CHAPTER 27

Patient Suicide and Litigation

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Suicides account for nearly 30,000 deaths annually in the United States and are the eleventh leading cause of death (National Center for Health Statistics 2000; National Institute of Mental Health 2004). Studies indicate that during the course of his or her career, a psychiatrist has a 50% chance of losing a patient to suicide (Chemtob et al. 1988). In a review of malpractice claims against psychiatrists between 1980 and 1985, Robertson (1988) reported that lawsuits involving suicide represented the largest number of suits and yielded the largest financial settlements (Baerger 2001).

In this chapter, we examine psychiatrists' roles in two areas of litigation. In the first, we provide an overview of malpractice litigation when the psychiatrist is a defendant in a lawsuit. In the second section, we review retrospective psychiatric evaluations conducted to determine whether a person's death was due to a suicide or resulted from other causes. In both situations, it is important that the psychiatrist be familiar with the legal principles that are relevant in approaching the referral issue.

In the following case example, the psychiatrist received a formal legal complaint against him alleging psychiatric malpractice:

> Mr. A, a 44-year-old married man being treated in an outpatient psychiatric clinic for major depression and narcissistic personality disorder, has a history of suicide attempts that includes an attempted hanging

while intoxicated when he was 33 years old. During the first week of that hospitalization, Mr. A denied having suicidal feelings and was taken off suicide precautions. Within 20 minutes of his change in status level, Mr. A attempted to hang himself with torn sheets. After 3 weeks of inpatient care, Mr. A was discharged and has been followed up as an outpatient on a weekly basis.

At his last outpatient psychiatric appointment, Mr. A tells his psychiatrist that his wife informed him that morning that she was in love with a coworker. He is despondent and tearful. Mr. A denies any specific suicide plan but also refuses to answer questions related to current homicidal or suicidal thoughts. The psychiatrist learned that Mr. A had received a driving under the influence citation the prior week, and he smells alcohol on Mr. A's breath during the interview. Mr. A refuses inpatient psychiatric admission, and the psychiatrist schedules a routine follow-up appointment for 4 weeks later. The following morning, the psychiatrist learns that Mr. A went home, shot and killed his wife, and then shot himself. The psychiatrist subsequently receives a formal legal complaint against him alleging psychiatric malpractice.

Suicide and Malpractice Litigation

Legal Concepts

Knowledge of general legal concepts assists the clinician in both providing mental health treatment and understanding medical-legal disputes that may arise when a patient dies. Tort law governs the legal resolution of complaints regarding medical treatment. A *tort* is a civil wrong. Tort law seeks to compensate financially individuals who have been injured or who have experienced losses because of the conduct of others. In cases involving suicide, the plaintiff is generally a surviving spouse or family member who seeks financial compensation for the loss of his or her loved one. Torts are typically divided into one of three categories: 1) strict liability, 2) intentional torts, and 3) negligence (Table 27–1).

Strict liability imposes liability on defendants without requiring any proof of lack of due care, and this standard is not used in malpractice litigation involving suicide. The most common example of strict liability is harm caused to an individual by a product proven to be unreasonably dangerous and defective (Schubert 1996). *Intentional torts* involve actions when an individual either intends harm or knows that harm may result from his or her behavior (Schubert 1996). Examples of intentional torts that involve mental health care include assault (an attempt to inflict bodily injury), battery (touching without consent), false imprisonment, and violation of a person's civil rights.

