Alan L. Berman

SUICIDE EXPERT

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March 10, 1997

~~PERSONAL AND CONFIDENTIAL~~

Alan L. Berman, Ph.D.
Washington Psychological Center, P.C.
4201 Connecticut Avenue, Northwest
Suite 602
Washington, D.C. 20008

Dear Dr. Berman:

Attached is a draft report on the Foster death for your review. While it still has a couple of loose ends, it is a fairly complete draft. We ask you to do two things. First, we seek your advice or suggestions about any and all aspects of the report. No question or suggestion is too minor. Second, before the report is filed with the Court, we want you to be very comfortable that the report accurately reflects your understanding of the evidence and your conclusions. That obviously will require a careful review on your part.

We would hope that you could turn this draft around within a week or so -- by about March 18. Depending on the responses we receive to this draft of the report, we may then ask you to review it one more time before it is filed.

We would ask that you continue not to answer any media inquiries about this matter. Please refer all such inquiries to this Office, and we will address them as appropriate.

Please feel free to contact me at 202-514-8688 or Jim Clemente if you have any questions. Thank you as always for your generous help.

Sincerely,

John D. Bates

Office of the Independent Counsel

1001 Pennsylvania Avenue, N.W.
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March 10, 1997

~~PERSONAL AND CONFIDENTIAL~~

Brian D. Blackbourne, M.D.
County Medical Examiner
555 Overland Avenue, Building #14
San Diego, California 92123

Dear Dr. Blackbourne:

Attached is a draft report on the Foster death for your review. While it still has a couple of loose ends, it is a fairly complete draft. We ask you to do two things. First, we seek your advice or suggestions about any and all aspects of the report. No question or suggestion is too minor. Second, before the report is filed with the Court, we want you to be very comfortable that the report accurately reflects your understanding of the evidence and your conclusions. That obviously will require a careful review on your part.

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March 10, 1997

~~PERSONAL AND CONFIDENTIAL~~

Dr. Henry C. Lee, Chief
Connecticut State Police
Bureau of Forensic Science
278 Colony Street
Meriden, Connecticut 06451

Dear Dr. Lee:

Attached is a draft report on the Foster death for your review. While it still has a couple of loose ends, it is a fairly complete draft. We ask you to do two things. First, we seek your advice or suggestions about any and all aspects of the report. No question or suggestion is too minor. Second, before the report is filed with the Court, we want you to be very comfortable that the report accurately reflects your understanding of the evidence and your conclusions. That obviously will require a careful review on your part.

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Sincerely,

John D. Bates

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SUMMARY C.V.: DR. ALAN L. BERMAN (LANNY)

Dr. Berman is Executive Director of the American Association of Suicidology (AAS). He is a Past-President of the AAS (1984-1985) and their 1982 Shneidman Award recipient (for Outstanding Contributions in Research in Suicidology). In addition, he serves on the Board of Directors of the National Committee on Youth Suicide Prevention.

Dr. Berman holds a B.A. degree from the Johns Hopkins University and a Ph.D. from the Catholic University of America. From 1969 to 1991 he taught at the American University where he attained the rank of tenured full professor. In 1991 Dr. Berman changed his appointment to that of Distinguished Adjunct Professor when he was named Director of the newly established National Center for the Study and Prevention of Suicide at the Washington School of Psychiatry.

A Diplomate in Clinical Psychology (American Board of Professional Psychology) and a Fellow of the American Psychological Association, Dr. Berman maintains a full time private practice of psychotherapy and psychological consultation at the Washington (D.C.) Psychological Center. He has published over 70 professional articles and book chapters. From 1990-1994, he served as Case Consultation Editor of the journal Suicide and Life Threatening Behavior (SLTB). He continues as a consulting editor to SLTB and two other journals, and writes a column for the international journal, Crisis.

Dr. Berman appears frequently on both national and local media. He has appeared on The Today Show (2x), Good Morning America, Hour Magazine, and The Larry King Show and has testified on Capitol Hill three times. He served on the HHS Federal Task Force on Youth Suicide Prevention (1985-6) and was an initiating member of the Centers for Disease Control sponsored "Working Group" on the operational criteria for the classification of suicide and the NIMH sponsored conference on developing a nomenclature for suicide morbidity. He frequently is asked to serve as an expert witness in legal cases involving suicide malpractice and wrongful death and has a national reputation as a

teacher and professional workshop leader on the topics of suicide and youth suicide (assessment and intervention).

Dr. Berman has edited (1) Suicide Prevention: Case Consultations (1990), N.Y.: Springer; is the senior author of (2) Adolescent Suicide: Assessment and Intervention (1991), Wash., D.C.: American Psychological Association (David Jobes, co-author); and co-edited (with Drs. Ronald Maris, John Maltsberger, and Robert Yufit) (3) Assessment and Prediction of Suicide (NY: Guilford Press). He currently is under contract with Guilford Press to write (4) The Comprehensive Textbook of Suicidology (with Drs. Ronald Maris and John Mann) and (5) Avoiding Liability with Suicidal Patients (with Drs. Bruce Bongar, Ron Maris, and Morton Silverman).

Revised: March, 1996

VITA

Name: Alan Lee Berman (Lanny)

Address: (office) Washington Psychological Center, P.C.
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(home) 7200 Maple Ave.
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Date of Birth: [redacted] FOIA(b)(6)

Marital Status: Married, 2 sons

Education: Malden, MA High School (1961)
The Johns Hopkins University (B.A., 1965)
The Catholic University of America (Ph.D., 1970)

Current Employment:

1995-: Executive Director, American Association of Suicidology, Washington, DC

1991-1995: Director, The National Center for the Study and Prevention of Suicide, Washington School of Psychiatry, Washington, DC

1977-present: Private practice of psychotherapy and psychological consultation. Washington Psychological Center, P.C.

1991-present: Distinguished Adjunct Professor of Psychology, American University, Washington, DC

Past Employment:

1969-1991: Department of Psychology, American University, Washington, D.C.: professor with tenure (1979-1991); associate professor (1975-79); assistant professor (1970-74); instructor (1969).

1971-1976: Part-time practice of psychotherapy and psychological consultation. Washington, D.C.

1969-1976: The American University Counseling Center. Joint appointment with

academic position. Director of internship and externship training; Co-director, A.U. Multiple Emergency Service.

Part-Time Past Employment:

1972-1976: Kingsbury Center, Washington, D.C.
1972: Guide, Inc., Montgomery County, MD.
1968-1972: Boy's Village of Maryland, Cheltenham, MD.

Honors/Awards

Edwin S. Shneidman Award for outstanding contribution in research, American Association of Suicidology, 1982.

Diplomate in Clinical Psychology, American Board of Professional Psychology, 1979.

Elected Fellow, Academy of Clinical Psychology, 1994.

Elected Fellow, International Academy of Suicide Research, 1993.

Appointed (April, 1994) Editor-in-Chief, Suicide and Life- Threatening Behavior, 1995-2000. Position returned to current editor in November, 1994 in order to accept following:

Elected (November, 1994) Executive Director, American Association of Suicidology.

Consulting Editor, Suicide and Life-Threatening Behavior, 1981-present.

Case Conference Editor, Suicide and Life-Threatening Behavior, 1989-1995.

President, American Association of Suicidology, 1984-1985.

Board of Directors, National Committee on Youth Suicide Prevention, 1984-present.

Elected Fellow, American Psychological Association, Division 12 (Clinical), 1986; Division 42 (Independent Practice), 1990; Division 29 (Psychotherapy), 1993.

Appointed, Task Force on the Prevention of Adolescent Suicide, U.S. Dept. of Health and Human Services, 1985-6.

Appointed, Violence Prevention Panel, Centers for Disease Control, Atlanta, GA, 1990-1991.

President, Mid-Atlantic Regional Chapter of the American Association of Suicidology (MARCASS), 1992-1993.

Appointed Founding Editorial Board Member, Crisis Intervention and Time-Limited Treatment, 1992-present.

Appointed, Columnist, Crisis, 1993-present

Elected, Faculty, Child and Adolescent Program, Washington School of Psychiatry (1993-); and Brief Psychotherapy Program (1993-).

Recipient, Governor's Citation, State of Maryland (1993)

Co-Director, Summer Institutes at Santa Fe, American Association of Suicidology, 1990-1994.

Publications:

Books

Berman, A. L. (Ed.) (1982). Proceedings of the fourteenth annual meeting of the American Association of Suicidology, Albuquerque.

Berman, A.L. (Ed.), (1990). Suicide Prevention: Case Consultations. N.Y.: Springer.

Berman, A.L. & Jobes, D.A. (1991). Youth Suicide: Assessment and Intervention, Washington, D.C.: American Psychological Association. (Currently in 4th Printing).

Maris, R. W., Berman, A.L., Maltsberger, J.T., & Yufit, R. (Eds.) (1992). Assessment and Prediction of Suicide. New York: Guilford. Chosen as Book-of-the-Month by the Behavioral Science Book Service.

Leenaars, A. A., Berman, A. L., Cantor, P., & Maris, R. W. (Eds.). (1993). Suicidology: Essays in Honor of Edwin S. Shneidman. Nothvale, New Jersey: Jason Aronson.

Maris, R. W., Berman, A. L., & Mann, J. (In Preparation). Comprehensive Textbook in Suicidology. New York: Guilford.

Berman, A. L. & Litman, R. E. (In Preparation). Forensic Suicidology: The Psychological Autopsy.

Bongar, B., Berman, A.L., Litman, R., Maris, R. W., & Silverman, M. M. (In Press). Avoiding Liability with Suicidal Patients. New York: Guilford.

Book Chapters, Articles, Monographs

Berman, A. L. The image of the University: Faculty perspectives of the American University. (1970). Washington, D.C.: The American University.

McCarthy, B. W. & Berman, A. L. (1971). A student-operated crisis center. Personnel & Guidance Journal, 49, 523-528. Reprinted in NIMH Mental Health Digest (1971), 3, 3-4. Reprinted in Zimpfer, D. (Ed.). (1973). Paraprofessionals in Counseling and Personnel Services.

Berman, A. L. (1971). Social Schemas: An investigation of age and socialization variables. Psychological Reports, 28, 430.

Berman, A. L. (1971). Reply to Kuethe: On replacing the replacement technique. Psychological Reports, 28, 430.

Berman, A. L. (1972). Videotape self-confrontation of schizophrenic ego and thought processes. Journal of Consulting & Clinical Psychology, 39, 78-85.

Berman, A. L. & McCarthy, B. W. (1972). Curriculum "relevance" and community mental health. Journal of College Student Personnel, 13, 77-78.

Berman, A. L., Messersmith, C. E., & Mullens, B. N. (1972). A profile on group therapy practice in university counseling centers. Journal of Counseling Psychology, 19, 353-354.

Berman, A. L. (1972). Crisis interventionists and death awareness: An exercise for training in suicide prevention. Crisis Intervention, 4, 47-52.

Berman, A. L. (Ed.) (1972). The university as community: Studies of the student and university culture. Washington, D.C.: The American University.

Berman, A. L. (1973). Experiential training for crisis intervention. In G. Spector & W. Claiborne (Eds.), Crisis intervention, Vol. 2: A topical series in community-clinical psychology (pp. 95-106). New York: Behavioral Publications.

Berman, A. L. (1973). Smoking Behavior: How is it related to locus of control, death anxiety, and belief in afterlife? Omega, 4, 149-155.

Berman, A. L. & Hays, J. E. (1973). Relation between death anxiety, belief in afterlife and locus of control. Journal of Consulting and Clinical Psychology, 41, 318.

Berman, A. L. (1974). Belief in afterlife, religion, religiosity, and life-threatening experiences. Omega, 5, 127-135.

Leventhal, A. L, Berman, A. L., McCarthy, B. W., & Wasserman, C. W. (1974). The P.E.A.C.E. program at American University: A report after one year's operation. Washington, D.C.: The American University.

Berman, A. L. (1975). Self-destructive behavior and suicide: Epidemiology and taxonomy. In A. R. Roberts (Ed.), Self-destructive behaviors. Springfield, IL: C.C. Thomas.

Berman, A. L. (1975). Group psychotherapy training: Issues and models. Small Group Behavior, 6, 325-344.

Berman, A. L. (1975). The epidemiology of life-threatening events. Suicide, 5, 67-77.

Krieger, H., Wasserman, C., Berman, A., McCarthy, B., & Krieger, J. (1975). The American University "Hotline": A model telephone crisis intervention service.

American Psychological Association Journal Abstract Service, 5, No. 862, 125 pp.

Leventhal, A., Berman, A., McCarthy, B., & Wasserman, C. (1976). The P.E.A.C.E. training program. In P.G. Schauble, J.L. Resnik, & J.I. Morgan (Eds.), Paraprofessional training: Functions, methods & issues, 2, (pp. 52-57), University of Florida Psychological and Vocational Counseling Center Monograph.

Leventhal, A., Berman, A., McCarthy, B., & Krieger, H. (1977). Peer counseling on a university campus. Journal of College Student Personnel, 504-509.

Berman, A. L. (1977-1978) (Associate Ed.). Spouse Abuse. Victimology, 2, No. 3-4.

Berman, A. L. (1979). Dyadic death: Murder-suicide. Suicide and Life-threatening Behavior, 9, 23-25.

Berman, A. L. (1979). An analysis of suicidal and non-natural deaths among the Duck Valley Indians. Final report to the McCormick Foundation. Washington, D.C.: American University.

Scruggs, J., Berman, A. L., & Hoage, C. (1980). The Vietnam veteran: Psychological consequences of the Vietnam war. Military Medicine, 145, 267-269.

Cohen-Sandler, R. & Berman, A. L. (1980). Diagnosis and treatment of childhood depression and self-destructive behavior. Journal of Family Practice, 11, 51-58.

Berman, A. L. (1980). Indian suicide: The Duck Valley Reservation. Nevada Public Affairs Review, 1, 24-31.

Berman, A. L. (1981). Equivocal death casebook. Unpublished manuscript.

Cohen-Sandler, R., Berman, A. L., & King, R. (1982). Life stress and symptomatology: Determinants of suicidal behavior in children. Journal of the American Academy of Child Psychiatry, 21, 178-186.

Cohen-Sandler, R., Berman, A. L., & King, R. (1982). A follow-up study of hospitalized suicidal children. Journal of the American Academy of Child Psychiatry, 21, 398-403.

Berman, A. L. & Cohen-Sandler, R. (1982). Childhood and adolescent suicide research: A critique. Crisis, 3, 3-15.

Berman, A. L. & Cohen-Sandler, R. (1982). Suicide and the standard of care: Optimal vs. acceptable. Suicide and Life-Threatening Behavior, 12, 114-122.

Berman, A. L. & Cohen-Sandler, R. (1983). Suicide and malpractice: Expert testimony and the "standard of care." Professional Psychology: Research and Practice, 14, 6-19.

Berman, A. L. & Carroll, T. A. (1984). Adolescent suicide: A critical review. Death Education, 8 (Suppl.), 53-64.

Berman, A. L. (1984). Prepared statement. Teenage Suicide. Hearing before the Subcommittee on Juvenile Justice, Committee on the Judiciary, U.S. Senate, 10-3/84. Washington, D.C.: Government Printing Office.

Berman, A.L. (1985). The teenager at risk for suicide. Medical Aspects of Human Sexuality, 19(5), 123, 124, 129.

Berman, A.L. (1986). Helping Suicidal Adolescents: Needs and Responses. In C. Corr & J. McNeil (Eds.). Adolescence and Death. (pp. 151-166), NY: Springer.

Jobes, D. A., Berman, A. L., & Josselson, A. R. (1986). The impact of psychological autopsies on medical examiners' determination of manner of death. Journal of Forensic Sciences, 31, 177-189.

Berman, A. L. (1986). Notes on turning 18 (and 75): A critical look at our adolescence. Suicide and Life-Threatening Behavior, 16, 1-12.

Berman, A. L. & Cantor, P. (1986). Putting a stop to youth suicide. Enterprise, 35, 22-27.

Berman, A. L. (1986). Adolescent Suicide: Issues and Challenges. Seminars in Adolescent Medicine, 2, 269-277.

