The Psychological Autopsy in Forensic Psychiatry

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The Centers for Disease Control and Prevention (CDC) define “suicide” as “death caused by self-directed injurious behavior with any intent to die as a result of the behavior” (CDC, 2014). The term “psychological autopsy” was coined by Dr. Edwin S. Shneidman, who stated, “the psychological autopsy is no less than a reconstruction of the motivations, philosophy, psychodynamics, and existential crisis of the decedent” (Shneidman, 1973, p. 132). Psychological autopsy is a specific example of forensic retrospective assessment of mental states, such as that used in assessing mental state at the time of a criminal offense; the altering of a last will and testament; or entering into a contract. In its original use, the psychological autopsy “was conceptualized as a thorough retrospective analysis of the decedent’s state of mind and intention at the time of death, and initially used by the medical examiner in ‘equivocal’ deaths where the manner of death could be either suicide or accident” (Botello et al., 2013). In addition to “cause of death” (e.g., gunshot wound of the head), the medical examiner determines “manner” (or “mode”) of death, which is usually certified as “natural,” “accidental,” “suicide,” “homicide,” or “undetermined.” Over the years, the most common reason for referral by the L.A. County Chief Medical Examiner-Coronor’s office for psychological autopsy was in cases of deaths due to alcohol and/or other drugs. Psychological autopsy also was used when family members contested a determination of suicide as the manner of death.

In addition to equivocal death cases, the principle of psychological autopsy, with its systematic method to understand the psychological and contextual circumstances preceding suicide, has been utilized, in clinical contexts (e.g., to help survivors of suicide better understand the “why?” in order to assist the grieving process); in medical/institutional contexts (e.g., quality improvement investigations/root cause analyses); in governmental inquiries into major public suicides (e.g., death of White House deputy counsel Vincent Foster, Jr.); and in legal contexts (e.g., litigation). Furthermore, it has informed efforts in suicide prevention, crisis intervention, and research efforts to identify individuals “at risk” of committing suicide. The psychological autopsy is a practical and widely-used approach to studying the proximal risk factors for suicide, i.e., psychological circumstances and contextual factors close in time to the suicide. Because suicide is a relatively rare condition (e.g., approximately 25 per 100,000 per year in men 25-64 years old in 2009), longitudinal studies requiring large sample sizes are impractical, while case-control psychological autopsy studies can reveal proximal factors that lead to suicide.

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Various methods are used to conduct psychological autopsies and there is no single standardized protocol. Common to all methods is the systematic collection of psychological, psychiatric, medical, and social data, including first-person accounts of the decedent’s last days of life, such that “conclusions can be drawn as to the intention of the decedent, therefore the decedent’s role in effecting his/her own death” (Berman, 2005, p. 365). Relevant information is obtained from review of available collateral records (e.g., police investigation; suicide note(s); autopsy report; postmortem toxicology; psychiatric, medical, pharmacy, criminal, employment, financial, military, and school records; personal journals; computer hard drive contents; insurance policies; wills) and interviews of survivors (e.g., significant others, family members, friends, coworkers) and other observers of the decedent in the last days of life. It must be kept in mind that family members and close friends may have feelings of guilt, anger, or shame, which may result in biased reporting. However, these survivors typically know the most about the decedent’s history and can provide specific observations and temporal milestones pertaining to events and circumstances occurring shortly before his/her demise. Snider et al. (2006) proposed a template of areas of inquiry: site of death; demographics; recent symptoms/behaviors; precipitants to death; psychiatric history; physical health; substance abuse; family history; firearm history; attachments/social supports; emotional reactivity; lifestyle/character; and access to care. Knoll (2009) similarly outlines a protocol for conducting the psychological autopsy.

In civil litigation, plaintiff’s attorney will make decedent’s family available for face-to-face or telephone interviews by plaintiff’s expert. However, these informant are typically not available to the defense expert, who instead must rely upon depositions and other sources of information. Both cause and manner of death may be contested as part of the litigation. Medical examiners variably have access to information from coroner’s investigator reports, police investigation reports, medical records, and pharmacy records. Through discovery, however, the forensic psychiatrist may have a large database, containing

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much information previously unavailable to the medical examiner who did the original certification of cause and manner of death.

Particularly in cases of suspected alcohol- or drug-related deaths, in which the meaning and implications of the toxicological results are at issue, it is useful for the forensic psychiatrist to have some working knowledge of toxicological concepts and methods, in addition to awareness of relevant case-specific data, e.g., antemortem pharmacokinetics and pharmacodynamics; physiological tolerance; postmortem redistribution; byproducts of postmortem decomposition; underlying medical pathology; and concomitant medications. The forensic psychiatrist should understand the questionable validity of: so-called "lethal" levels of drugs; estimation of antemortem plasma concentrations or drug dosage based upon postmortem toxicoLOGY; and determination of cause of death based upon toxicoLOGY textbooks or tables without reviewing the extant scientific literature or considering case-specific details (Palmer, 2010). Discussion with a retained forensic toxicologist and/or forensic pathologist, review of corresponding expert reports, and/or review of the relevant scientific literature also assist the forensic psychiatrist in understanding the case.

In criminal and civil litigation contexts, forensic psychiatrists are called upon to perform a retrospective assessment of intent in cases involving death. Such contexts include: criminal cases in which there is contention that an apparent homicide was actually a suicide; allegations of criminal child abuse; wrongful death litigation involving possible "suicide-by-cop"; malpractice claims alleging suicide; institutional care (jail/prison suicides); product liability claims; insurance policies that cover accidental death or disability, but exclude suicide; motor vehicle insurance claims (e.g., single vehicle fatalities); workers compensation; and military benefits awards to surviving families. The court determines whether expert opinion testimony based upon a psychological autopsy is admitted into evidence. In federal court, the Daubert standard applies, i.e., scientific knowledge assists the trier of fact in understanding the evidence; and the expert witness is qualified by knowledge, skill, experience, training, or education. Sixteen states, including California, utilize the Frye standard, i.e., general acceptance within the field (Kiri, 2014).

Systematic suicide risk assessment has been utilized in clinical settings for many years and is within the expertise of clinical psychiatrists. Retained forensic psychiatrists and psychologists can assist the trier of fact with expert opinions based upon careful postmortem assessment of suicide risk, based upon a systematic review of relevant sources of information that inform requisite areas of inquiry. In addition, the expert can analyze the data for "factors descriptive of high intentionality, which include "conscious awareness of consequences; goal of cessation; expectation of fatal outcome; implementation of a method of high lethality; minimal rescuability or precautions; premeditation [i.e., planning]; and communications [of intent]" (Berman, 2005: p. 369). A probabilistic assessment of suicide risk (e.g., low, medium, high) can be offered as expert opinion, without opining on the ultimate issue to be decided by the trier of fact. As noted by Berman (2005), while "the psychological autopsy is a powerful tool for the skilled suicidologist," nevertheless it "cannot definitively define cause-and-effect relationships, thus it cannot validly inform an expert that a suicide definitely occurred; rather it can better inform opinions as to whether a defendant likely completed suicide and provide a better understanding of pathways to the determined manner of death. As such, it informs coroners and medical examiners and the courts which are ultimately the decision-makers" (p. 369).

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tionally, and the relative paucity of literature available on the topic of criminal responsibility and rape, further research and discussion on this important issue is warranted.

REFERENCES:

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