Negligence occurs when a clinician's behavior unintentionally causes an unreasonable risk of harm to another. This type of tort is typically used in

TABLE 27–1. Types of torts

Strict liability	Imposes liability without proof of lack of due care
Intentional tort	Individual intends harm or knows harm will result from his or her actions
Negligence	Individual's behavior unintentionally causes an unreasonable risk of harm to another

a lawsuit against a clinician involving a suicide. Medical malpractice is based on the theory of negligence. The four elements required to establish medical negligence are commonly known as the four *D*'s. These include a *dereliction* of *duty* that *directly* causes *damages* (Table 27–2). A duty is most commonly established for a clinician when the patient seeks treatment, and treatment is provided. The provision of services does not require the patient's presence and can even extend to assessment and treatment provided over the telephone. Dereliction of duty is usually the most difficult component of negligence for the plaintiff to establish. Dereliction of duty is divided into acts of commission (provision of substandard care) and acts of omission (failure to provide care). Acceptable care does not have to be perfect care but care provided by a reasonable practitioner. Medical malpractice is defined as "a doctor's failure to exercise the degree of care and skill that a physician or surgeon of the same medical specialty would use under similar circumstances" (Garner 2004, p. 978). Two aspects of causation generally cited as establishing negligence include the foreseeability of the suicide and the clinician's role in directly causing the harm.

Damages are the amount of money the plaintiff is awarded in a lawsuit. Various types of damages may be awarded. *Special damages* are those actually caused by the injury and include payment for lost wages and medical bills. *General damages* are more subjective and provide financial compensation for the plaintiff's pain and suffering, mental anguish, loss of future income due to injury, and loss of companionship. A third category of damages is referred to as *exemplary* or *punitive damages*. Punitive damages may be awarded when the defendant has been determined to have acted in a malicious or grossly reckless manner. Because punitive damages generally involve harm that is intentionally caused, they are rarely awarded in suicide malpractice cases. Table 27–2 summarizes the four key components necessary to establish a claim of medical negligence.

Treatment Settings and Malpractice Litigation

The possibility of a patient committing suicide represents one of the greatest emotional and legal concerns of clinicians. This concern is realistic given that 10%–15% of patients with major psychiatric disorders

TABLE 27–2. Four *D*'s of negligence

Duty	Established when a professional treatment relationship exists between a clinician and a patient
Dereliction	Deviations from minimally acceptable standards of care
Directly causing	Relation between dereliction of duty and harm caused
Damages	Amount of money awarded the plaintiff to compensate for harm caused

will die by suicide (Brent et al. 1988a). Lawsuits related to suicide usually involve one of three scenarios: 1) an inpatient suicide when the facility and its practitioners provide inadequate care or supervision; 2) a recently discharged patient who commits suicide; or 3) an outpatient who commits suicide (Knapp and VandeCreek 1983).

Suicidality is the most common reason for inpatient psychiatric hospitalization (Friedman 1989). When a patient is admitted to the hospital because of thoughts of self-harm, the clinician is on notice that the patient is at an increased risk for suicidal behavior. Nearly one-third of inpatient suicides result in a lawsuit (Litman 1982). Malpractice actions often name the hospital in addition to the treating clinicians. For example, when hospital staff members are aware of the patient's suicidal tendencies, the hospital assumes the duty to take reasonable steps to prevent the patient from inflicting harm (Robertson 1988). Common allegations of psychiatric malpractice following inpatient and outpatient suicides are outlined in Table 27–3 and Table 27–4, respectively.

TABLE 27–3. Common allegations of negligence following inpatient suicides

The treater(s) failed to
Diagnose or foresee the suicide
Control, supervise, or restrain
Evaluate adequately suicidal intent
Provide appropriate pharmacotherapy
Provide adequate monitoring
Gather an adequate history
Remove potentially harmful items such as belts or shoelaces
Provide a safe, secure environment

Source. Robertson 1988.

TABLE 27–4. Common allegations of negligence following outpatient suicides

The treater(s) failed to
Evaluate properly the need for psychopharmacological intervention or provide suitable pharmacotherapy
Implement hospitalization
Maintain an appropriate clinician–patient relationship
Obtain supervision and consultation
Evaluate for suicide risk at intake and at management transitions
Secure records of prior treatment or perform adequate history taking
Conduct a mental status examination
Diagnose a patient's symptoms appropriately
Establish a formal treatment plan
Safeguard the outpatient environment
Document adequately clinical judgments, rationales, and observations

Source. Packman et al. 2004.