Jobes, D. A. & Berman, A. L. (1987). Improving the validity and reliability of officially reported suicide statistics. Suicide and Life-Threatening Behavior, 17, 310-325.

Berman, A. L. (1987). The problem of adolescent suicide. Division (37) of Child, Youth and Family Services Newsletter, American Psychological Association, 10, 1, 14-16.

Berman, A. L. (1987). Adolescent suicide: Clinical consultation. The Clinical Psychologist, 40, 87-89.

Berman, A. L. (1988). Fictional depiction of suicide in television films and imitation effects. American Journal of Psychiatry, 145, 982-986.

Rosenberg, M. L., Davidson, L., Smith, J., Berman, A. L., Buzbee, H., Ganter, G., Gay, G., Moore-Lewis, B., Harper Mills, D., Murray, D., O'Carroll, P., & Jobes, D. A. (1989). Operational criteria for the classification of suicide. Journal of Forensic Sciences, 33, 1445-1456.

Berman, A. L. (1989). Mass media and youth suicide prevention. In Alcohol, Drug Abuse, and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide. Volume 3: Prevention and Intervention in Youth Suicide. DHHS Pub. No. (ADM) 89-1623. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off.

Berman, A. L. (1989) Intervention in the media and entertainment sectors to prevent suicide. In Alcohol, Drug Abuse, and Mental Health Administration. Report of the Secretary's Task Force on Youth Suicide, Volume 4: Strategies to Prevent Youth Suicide, DHHS Pub. No. (ADM) 89-1624. Washington, D.C.: Supt. of Docs., U.S. Govt. Print. Off.

Berman, A.L. & Schwartz, R.H. (1990). Suicide attempts among adolescent drug users. American Journal of Diseases of Children, 144, 310-314.

Berman, A. L. (1990). Suicide interventions in schools: Critical reflections. In A. A. Leenars & S. Wenckstern (Eds.), Suicide Prevention in Schools, (pp. 243-255). Washington, D.C.: Hemisphere Publishing Co.

Berman, A. L. (1991). Child and Adolescent Suicide: From the Nomothetic to the Idiographic. In A. Leenars & D. Lester (Eds.). Suicide across the Life Span. (pp. 109-120). N.Y.: Plenum.

Berman, A.L. (in press). Child and Adolescent Suicide: Research Findings. In J. McIntosh, & J. Santos (Eds.). Suicide and the Life Cycle.

Jobes, D. A. & Berman, A.L . (1991). Crisis intervention and brief treatment of suicidal youth. In A.R. Roberts (Ed.), Contemporary perspectives on crisis intervention and prevention. Englewood Cliffs, N.J.: Prentice Hall, Inc. (pp. 53-69)

Berman, A. L. (1990). Standard of care in the assessment of suicidal potential. In D. Shapiro, (Ed.) Symposium on standards of care. Psychotherapy in Private Practice, 8(2), 35-41.

Ragland, J. D. & Berman, A. L. (1990-1991). Farm suicide: Dying on the Vine? Omega, 22 (3), 173-185.

Jobes, D. A., Casey, J. O., Berman, A. L., & Wright, D. G. (1991). Empirical criteria for the determination of suicidal manner of death. Journal of Forensic Sciences, 36 (1), 244-256.

Berman, A. L. & Jobes, D. A. (1992). Youth suicide. In B. Bongar (Ed.). Suicide: Guidelines for Assessment, Management, and Treatment. N.Y.: Oxford University Press (pp. 84-105).

Berman, A. L. (1992). Five potential suicide cases. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.). Assessment and Prediction of Suicide. New York: Guilford (pp. 235-254).

Maris, R. W., Berman, A. L. and Maltsberger, J. T. (1992). Summary and conclusions: What have we learned about suicide assessment and prediction? In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I Yufit (Eds.). Assessment and Prediction of Suicide. New York: Guilford (pp. 640-672).

Berman, A. L. (1992, June). What is the relationship between psychiatric diagnoses and suicidal behavior in adolescence? The Harvard Mental Health Letter, (p. 8).

Bongar, B., Maris, R. W., Berman, A. L., & Litman, R. E. (1992). Outpatient standards of care and the suicidal patient. Suicide and Life-Threatening Behavior, 22, 453-478.

Berman, A. L., Leenaars, A. A., McIntosh, J. & Richman, J. (1992). Case consultation: Mary Catherine. Suicide and Life-Threatening Behavior, 22, 142-149.

Also in Leenaars, A. A., Maris, R. W., McIntosh, J., & Richman, J. (Eds.), (1992). Suicide and the Older Adult, New York: Guilford (pp. 142-149).

Berman, A. L. (1993). Forensic suicidology and the psychological autopsy: Asphyxiation by drowning. In A. A. Leenaars, A. L. Berman, P. Cantor, & R. W. Maris (Eds.). Suicidology: Essays in Honor of Edwin S. Shneidman, Northvale, New Jersey: Jason Aronson (pp. 248-266).

Jobes, D. A. & Berman, A. L. (1993). Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient settings. Professional Psychology: Research and Practice, 24, 91-99.

Berman, A. L. & Samuel, L. (1992). Suicide among MS patients. Final Report to the Health Services Research Grant Program, National Multiple Sclerosis Society.

Berman, A. L. & Horgas, P. (1992). Investigative Study of Suicides. Final Report to the U. S. Postal System, Merrifield, VA.

Bongar, B., Maris, R. W., Berman, A. L., Litman, R. E., & Silverman, M. M. (1993). Inpatient standards of care and the suicidal patient. Part I: General clinical formulations and legal considerations. Suicide and Life-Threatening Behavior, 23, 245-256.

Bauer, M. N., Leenaars, A. A., Berman, A. L., & Jobes, D. A. (In Preparation). Late adult suicide: A life-span analysis of suicide notes.

Jobes, D. A. & Berman, A. L. (In press). Crisis assessment and time limited intervention with suicidal youth. In A. R. Roberts (Ed)., Clinical issues, crisis intervention, and time-limited treatment. New York: Guilford (pp).

Berman, A. L. & Samuel, L. (1993). Suicide among people with multiple sclerosis. Journal of Neurological Rehabilitation, 7, 51-59.

Silverman, M., Berman, A. L., Bongar, B., Litman, R., & Maris, R. (1994). Inpatient standards for the suicidal patient. Part II. An integration with clinical risk management. Suicide and Life-Threatening Behavior, 24, 152-169.

Berman, A. L. & Jobes, D. A. (1994). Treatment of the suicidal adolescent. Death Studies, 18 (4), 375-389.
Also in A. A. Leenaars, J. T. Maltsberger, & R. A. Niemeyer (Eds.) (1994). Treatment of suicidal people. London: Francis & Taylor.

Reynolds, F. M. T. & Berman, A. L. (1995). An empirical typology of suicide. Archives of Suicide Research. 1, 97-110.

Jobes, D. A., Berman, A. L., O'Carroll, P., Eastgard, S., & Knickmeyer, S. (in press). The Kurt Cobain suicide crisis: Perspectives from research, public health, and the news media. Suicide and Life-Threatening Behavior.

O'Carroll, P., Berman, A. L., Maris, R. W., Moscicki, E. K., Tanney, B. L., & Silverman, M. M. (in press). Beyond the Tower of Babel: A nomenclature for

suicide. Suicide and Life-Threatening Behavior.

Engelman, N. B., Jobes, D. A., & Berman, A. L. (submitted for review). Involuntary commitment: An investigation of the clinician's decision-making process.

Berman, A. L. (in press). Vulnerability and resilience: Depression and suicide. In F. H. Gabbay, R. J. Ursano, A. E. Norwood, C. S. Fullerton, & C. C. Duncan (Eds.) Sex differences, stress, and military readiness. Volume II. Bethesda, Maryland, USUHS, Department of Psychiatry.

Book Reviews

Berman, A. L. (1976). Book Review: The person in distress. Victimology, 1, 353-354.

Berman, A. L. (1979). Book Review: People in crisis. Victimology, 4, 156-158.

Berman, A. L. (1986). Book Review: Suicide in the Young. Suicide and Life-Threatening Behavior, 16, 70-72.

Berman, A. L. (1988). Essay/Book Review: "Playing the suicide game." [Review of The Suicidal Child and Suicide Clusters], Readings, 3, 20-23.

Berman, A. L. (1992). Book Review: Words I Never Thought to Speak. New England Journal of Medicine. (p.).

Berman, A. L. (In press). Book Review: The Suicidal Patient: Clinical and Legal Standards of Care. In Suicide and Life-Threatening Behavior,

Berman, A. L. (In press). Book Review: Suicide and Homicide Among Adolescents. In New England Journal of Medicine. (p.)

Proceedings

Berman, A. L. (1976). The physician and suicide. In B. Comstock & R. W. Maris (Eds.). Proceedings of the eighth annual meeting of the American Association of Suicidology, St. Louis.

Berman, A. L. (1976). An interactive research/training/outreach model for community gatekeepers. In Proceedings of the ninth annual meeting of the American Association of Suicidology, Los Angeles.

Berman, A. L. (1977). Homicide-suicide revisited. In P. Cantor (Ed.), Proceedings of the tenth annual meeting of the American Association of Suicidology, Boston.

Berman, A. L. (1979). A sociocultural autopsy: Self-destructive behavior among

the Duck Valley Indians. In J. Selkin & E. L. Martin (Eds.), Proceedings of the twelfth annual meeting of the American Association of Suicidology, Denver.

Cohen-Sandler, R. & Berman, A. L. (1983). Training suicidal children to problem-solve in non-suicidal ways. In C. Pfeffer & J. Richman (Eds.). Proceedings of the fifteenth annual meeting of the American Association of Suicidology, New York.

Berman, A. L. & Cohen-Sandler, R. (1984). The therapeutic alliance with suicidal patients: Thoughts on attributions of responsibility. In C. Vorkoper & K. Smith (Eds.). Proceedings of the sixteenth annual meeting of the American Association of Suicidology, Dallas.

Berman, A. L. & Tanney, B. L. (1985). Taking the mystery out of research. In R. Cohen-Sandler (Ed.). Proceedings of the seventeenth annual meeting of the American Association of Suicidology, Anchorage.

Cohen-Sandler, R. & Berman, A. L. (1986). Dyadic deaths and double phenomena. In Cohen-Sandler, R. (Ed.). Proceedings of the eighteenth annual meeting of the American Association of Suicidology, Toronto.

Berman, A. L. (1986). Suicidal youth-Review and assessment panel: Research perspective. In Cohen-Sandler, R. (Ed.). Proceedings of the 19th Annual Meeting of the American Association of Suicidology, Denver, CO.

Jobes, D. A., & Berman, A. L. (1986). To be or not to be? That was the question. In R. Cohen-Sandler (Ed.). Proceedings of the 19th Annual Meeting of the American Association of Suicidology. Denver, CO.

Berman, A. L. (1986). Suicide and the American film. In R. Cohen-Sandler (Ed.). Proceedings of the 19th Annual Meeting of the American Association of Suicidology. Denver, CO.

Ragland, J., & Berman, A. L. (1987). Farm crisis and suicide: Dying on the vine? In R. I. Yufit (Ed.). Proceedings of the 20th Annual Meeting of the American Association of suicidology and the 19th International Congress of the International Association of Suicide Prevention. Denver, CO.

Berman, A. L. (1987). Suicide and the mass media. In R. I. Yufit (Ed.). Proceedings of the 20th Annual Meeting of the American Association of suicidology and the 19th International Congress of the International Association of Suicide Prevention, Denver, CO.

Berman, A. L. & Schwartz, R. (1989). Suicide attempts among adolescent drug abusers. In D. Lester (Ed). Proceedings of the 22nd Annual Meeting of the American Association of Suicidology, San Diego, CA.

Berman, A. L. (1990). Assessment and prediction of suicide: A case approach. In D. Lester (Ed). Proceedings of the 23rd Annual Meeting of the American Association of Suicidology, New Orleans, LA.

Berman, A. L. & Samuel, L. (1990). Suicide among multiple sclerosis patients. In D. Lester (Ed.). Proceedings of the 23rd Annual Meeting of the American Association

of Suicidology, New Orleans, LA.

Berman, A. L. & Maris, R. W. (1991). Suicidal behaviors -- Toward consnsus definitions. In D. Lester (Ed.). Proceedings of the 24th Annual Meeting of the American Association of Suicidology, Boston, MA.

Lester, D., Berman, A. L., Clarke, R., Richman, J. (1991). The psychological meaning of the method of suicide. Proceedings of the 24th Annual Meeting of the American Association of Suicidology, Boston, MA.

Berman, A. L. & Horgas, P. (1992). Analysis of an adult cluster. Proceedings of the 25th Annual Meeting of the American Association of Suicidology, Chicago.

Papers, Presentations

Berman, A.L. The effect of videotape self-confrontation on schizophrenic functioning. Presented to the Overholzer Division of Clinical Research, St. Elizabeth's Hospital, Washington, D.C., 3/70.

Berman, A.L. The American University Multiple Emergency Service. Presented at the Manpower Innovations and Mental Health Crisis Intervention Services Workshop, The American University, Washington, D.C. 1/71.

Berman, A.L. Standards for campus crisis centers. Presented at the American Association of Suicidology Convention, Washington, D.C., 3/71.

Berman, A.L. Crisis intervention on a college campus. Presented at the American Personnel Guidance Association Convention, Atlantic City, NJ, 4/71.

Berman, A.L. & McCarthy, B.W. Adolescent crises and peer intervention. Presented at the Crisis Intervention with Youth Workshop, NIMH Center for the Study of Suicide Prevention, Prince George's (MD) Community College, 5/71.

Berman, A.L. & McCarthy, B.W. The university counseling center as a training-consultation center. Presented at the 79th Annual Convention of the American Psychological Association, Washington, D.C., 9/71.

Berman, A.L. Throwing the egg. Letter to the editor, New York Times Magazine, 6/71.

Berman, A.L. Experiential training for crisis intervention. Presentation given to the 3rd International Conference on Gaming and Simulation. University of Birmingham, England, 7/72.

Berman, A.L. Mental health referral systems. Presentation given to the D.C. College Health Association, Annual Meeting, Washnington, D.C., 5/72.

Berman, A.L. & Mullens, B.N. The experimental training of beginning group therapists. Presented at A.P.A. Division 29 (Psychotherapy) Mid-Year Convention, Freeport, Grand Bahamas, 3/73.

Berman, A.L. & Mesersmith, C.E. Roles and problems in group psychotherapy training--A colloquy. Presented at A.P.A. Division 29 (Psychotherapy) Mid-Year Convention, San Diego, CA, 3/74.

Berman, A.L. The P.E.A.C.E. Program: Research and evaluation. Presented as part of a symposium: The training of paraprofessionals on a university campus. American College Personnel Association, Chicago, IL, 4/74.

Berman, A.L. & McCarthy, B.W. Assessment of university based paraprofessional services. Presented at the American Educational Research Association Convention, Chicago, IL, 4/74.

Chairperson, Session of Behavior Modification: Therapeutic. Eastern Psychological Association Convention, Philadelphia, PA, 4/74.

Berman, A.L. The epidemiology of life-threatening events. Presented at the American Association of Suicidology Convention, Atlantic Beach, FL, 4/74.

Berman, A.L. & McCarthy, B.W. The psychotherapist as consultant/supervisor in a peer counseling program. Presented at A.P.A. Division 29 (Psychotherapy) Mid-Year Convention, Marco Island, FL, 2/75.

Berman, A.L. Male/female therapist: Problems related to the sex of the therapist. Presented at A.P.A. Division 29 (Psychotherapy) Mid-Year Convention, Marco Island, FL, 3/75.

Berman, A.L. The physician and suicide. Presented at the American Association of Suicidology Convention, ST. Louis, MO, 4/75.

Berman, A.L. An interactive research/training/ outreach model for community gatekeepers. Paper presented at the American Association of Suicidology Convention, Los Angeles, CA, 4/76.

Berman, A.L. University psychological center--a five year follow-up. Presented at the American Psychological Association Convention, Washington, D.C. , 9/76.

Berman, A.L. Discussant: Is death necessary? An experiential approach. Presented at the American Psychological Association Convention, Washington, D.C., 9/76.

