Considering the essentially phenomenological focus of psychological autopsy, an explicit termination message from the deceased is seen as a critical element in recommending a verdict of suicide. A combination of a reliably reported *I want to die* message with behavioral evidence of significant life stress, frequently involving loss of a significant role or relationship, constitutes, in my opinion, sufficient and necessary conditions for a suicide recommendation.

Differing points of view about necessary and sufficient criteria for making a recommendation to the coroner certainly exist, and those that are used should be identified in the formal psychological autopsy report. The failure to develop specific criteria for the recommendations about probable mode of death will maintain psychological autopsy at the conceptual level of clinical intuition and doom any effort to incorporate the procedure into coherent knowledge about the processes of death.

As an organized method of investigation, psychological autopsy is in its infancy. Careful nourishment with defined procedures and criteria is necessary to prevent its premature and equivocal expiration.

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The Psychological Autopsy

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I wish to make some comments relative to the report of the USS *Iowa* incident (Poythress, Otto, Darkes, & Starr, January 1993).

In general, it can be said that there are four kinds of death investigations: the medical autopsy, the forensic investigation, the statistical or demographic report, and the psychological autopsy. Unfortunately, the forensic investigation and the statistical report are often confused with (or passed off as) a psychological autopsy. A brief description of each type of death-follow-up procedure might be useful.

1. Autopsy. The autopsy involves inspection and partial dissection of a dead body to learn the cause of death, the nature and extent of disease, and where possible, the mode of death. It is an examination by a physician–pathologist (and ancillary personnel). It is objective; it reports the facts—the weight of the brain, alcohol content of the blood, appearance of the liver, and so forth. The pathologist acts as an amicus curiae, specifically as a friend to the state, reporting the findings concerning a particular dead person for public and archival record. The autopsy is not adversarial; it does not pull for one particular mode of death over another or for the indictment of a particular individual.

2. Forensic investigation. The forensic investigation relates to the physical evidence surrounding the death. It may include a plethora of relevant details: windows open, doors locked, trajectory of bullets, powder marks, fingerprints, handwriting analyses, personal documents (suicide notes, threatening letters, cashed checks, etc.). Although these facts can be centrally relevant in either criminal or civil cases and need to be done as thoroughly as possible, a report of forensic details is, of course, not an autopsy at all—and certainly not a psychological autopsy—but an *investigation*. Often these investigations in civil suits, conducted as they are in an adversarial situation and paid for by one side or another, are "gumshoe" investigations, contaminated by conscious or unconscious bias, in which data are sometimes selectively reported or even deliberately perverted.

3. Statistical or demographic reports. If one is interested in, for example, the prevention of suicide, then it is obvious that knowledge of past patterns of behavior of individuals who have committed suicide can be a useful tool. These patterns might be called *prodomal indices* or *premonitory signs*. They make up the now well-known "clues to suicide" (Shneidman & Farberow, 1957). What may not be so obvious is that the statistical truths about a large number of committed suicides do not necessarily tell us anything about any particular case. The frequent error in this field is to confuse statistics with individual events and then to argue that because this individual does (or does not) have certain desiderata characteristic of a group, suicide must have (or must not have) occurred. Statistics are made up of individual cases; an individual case is not controlled by statistics. To argue from statistics to an individual case is a tyro's error. An example from my experience: In a recent criminal case (in which a man was accused of murdering his wife) the "expert witness" for the prosecution seriously argued that the wife could not have committed suicide because she was in the nude, and there was no record in his jurisdiction of a woman (in that age range) committing suicide whilst nude; hence, the husband must be guilty of homicide (Shneidman, 1993b). One must be on the alert for this kind of reverse reasoning. In any event, the citation of statistical and demographic data, even when cogent and sensible, is clearly not a psychological autopsy—although it was so asserted in the case cited above.

4. Psychological autopsy. The clarification of the mode—natural, accident, suicide, homicide—of some deaths devolves on the *intention* of the decedent in relation to the death (suicide, by definition, is an intentioned death). The psychological autopsy was devised to assist certifying officials to clarify deaths that were initially ambiguous, uncertain or equivocal as to the mode of death (Curphey, 1961; Litman, Curphey, Shneidman, Farberow, & Tabachnick, 1963; Shneidman, 1969, 1973, 1977, 1993b). A psychological autopsy is a consultation to the chief medical examiner, coroner, or certifying official. It should be as objective as an autopsy. It is something of a contradiction to talk about an adversarial psychological autopsy that, for example, interviews the survivors on only one side of a litigation or has a monetary or an ego-centered stake in one outcome or another. Simply put, the psychological autopsy seeks to make a reasonable determination of what was in the mind of the decedent vis-à-vis his or her own death. It does this by looking at lifestyle, behavioral history, as well as the characterogical elements that contribute to that history: the degree of ambivalence, the clarity of cognitive functioning, the amount of organization or obsession, the state of turmoil or agitation, and the amount of psychic pain (Shneidman, 1993a). A psychological autopsy is a behavioral science impartial investigation of the psychological (motivational, intentional) aspects of a particular death. It legitimately conducts interviews (with a variety of people who knew the decedent) and examines personal documents (suicide notes, diaries, and letters) and other materials (including the autopsy and police reports) that are relevant to the *psychological* assessment of the dead individual's role in the death. Often the results cannot be stated with certainty. The