Stages of Malpractice Litigation

A malpractice case usually begins after a bad outcome coupled with the survivors' bad feelings toward the clinician (Appelbaum and Gutheil 1991). Malpractice litigation goes through several steps before the case actually reaches trial. Laws governing the rules of civil procedure vary from state to state but typically have several components. The party believed to be injured first seeks legal advice to determine whether a basis exists for a malpractice claim. At this early stage, a plaintiff's attorney often sends the medical records to a mental health expert to review the merits of the case. The attorney may provide a summary of the facts to the potential expert to see how he or she reacts before selecting a psychiatrist to review the records.

A review by a mental health professional is important to determine whether potential negligence has occurred. Experts working with plaintiff's counsel may be asked to identify deviations from the standard of care. Defense attorneys may seek help in defending any alleged deviations in care and in identifying critical areas to review as part of their deposition preparation. The reviewing expert on either side may be asked whether he or she believes that the hospital staff fell below the standard of care in addition to the care provided by the defendant physician.

Some states require that 50%–75% of the expert's time be spent in practice and teaching to be allowed to testify on standard of care in malpractice cases. Furthermore, experts should clarify with attorneys in-

volved in cases outside of their home state if they are required to have a license in that state before giving expert testimony (Simon and Shuman 1999). Psychiatrists also should refer out those cases they are not qualified to do, such as a case involving complex psychopharmacology.

If the plaintiff's attorney decides to take the case, he or she then drafts a document known as the *complaint*. The complaint outlines specific claims of negligence, the form of relief sought (generally monetary), and the specific names of sued defendants. The complaint may be overly inclusive in both allegations of negligence and the number of parties sued. For an inpatient suicide, multiple defendants are likely. During the process of litigation, certain parties may eventually be dropped when evidence is insufficient to support a cause of action against them.

Once the parties being sued are served with the complaint, they must provide a formal response, known as the *answer*, within a specified time. In the answer to the complaint, the responding party outlines his or her defense to each claim asserted and either admits or denies the claims as outlined in the plaintiff's complaint. In certain situations, the response to the complaint involves a *demurrer* or a motion to dismiss for failure to state a cause of action. A demurrer is a written response to the complaint that requests dismissal because even if the facts as outlined in the complaint were true, no legal basis exists for the lawsuit. A judge holds a hearing to determine the validity of the demurrer and to decide if the case should be dismissed.

If a demurrer is not granted, the next stage of litigation is known as *discovery*. The discovery phase involves an exchange of information so that each side has knowledge of the facts and anticipated testimony and is not surprised should the case proceed to trial. Information may be exchanged through a series of written documents known as *interrogatories*. Interrogatories are a set of written questions posed by one party to the other that require a written response (also termed *answer to interrogatories*) under oath within a specified time frame. Interrogatory questions commonly request detailed specifics about the suicide, care providers, and treatment provided. The discovery process can involve demands for production of documents such as nursing policies regarding suicide precautions or a mental health examination of a plaintiff alleging emotional damages.

During the discovery stage of litigation, *depositions* of parties and potential witnesses are usually requested. Discovery depositions in suicide malpractice cases usually involve three phases: 1) depositions of the parties, treating health care professionals, and fact witnesses; 2) depositions of the various standard of care experts; and 3) depositions of the causation experts and damage experts. During a deposition, the testimony of a fact or expert witness is taken under oath before a court reporter, and a

written transcript of this proceeding can be used to assist in trial preparation or to impeach the testimony of a witness during trial.

After the discovery phase has concluded, either party may file a *motion for summary judgment*. A motion for summary judgment asserts that a trial is not necessary because there is no dispute as to any material fact issues in the case, and the law clearly favors judgment for the moving party. If the court grants summary judgment for the requesting party, the case ends at this point.