Berman, A.L. Dyadic death: Homicide-suicide revisited. Presented at the American Association of Suicidology Convention, Boston, MA, 5/77.

Berman, A.L. & Decker, R.E. Observation and recording effects on group therapy client behaviors. Presented at the American Psychological Association Convention, San Francisco, CA, 8/77.

Berman, A.L. Sex roles and attribution of suicidality. Presented at the American Association of Suicidology Convention, New Orleans, LA, 4/78.

Berman, A.L. The role of the victim. Presented at a symposium on the Clinical Management of Aggression, Psychiatric Institute, Washington, D.C., 12/78.

Berman, A.L. The psychopathology of multiple sclerosis. Presented at a symposium on Multiple Sclerosis, sponsored by the Neurology Center, Washington, D.C., 12/78.

Berman, A.L. A socio-cultural autopsy: Self-destructive behavior among the Duck Valley Indians. Presented at the American Association of Suicidology Convention, Denver, CO, 5/79.

Berman, A.L. & Cohen-Sandler, R. Suicidal behavior in childhood and early adolescence. Presented at the American Association of Suicidology Convention, Nashville, TN, 4/80.

Berman, A.L. Standards: Optimal vs. acceptable. Presented as part of a symposium on the hospital's obligations to the suicidal patient, American Association of Suicidology Convention, Albuquerque, NM, 4/81.

Berman, A.L. & Cohen-Sandler, R. Suicide and malpractice: A test case of standard of care. Presented at the American Association of Suicidology Convention, Albuquerque, NM, 4/81.

Cohen-Sandler, R. & Berman, A.L. A follow-up of hospitalized suicidal adolescents. Presented at the American Association of Suicidology Convention, Albuquerque, NM, 4/81.

Cohen-Sandler, R. & Berman, A.L. Teaching suicidal children how to problem-solve in non-suicidal ways. Presented at the American Association of Suicidology Convention, New York, NY, 4/82.

Berman, A.L. & Cohen-Sandler, R. The therapeutic alliance with suicidal patients: Thoughts on attributions of responsibility. Presented at the American Association of Suicidology Convention, Dallas, TX, 4/83.

Jobes, D.A. & Berman, A.L. Response biases and the impact of psychological autopsies on medical examiners' determination of mode of death. Presented at the American Association of Suicidology Convention, Anchorage, AK, 5/84.

Berman, A.L. From the laboratory to the couch: Child and adolescent suicide. Presented at the American Association of Suicidology Convention, Anchorage, AK, 5/84.

Berman, A.L. Panel member. Public Forum on Youth Suicide sponsored by the Dallas Times-Herald, Dallas, TX, 12/84.

Cohen-Sandler, R. & Berman, A.L. Dyadic death and "double" phenomena. Presented at the American Association of Suicidology Convention, Toronto, Canada, 4/85.

Berman, A.L. The numbers game: A critique of mortality stats. Panel presentation at the American Association of Suicidology Convention, Toronto, Canada, 4/85.

Berman, A.L. Notes on turning 18 (and 75): A critical look at our adolescence. Presidential address presented at the American Association of Suicidology

Convention, Toronto, Canada, 4/85.

Berman, A.L. Discussant, Session on Adolescent Suicide. American Orthopsychiatric Association Convention, New York City, 4/85.

Berman, A.L. Keynote address. American College Health Association Convention, Washington, D.C., 5/85.

Berman, A.L. Panel member. Public Forum on Youth Suicide ("Teenage Suicide: A Call to Action"), sponsored by The Denver Post, Denver, CO, 11/85.

Berman, A.L. Keynote Address: Youth Suicide. Mental Health Association of Greater New Orleans, LA, 11/85.

Berman, A.L. Keynote Address: The Dark Side of Human Behavior: Suicide and Life-Threatening Behavior, Annual Convention, Forum for Death Education, Atlanta, GA, 4/86.
Berman, A.L. Keynote Address: Suicidal Behaviors in Children and Adolescents. Maryland School Psychologists' Convention, Greenbelt, MD, 5/86.

Berman, A.L. Discussant, Session on Adolescent Suicide, American Orthopsychiatric Association Convention, Chicago, 4/86.

Berman, A.L. Suicide and the American Film. Presented at the American Association of Suicidology Convention, Atlanta, GA 4/86.

Berman, A.L. Adolescent Suicide Research. Presented at the American Association of Suicidology Convention, Atlanta, GA, 4/86.

Jobes, D.A. & Berman, A.L. To Be or Not To Be: That Was the Question. Presented at the American Association of Suicidology Convention, Atlanta, GA, 4/86.

Berman, A.L. The media and youth suicide prevention. Presented at the DHHS Conference on Youth Suicide Prevention, Oakland, CA, 6/86.

Berman, A.L., Suicide Defined. Presented at Conference on Non-natural Death, sponsored by the Center for Applied Biomedical Ethics at the Rose Medical Center, Denver, CO, 6/86.

Berman, A.L. Suicide as a Malpractice Issue. Presented at the Annual Meeting of the American Psychological Association, Washington, D.C., 8/86.

Berman, A.L. Discussant of film, "Teen Suicide," at the Annual meeting of the American Psychological Association, Washington, D.C., 8/86.

Berman, A.L. Keynote Address: Update 1986: Youth suicide. Presented at Conference sponsored by F.A.C.T. and Four Winds Hospital, Washington, D.C. 10/86.

Berman, A.L. Interventions in the Media and Entertainment sectors to prevent suicide. Presented at D.H.H.S. Conference on strategies to Prevent Youth Suicide, Bethesda, MD, 11/86.

Berman, A.L. Keynote Address: Youth Suicide Prevention--A Critical Look. Presented at Conference on Youth Suicide Prevention, sponsored by the University of Medicine and the Community Mental Health Center of Rutgers University, Piscataway, NJ, 1/87.

Berman, A.L. Panelist: Adolescents in the News: Fair Representation or Cheap Exploitation? Meeting of the American Orthopsychiatry Association, Washington, D.C., 3/87.

Berman, A.L. The Mass Media and Youth Suicide. Presented to the Maryland Chapter, National Committee on Youth Suicide Prevention, Baltimore, MD, 5/87.

Berman, A.L. Keynote Address: Beyond Bergenfield: The Influence of Media on Youth Suicide. Presented at Conference sponsored by the University of Southern Maine, Kennebunkport, ME, 5/87.

Ragland, D. & Berman, A.L. Farm Suicide: Dying on the Vine: Presented at the Annual Meeting of the American Association of Suicidology, San Francisco, 5/87.

Berman, A.L. A Model School Program: The Wingspread Conference. Presented at the Annual Meeting of the American Association of Suicidology, San Francisco, 5/87.

Berman, A.L. Suicide and the Mass Media. Presented at the Annual Meeting of the American Association of Suicidology, San Francisco, 5/87.

Berman, A.L. Keynote Address: Youth Suicide Prevention, Presented to the Annual Meeting of the Westchester County (NY) Psychological Association, Pace University, 7/87.

Berman, A.L. Youth suicide. Presented at Conference on Adolescent Self-destructive Behavior, Fair Oaks Hospital, Summit, NJ, 10/87.

Berman, A.L. Suicide prevention--A critical need and a critical perspective. Plenary address, First National Conference on Suicide Prevention and the Schools. Orlando, FL, 11/87.

Berman, A.L. Suicidal behaviors in adolescence: Meanings and implications. Presented at Sixth Annual Lee B. Macht Memorial Suicide Symposium: Suicide Treatment and Meaning, Harvard Medical School/Cambridge Hospital, Cambridge, MA, 2/88.

Berman, A.L. Youth Suicide: Update-1988. Presented at Eleventh Annual Conference: Children and Death, St. Francis Center, Washington, D.C., 5/88.

Berman, A.L. Research findings across the life span: Children and adolescents. Presented at symposium Suicide Across the Life Span: Emerging Issues, Center for Gerontological Education, Research and Services, University of Notre Dame, Notre Dame, IN, 5/88.

Berman, A.L. Panelist: Teaching Suicidology. American Association of Suicidology Convention, Washington, D.C., 4/88.

Berman, A.L. Panelist: Psychological Autopsy in the Courtroom: The Fort Lauderdale Case. American Association of Suicidology Convention, Washington, D.C., 4/88.

Berman, A.L. Standard of care in the assessment of suicide potential. Presented at the American Psychological Association Convention, Atlanta, GA, 8/88.

Berman, A.L. Suicide prevention: What works, what doesn't? Presentation to Governor Schaefer's conference: Marylanders helping Marylanders: A youth suicide symposium. UMBC, Catonsville, MD, 10/88.

Berman, A.L. Youth suicide. Presentation made to Brown University Child Study Center Teleconference on Risk Taking Behavior in Children and Adolescents. Washington, D.C., 10/88.

Berman, A.L. Suicide Prevention: Critical need and critical perspective. Keynote address to Illinois Association of Suicidology, Beloit, IL, 11/88.

Berman, A.L. Youth suicide prevention. Keynote address to Greater Federation of Women's Clubs, Arlington, 3/89.

Berman, A.L. & Schwartz, R. Suicidal behaviors among drug using adolescents. Presented at Annual meeting of the American Association of Suicidology, San Diego, CA, 4/89.

Berman, A.L. Suicide Assessment: The first interview. Panel presentation at Annual meeting of the American Association of Suicidology, San Diego, CA, 4/89.

Berman, A.L. Depression and suicide among adolescents. Presented at ADAMHA Conference on Treatment of Adolescents with Alcohol, Drug Abuse, and Mental Health Problems, Alexandria, VA, 10/89.

Berman, A.L. The psychological autopsy. Presented at the 20th Annual Meeting of the American Academy of Psychiatry and the Law, Washington, D.C., 11/89.

Berman, A.L. Avoiding legal liability in treating the suicidal patient. Keynote address, Florida Association of Suicide Prevention Services & Pinellas County Emergency Mental Health Services Annual Conference, Clearwater, FL, 11/89.

Berman, A.L. The treatment of the suicidal adolescent. Keynote Address, Alberta Suicide Prevention Conference, Calgary, Alberta, 2/90.

Berman, A.L. Suicide attempts and drug using adolescents. Presented at Illinois State Suicide Prevention Conference, Springfield, IL, 4/90.

Berman, A.L. Youth suicide and the media. Panel presentation at the Annual Meeting of the American Association of Suicidology, New Orleans, LA, 4/90.

Berman, A.L. The case method. Panel presentation at the Annual Meeting of the American Association of Suicidology. New Orleans, LA, 4/90.

Berman, A.L. Suicide among multiple sclerosis patients. Poster presentation at the

Annual Meeting of the American Association of Suicidology, New Orleans, LA, 4/90.

Berman, A.L. Presenter: The Assessment and Treatment of Adolescent Suicide, American Association of Suicidology's Snowmass at Aspen Summer Institute, July 22-26, 1990.

Berman, A.L. The USS Iowa investigation. Panel presentation at the annual meeting of the American Psychological Association, Boston, MA, 8/90.

Berman, A.L. Suicide and the media. Panel presentation at the annual meeting of the American Psychological Association, Boston, MA, 8/90.

Berman, A.L. Youth suicide. Panel presentation at the annual meeting of the American Psychological Association, Boston, MA, 10/90.

Berman, A.L. Treating the suicidal adolescent. Presentation to the Canadian Association for Suicide Prevention, Vancouver, BC, 10/90.

Berman, A.L. Suicide Liability: Outpatient policies and procedures. Panel presentation at the annual meeting of the American Association of Suicidology, Boston, MA, 4/91.

Berman, A.L. Professional training in suicidology: Past, present, and future. Panel presentation at the annual meeting of the American Association of Suicidology, Boston, MA 4/91.

Berman, A.L. Suicidal behaviors: Toward consensus definitions. Case conference at the annual meeting of the American Association of Suicidology, Boston, MA, 4/91.

Berman, A.L. Suicide coping and the life-span. Panel presentation at the Annual meeting of the American Association of Suicidology, Boston, MA, 4/91.

Berman, A. L. Presenter: Assessment and Treatment of Adolescent Suicide. Presenter: Forensic Suicidology. American Association of Suicidology's Snowmass at Aspen Summer Institutes, 7/91.

Berman, A. L. Youth suicide prevention. Keynote address to Statewide Training Conference, Dover, DE, 2/92.

Berman, A. L. & Horgas, P. Analysis of an adult suicide cluster. Presented to the Annual Meeting of the American Association of Suicidology, Chicago, 4/92.

Berman, A. L. Panelist, Past President's Symposium. Annual Meeting of the American Association of Suicidology, Chicago, 4/92.

Berman, A. L. Suicide Intervention. Keynote address to Annual Meeting of the NJ State Chapter of the American Association of Suicidology, Morristown, NJ, 5/92.

Berman, A. L. Keynote Speaker. Meeting of Chief Psychologists, Federal Bureau of Prisons Conference, Baltimore, MD, 5/92.

Berman, A. L. Presenter: Assessment and Treatment of Adolescent Suicide. Presenter: Case Consultations. American Association of Suicidology's Snowmass at Aspen Summer Institutes, 7/92.

Berman, A. L. Risk management strategies for the treatment of suicidal adolescents. American Psychological Association Convention, Washington, DC. 8/92.

Berman, A. L. Primary prevention of adolescent and young adult suicide. Conference of the Primary Prevention of Psychosocial Problems of Native American Children, Indian Health Service, Tempe, AZ, 8/92.

Berman, A. L. Plenary Presentation, 4th Annual Maryland State Youth Suicide Prevention Conference, Hunt Valley, MD, 10/92.

Berman, A. L. Interventions for suicidal adolescents: Clinical vignettes. Suicide Symposium, Harvard Medical School/Cambridge Hospital, Boston, MA, 2/93.

Berman, A. L. Suicide prevention: If we're not sure it works, why do we do it? Annual Meeting of the American Association of Suicidology, San Francisco, 4/93.

Berman, A. L. Community Suicide Prevention: Bridge Barriers. Annual Meeting of the American Association of Suicidology, San Francisco, 4/93.

Berman, A. L. and Jobes, D. A. Adolescents and suicide: An update. Annual Meeting of the American Association of Suicidology, San Francisco, 4/93.

Berman, A. L. Keynote Address: The impact of suicide on the helper. International Association of Suicide Prevention Congress, Montreal, 6/93.

Berman, A. L. Legal liability and the schools. Prince William County, VA, 9/93.

Berman, A. L. & Jobes, D. A. Suicide and Malpractice. Maryland State Youth Suicide Conference, Bethesda, MD, 10/93.

Berman, A. L. Working Group on Suicidal Behaviors: Terminology and Classification, Annual Meeting of the American Association of Suicidology, New York, NY, 4/94.

Berman, A. L. Panelist: Expert Testimony and the Standard of Care in Working with Suicidal Patients. Annual Meeting of the American Association of Suicidology, New York, NY, 4/94.

Berman, A. L. Standards of Care -- Practical Applications. Pre-Conference Institute, Annual Meeting of the American Association of Suicidology, New York, NY, 4/94.

Berman, A. L. Panelist: Ethical Issues in Caregivers' Suicide Interventions. Annual Meeting of the American Association of Suicidology, Phoenix, AZ, 5/95.

Berman, A. L. Moderator: The Cobain Suicide: Research, Crisis, Prevention, and Media Perspectives. Annual Meeting of the American Association of Suicidology, Phoenix, AZ, 5/95.

O'Carroll, P., Berman, A. L., Maris, R. & Moscicki, E. Beyond the Tower of Babal: A Nomenclature for Suicidology. Annual Meeting of the American Association of Suicidology, Phoenix, AZ, 5/95.

Berman, A. L., Jobes, D. A., & O'Carroll, P. The Aftermath of Kurt Cobain's Suicide. Congress of the International Association of Suicide Prevention, Venice, Italy, 6/95.

Berman, A. L. An Idiographic Approach to Understanding Suicide in the Young. International Conference on Suicide in Youth. Tel Aviv, Israel, 8/95.

Berman, A. L. "Why are our children killing themselves?" Distinguished visiting scholar lecture, John Hazen White Honors Colloquium, University of Rhode Island, Kingston, March 11, 1996.

Workshops/Consultations

1970: Boy's Village, Cheltenham, MD.