psychological autopsy is not a gumshoe operation. I believe that a detective, a prosecutor, or a "hired gun" psychologist (or psychiatrist) cannot properly conduct a psychological autopsy. In the recent past, regrettably, we have seen misrepresentations of the psychological autopsy procedure by avid expert witnesses who seek to cloak themselves with the honorific aura of an impartial procedure. The court or the attorneys have a responsibility to clarify what the psychological autopsy procedure actually is before anyone involved in the courtroom proceedings is permitted to claim that it has been used.

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Mixed Emotion About Richard Lazarus's Theory of Emotion

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Doubtless my bias as a clinician affected my reading of Richard Lazarus's article in the August 1991 issue of the *American Psychologist* ("Progress on a Cognitive–Motivational–Relational Theory of Emotion"). Clinicians are interested in the problem of emotion, even when discussed by a person with a substantial reputation in the field of social psychology.

The article troubled me because (a) Although it promised a theory of emotion, I failed to recognize it as a theory, and (b) although progress on the theory was claimed on the basis of increased numbers of publications, the equation of popularity with convincing proof struck me as odd.

Lazarus (1991) designated anxiety as one of the four emotions he would discuss in relation to his theory (the others were anger, sadness, and pride), and with naivete I assumed there would be some reference or allusion to the work of Harry Stack Sullivan—arguably the greatest American psychiatrist of the 20th century—whose interpersonal theory rested on the concept of anxiety; but no, there was neither reference nor allusion. Even though Sullivan must have suffered considerably from the abuse of colleagues when he defined psychiatry as the study of interpersonal processes and, therefore, of processes of obvious interest to social psychologists, I had to conclude that Lazarus was following a track that excluded the relevant work of clinicians on the ground of fundamental differences between clinicians and social psychologists.

Anger was an emotion to which Lazarus (1991) paid special attention. He cited research on five- to six-month-old infants in which they attempt to pull away from a restraining force as signifying that the infants were able to identify the restraining force and react with anger, further signifying that the infants had by then achieved an "ego identity" capable of distinguishing self and other. The formulation sounds similar to that of two well-known child psychoanalysts, Melanie Klein and Margaret Mahler; but once more Lazarus failed to reference or allude to them. Aside from the duty to reference or allude to the work of relevant others, how could Lazarus be so certain that the infants' response was anger rather than, say, a reflex response to restraint? As an academic psychologist, I would have expected him to offer alternatives.

At a certain point in reading Lazarus (1991) on emotion, it occurred to me that his cognitive–motivational–relational theory, or what passed for it, sounded strikingly like the psychobiosocial "theory" espoused, I believe, by the psychiatrist George Engel some years ago, which has received surprising acceptance by psychiatrists. Of course, there is no such thing as a psychobiosocial "theory," regardless of popularity, because all the term can possibly mean is that psychiatry is in part psychological, in part biological, and in part sociological.

Particularly in his discussion of anger, Lazarus (1991) referred to blame. I was especially interested because blame for several years during the latter part of the 1980s was a topic to which I gave considerable attention as it occurs in the arena of family therapy. Lazarus appeared to consider blame, in relation to anger, as a consequence in which a party holds another accountable for some action or another and credits a colleague for bringing the concept of accountability to his or her attention. I would suggest, however, that Lazarus failed to define accountability in blame with sufficient specificity. In blame, someone is held accountable for committing a *wrongful* act, an act that produced harm. Someone can be held *accountable* for paying a debt but not be *blamed* until there has been failure to pay.

Lazarus (1991) was not shy to use anecdotal material when he felt it was necessary to illustrate a point, but not everyone would accept his anecdotes. For example, he attempted at one point to illustrate the difference in emotional reaction of a customer who enters a store for a purchase, only to find the clerk on the phone talking to a friend, with the reaction when the same customer enters the store and finds the clerk inundated with customers. In the first instance, Lazarus concluded that the customer would be angry at the clerk, but in the second instance would be sympathetic because the clerk was overwhelmed. In the second instance, the customer might hold the store owner responsible for not providing sufficient clerks for his customers.

Now, I am not suggesting that Lazarus (1991) was wrong in his anecdote, but I wonder why he failed to recognize that the customer could be as angry with the clerk in the first instance as in the second—that is, that the clerk would be held to blame regardless of the circumstances. Lazarus claimed in his article that he had found it useful to describe emotion in metaphors. For him, for example, emotion is "personal, hot"; whereas the absence of emotion is "impersonal, cold." This distinction strikes me as correct only in a minimal sense. Has Lazarus never met the person who at first glance appeared "impersonal, cold," but experience with that person showed the opposite to be true because the observer judged emotional responsivity wrongly or inadequately?

How can it be that at this moment in the state of the art that the clinician and social psychologist can be so far apart with respect to a topic with which both are intimately connected?

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