If the case is not dismissed, an *arbitration* or *settlement conference* may be arranged to determine whether the parties can agree to a settlement and avoid the time and expense of a trial. Various factors that influence whether a case settles include an assessment of the defendant physician's demeanor as caring or arrogant, the ability of the experts, the strength of the attorneys, the attitude of the particular judge, and the nature of the local jury pool. If the legal parties are unable to settle the case, litigation then proceeds to *trial*, at which the evidence is presented to the *trier of fact*. The trier of fact is either a judge or a jury and is responsible for determining the outcome of the litigation, known as the *judgment*. The types of damages resulting from the judgment are discussed earlier in this section.

Litigation and Retrospective Analysis of Suicidal Intent

The psychiatrist's evaluation of suicidal intent plays a pivotal role in various types of litigation surrounding an individual's death. Whereas the actual cause of death may be clear (e.g., gunshot wound to the head or crush injury from a car accident), the mode of death examines the person's intent to die. When assessing the mode of death, the examiner determines whether the death was from natural causes, an accident, a suicide, or a homicide (Ebert 1987). In 5%–20% of death cases reviewed by the medical examiner (coroner), the mode of death is unclear (Schneidman 1981). Common situations in which the cause of death is clear but the *mode* of death is not include autoerotic asphyxia, a fatal car accident, and death resulting from Russian roulette. Any one of these scenarios could result from suicidal intentions or from a tragic accident. When the circumstances surrounding a death are unclear, litigation may follow to answer such unresolved questions, especially if there are financial consequences. Multiple areas of potential litigation may follow a death from unclear reasons, and some of these are noted in Table 27–5 (Simon and Shuman 1999).

Robins et al. (1959) conducted the first retrospective psychological study of suicides through their detailed analysis of 134 consecutive sui-

TABLE 27–5. Areas of potential litigation following death from unclear reasons

Life, health, or disability benefits from insurance policies that allow financial recovery for accidents but not suicides
Homeowners' policies that exclude coverage for intentionally violent acts
Legal actions related to workers' compensation benefits
Malpractice actions alleging suicide
Product liability claims
Motor vehicle insurance claims
Contested wills
Awarding of military benefits to surviving family members
Criminal prosecution when homicide by a third party rather than suicide of the decedent is alleged
Determination of whether death from police intervention was "suicide by cop"

Source. Simon 1990.

cides that occurred during a 1-year period. This retrospective investigation of a victim's mental state was further developed by the Suicide Prevention Center in Los Angeles, California, during the 1950s to assist coroners' accuracy in the determination of death (Beskow et al. 1990; Curphey 1961; Jobes et al. 1986).

The term *psychological autopsy* was coined by Schneidman (1981) to describe the method by which an evaluator conducts a retrospective review in equivocal deaths to determine whether the death involved suicidal *intent*. Three important legal components of intent are

> 1) that it is a state of mind, 2) about consequences of an act [or omission] and not about the act itself, and 3) it extends not only to having in mind a purpose [or desire] to bring about given consequences but also to having in mind a belief [or knowledge] that given consequences are substantially certain to result from the act. (Keeton et al. 1984)

More simply stated, suicidal intent involves a person's understanding that an action he or she takes will result in his or her own death.

Whereas suicidal intent involves an appreciation of the permanent consequences of the suicidal act, *motive* refers to the reasons that the person wants to die. Such reasons may include a desire to have insurance money cover a family debt in the face of overwhelming financial stress or the hope that suicide will provide an escape from personal problems or emotional pain. Retrospective reviews of suicidal intent and motive are potentially helpful in a variety of civil and criminal matters discussed in the following sections (Simon 2002).