1971: American University, Washington, D.C.
Mental Health Assoc., Montg. Cty., Md.
SUNY, Delhi, NY.
Psychology Svc. Area C CMHC, Wash., D.C.

1972: Psychol. Svc., Walter Reed Hosp., D.C.
Livingston College, Rutgers Univ., NJ.
Psychol. Dept., Univ. of MD, College Park.
Psychol. Program, St. Eliz. Hosp., D.C.
Prince George's County Bd. of Ed., Md.

1973: Georgetown Univ. Medical School, D.C.

1974: Passage Crisis Center, Silver Spring, Md.
Georgetown Univ. Medical School, D.C.

1975: Sedgwick County CMHC, Wichita, KS
No. Va. Community College Couns. Ctr.
Falls Church, Va. Dept. of Welfare
Prince George's County, MD. Housing Dept.
Passage Crisis Center, Silver Spring, Md.
Georgetown Univ. Medical School, D.C.
FACT Hotline, D.C.

1976: Conf. of Friends' School Cnslrs, D.C.
Georgetown Univ. Medical School, D.C.
Am. Orthpsy. Ass. Pre-Conf. Inst., NYC
FACT Hotline, D.C.

1977: Passage Crisis Center, Silver Spring, Md.
Am. Orthpsy. Ass. Pre-Conf. Inst., Atlanta
FACT Hotline, D.C.

Va. Council on Social Welfare, Alex., Va.
D.C. Psych. Assoc. Conf., D.C.
McCully Conf., Nat'l. Cap. Personnel & Guidance Assoc., College Park, Md.

1978: APA Div. 29 Conf., Phoenix, AZ.
Montgomery Cty., Md. Health Dept.
Catholic Univ. School of Soc. Wk., D.C.
Passage Crisis Center, Silver Spring, Md.
Charles Cty., Md. Dept of Health

1979: Am. Orthopsy. Ass. Pre-Conf. Inst., D.C.
Md. Inst. for Emerg. Medicine, Balto.
Wash. Psychol. Ctr. CE Program
Boys & Girls Homes of Montg., Cty., Md.
Arlington, County, Va. Hotline
Norristown State Hosp. Psychiat. Dept. PA.
Catholic Univ. School of Soc. Wk., D.C.
Montgomery Cty. Youth Svcs., Md.

1980: Alternative House, Fairfax, VA
The Green Door, Wash., D.C.
United Central Service, Toledo, OH
The Crossing Place, Wash., D.C.
Nat'l Youth Workers Alliance Conv., D.C.
Mt. Tom Institute, Holyoke, MA
San Luis Obispo County, CA Psych Assoc.
CMHC Services, San Luis Obispo, CA
Catholic Univ. Schl. of Soc. Wk., D.C.
St. Francis Center, Wash., D.C.

1981: VA Dept. of Corrections, Fairfax, VA
Pastoral Couns. & Consult. Ctr., D.C.
Prince William County, VA M.H.C.
Arlington County, VA Dept. Soc. Svc.
Fairfax County, VA Dept. Soc. Svcs.
Wash. Psy. Ctr.: Scottsdale, AZ
Norristown State Hosp., Norristown, PA
Catholic Univ. Couns. Ctr., Wash., D.C.

1982: Catholic Univ. Schl. of Soc. Wk., D.C.
Wash. Psych. Ctr., Wash., D.C.
Prince William County M.H., VA
Loudon County, VA Mental Health (2x)
Hall-Brooke Foundation, Westport, Ct. (2x)
Danville, VA Mental Health
U.S. Dept. of State, Foreign Svc. Inst. (2x)
Prince George's County, Md. Mental Health
Children's Defense Fund, Wash., D.C.
Montgomery County, Md. Mental Health

1983: Los Angeles, CA Suicide Prevent. Ctr.

Phoenix Schools, Montgomery County, Md.
Family Stress Svcs., Wash., D.C.
Catholic Univ. Schl. of Soc. Wk., D.C.
Multiple Sclerosis Society, Wash., D.C.
U.S. Dept. of State Foreign Svc. Inst. (2x)
St. Elizabeth's Hospital, Wash., D.C.
West Virginia Psychological Assn., Wheeling
Wash. Psych. Ctr.: Indianapolis, IN
Armed Forces Institute of Pathology, D.C.
Psychological Associates of the Albemarle:
Harrisburg, PA, Pittsburgh, PA,
Colorado Springs, CO.,
Sacramento, CA., Long Beach, CA, Boston, MA.,
Charlottesville, VA.

1984: Hall-Brooke Foundation, Westport, CT
Grad. Schl. Profsl. Psych., Rutgers U. NJ (2x)
Wash. Psych. Ctr.: Wash., D.C., Salt Lake City, UT,
Portland, OR
No. VA Mental Health Inst., Falls Church
Psychological Associates of the Albermarle:
Cincinnati, OH., Miami, FL., St. Petersburg, FL.,
Jacksonville, FL., Syracuse, NY., Albany, NY., Minneapolis,
MN., Madison, WI.
U.S. Dept. of State Foreign Svc. Institute (3x)
Maryland Assoc. of Youth Svc Bureaus, Greenbelt, Md.
Human Services Consultants, Wilkes-Barre, PA
Salt Lake City (UT) Mental Health
Niagara University, Office of Continuing Education,
Buffalo, NY
Rutgers University Graduate School of Psychology,
Piscataway, NJ

1985: Montgomery County (MD) Crisis Center
Georgetown University (DC) Counseling Center
Jewish Family Service, Memphis, TN
Washington (DC) School of Psychiatry
Niagara University, Office of Continuing Education,
Buffalo, NY
Georgetown University (DC), Office of Residential Life
Human Services Consultants, Philadelphia, PA
University of Western Ontario, London, Ontario, Canada
Topeka Youth Council, Topeka, KS
Washington Psychol. Ctr: Westbury, NY
Connecticut Youth Services, Groton, CT
Family Liaison Office, US Dept. of State
Mental Health Association, Indianapolis, IN
Mental Health Association, Prince Georges County, MD
Lehigh University, Bethlehem, PA
National Conference, National Association of Student
Councils, Pittsburgh, PA
Suburban Hospital, Department of Psychiatry, Grand Rounds,

Bethesda, MD
Juvenile Welfare Board, Pinellas County, (Largo/St. Petersburg) FL
Suffolk County, NY Dept. of Training & Education
Hardin-Simmons University, Irvin School of Education, Abilene, TX
Florida State School Psychologists Association, Tampa, FL
Louisiana Chapter, American Association of Suicidology, New Orleans, LA
Jewish Center of Greater Buffalo, NY
Rutgers Medical School Community Mental Health Center, Piscataway, NJ
Maryland State PTA Convention, Baltimore, MD

1986: Marquette University School of Nursing, Milwaukee, WI
University of So. Alabama, School of Education, Mobile, AL
Centennial Area Health Education Center, Greeley, CO (2x)
University of Connecticut School of Social Work, West Hartford, CT
Family Life Center, Columbia, MD
Hall-Brooke Foundation, Westport, CT (2x)
U.S. Dept. of State Family Liaison Office, Rosslyn, VA
Bethesda Naval Hospital, Dept. of Psychiatry Grand Rounds, Bethesda, MD
Washington School of Psychiatry, DC
Washington Psychological Center Continuing Education: Little Rock, AR & San Antonio, TX
Fort Morgan, CO Public Schools
Texas Dept. of Mental Health, Univ. of Texas, Austin, TX
Outreach South Hills Mental Health Center, Pittsburgh, PA
Niagara University, Buffalo, NY
Rivendell Foundation, Memphis, TN
National Multiple Sclerosis Society, Houston, TX

1987: Board of Education, Anne Arundel Co. (MD), Annapolis
Washington Psychological Center, Oklahoma City, OK
University of Maryland Counseling Center, College Park, MD
U.S. Public Health Service, Salt Lake City, UT
Connecticut Dept. of Mental Healthy, Bridgeport, CT
Life Crisis Services, St. Louis, MO
Niagara University, Buffalo, NY
Washington Psychological Center: Cleveland, OH and Dallas, TX
North Carolina Psychological Association Annual Conference, Winston-Salem, NC
Holy Cross College, Worcester, MA
St. John Medical Center, Tulsa, OK

1988: University of Maryland Counseling Center, College Park, MD
Mental Health Services of Clark Co., Springfield, OH

Suicide Prevention & Awareness, Windsor, Ontario, Canada
Charter Pines Hospital, Charlotte, NC
Baltimore County School System, Suicide Prevention Task Force, Solomons Island, MD
ABC Television, Public Affairs Office (Movie: Surviving)
Martin Wender Productions (Script review)
Suicide Prevention Task Force, Montgomery County, MD
Kingsbury Center, Washington, D.C. (Tutors)
Jewish Community Center, Rockville, MD (Community Forum)
Northern Virginia Jewish Community Center, Falls Church, VA (Community Forum)
Community Psychiatric Clinic, Wheaton, MD (Staff)
Bethesda Naval Hospital, Bethesda, MD (Psychology Interns)
New England Educational Institute and Brattleboro Retreat Cape Cod Summer Institute
Clinical Treatment Staff, Patuxent Institution, MD.
American University Counseling Center, DC.
Convalescent Hospital for Children, Rochester, NY.
Orange County School System and Laurel Oaks Hospital, Orlando FL.

1989: Edmund Burke School Parents Association, Washington, DC.
Washington Psychological Center, P.C.: Birmingham, AL, Tulsa, OK, Des Moines, IA.
Bethesda Naval Hospital Psychology Training Program, MD.
Suicide Prevention & Education Center, Louisville, KY
Arkansas Council of Community Mental Health Centers Summer Institutes, Hot Springs, AR
Community Service Board, Prince William County, VA.
Niagara University, Buffalo, NY.
Mental Health Association, Ulster County (Kingston), NY
Arlington County (VA) Department of Human Services

1990: Alberta Suicide Prevention, Calgary, Alberta, Canada
Georgetown University Hospital Pediatrics Department
Bethesda Naval Hospital Psychology Training Program
Gallup Organization, Princeton, NJ
University of Wisconsin, Madison, WI
Fairfax-Falls Church (VA) Community Services Board
Washington School of Psychiatry, Washington, D.C.
Community Mental Health Subsystem, San Jose, CA
Mental Health Association, Dutchess County (Poughkeepsie) NY
Division of Child Mental Health, State of Delaware, DE
American Psychological Association Pre-Conference Institute on Suicide and Malpractice, Boston, MA

1991: Edmund Burke School, Washington, DC
American University Counseling Center, Washington, DC
Gallup Organization and Institute, NYC
Drew Leavens & Associates, Seattle, WA

Bethesda (MD) Naval Hospital, Psychology Intern Program
Psychological Association of Western NY, Buffalo
DC Psychological Association
Washington School of Psychiatry

1992: Washington School of Psychiatry (3x)
Specialized Training Services (San Diego, CA): San Diego, Seattle, San Francisco, Pasadena, CA
Capitol Hill (DC) Psychotherapy Network
Children's Crisis Management Program, United Way, New Orleans, LA
Talbert House/Crisis Center, Cincinnati, OH
Mental Health Association, Phoenix, AZ
Kingsley House, New Orleans, LA
Gallup Organization (Elderly Suicide), New York City

1993: Children's Hospital Dept. of Psychiatry, Washington, DC
Specialized Training Services, Schaumberg, IL
Quinco Counseling Services, Nashville, IN (2x)
DuPage County Mental Health, Oakbrook, IL
Bethesda Naval Hospital, Dept. of Psychology
Saratoga Springs, NY Mental Health Association
West Virginia Psychological Association Fall Conference
Georgetown University Student Health Services
Metropolitan Psychiatric Group: Depression Screening Day

1994: Springfield State Hospital (MD) Grand Rounds
Delaware Office of Prevention and Mental Health Assoc. Conference (Dewey Beach)
Bethesda Naval Hospital Dept. of Psychology
Center for Mental Health Services/National Institute of Mental Health Dimensions and Classifications of Suicide Morbidity Workshop, Wash., DC

1995: Sedgwick County Mental Health Asociation, Wichita, KS
Washington Pastoral Counseling Association
Community Psychiatric Clinic, Gaithersburg, MD
Loudon County Mental Health Assoc., Leesburg, VA
BeaverCreek (OH) School System
Bergin Pines Hospital, Paramus, NJ
Oregon Psychological Association, Portland, OR
Uniformed Services University Hospital, Psychiatry Dept., Bethesda, MD
AAS Summer Institutes, Santa Fe, NM
Hyland Training Institute, St. Louis, MO

1996: The Menninger Clinic, Topeka, KS

Grants/Contracts

Faculty Academic Development Grant, American University, Washington, D.C., 1970.

Assoc. Director for Research Office of Child Development. DHEW Grant #OCD-CB-478, Training Paraprofessionals to Work on the University Campus, 1973-1976.

Summer Faculty Research Grants, American University, Washington, D.C., 1976, 1983.

Principal Investigator, Suicide and self-destructive behaviors among Duck Valley Reservation Indians, Roger McCormick Foundation, 1978-1979.

Principal Investigator, Duck Valley Reservation Follow-up Project, Roger McCormick Foundation, 1979-1980.

Mellon Foundation Grant for Faculty Development, American University, Washington, D.C., 1980.

Faculty Research Grant, Dean's Office, College of Arts & Sciences, American University, 1986-1987: "Televised Fictional Suicide and Imitative Youth Suicide."

Principal Investigator, Duck Valley Reservation: Suicide at Duck Valley: A Decade Later, Roger McCormick Foundation, 1988-1990.

Principal Investigator, Suicide among Multiple Sclerosis Patients. National Multiple Sclerosis Society, 1990-1991.

Co-Principal Investigator, Investigative Study of Suicide, U.S. Postal Service, 1991.

Principal Investigator, Suicide Risk and Multiple Sclerosis: A Validation Study. National Multiple Sclerosis Society, 1993-1995.

Joyce Foundation Grant: Youth Suicide and Firearms: A Town Meeting, 1996.

Scholarly, Professional, & Community Service:

Director, Placement Service, Eastern Psychological Association Convention, May, 1973, Washington, D.C.

Board of Director, Concepts for Human Services, Inc., Washington, D.C. 1972-1975.

Chairman, Social Action Committee, D.C. Psychological Association, 1972-3.
Editorial Board, Crisis Intervention. 1973-75.

Consultant to D.C. Mental Health Association Report: Focus on Children under Stress, Washington, D.C., 1975.

American Association of Suicidology:
Member, Membership Committee, 1975.

Member, Nomenclature Committee, 1978-79
State Chairperson, Regionalization Committee, 1978-79.
Member, Hospital Standards Committee, 1980-81
Chair, Training Committee, 1983-1991
Chair Publications Committee, 1991-1993
Member, Board of Directors, 1980-81; 1986-88, 1993-1995.
Chair, Nominating Committee, 1985-86.
Treasurer, 1981-83.
President-Elect, 1983-84.
Past-president, 1985-1986.
Co-Program Chair, Annual Meeting, 1987-1988.
Co-Director, Snowmass at Aspen Summer Institutes, 1990-1992; Institutes at Santa Fe, 1993-1994.

Member, Death and Dying Course Instructors Group, Kennedy Institute, Georgetown University, Washington, D.C. 1975-1977.

Invited Editorial Reviewer: American Psychologist, Victimology, Psychological Reports, American Journal of Orthopsychiatry (1988-present), Omega, Journal of Nervous and Mental Disease, Journal of Hospital and Community Psychiatry (1975-present), Psychological Assessment, Death Studies, U.S. Preventative Services Task Force (Public Health Service), Professional Psychology: Research and Practice (1995).

Chairperson, D.C. Psychological Association Ethics Committee (1979); Member (1977, 1978).

Invited testimony before U.S. Senate Sub-Committee on Health and Readjustment, Committee on Veterans' Affairs (RE: S.1693), June, 1977.

Member, Contract Review Committee, NIDA, DHEW, Rockville, Md., 1978.

Grant Reviewer, NEH Implementation Grants, 1978.

Director of Externship and Internship Training, American University Counseling Center, 1975-1977. Coordinator for Continuing Professional Education, Washington Psychological Center, P.C., Wash., D.C., 1977-1986.

Board of Directors, Samaritans of Washington, D.C., 1979-1981.

