairly used across the board, measured by the individual's intention. Finally, the lethality intention item provides an unexampled source of information by means of which biostatisticians, public health officials, and social scientists could assess the mental health of any community. It is obvious that the number of deaths that are caused, hoped for, or hastened by the decedents themselves is a measure of the prevalence of psychological disorder and social stress. At present we do not have this measure, and we need it.

It might be protested, inasmuch as the assessments of these intention states involve

the appraisal of unconscious factors, that some workers (especially lay coroners) cannot legitimately be expected to make the kinds of psychological judgments required for this type of classification. To this, one answer would be that medical examiners and coroners throughout the country are making judgments of precisely this nature every day of the week. In the situation of evaluating a possible suicide, the coroner often acts (sometimes without realizing it) as psychiatrist and psychologist, and as both judge and jury in a quasijudicial way. This is because certification of death as suicide does, willy-nilly, imply some judgments or reconstruction of the victim's motivation or intention. Making these judgments—perhaps more coroners ought to use the category of Undetermined—is a part of a coroner's function. But it might be far better if these psychological dimensions were explicit, and an attempt, albeit crude, made to use them, than to have these psychological dimensions employed in an implicit and un verbalized (yet operating) manner. The dilemma is between the polarities of the presently used oversimplified classification, on the one hand, and a somewhat more complex, but more meaningful classification, on the other. The goal should be to try to combine greatest usefulness with maximum meaningfulness.

In Marin County, California, the coroner's office is currently assessing each death processed by that office in terms of *both* the traditional NASH classification of mode of death and the lethality intention of the decedent. For a 2-year period, 1971-1972 (978 cases), the breakdown was as follows:⁴

Natural deaths (630): high lethality intent, none; medium lethality, 33 (5%); low, 37 (6%); absent, 560 (89%).

Accidental deaths (176): high lethality intent, 2 (1%); medium, 77 (44%); low, 40 (22%); absent, 57 (33%).

Suicidal deaths (131): high lethality intent, 131 (100%).

Homicidal deaths (37): high lethality intent,

none; medium, 20 (54%); low, 9 (24%); absent, 8 (22%).

Four deaths were of unknown origin.

The first thing we notice is that *some* natural, accidental, and homicidal deaths were classified as having *some* degree of lethal intention. If the medium-intention and low-intention categories are combined, then over one-fourth (26%) of all natural, accidental, and homicidal deaths (216 in 843) were deemed to be *subintentioned*. If one then adds the suicidal deaths, in which the decedent has obviously played a role in his own death, then only 64 percent of all deaths (625 in 978) were deemed to have been totally adventitious; conversely, 36 percent were deemed to have had some psychological components.

Also of special interest in these Marin County data is the finding that coroners can, with apparently no more difficulty than they experience in assigning deaths to the NASH categories, simultaneously (and by essentially the same process of inference and induction) assign deaths to intentional categories as well. It is an important pioneer effort and deserves widespread emulation.

In summary, the following points may be emphasized.

Causes. The classification of causes of death has been rather well worked out and is consistent with contemporary knowledge. There is currently an accepted international classification which has wide acceptance.

Modes. The modes of death have not been stated explicitly and have not been too well understood. In general, four currently implied modes of death—natural, accidental, suicidal, and homicidal—suffer from the important deficiency of viewing man as a vessel of the fates and omitting entirely his role in his own demise.

Intent. The addition of the dimension of lethal intention serves to modernize the death certificate, just as in the past advances have been made from the teachings of bacteriology, surgery, anesthesiology, immunology, etc. The time is now long overdue for the introduction of the psychodynamics of death into the death certificate. The addition of a single item on imputed lethal intent (High, Medium, Low, Absent) would provide an appropriate

⁴I am especially grateful to Keith C. Craig, coroners' deputy, Marin County, for his interest and help in supplying these data.

reflection of the psychological state of the subject and begin, at last, to reflect the teachings of 20th century psychology. In this way we might again permit the certification of death to reflect accurately our best current understanding of man.

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