Role of Psychological Autopsies in Litigation

Life Insurance Claims

Many life insurance policies differentiate the extent of death benefits according to whether the death was due to natural or accidental causes rather than a suicide, as in the following example:

> Mrs. and Mr. B are enjoying their routine Sunday morning coffee and newspaper. Mr. B leaves the room to take his shower while Mrs. B begins tackling the weekly crossword puzzle. After 5 minutes, Mrs. B hears a loud shot from their bedroom and rushes to the room, where she discovers her husband lying dead on the floor. His .45-caliber revolver is in his right hand, and he has a gunshot wound to his head. Mr. B never communicated to her any suicidal thoughts, and she reports that he was not depressed. Mr. and Mrs. B each took out a life insurance policy 18 months ago that included an exclusion clause for any suicide that occurred within the first 2 years of the policy. The insurance company refuses to pay benefits to Mrs. B, stating that her husband's death was a suicide, and she therefore is not entitled to the life insurance benefits. Mrs. B's attorney contacts a psychiatrist to ask his assistance in conducting a "psychological autopsy" to offer an opinion about whether the decedent died by suicide.

When conducting an assessment of a deceased person's suicidal intent, the evaluator should see the relevant insurance policy language. In particular, the psychiatrist should examine whether the policy governed by the relevant jurisdictional statute and case law distinguishes "sane" from "insane" suicides. In some jurisdictions, a person who commits a suicide but is assessed as insane is determined not to have intentionally committed the suicide; therefore, the beneficiaries have a right to the policy proceeds. One definition of an *insane suicide* was described more than 100 years ago in the U.S. Supreme Court case *Mutual Life Insurance Company v. Terry* (1873, p. 242). In this 1873 case, the Court wrote:

> If the death is caused by the voluntary act of the assured, he knowing and intending that his death shall be the result of his act, but when his reasoning faculties are so far impaired that he is not able to understand the moral character, the general nature, consequences and effect of the act he is about to commit, or when he is impelled thereto by an insane impulse, which he has not the power to resist, such death is not within the contemplation of the parties to the contract and the insurer is liable.

The following example illustrates a situation in which life insurance benefits may be granted if insane suicides are not specifically excluded from policy coverage:

> Mr. C, a psychotic man, shoots himself in the head with a revolver in the delusional belief that he is immortal and cannot be killed. Although Mr. C may have understood that he was pulling the trigger of a loaded weapon, if his delusional beliefs prevented him from understanding that he would die as a result of this gunshot wound, his death could be determined an insane suicide.

Some insurance companies have revised their policies to exclude specifically the recovery of benefits by suicide, whether sane or insane. In *Bigelow v. Berkshire Life Insurance Company* (1876), the Supreme Court upheld the exclusion of insane suicides from coverage under a particular life insurance policy, thereby preventing the distribution of life insurance benefits following a suicide, regardless of the mental state of the deceased.

Workers' Compensation Claims

Workers' compensation awards monetary benefits when mental harms are determined to have been caused by a work-related injury. When an employee commits suicide following a work-related injury, can a family member seek workers' compensation benefits? In this situation, a psychological autopsy may be useful in determining the relation, if any, between a work-related injury and a suspected suicide. In the 1984 Montana case *Campbell v. Young Motor Co.*, the court allowed Dr. Walters, a psychologist who conducted a psychological autopsy, to testify whether a back injury Mr. Raymond Campbell sustained working as a car body repairman was a proximate cause of his suicide 5 years after the injury occurred. The trial court found that there was a causal connection between the injury and the suicide and commented as follows:

> Where can this Court find the bright line that distinguishes the act, the act premeditated by intellect from the act that is the result of the diseased mind? This Court must, and can only, discover this line by examining the pre-accident and post-accident conduct of the decedent, conduct which steps forward and speaks on his behalf, and the expert testimony of the psychologist who performed the psychological autopsy. (*Campbell v. Young Motor Co.* 1984)

In the subsequent 1992 Kansas case of *Rodriguez v. Henkle Drilling and Supply Company*, a deceased man's wife sued for benefits, alleging that injuries her husband sustained while working on irrigation wells resulted in constant pain, decreased self-esteem, and depression that resulted in his suicide 2 years later. The employer presented findings from two psychological autopsies that indicated that the deceased had had difficulties with alcohol and drug use, prior suicidal threats, and marital problems.