Member, Working Committee on Criteria for the Determination of Suicide, Centers for Disease Control, Atlanta, GA, 1984.

Invited testimony, (The Problem of Teenage Suicide) Senate Sub-committee on Juvenile Justice, U.S. Senate Committee on the Judiciary, October 3, 1984.

Consultant and Technical Advisor, ABC-TV's "ABC Notebook: Teen Suicide," 1985.

Resource Panelist, Keeping Posted Magazine, 1985.

Resource, Panelist, Phi Delta Kappan Magazine, 1985.

Appointed to Community Advisory Council, St. Francis Center, Washington, D.C., 1987-present.

Invited testimony, D.C. Dept. of Commerce and Regulatory Affairs, (on Ellington Bridge Suicide Barriers), July, 1987.

Letter to Editor: (with C.P. Ross): "Yes, There is a Teen Suicide Crisis." Washington Post, Feb. 7, 1987, A7.

Book prospectus reviewer, Allyn & Bacon Co.,1987.

Invited testimony on behalf of the American Psychological Association, House Armed Services Committee Hearings on the USS Iowa Explosion, December 21, 1989.

Member, American Psychological Association Media Awards Committee, 1990.

Research Grant Evaluator, Social Sciences and Humanities Research Council of Canada, 1990.

Adjunct Professorships:

Western Maryland College, 1971
Federal City College, D.C., 1972

Professional Organizations:

American Psychological Association (Divs., 12 - clinical, 29 - psychopathology, & 42 - independent practice)
D.C. Psychological Association
American Association of Suicidology
International Association for Suicide Prevention
International Academy of Suicide Research
American Orthopsychiatric Association

License/ Certifications:

Washington, D.C., 1972-present
Maryland, 1975-present
National Register of Health Service Providers in Psychology, 1975-present

Inpatient Admitting Priveleges:

Courtesy Staff: Psychiatric Institute of Washington

Report to the Office of Independent Counsel

The Death of Vincent W. Foster, Jr.

Alan L. Berman, Ph.D.

September 4, 1996

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Report to the Office of Independent Counsel
Death Investigation: Vincent W. Foster, Jr.

Introduction

In the summary of a March, 1996 Office of Independent Counsel (OIC) "State of Mind" analysis by the FBI, the need for a "suicide expert" was raised regarding the apparent suicide of Vincent W. Foster, Jr. Several specific questions were addressed: e.g., Was Vincent Foster suffering from depression?, Why was there no suicide note?, Were indications of his impending suicide given?, etc. In addition, divergent on-site observations, investigative lapses and inconsistencies had given rise to alternative (cover-up and conspiratorial) theories and questions (e.g., the Sprunt report), necessitating a behavioral scientist's review of available evidence.

Between May and July, 1996 this author was given access to an array of documentary evidence (see below). In addition, a site visit to Fort Marcy Park was made on May 24, 1996 in the company of two FBI agents [redacted] Independent interviews, as requested, of Foster family members, however, were blocked by attorneys for surviving family members; thus, none were conducted. The following analysis and conclusions, therefore, are based entirely on the sources of information listed below.

Case Synopsis

Between 5:00 pm and 6:00 pm on Tuesday, July 20, 1993, Deputy White House Counsel Vincent W. Foster, Jr., age 48: D.O.B.: 1-15-45, was found dead of an apparent self-inflicted gunshot wound to the mouth. His body was located by a passerby some 700 feet from his parked car in Fort Marcy Park, VA, lying face up on his back on the slope of a berm near the northernmost cannon (cannon #2). His eyeglasses were located 13' down the berm. In his right hand was found a 38 caliber, six shot Colt, Army Special revolver. There was one live round of ammunition in the gun. An exhaustive search of Ft. Marcy Park, in an arc of 90° to a distance of 175 meters, failed to produce the fatal bullet.

Foster was last seen leaving the White House shortly after 1:00 pm. His whereabouts on the afternoon of July 20-- from the time he left the White House till when his body was discovered-- remain unknown.

Investigative Procedures and Sources of Information

The following sources of information were supplied by the OIC and reviewed for this report:

U.S. Park Police Investigative Reports and Exhibits; Site pictures and Maps/Plats, the "Fiske Report" (6/30/94);*The Wall Street Journal* articles of 6/17, 6/24, and 7/19/93; transcripts of Foster's torn note found after his death in his briefcase, and his University of Arkansas Law School Commencement Address of May 8, 1993; the Autopsy Report, a report of Fort Marcy Park Artifacts Inventory; 1/30/96 Summary of Fort Marcy Park Search; the Blackbourne and Lee Forensic Pathology Reports; Dr. Henry Lee's Forensic Report (vols. I&II); Ballistics Test results (8/29/95); Citizen's Independent Report (Sprunt: 7/31/95); Reports drafted by Alexander Magnus and

Christopher Ruddy; Time Line written by Jim Bell; Medical Records from Dr. Watkins, "State of Mind" Summary, and videotapes of the Law School Commencement Address and "Unsolved Mysteries" (3/22/96).

In addition, interview summaries, FBI "302s," depositions, and/or Grand Jury Tesimony transcripts from the following individuals were made available and reviewed:

Crime Scene Evidence/Site Investigation

Standard operating investigative procedures at Fort Marcy Park were not followed. As noted in Dr. Lee's report, a number of limitations in the available data made death reconstruction difficult. The lack of certain records and photographs, moreover, presented more of a Rorschach card for analysis than is typical, particularly in a death of this import. The relative inexperience of U. S. Park Police officers and Fairfax County Fire and Rescue paramedics/EMTs in death investigation procedures, and the lack of sufficient photographic documentation, made for an extraordinary divergence of reported and validated observations. For example, witness statements (numbers of witnesses in parentheses) allegedly referring to Foster's car in the parking lot described: a white Honda (2), a brown honda (1), a gray Honda (2), a blue Toyota Corolla (1), an older model Subaru (1), and a Chrysler Corporation K-car (1). Moreover, Foster's suit jacket was either: on the front passenger side seat (3), on the rear seat (2), hanging behind the driver's seat (1), or neatly folded over the passenger seat back (1). Furthermore, the lack of x-rays taken at the time of autopsy and the lack of identifiable fingerprints on the textured handle of the gun added to the absence of confirmatory data regarding the manner of death.

In spite of these issues, the following incontovertible facts appear established and developed in the Blackbourne and Lee reports:

1. Vincent Foster died from a single gunshot wound to the mouth.

2. Residue on his hands, glasses, etc. and blood and tissue matter taken from the gun describe this as a contact wound.

3. No signs of a struggle, e.g., other trauma, or evidence for the body having been moved to the location where it was discovered were in evidence. Furthermore, alternative access to this site, e.g., through the Rt. 123 access to the Park, was highly unlikely without being observed or recorded by a security camera from the Saudi compound.

4. Trace materials strongly suggest that the gun was transported from the Foster home, first in the oven mitt found in his car and, subsequently, in his pants pocket to the site of his death.

Psychological Autopsy

Basic Personality and Character

Descriptors used by interviewees with regard to Vincent Foster's basic personality were extraordinarily consistent in describing a controlled, private, perfectionistic character whose public persona as a man of integrity, honesty, and unimpeachable reputation was of utmost importance. The following verbatim remarks reflect these and related themes [numbers refer to multiple reporters using the same descriptor]:

Private: kept own counsel; not open; did not engage in casual conversation; very private [4]; tough to read; laconic; taciturn; carried confidentiality to extreme [2]; inward; introverted [4]; an internalizer; did not openly display emotions; strong, silent type; close to the vest; shut off; uncomfortable talking about personal feelings; kept distance from associates; difficult to get close to;...to get to know; quiet.

Always in Control; used to being in control [4]; rigidity; no resilience; (too) responsible; intellectual/thoughtful [2]; reflective; not given to rash judgments; disciplined; mild-mannered; calm; reserved [5]; sober/serious [3]; cautious [2]; restrained [2]; careful; never effervescent; an anchor, a rock; a Rock of Gibralter.

Perfectionist [7]; demanding; not tolerant of mistakes or sloppiness [2]; intense [6]; focused [2]; meticulous/methodical [2]; a detail man; lacked experience at failure; never seemed to have any difficulties; **Thin-skinned , not used to criticism**; did not like having honor questioned; moody; took too much to heart; paranoid.

Persona: Reputation (unimpeachability) [2]; Impecccable reputation [3]; lived his life to maintain his reputation; man of high principle, high honor; integrity/honesty [3]; ethical [2]; loyalty [2]; the perfect family.

Hobbies/Interests;Typical Patterns of Coping with Stress/Change

Foster's life, since arriving in Washington, was filled with long, intense and demanding hours of work. The relative comfort of his lifestyle in Little Rock and his civic/social involvements, theater, etc. were no longer in evidence. As well, his retreat in Michigan was not replicated in DC [neither was his advice to the University of Arkansas Law School graduation class to "Take some time out for yourself. Have some fun...Take an occassional walk in the woods...Learn to relax"] . Where he once exercised daily in the RLF gym, he now only had/took time to read and jog to "relax." Until the week before his death, he appears not to have taken time off. Religion as a protective factor was not significantly in his life.

Significant Relationships

Driven, self-reliant men value their autonomy and tend to avoid intimate relationships. Foster was an intensely private man whom few felt close to. His most significant relationships were with his wife, Lisa, and his three children. Since coming to Washington, and until early June when they arrived to stay, these relationships were strained by distance and the demands of his work; as were those with his working associates at the Rose Law Firm. Most significant among these was a falling out with a father figure at the firm, Phillip Carroll, and the change in his relationship to Hillary Rodham Clinton, a partner and friend, who now was in a conflictual role as a superior whom Foster was to protect.

In addition, he was close to his sister Sheila and her husband Berl Anthony, with whom he lived upon coming to DC. Marsha Scott may have been a confidante.

Communication Style

As noted above, Foster generally was not open with others. His role as a protector, as responsible and serious, was more important to him than his comfort with others as an emotionally vulnerable and communicative person. Significant changes in this controlled style were evident beginning in 1993 and escalated as he neared his death.

Note should be made here of his two written communications: (1) his Commencement Address, delivered in early May, which is a study in regret, and (2) the "Torn Note," allegedly written within two weeks of his death, which highlights his preocupation with themes of guilt, anger, and his need to protect others (see below).

Method/Familiarity/Knowledge/Frequency of Use

Foster was not known to use guns, to hunt or target shoot. The lethal weapon, however, was known to him and, most probably, was one (of several) confiscated from his parents' house in 1991, when there was some anxiety that his father might suicide with one of them; and packed in his suitcase when he moved to DC. Within two weeks of his death, his wife twice told him to remove the guns from their house. Upon learning of her husband's death, she reportedly went to a closet and found a gun was missing. Her behavior suggests an awareness of her husband's potential for suicide.

History and Recent Status:

Marital History/Children

Vincent Foster met Lisa while he attended Vanderbilt Law School; they married in April, 1968. This was the first marriage for both. There is a strong implication that there was considerable marital strain during the last several months after his move to DC. Lisa Foster's interview reported in the September 11, 1995 *New Yorker* quoted her as "unreserved about

voicing her feelings," "angry with Vince about 90% of the time," and "that it was not easy for us to console each other." Moreover, it is probable that his intense and stressful work life, in addition to their separation, had significantly and negatively impacted their sexual relationship.

Foster was described as "family oriented." His children, two sons and a daughter: Vincent W. Foster, III, Laura Foster, and John Brugh Foster, were born, respectively, in 1972, 1973, and 1975. The two oldest children described their relationship with Foster as "excellent" and "great." He appears to have been least close with Brugh. Foster was described as most anxious about the effect of the family's move on [redacted] Moreover, he felt responsible for his son, Brugh's unhappiness about being in DC.

Educational History

Foster graduated Davidson in 1967, entered law school at Vanderbilt, graduating from the University of Arkansas Law School in 1971. He graduated first in his class and had the top score on the Arkansas bar exam.

Military History

After 1 and ½ years at Vanderbilt Law School, Foster dropped out to enter the New Jersey National Guard, during the Viet Nam War, but decided to return to the study of the law at the University of Arkansas, during which time he was defered from military service..

Occupational History

Foster began employment at the Rose Law Firm (RLF) in 1971, upon his graduation from the University of Arkansas Law School. Until President Clinton's election, Foster's entire professional life was spent with the RLF. In January, 1993 he resigned his partnership with the RLF, arriving in DC for the innauguration. In Little Rock, he was on a pedestal, well-respected and admired. His work style was pressured by self-imposed demands for perfection; however, he generally had the luxury of a measured pace. At the RLF, "20 drafts" were possible. His May 8th (1993) Commencement Address to the University of Arkansas Law School graduates is replete with reflections upon and regret regarding the changes wrought by his experiences in Washington.

At the White House, Foster was second in command to Bernard Nussbaum with primary responsibilities for issues affecting the first family and their finances. Upon his death, several files were found in his office regarding open cases on which he was working. In addition, during early 1993 Foster had responsibilities relating to Whitewater, the White House Travel Office firings, various nominations, and the remodeling of the White House; all issues of considerable stress.

Medical/Physical Health History

Dr. Larry Watkins in Little Rock was Foster's personal physician since 1979. His records are relatively unremarkable. However, beginning in late 1992, there are signs of increased stress and complaints of insomnia, for which a prescription for Restoril (30 mg PRN) was ordered. Foster's weight ranged from 200# in 1987 to 207# in August, 1990 to 194# on 12/31/92. [Reports of Foster having lost weight during the spring of 1993 are not verified in these, or any other records; Foster's weight at autopsy was 197#]. Foster's blood pressure appears to have been mildly elevated, ranging as high as 140/90 in 1990; no treatments are noted.

Most notable is Watkins' characterization of Foster's insistent telephone call of July 19th as "unprecedented." Over the phone Watkins prescribed trazadone (Deseryl), a heterocyclic antidepressant, for what he referred to as symptoms of a mild depression (insomnia and anorexia), "lots of stress, criticism, and long hours." Watkins did not ask Foster about suicide ideation, nor did he refer him to a local (DC area) colleague for further evaluation, monitoring of medication effects, or psychotherapy. Watkins appears not to have any records regarding Foster's family medical history and did not know that Foster's daughter had been treated psychologically for her eating disorder.

Foster took only one (of 30 available) Desyrel (50 mg) the night prior to his death. One pill would have had no significant therapeutic effect as the majority of those prescribed this drug do not report benefit for at least two weeks' treatment.

The Friday before his death Foster admitted to his sister Sheila that he was depressed. This was most uncharacteristic of him. She passed three names of DC area psychiatrists to him. Foster attempted to call one of the three, but never connected. His lack of follow-through reflects his ambivalence about help-seeking and, perhaps, his feared vulnerability and paranoia about the confidentiality of mental health treatment.

Mental Health History -none; see above.

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Family Mental Health History

Both sisters (Sheila and Sharon)

Sheila believes both parents were depressed. Foster's father hinted to "family members that he might use a weapon to end his ...life" before his death from cancer in June, 1991. Vincent Foster expressed concern and removed multiple firearms from his parents' house.

Financial History

The Fosters lived well in Little Rock on his salary reputed to be almost $300,000 per annum. Foster took a sizable pay cut in moving to his White House position (see Commencement Address reference) and downsized his personal lifestyle in a more expensive

Washington, DC. References to a possible overdrawn credit union account appear to be unsupported.

Religious Involvement

Foster's religiosity was low. There are no references to church-related activity during his days in Washington.

Alcohol and Drug Use (licit and illicit) History

Foster was a social drinker and collected fine wines. No increase (in 1993) in his alcohol use was reported.

Evidence of Thought Disorder

None; although signs of paranoia in the late sping, 1993 were evident (see below).

Cognitions/Hopelessness/Negativity

Foster's drive for perfection masked his fear of failure and criticism. When criticism came, Foster responded to the public scrutiny and criticism with anger and anxiety. He feared these issues would "never die." The publicity "ate him up." He no longer was in control. He felt trapped and talked of resigning, but considered a return to Little Rock to be a "humiliation." But, his wife pressured him to stay ("You can't quit; I just got here."). He "saw no light at the end of the tunnel." He and his wife "compromised" that he would not leave his job until Christmas (1993), but Foster had too much guilt and sense of failure to last that long.