The experts conducting the psychological autopsy testified that work-related injuries were not a significant cause of the man's suicide. The trial court found that although a worker's suicide does not automatically preclude compensation, the claimant failed to prove that her husband's work injuries resulted in his suicide (*Rodriguez v. Henkle Drilling and Supply Company* 1992). In both of these workers' compensation cases, the findings from the psychological autopsies were allowed into evidence to assist the court's understanding of the relation between a work-related injury and the employee's later suicide.

Inheritance Litigation

A psychological autopsy may be helpful in determining whether an individual was sane or insane regarding his or her estate's legal right to a potential inheritance following the individual's commission of a homicide-suicide. In general, a perpetrator who takes a person's life cannot inherit or profit from his or her crime. For example, if a son shoots his father because his father was about to alter his will to exclude his son, the son could not profit from his father's death. Does this principle apply if a person commits a homicide and then takes his own life? Would the homicide victim's assets be included in the deceased perpetrator's estate if this perpetrator had been included in the victim's will? In some states, the answer to this question requires a determination of whether the killer would have met the state's legal test of criminal insanity at the time of the homicide. For example, in New York, if the evaluation finds that the deceased perpetrator would have met the criminal test for insanity, then the killer's estate may profit from the victim's estate (Goldstein 1986).

Criminal Cases

The psychological autopsy also may provide useful information in the evaluation of defendants involved in the criminal justice system. Most commonly, a psychological autopsy may be requested from a defendant charged with homicide to support his or her defense that the death with which he or she is charged was actually a result of the victim's suicide. In the case of *United States v. St. Jean* (1995), a husband charged with the premeditated murder of his wife argued that his wife's death was as likely a result of a suicide as a homicide, and therefore reasonable doubt existed as to his guilt. To rebut this assertion, the prosecutor called an expert who had conducted a psychological autopsy of the victim and was prepared to testify that none of the factors normally associated with suicide was present. The defense challenged the admissibility of the psychological autopsy results, alleging that they were unreliable and that the evaluator

was not an expert in suicidology. The court allowed the expert's testimony, and the results of the psychological autopsy were deemed admissible on appeal (Biffl 1996; *United States v. St. Jean* 1995).

Results from psychological autopsies also may be allowed in cases involving criminal child abuse. *Jackson v. State* (1989) is a frequently cited case in which a psychological autopsy examined the alleged relation between a mother's alleged abusive behavior and her daughter's subsequent suicide. In this case, a mother altered her 17-year-old daughter's birth certificate so that she could work as a nude dancer in a nightclub. The teenager subsequently shot herself, and a psychiatrist was prepared to testify that the mother's behavior was a substantial factor in the daughter's suicide. Although the defense argued that psychological autopsies were not reliable and therefore not admissible, the court reasoned that the jury could determine the reliability of this testimony and allowed the psychological autopsy results into evidence. Dr. Douglas Jacobs, a psychiatrist specializing in suicidology, testified that the abusive relationship with the mother was a substantial contributing cause of the teenager's suicide. The mother was found guilty of child abuse, and this verdict was challenged. A Florida appellate court held that the state had presented sufficient evidence to establish that psychological autopsies examining suicides had gained acceptance in the field of psychiatry and that the trial judge did not err in allowing the psychiatrist's testimony (*Jackson v. State* 1989).