His admission to his sister that he needed help was a profound expression of his depression. Concurrently, he had concerns about the confidentiality of therapy.

Foster appears to have lost perspective in his thinking, "blowing [things] out of proportion" according to observers. Indeed, a reading of the *New Yorker* editorials does not lead the disinterested observer to anywhere near the same level of sensitivity or outrage.

Stressors: Anticipated/threatened changes/losses/transitions

1. The Move to Washington:

Foster missed his life in Little Rock (his house, being able to walk to work). In addition, the move was costly financially--Foster was living in a more expensive city on a lessened income in a "cramped house."

2. Family/Marital problems:

Foster's separation from his family in the early months of his job, then the increasing pressure from and demandingness of his wife about his long working hours led to

marital tension and an unavailability of each to the other, as well as probable sexual distance, etc. As a responsible family man these demands would have placed a burden on Foster and concomitant feelings of conflict (between work and home) and role failure. It is unknown what, if any, problems were surfacing with his children; however, there is clearly an emotional shift in his Commencement Address when he talks of his children ("The office can wait..."). That his [redacted] morever, strongly indicates family conflicts.

3. Job Stress:

Foster was excited about and wanted an influential role in the Administration; but, soon was overwhelmed with the demands of his job: its long hours and seemingly never-ending emergencies; a lack of felt success as evidenced by the problems listed below; the immediacy of the White House pace, so different from the luxury of time afforded most of his work at the RLF where time and pace allowed his meticulousness to flourish. He now was "forced to fire at the hip" with the added demand to be correct all the time. Where he once was "the guy in charge;" he now was always on call to others. According to his wife, he "lost control once at the White House."

4. Role Failure:

Foster was known both as a star and as a protector of others. There were readily apparent cracks in the dike (see below): the failed nominations, Travelgate (and consequent blame shouldered by associate counsel Kennedy whom Foster felt was "scapegoated"), Hillary Rodham Clinton's upset with him, his wife's apparent unhappiness, etc., that placed in question his sense of self. According to his wife, he took these failures personally and hard. Foster reportedly was angry about the cost overruns in remodeling the White House, blamed himself as responsible for the failure of various nominations, e.g., Zoe Baird as Attorney General, and for the Waco Branch Davidian raid. It is probable that Whitewater issues also weighed heavily in the background.

5. Anticipated Hearings:

As an intensely private man, Foster was alarmed by the possibility of Congressional Hearings regarding Travelgate. He "thought the worst was yet to come," and was observed as "brooding" and "consumed." He told his daughter that a Congressional investigation might be "rough on the family" (see #4 above).

6. Tarnished Reputation:

As evidenced in his Commencement Address, Foster considered his reputation to be his "greatest asset" and "dents to [his] reputation...[to be] irreperable." Beginning with the June 17 *Wall Street Journal* editorial, public criticisms of him and his performance caused him "severe distress." He "hated to be on display; he was now being questioned in public. He viewed these articles as "trashing" him and attempting to "ruin the administration," again speaking to his failure as protector. He told his sister, Sheila, "We can't stop the bleeding."[see Role Failure, above]. He was angry and constantly tense. The "Torn Note," again, speaks eloquently to these foci.

7. Loss of Support:

Foster increasingly felt alone, responsible for failures, and untrusting to the point of an increasing paranoia. To Webster Hubbell he "would not speak openly over the phone," and "did not trust the walls of the White House." He told Jim Lyons that he "would not talk with him at the White House."

Evidence of recent change in behavior, mood, life style

There is little doubt that Foster was clinically depressed (see below) in early 1993, and, perhaps, sub-clinically even before this. Additionally, signs of intense anxiety (insomnia, "absently wringing his hands, pacing, tension, profuse sweating) appeared, perhaps reactivating earlier experienced panic attacks. He increasingly started his sentences with, "I just can't handle..." Numerous observations are documented of changes in his last few months, e.g., "His sense of humor wasn't quite as available;" "He was more reserved than usual;" " In last 2 weeks his tone of voice changed...he wasn't participating; he just wasn't there." He called in sick for two days during the week before his death. His morning call to Dr. Watkins on the 19th was "unprecedented." He did not get up to greet Marsha Scott, as usual (in their meeting on the 19th): He "seemed preoccupied; quieter than usual." On July 20th he "was very quiet;" "He was more reserved and non-responsive;" He was uncharacteristically anxious to get his lunch and seemed rushed to eat; He was distracted; the newspapers on his office table were left in "uncharacteristic disarray."

Future Orientation

Foster had a scheduled meeting on Wednesday, July 21 with Jim Lyons, his personal attorney, on legal issues related to "Travelgate." Telephone calls were placed to Lyons on Sunday night, the 18th, upon returning from the Eastern Shore and again on the morning of the 20th. It was understood that Foster was anxious about his vulnerability.

Foster's sister, Sharon Bowman, had arrived in town on the 20th. It is not known what or if they had any plans scheduled, although his calendar listed a dinner date with her later in the week.

Talk of Death or Evidence of Suicide Ideation

None known; however, in the last two weeks of his life his wife wanted the guns removed from their house. References to death are noted in two circled passages found among his belongings.

Evidence of Exposure

Foster recently (date unknown) watched the movie "A Few Good Men," which involved a

scene involving a gunshot wound suicide in the mouth. Foster's father was allegedly suicdal shortly before his death from cancer.

Specific Description of Behavior in Last Four Days Before Death

Foster's last 96 hours show clear signs of crisis and uncharacteristic vulnerability: He admits his depression to his sister, Sheila, and asks for help. His ambivalence about help-seeking is evident in his not following through to reach the one psychiatrist to whom he placed a call, and making no attempt to reach either of the other two names given him by his sister.

The weekend getaway to the Tidewater Inn was intended to relax him, but appears to have been a disappointment. He was stressed; tears welled in his eyes when he talked of feeling trapped. At the Cardozo's he was non-interactive and withdrawn. It is not known if there was any attempt at a sexual interaction (and possible performance failure) with his wife during the weekend. It is not known what the content of their discussions were, for example, in the car upon returning to DC. [Here it would be most helpful to have his wife's further observations and recollected verbalizations both during this weekend and in the car while in transit]. The night of his return to DC (Sunday), he evidently was immediately focused on (and anxious about) a possible Congressional inquiry. Immediately upon returning home he called his attorney, Jim Lyons.

By Monday, he turns, uncharacteristically, to Dr. Watkins and discloses enough to get medication, but not enough to alarm his physician to insist he be evaluated in person. He meets with Marsha Scott for what appears to be longer than usual. She has not been forthcoming about this meeting.

On Tuesday, he uncharacteristically asks about his wife's plans. Awaiting lunch he shows signs of impatience. It is unknown what he might have read in the paper, however the *Wall Street Journal* column regarding the FBI director's replacement appeared the day before and Freeh was presented this morning. Out of character, he leaves the White house in mid-afternoon (and leaves the newspapers in disarray on his table). It is probable that he developed his plan to suicide before this date and was ambivalent to the end about carrying it out. He knew his family's schedule on the 20th, most probably secreted the gun from his house in the early afternoon, and drove around for some time before arriving at a secluded, pastoral setting, at which he killed himself.

Indicators Signaling a Troubled Employee (Scale from Dietz)

1. Harsh criticism of others or self √
2. Difficulty concentrating, remembering, thinking, problem-solving, or decision-making
3. Ruminating/excessive preoccupation √
4. Negativity √
5. Inability to receive criticism and/or compliments √
6. Excessive vigilance and preoccupation about breach of rules or procedures √
7. Marked change in usual mamnner, patterns, or grooming √
8. Irritability, belligerence, hostility, insubordination, anger, temper tantrums
9. Excessive use of alcohol, drugs, compulsive gambling
10. Avoidance of situations and problem-solving
11. Consistently non-compliant, resistant, or uncooperative
12. Extreme mood swings, unpredictability
13. Problems with performance despite adequate training and motivation
14. Overwhelming emotional pain √
15. Blocked emotions; can't feel anything
16. Stuck feelings; can't get beyond anger, disappointment, sadness, or guilt over time √
17. Depressed, anxious, or angry mood √
18. Fatigue, exhaustion √
19. Eating and/or sleeping disturbance √
20. Inability to stand up for self
21. Strained relationships √
22. Inability to let go of a grudge √
23. Isolation; social withdrawal √
24. Consistent blaming of others √
25. Persistent unresolved conflict at work √

Indicia for Suicide

1. Depression, complicated by anxiety
2. Perfectionistic character
3. Self-blame; rage
4. Non-help seeker
5. Loss of security/connectedness
6. Cognitive rigidity
7. Work problems/stress
8. Marital stress
9. Lethal weapon accessible and available
10. Breakdown of usual defenses/coping strategies
11. Trapped/talk of quitting
12. Middle-aged, white male

Suicide Risk: Clinical Approach

1. Mental Status: Foster's judgment was severely affected by his depression and anxiety. His usual defenses and coping strategies showed signs of breakdown.

2. Presence of a Psychiatric Disorder:

A. Evidence for Major Affective Disorder (MAD)

loss of interest or pleasure ✓
loss of appetite or weight ??
insomnia ✓
trouble thinking, concentrating, making decisions ✓
reduced general activity level ✓
feelings of worthlessness ✓
perceived inability to cope ✓
loss of energy or fatigue ✓
hopelessness ? [trapped] ✓
less talkative ✓
social withdrawal ✓

Commentary: In addition to the diagnostic criteria above, there is sufficient evidence for a history of major depression in Foster's family. Affective disorders are the most important diagnoses related to suicide (Tanney, 1992), with proportional mortality by suicide as high as 26%. Males, ages 18-35, with major depression, are 32 times as likely to complete suicide as those in the general population (Boyer et al, 1992); studies have shown that up to 65% of completed suicides had a major affective disorder (Roy, 1982); suicides among those with major affective disorder are more common early in course of the disorder. (Maris, Berman, Maltsberger, & Yufit, 1992). Moreover anxiety (panic, obsessive-compulsive features, insomnia) increases acute suicidality in major affective disorder (Fawcett et al, 1990). Clear signs of anxiety and probably depression, as well, date back to 1992 (Dr. Watkins' records) and possibly to the time of his father's death.

2. Underlying Character Structure: Foster's character displayed an unyielding need for perfection in both his and other's eyes. He had self-imposed high standards, was competitive, hard-working, demanding detailed perfection of himself and others. He placed demands on himself for excessive achievement, to protect and be loyal to others, and to be strong (a "Rock of Gibralter," a "Tower of Strength"). To accomplish this he had to engage a critical self-scrutiny--in psychoanlytic jargon he had a harsh, punitive super-ego: to be "less than" was intolerable and unacceptable. He could tolerate self-criticism as a whip toward better performance, but could not accept external criticism. This type of thinking is unrealistic, but in Little Rock it generally "worked."

Most important to Foster was that he maintain his reputation, his public image for honesty and integrity, so well-achieved in Little Rock.

Commentary: Recent studies by Hewitt and his colleagues (Hewitt et al, 1992, 1994) have documented a significant relationship between perfectionism and both depression and suicidality, particularly when mediated by stress.

3. Help-seeking Interaction: Foster was not a help-seeker; he was private and fearful (paranoid?) about the consequences of seeking help for his depression and anxiety. He sought help only in his last few days and preferred the safety of his family physician, who asked few evaluative questions, to the immediacy and presence of other, unknown professionals in the DC area.

4. Behavioral: Foster was methodical and perfectionistic in character. He showed no signs of impulsivity. He was known to be moody, and, although not aggressive, was clearly angry at both others and self-blaming in his last few weeks. Generally his aggression was handled in a controlled fashion through a rigid demandingness of self and others. His history of handling stress was good. However, in his last few months there are clear and evident signs of a breakdown in his ability to cope with stress. He, uncharacteristically and unacceptably (to his ego) talked of quitting. There is no indication in his history of ever giving up or not engaging the battle.

5. Environment: A social support system, although present, was burdensome for Foster. He felt responsible for increasing family stress and was not/could not accept being supported at home. He kept his own counsel for the most part and did not have any clear intimate friendships. He disliked his living arrangements in DC. His daily routine was intense, filled with long hours of defending the fort. He did not work out physically as he used to.

A Suicide Paradigm

Death Before Dishonour

Litman (personal communication) has used the phrase "death before dishonour" to describe the suicides of executive personalities facing public disgrace, humiliation, disclosure of wrong-doing, etc. In essence, death is preferred to preserve one's identity. The suicide has an inability to tolerate an altered view of himself; suicide maintains a self-view and escapes having to incorporate discordant implications about the self. These types of suicides are typically complete surprises to others in the available support system.

Vincent Foster showed a real vulnerability and sensitivity to external criticism (rigid/fragile defenses). A number of negative life-events, now opened to public scrutiny by the *Wall Street Journal* articles and the threat of a Congressional Inquiry, posed serious questions of character and exposed him to feelings of failure and the threat of punishment. Mistakes, real or perceived, posed a profound threat to his self-esteem/self-worth and represented evidence for a lack of control over his environment. Feelings of unworthines, inferiority, and guilt followed and were difficult for him to tolerate. There are signs of an intense and profound anguish, harsh self-evaluation, shame, and chronic fear. All these on top of an evident clinical depression and his separation from the comforts and security of Little Rock. He, furthermore, faced a feared humiliation should he resign and return to Little Rock in disgrace. Foster felt trapped and had no felt hope of changing his circumstances in the near term. Feelings of hopelessness increases suicide risk significantly (see Figure 1).

Aware he was in trouble psychologically, Foster, nevertheless, was reluctant to seek help. This difficulty accepting the vulnerable position is common to successful executives. By the Friday before his death he was desperate; calling for names of psychiatrists was a clear public (and personally intolerable) admission of his failure. He was ambivalent and fearful about this help-seeking. Even his call to Dr. Watkins on Monday signals his attempt to minimize while announcing his depression to someone other than Lisa or Sharon (and, perhaps, Marsha Scott on the 19th).

Specific Questions:

1. **If Foster was intent on his suicide, why did he eat lunch?**

There is no study in the professional literature that has examined eating behavior prior to suicides. Gastric contents are usually not recorded on autopsy unless there is a specific reason to look and record.

Foster was ambivalent about his death until the end. His behavior on the 20th is consistent with this: He did not need to go to work if he was unambivalent in his suicide intent that morning. I believe the fatal decision was not made until lunch-time, perhaps triggered by something read in the newspaper. However, the plan to secret the gun from the home was probably formed over the weekend. In any event, even death row inmates, knowing they are to die within a short time, eat a last meal.

2. **Does the finding of semen on his boxer shorts reflect a possible sexual liason in Fort Marcy Park?**

No: involuntary urination, secreted seminal fluid, and defecation often occur upon death from any cause.

3. **Why did this death occur in Fort Marcy Park?**

If we accept the idea that Foster was ambivalent to the end and that he may have driven his car for some time after secreting the gun from his home, the following possibilities are apparent: he may have simply and inadvertently happened upon the park or he may have purposely picked it off the area map found in his car.

We know Foster valued privacy. He spoke in his Commencement Address of taking "an occassional walk alone in the woods." Similar to the typical male physician who suicides by seeking the guaranteed privacy of a hotel room, and a "do not disturb" sign, Foster, protective of his family, would be most unlikely to suicide at home, leaving the possibility of being discovered by his children as a legacy.

4. **Why was no suicide note left by Foster?**

First, it is less, vs. more, common to leave a suicide note. Only 12-15% of suicides leave a note; 85-88% do not (Leenaars, 1992).

Secondly, Foster, again, was intensely private, protective, and loyal to his family and the president/first family. It would be out of character for him to leave a disclosure such as a note.

Thirdly, I believe Foster was intensely self-focused at this point; overwhelmed and out of control.

5. **Why did the pressure get to Foster now?**

He was under an increasing burden of intense external stress, a loss of security, a painful scanning of his environment for negative judgments regarding his performance, a rigid hold of perfectionistic self-demands, a breakdown in and the absence of his usual ability to handle that stress primarily due to the impact of a mental disorder which was undertreated. He simply could not maintain control or see a way out. Most likely, the precipitating "event" that triggered his suicide was a complex of: dashed expectations of relief from the weekend away, anxiety pertaining to the possible Congressional inquiry, highlighted by the meeting planned with his attorney, and the Freeh nomination placed in the context of the *Wall Street Journal* column the day before.

Mode of Death Determination:

In my opinion and to a 100% degree of medical certainty, the death of Vincent Foster was a suicide. No plausible evidence has been presented to support any other conclusion.

At worst, there remains a lack of **additional** validating evidence answerable by a number of yet unresolved/unanswered questions posed by the unavailabilty of family members for direct

interview, a paucity of information regarding Foster's early childhood (which would help to better understand the formation of his character structure) and, particulrly, communications on the weekend of June 16-18, and the unknowability of other evidence, including the remote possibility that other documentation was removed from his office before it was secured two days after his death.

References

Boyer, R., Lesage, A. D., Grunberg, F., Morisette, R., Vanier, C. Buteau-Menard, C., & Loyer, M. (1992). Mental illness and suicide: Psychological autopsy (pp. 250-251). In D. Lester (Ed.). Suicide '92: Proceedings, Silver Anniversary Conference, American Association of Suicidology. Denver: American Association of Suicidology.

Fawcett, J., Scheftner, W. A., Fogg, L., Clark, D. C., Young, M. A., Hedeker, D., & Gibbons, R. (1990). Time-related predictors of suicide in major affective disorder. American Journal of Psychiatry, *147* (9), 1189-1194.

Hewitt, P.L., Flett, G. L., & Turnbull-Donovan, W. (1992). Perfectionism and suicide potential. British Journal of Clinical Psychology, *31*, 181-190.

Hewitt, P.L., Flett, G. L., & Weber, C. (1994). Dimensions of perfectionism and suicide ideation. Cognitive Therapy and Research, *18*, 439-460.

Leenaars, A. A. (1992). Suicide notes, communication, and ideation (pp. 337-355). In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.). Assessment and prediction of suicide. New York: Guilford.

Litman, R. (Personal Communication, June, 1996).

Maris, R. W., Berman, A. L., Maltsberger, J. T., & R. I. Yufit, R. I. (Eds.). Assessment and prediction of suicide. New York: Guilford.

Roy (1992). Risk factors for suicide in psychiatric patients. Archives of General Psychiatry, *39*, 1089-1095.

Tanney, B. L (1992). Mental disorders, psychiatric patients, and suicide (pp. 277-320). In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.). Assessment and prediction of suicide. New York: Guilford.

Foster Suicide Paradigm

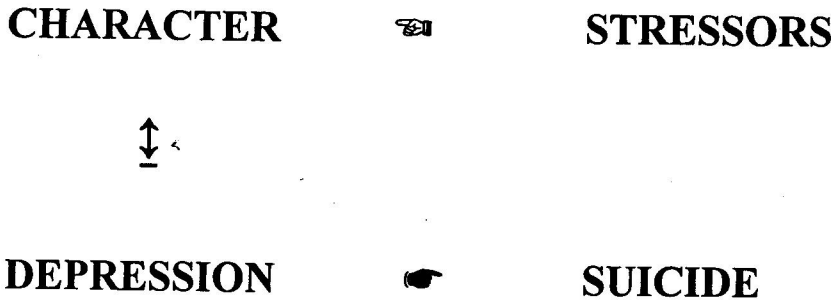

Figure 1

Addendum

Chronology of Major Events in Last Several Months

December, 1992

Foster tells Dr. Watkins he's under stress/has insomnia (post-election) and is prescribed Restoril. Weight = 194

January, 1993

Foster resigns RLF; arrives in DC on 20th for Innauguration; lives with Berl and Sheila Anthony.

March, 1993

Leases house

April, 1993

Receives buy-out from RLF building

May, 1993

Commencement Address delivered at University of Arkansas Law School: affect = flat; content = regret. Travel Office Report Issued. End of month: Dinner with Sheila, Webb Hubbell: "to cheer Vince up." Tells wife he wants to resign (two weeks prior to her arrival).

June, 1993

5th: Family moves to DC
8th Lisa notices Vince is emotionally down
2nd week: comments re seeking job with less pressure to Kennedy
17th WSJ editorial: "Who is Vincent Foster?"
24th WSJ Review & Outlook: "VF's victory"
29th Comments to Berl: "I spent a lifetime building my reputation and now I am in the process of having it tarnished."

July, 1993

2nd His sister (Sheila) last sees him at dinner, at which he confides his thoughts of resignation
Kennedy et al given formal reprimands
4th-20th: Lisa Foster twice tells him to remove guns; she and their eldest son call office to ask how he's doing (Gorham)
12th Telephone call to Berl re travel office/congressional inquiry -- asks names of

attorneys. Takes "unusual" day off

13th Talks to wife about resigning; looked "very tired" [Rutherford]

14th Talks with Susan Thomases about needing more legal help, anticipating congressional inquiry, and being unhappy. Calls Jim Lyons; pulls him out of deposition.

15th Wife expresses concern about account being overdrawn. Receives names of attorneys from Berl.

16th Telephone conversation with Sheila ("strained voice"); Admits depression, concerned about security clearance if sees Therapist; Sheila gives 3 psychiatrists' names; Foster asks re Eastern Shore getaway. Blood Pressure reading: 160/100; 10' later: 140/90. Calls/Books Tidewater Inn for weekend; Calls R. Hedaya, MD. Arrives home at 4:00 pm, leaves for Tidewater.

16th-18th: "very upset/emotional" at Tidewater; tearful. At Cardozo's: jogs with Harolyn Cardozo; not interested in watching tennis, did not want to stay for dinner, more withdrawn.

18th: At home, 6:00 pm: speaks with Jim Lyons regarding meeting on the 21st. Talks by phone with mother: "sounded unhappy"

19th: jogs in morning. WSJ article published: Review & Outlook: "What's the Rush" (re Freeh nomination). Makes "unprecedented" call (10:30 am) to Dr. Watkins, reports he is not eating well, not sleeping well, depressed. Watkins prescribes 30 tabs trazadone (Desyrel): 50 mg.

Marsha Scott spends 20-30' [afternoon] and/or 1-2 hours in a.m. with him, discusses weekend. Foster did not get up to greet her ("unusual")--seemed more relaxed. Tells her he's "going to get some rest." Sends life insurance payment

Evening: takes 1 Desyrel 50mg

20th: Does not jog

8:30 am: leaves for work: according to his wife his "mood [is] better." He, uncharacteristically, asks about her plans for the day

8:50 am: at work; has breakfast

10:00 am: attends Freeh nomination Rose Garden; makes "weak" response to Nussbaum's comment about "2 home runs."

12:00-12:30 pm: Orders then eats hamburger, french fries, coke, some M&Ms; expresses impatience with time taken to get luch); reads news clippings.

12:45 pm: appears "distracted" to Chadwick and Tripp. Tripp conjectures he's "very distressed" re an article in the paper.

1:00 pm: Leaves office, stating "I'll be back" to B. Pond; does not respond to Tom Castleton's "so long." He has his suit jacket with him.

1:10 pm: leaves the White House in his car.

3:05 pm: car possibly seen by J. Ferris making abrupt cut into Fort Marcy Park

4:15 pm: Knowlton sees Honda at FMP

5:10 pm: Wife calls ofc

5:15-5:30 pm: Doody/Feist arrive FMP - leave car @ 6:00 for walk

5:30-5:45 pm: CW discovers body
6:00 pm: 911 call from Swann
6:03 pm: US Park Police receive notice
6:10 pm: Gonzalex & Fornshill discover body
7:15 pm: Medical Examiner arrives

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Operational Criteria for the Determination of Suicide

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REFERENCE: Rosenberg, M. L., Davidson, L. E., Smith, J. C., Berman, A. L., Buzbee, H., Gantner, G., Gay, G. A., Moore-Lewis, B., Mills, D. H., Murray, D., O'Carroll, P. W., and Jobes, D., **"Operational Criteria for the Determination of Suicide,"** *Journal of Forensic Sciences*, JFSCA, Vol. 33, No. 6, Nov. 1988, pp. 1445-1456.

ABSTRACT: Suicide is an important public health problem for which we have an inadequate public health database. In the United States, decisions about whether deaths are listed as suicides on death certificates are usually made by a coroner or medical examiner. These certification decisions are frequently marked by a lack of consistency and clarity, and laws and procedures for guiding these decisions vary from state to state and even from county to county.

Without explicit criteria to aid in this decision making, coroners or medical examiners may be more susceptible to pressures from families or communities not to certify specific deaths as suicide. In addition, coroners or medical examiners may certify similar deaths differently at different times. The degree to which suicides may be underreported or misclassified is unknown. This makes it impossible to estimate accurately the number of deaths by suicide, to identify risk factors, or to plan and evaluate preventive interventions.

To remedy these problems, a working group representing coroners, medical examiners, statisticians, and public health agencies developed operational criteria to assist in the determination of suicide. These criteria are based on a definition of suicide as "death arising from an act inflicted upon oneself with the intent to kill oneself." The purpose of these criteria is to improve the validity and reliability of suicide statistics by: (1) promoting consistent and uniform classifications; (2)

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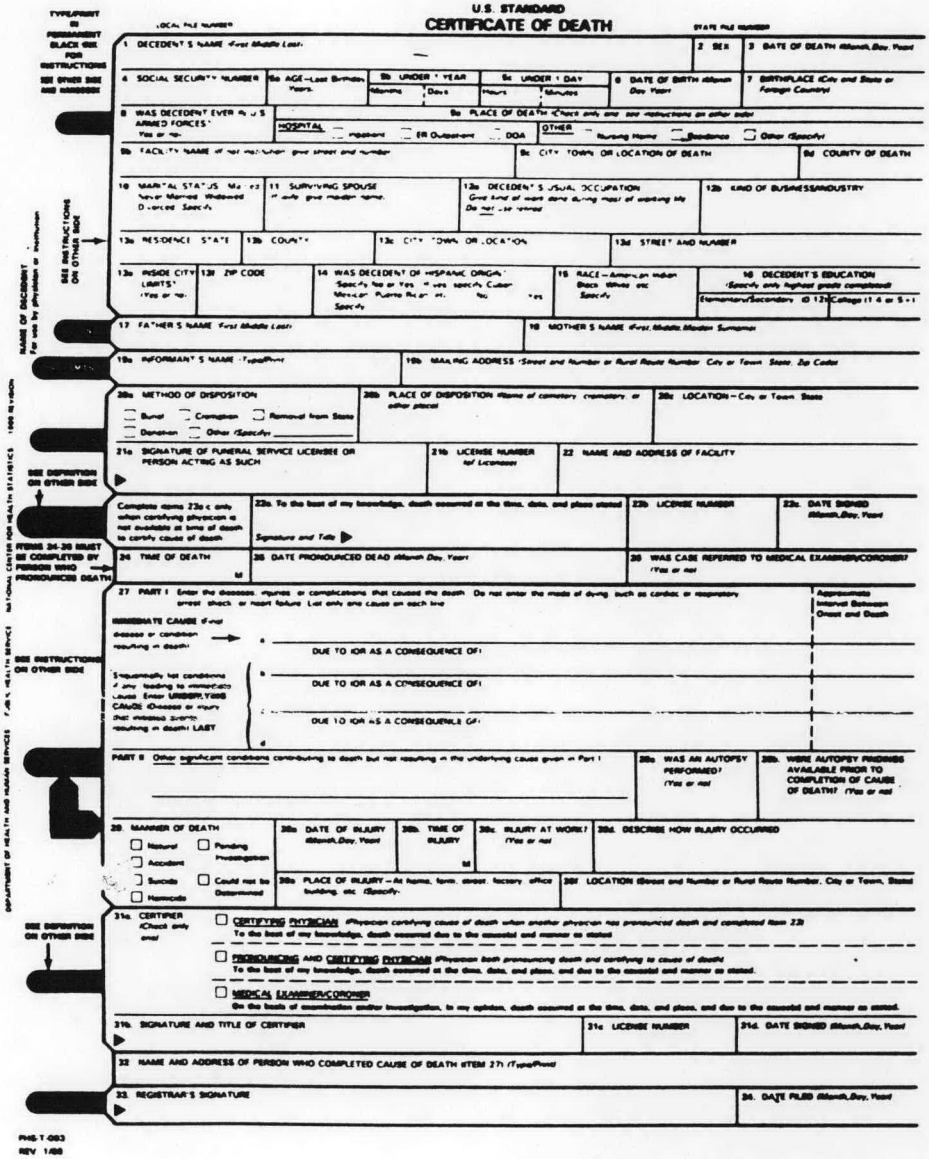

U.S. STANDARD
CERTIFICATE OF DEATH

FIG. 1—*U.S. Standard Certificate of Death.*

(IACME), National Association of Counties (NACO), National Association of Medical Examiners (NAME), and National Center for Health Statistics (NCHS). The representatives developed operational criteria and refined them by obtaining comments from their respective organizations on multiple revisions. Other leaders in the areas of suicide and medical and psychiatric classification critiqued drafts of the criteria, and their comments were reviewed and incorporated by the group.

Criteria for the Determination of Suicide

Self-Inflicted

There is evidence that death was self-inflicted. This may be determined by pathological (autopsy), toxicological, investigatory, and psychological evidence, and statements of the decedent or witnesses.

Intent

There is evidence (explicit, implicit, or both) that at the time of injury the decedent intended to kill himself or herself or wished to die and that the decedent understood the probable consequences of his or her actions.

1. Explicit verbal or nonverbal expression of intent to kill self.
2. Implicit or indirect evidence of intent to die, such as
   - preparations for death inappropriate to or unexpected in the context of the decedent's life,
   - expression of farewell or the desire to die or an acknowledgment of impending death,
   - expression of hopelessness,
   - expression of great emotional or physical pain or distress,
   - effort to procure or learn about means of death or to rehearse fatal behavior,
   - precautions to avoid rescue,
   - evidence that decedent recognized high potential lethality of means of death,
   - previous suicide attempt,
   - previous suicide threat,
   - stressful events or significant losses (actual or threatened), or
   - serious depression or mental disorder.

Elaboration of Specific Terms for the Determination of Suicide

The following discussion of specific terms and parts of the criteria is meant to reduce ambiguity and clarify the actual use of the criteria in certifying deaths.

Self-Inflicted

Pathological evidence from an autopsy may indicate the relative probability of a particular injury being self-inflicted. A bullet wound is more likely to have been self-inflicted, for example, if autopsy evidence indicates that a gun had been fired from a distance close enough to leave powder burns on the skin or to cause a contact wound.

Toxicologic evidence might indicate if death resulted from a potentially lethal substance that was accessible to the decedent. Toxicologic screens are limited, however, by their sensitivity and specificity and by the range of specific toxins they are designed to detect. A full analysis, however, might pick up any drug or metabolite. In addition, an individual may survive long enough to allow the substance to "metabolize away" or diminish to a nonlethal or nondetectable level. In many possible suicides, toxicologic studies may not have been performed if suicide had not been suspected or if appropriate specimens had not been obtained at the time of death.

Investigational evidence includes data from police reports; photographs, notes, and diagrams from the scene of death; and information collected from the deceased's medical or mental health records.

Psychological evidence includes explicit or implicit evidence that the decedent planned to harm himself or herself based on observed behaviors, communications, and characteriza-

tions of personality, habit, and life-style. This evidence may be gathered through interviews with family, friends, employers, physicians, and others in a position to provide relevant information about the decedent. Standardized interview formats for such investigations are available and can be routinely completed with a minimum of time and personnel for most cases. Routine police reports of death investigations frequently do not provide the minimum necessary information.

Statements by the deceased can also constitute evidence as to whether or not the injury was self-inflicted. Verbal statements may have been made indirectly in the course of conversation, directly to a witness, or recorded on audiotape or videotape. Written statements may include diaries, letters, drawings, or notes (handwritten, typed, or stored in a word processor, tape, or diskette).