In a subsequent Ohio case, a father was alleged to have repeatedly sexually abused his daughter. After she committed suicide, he was charged with nine counts of sexual battery and involuntary manslaughter. A psychological autopsy was conducted to determine if there was a connection between the father's alleged sexual abuse and his daughter's suicide. The father filed a motion to exclude the results of the psychological autopsy. Although the courts ultimately determined that the father could not be charged with involuntary manslaughter for his daughter's suicide, they commented that the results of the psychological autopsy could be relevant to the charges of sexual abuse. The court also emphasized that the possible relation of the father's sexual abuse to his daughter's suicide could be considered as evidence during his sentencing phase (*State v. Huber* 1992).

Components of the Psychological Autopsy

Schneidman (1981) recommended that forensic evaluators review 14 areas when conducting the psychological autopsy (Jacobs and Klein-Benheim 1995). Table 27–6 outlines important areas to review when conducting a psychological autopsy.

TABLE 27–6. Areas to review for psychological autopsy

Basic identifying information (e.g., age, gender, marital status, occupation)
Specific details of the death
Outline of the victim's history to include previous suicide attempts
Family psychiatric history (i.e., suicides and mood disorders)
Victim's personality and lifestyle characteristics
Victim's historical pattern of reaction to stress and emotional lability
Recent stressors or anticipated conflicts
Relation of alcohol and drugs to the victim's lifestyle and death
Quality of the victim's interpersonal relationships
Changes in the victim's routine, schedule, and habits before death
Information relating to the "lifeside" of the victim (i.e., successes and plans)
Rating of lethality
Reaction of informants to the victim's death
Assessment of suicidal intention

Source. Jacobs and Klein-Benheim 1995; Shneidman 1981.

To accomplish such an analysis, the evaluator examines two sources of information when conducting the psychological autopsy (Isometsa 2001). The first source involves extensive interviews of family members, friends, and other individuals close to the victim. Such interviews are considered the more important source of information (Hawton et al. 1998). The second source is a thorough review of collateral records. Collateral documents that should be considered for review include the victim's psychiatric records, medical records, suicide notes, personal journals, computer hard drive, employment records, academic records (when indicated), and relevant legal documents such as the person's will or new insurance polices; police reports; witness statements; accident reports; and autopsy reports.

Although often admitted into evidence in a courtroom proceeding, psychological autopsies have been criticized for lacking basic psychometric test qualities such as reliability and validity. To address these concerns, the Centers for Disease Control and Prevention developed the Empirical Criteria for Determination of Suicide (ECDS). This instrument has 16 items that review a person's mental state at the time of his or her death and has been shown to be 92% accurate in differentiating between a suicide and an accident. The 16 items included on this instrument are listed in Table 27–7 (Jobes et al. 1986; Simon 1998).

The ECDS serves to supplement the evaluator's clinical judgment and may provide useful data to submit to support opinions reached in the psychological autopsy (Simon 1998).

TABLE 27–7. Suicide and mental state checklist

1. Pathological evidence (autopsy) indicates self-inflicted death.
2. Toxicological evidence indicates self-inflicted harm.
3. Statements by witnesses indicate self-inflicted death.
4. Investigatory evidence (e.g., police reports, photographs from scene) indicates self-inflicted death.
5. Psychological evidence (observed behavior, lifestyle, personality) indicates self-inflicted death.
6. States of the deceased indicate self-inflicted death.
7. Evidence indicates that decedent recognized high potential lethality of means of death.
8. Decedent had suicidal thoughts.
9. Decedent had recent and sudden change in affect (emotions).
10. Decedent had experienced serious depression or mental disorder.
11. Decedent had made an expression of farewell, indicated desire to die, or acknowledged impending death.
12. Decedent had made an expression of hopelessness.
13. Decedent had experienced stressful events or significant losses (actual or threatened).
14. Decedent had experienced general instability in immediate family.
15. Decedent had recent interpersonal conflicts.
16. Decedent had history of generally poor physical health.

Source. Jobes et al. 1991; Simon 1998.

Conducting the Psychological Autopsy

Surviving family members, friends, and colleagues may be reluctant to speak with an examiner following the victim's death. Because the evaluator may have only one opportunity to interview a key informant, it is helpful to review carefully in advance the collateral documents when formulating interview questions. The evaluator should be sensitive to a variety of feelings that the person interviewed may experience. Such feelings range from extreme grief accompanied by guilt, sadness, or anger to suspicion and mistrust regarding the examiner's role. In some circumstances, if the examiner determines that the cause of death was an intentional suicide, the individual being interviewed may endure a financial loss and therefore may have substantial reluctance to participate in the postmortem analysis. Such individuals also may have significant motivation to misrepresent information.

Although some family members may be reluctant to discuss suicidal communications, a sudden death from suicide may be genuinely surprising to most family members. Research indicates that only one-third

to one-half of all victims examined in a psychological autopsy had communicated explicit statements of suicidality to their family members or health care professionals during the months before their death (Barraclough et al. 1974; Isometsa et al. 1994; Robins 1959). Likewise, a clinician may not know that his or her patient was contemplating taking his or her own life. In a Finnish review of 100 suicides of persons who had met with a health care professional on the day of their suicide, only 21% had communicated their suicidal intent to their clinician (Isometsa 2001; Isometsa et al. 1995).

When is the best time to conduct the interviews? Postmortem researchers of suicide have conducted interviews of informants ranging from a few weeks to 6 months after the victim's death. Brent and colleagues (1988b) reported that when interviews were performed between 2 and 6 months after the suicide, no significant relation was found between the timing of the interview and the reporting of important diagnostic history and familial variables. However, studies also have found that survivors are more satisfied when interviews are conducted less than 10 weeks following the suicide rather than later (Runeson and Beskow 1991).

Various approaches have been proposed for contacting informants to arrange the interview. Researchers have found that contacting informants by letter followed by a telephone call 1 week later resulted in a high acceptance rate, with 77% of the approached families agreeing to be interviewed (Brent et al. 1988b). In contrast, other researchers have achieved a low rejection rate by first contacting the survivors by telephone before sending a letter. By speaking directly with the informant during the initial contact, the evaluator is able to assess the reaction of the survivor (Beskow et al. 1990). When a letter is used to contact a close survivor, improved outcomes may be achieved through attempts to personalize the letter by referring to the deceased as "your son," "wife," "partner," or other appropriate phrase (Cooper 1999). Procedures that require the informant to complete a personality inventory of the deceased in advance of the interview have generated negative reactions from interviewees and are not recommended (Beskow 1979).

The evaluator must use caution in setting up the interview on potentially sensitive dates such as the victim's birthday or the anniversary of his or her death. The examiner needs to be flexible and sensitive to the emotional needs of the interviewee. In a pilot study that examined factors increasing the acceptability of the interview, Cooper (1999) determined that asking questions surrounding the death during an early stage of the interview was recommended to alleviate anxiety as soon as possible. In addition, the use of the phrase "sudden death" instead of

"suicide" was generally preferred, especially in those cases in which the informant did not believe the death was a result of suicide.

The evaluator needs to anticipate the potential grief, guilt, or distress that an informant may experience during the interview. A refusal to participate during the first contact should be respected. The examiner may invite the individual to contact him or her when and if he or she is ready to do so. Although the investigator may discuss the factual circumstances of the death, information that has been concealed from relatives or close friends generally should not be disclosed (Beskow et al. 1990). In summary, the psychological autopsy is a delicate examination that balances the need to obtain sufficient relevant information with the requirement to treat both the survivors and the deceased person with dignity and respect.

❑ Key Points

- The most common malpractice claims against psychiatrists are those that involve a patient's suicide.
- To establish malpractice, the plaintiff must prove that a dereliction of duty directly resulted in damages.
- Psychological autopsies have been accepted into evidence in legal proceedings and can play a critical role in the outcome of both civil and criminal litigation.
- The psychological autopsy involves a combination of in-depth interviews with surviving family members and friends and an extensive review of collateral records.

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