Intent

Whether or not the decedent intended to kill himself or herself is usually more difficult to determine than whether the injury was self-inflicted or not. "Intent" requires that the decedent knew or had in mind that a specific act would probably result in death. Alcohol, drugs, mental illness, or youth may all contribute to an individual's inability to have the mental capacity to form intention. But evidence that the decedent consumed a large amount of alcohol before death, for example, does not by itself demonstrate inability to form intent. In such a case, the investigator should attempt to determine whether or not evidence demonstrated that the subject had intended to kill himself or herself before becoming too intoxicated to form intent. About 25% of all suicides involve recent alcohol consumption [*12*]. In all such cases, the specific relationship of alcohol consumption to formation of intent should be examined. Similarly, mental illness does not make it impossible to form intent: it is important to look for specific evidence that the deceased understood and intended the likely consequences of this act near the time he or she decided to proceed with the act. Conversely, evidence may suggest that the decedent had an impaired state of consciousness or impaired judgment at the time the critical decision was made; impairment may have been due to alcohol, drugs, metabolic state, or illness.

Specific types of evidence often suggest that death resulted from unintended or accidental injuries. First, evidence may show that the subject intended to survive. The subject may have a history of carelessness, poor judgment, or previous unintentional injuries similar to the fatal injury. In the case of death as a result of drug or alcohol overdose, a subject's history of nonfatal abuse of the same substances suggests that the fatal overdose might have been unintentional. A history of previous misuse of a fatal modality with evidence that self-destructive consequences were not intended (such as playing with loaded guns, driving recklessly, or playing on high, unprotected ledges) suggests that death might have been unintentional. Finally, evidence that the subject did not recognize the high potential lethality of the means of injury could indicate the death was unintentional.

Several types of death present more difficult decisions to the person completing the death certificate. Since even experts disagree as to whether or not Russian roulette should be classified as suicide, establishing criteria for such decisions is essential. Drug or alcohol intoxication raises the difficult questions of whether or not the fatal outcome was intended or accidental and whether or not the individual had the mental capacity to form intention. Single motor-vehicle crashes may result from suicidal behavior, for instance, and may be too commonly dismissed as "accidents" [*13*]. Intent is often difficult to determine in the following situations: (1) when death is delayed or when it is the unanticipated consequence of a potentially self-destructive act; (2) when a body is never found; (3) when drownings, leaps, or falls are unwitnessed; or (4) when the death is of a child too young to realize the consequences of jumping from a window, swallowing poison, or running in front of a car.

In these criteria, the term "implicit evidence of intent" refers to an indicator of intent

communicated by the decedent but not explicitly stated; "indirect" evidence includes what are commonly called "risk factors." A risk factor is an attribute or exposure that is associated with an increased likelihood of suicide; a risk factor is not necessarily a causal factor. A family history of suicide, for example, is a risk factor but not an implicit indicator of intent or implicit evidence of an intention to commit suicide.

Specific Phrases and Criteria Related to Intent—Explanations and Examples

The types of evidence of intent that follow *are not* listed in order of significance or importance. Examples of verbal expressions include written diary notes, audiotape recordings, and videotape messages; nonverbal expressions might include drawings or a very recent, potentially lethal attempt where a timely discovery led to rescue. This list is not meant to be exhaustive. Recent behaviors and feelings are deemed more important, but historical data also bear on the decision. Serious depression, for example, is usually a recurrent problem, and a person who has experienced a serious depression in the past is at higher risk of another depressive episode years later [*14*].

1. *Preparations for death inappropriate to or unexpected in the context of the decedent's life.* Examples: Unexplained giving away of possessions and making provisions for the future care of children or pets.

2. *Expression of farewell or the desire to die or an acknowledgment of impending death.* Examples: "I won't be here to be kicked around anymore"; "You were real important to me"; "Have a good life"; "You'll be sorry when I'm gone"; "I can't stay around to face the future."

3. *Expression of hopelessness.* Examples: "It just doesn't matter anymore"; "It wouldn't make any difference if I . . ."; "What's the use of . . .?" Actions signaling hopelessness include giving up activities or medical treatments that are clearly necessary to sustain life.

4. *Expression of great emotional or physical pain or distress.* Examples: "This pain is killing me; I can't stand it anymore"; "I cannot live like this"; "It is too much for me to take." Indirect manifestations of extreme pain may be seen in failures to obtain relief from standard medical treatments.

5. *Effort to procure or learn about means of death or rehearse fatal behavior.* Examples: Recently purchasing firearms or ammunition, stockpiling potentially lethal drugs, purchasing rope, and obtaining access to high places.

6. *Precautions to avoid rescue.* Examples: Locking doors, going to a prearranged, secluded place, telling lies about one's whereabouts, and arranging to be alone.

7. *Evidence that decedent recognized high potential lethality of means of death.* Examples: A pharmacist or physician taking an overdose of a highly lethal drug or the decedent's "researching" different drugs to determine their degree of lethality.

8. *Previous suicide attempt.* Previous attempts include self-destructive acts carried out with the goal of killing oneself or with an awareness that the consequences could be lethal. The more recent attempts and those with a high potential lethality may be more significant indicators of intent. Previous attempts, however, need not be recent or potentially highly lethal. Furthermore, the methods used in the previous attempts may differ.

9. *Previous suicide threat.* A "threat" need not be a coercive statement made to force another person to do something—it can be a statement of intent. Examples of threats include playing with a gun and saying "I'm going to shoot myself." Thoughts or fantasies about suicide (such as an imagined reunion with a dead relative) should be differentiated from threats, although questions about such thoughts or fantasies should be asked.

10. *Stressful events or significant losses (actual or threatened).* Examples: Loss of a relationship (with a boyfriend, girlfriend, child, or spouse), intangible losses (not being elected to a desired office or being passed over for a promotion), loss of self-esteem, or financial

losses. Anticipating difficult changes may constitute severe stress, even when those changes represent "desired" transitions such as leaving for college or getting promoted at work.

11. *Serious depression or mental disorders.* Depression is not used here to refer to a brief period of sadness. It is a mental disorder characterized by a serious and pervasive loss of pleasure and loss of interest in one's usual activities that lasts at least two weeks. Additional signs of depression include sadness, sleep disturbances, difficulty concentrating, excessive guilt ruminations, loss of energy, loss of appetite, or a marked change in weight. Since depression is usually a recurrent disorder, a past history of depression may indicate a persistent problem. A person may commit suicide when he or she appears to be recovering or getting more energy. Depression or another mental disorder need not have been diagnosed by a mental health professional. Signs of impairment by a mental disorder might include inability to care for oneself, inability to maintain relationships, or previous psychiatric hospitalization. Other mental disorders include manic state or manic-depressive illness, difficulty controlling impulses, psychoses, substance abuse disorders, and organic mental disorders. A person with a mental disorder may commit suicide in response to a perceived command that was part of a hallucination (for example, "My mother is calling me to join her in heaven"; "The space creatures told me that if I did not kill myself they would torture me.").

Applications of These Criteria

These criteria are meant to aid decision makers in exercising their judgment, not to replace judgment with a mathematical formula for decision making. These criteria are intended as guidelines to promote accuracy, consistency, and uniformity in certifying and reporting suicide. They are also intended to make the decision making process more explicit, which can help decision makers minimize bias and resist family and community pressures to avoid calling a death a suicide.

The definition of suicide implicit in these criteria is "death arising from an act inflicted upon oneself with the intent to kill oneself." Thus, the two fundamental questions for the decision maker are (1) whether or not the injury was self-inflicted and (2) whether or not the decedent intended to kill himself or herself. The criteria are designed to allow separate and sequential determinations of a death as being self-inflicted and intentional.

Absolute certainty is not the goal in certifying deaths. With respect to suicide deaths in particular, no decision maker will ever be certain of the decedent's intent because the decedent is unavailable for questioning and because almost everyone who contemplates suicide has some degree of ambivalence [*15*]. Rather than absolute certainty, a "yes" or "no" decision is needed representing the decision maker's best judgment after collecting and reviewing all the evidence. These criteria can help decision makers specify the types of evidence that should be collected and used in the decision. The criteria specify, for example, that information about the decedent's past mental health, previous suicidal behavior, and recent communications with acquaintances should be collected and considered. Determining the manner of death will not result from applying a mathematical formula to the yes and no answers for various criteria. Instead, the basis for the decision should correspond to the legal notion of "the preponderance of the evidence"; otherwise stated, it is an opinion based on "reasonable probability." Obviously, certain types of evidence may be helpful in deciding between suicide and homicide, for example, and other types of evidence may be helpful for deciding between suicide and accident.

The relative importance of particular criteria may vary with the victim's age, sex, race, or socioeconomic status. Among young persons who commit suicide, for example, depression may be uncommon; among older persons, depression may be very common. Similarly, serious mental disorders may be expressed differently among young persons. Manic-depressive illness might be easily diagnosed in an adult who has had several episodes of depression and at least a single manic episode. In a young person with no history of full-blown manic or

depressive episodes, however, the diagnosis might be suggested only by a labile mood, impulsivity, family history of manic-depressive illness, and a positive response to treatment (lithium).

Since these criteria indicate the kinds of information that should be collected during the investigation of possible suicides, they should be available to the investigator before and during the investigation. Criteria could be printed on a pocket reference card that would be available to the investigator if he or she wishes to use it. They might also be printed on the investigation report form, but labeled "Guidelines." This would allow the decision making process to be reconstructed in difficult cases and would also document cases that are subsequently reviewed for legal or quality assurance purposes. The criteria could be incorporated into software packages now being developed to assist both in analyzing data and in preparing medical examiner reports [*16*]. The criteria could help in training personnel who investigate or certify possible suicides. Teaching a procedure that has been made explicit through criteria specification is easier than teaching an "intuitive" process. These criteria could also be used to analyze the quality of the death certification process, since case reviewers could identify both the amount and content of the information upon which the decision about manner of death had been made and the decision making process itself.

Discussion

Accurate determination of true suicide deaths is essential in identifying high-risk groups and targeting preventive programs and interventions to those groups. Recognizing that specific subpopulations, such as white males or Native Americans, are at increased risk is an outgrowth of suicide reporting [*17,18*]. Although our presently imperfect suicide statistics are useful, the possibility of systematic and selective certification errors may undercut our ability to identify other potential groups at high risk for suicide [*19*]. For example, certifiers who discount suicide as a possible manner of death in younger children may skew reported suicide rates toward older age groups. We need more educational materials to highlight the differences between adult and child suicide.

Consistent and accurate suicide certification also allows us to follow trends. Among young persons today, firearms are the most frequently used method of suicide, whereas at the turn of the century hanging and poisoning were more common [*20,21*]. Such trend information is vital in assessing the potential and actual impact of prevention strategies. For example, lower suicide rates in Great Britain following the conversion of household fuel supplies from carbon-monoxide-containing coal gas to less lethal natural gas demonstrate the beneficial effects of changing the availability of one method of suicide [*22*].

Additionally, accurate determination of suicide deaths is important for understanding suicide risk factors and causes. Long-term outcomes of various disease processes and events have been determined through analyses of death certificates. For example, causes of mortality for persons with mental disorders such as schizophrenia, alcoholism, and depression have been identified by matching treatment records with death certificates [*23–25*]. From this type of study, epidemiologists can estimate the lifetime risk of suicide, the years of potential life lost to suicide, or the health care costs attributable to suicide for these disorders. The relative frequency of suicide is also being examined for persons with specific exposures, such as military service in Vietnam [*26*]. Adverse perinatal events also have been reviewed as risk factors for adolescent suicide in a study linking hospital records with death certificates [*27*]. The recently inaugurated National Death Index will allow large studies of this sort to be conducted.

Factors temporally associated with suicide have been identified from medical examiner data. Toxicology studies have documented how commonly suicidal persons consume alcohol just before death [*28,29*]. Other toxicologic studies have provided information on the specific

substances ingested in suicides by overdose and show the predominance of overdose suicides by antidepressant medications. This information may be important in preventing suicides by improving prescribing practices [*30*].

The death certificate or medical examiner's file may be a starting point for more in-depth studies that relate sociological and psychological characteristics to suicide. Information beyond that on a death certificate or in a medical examiner's file has been obtained through interviews termed "psychological autopsies." One such study of deaths classified as suicide highlighted the negative impact of the recent loss of a significant other on the decedent [*31*]. Although these studies require information sources beyond death certificates, their foundation is the identification of valid cases of suicide as determined by the certifier.

The operational criteria for the determination of suicide (OCDS) will improve suicide determination by standardizing the type of information collected and incorporated into determining the manner of death. The certifier is more likely to identify a suicide correctly when the case file contains objective information regarding intent to die. Certifying districts might develop checksheets for case files that could be used in all types of cases referred to the coroner or medical examiner (see Appendix for example). The checksheet would provide documentation either for or against the decedent's intent to die. Thus, the process for information collection becomes systematic. These data, when routinely collected, will form a practice standard for determining cause of death. The OCDS will allow more meaningful comparisons of vital statistics data among various geographic, age, racial, and socioeconomic groups. Such comparisons would more closely reflect actual differences in rates of occurrence, rather than different practices for determining mode of death.

We hope these criteria will be disseminated, used, and subsequently revised to incorporate the suggestions of medical examiners and coroners. We also hope to measure the validity, sensitivity, and specificity of these criteria and to revise them in light of these measurements. And we will look for ways to make them clearer, more practical, and more useful.

From its inception, the working group felt that the role of the Centers for Disease Control (CDC) and the National Center for Health Statistics (NCHS) was to catalyze the process of criteria development by helping to bring the relevant parties together; because the group did not want these criteria to be government guidelines imposed upon certifiers, the group did not seek official government endorsement. Because the primary users of these criteria are medical examiners and coroners, we presented the criteria to the International Association of Coroners and Medical Examiners. Their executive board approved the criteria in June 1987. Representatives of the National Association of Medical Examiners participated in every step of criteria development. These criteria were also presented to the American Association of Suicidology (AAS) membership—which includes psychiatrists, psychologists, and suicide prevention researchers and practitioners—several times during the course of their development. While the AAS does not endorse scientific research or findings, their board of directors in May 1987 officially recommended dissemination of these criteria.

Disseminating and successfully implementing the OCDS will depend on the initiative of relevant individuals and organizations such as those involved in developing the criteria. To assist in their dissemination, the working group is developing a training manual and conducting research to assess the validity and value of the criteria, and to assess such characteristics as intra- and inter-observer variability. Widespread adoption of these criteria could result in an apparent increase in reported rates of suicide. It will be important to understand the effect of these criteria in changing reported suicide rates so that future rates could still be compared to historical rates and so that the effect of any reporting artifacts could be estimated.

Suggestions or inquiries should be addressed to OCDS Working Group, c/o Division of Injury Epidemiology and Control, Center for Environmental Health and Injury Control, Centers for Disease Control, Atlanta, GA 30333.

Acknowledgments

Many persons assisted the working group with the formulation of these criteria through their careful review and comment. In particular, we thank Norman L. Farberow, Ph.D., Robert E. Litman, M.D., Edwin S. Schneidman, Ph.D., and Robert L. Spitzer, M.D. We also thank Elizabeth Fitch, Joyce M. Hughes, and Donna C. Hiett for their invaluable assistance to the working group and in the preparation of this manuscript. James A. Mercy, Ph.D., provided valuable comments on the manuscript.

APPENDIX

Example of a Questionnaire For Possible Use by Medical Examiners and Coroners

Fill in every column and row. Use the following codes:

Y = yes, decedent showed positive evidence of intent to die
N = no, decedent showed evidence contrary to intent to die
0 = there was no evidence relating to this category, or respondent did not know
- = respondent was not asked

Write in details for any Y or N codes.

	Source of Information			
	Family	Acquaintance	Other	Details
A. Explicit expression of decedent's intent to die:				
1. Verbal statement				
2. Handwritten suicide note, unambiguous				
3. Recorded statement, e.g., audio tape, word processor disk, typewritten note, video tape				
B. Implicit or indirect evidence of decedent's intent to die:				
1. Expressions by the decedent of farewell, desire to die or acknowledgement of impending death				
2. Expressions by the decedent of hopelessness				
3. Expressions by the decedent of great emotional or physical pain or distress				
4. Expressions by the decedent that the decedent recognized high potential lethality of means of death				
5. Efforts or actions by the decedent to prepare for death, inappropriate to or unexpected in the context of his or her life				

6. Efforts or actions by the decedent to procure or learn about means of death or rehearse fatal behavior				
7. Efforts or actions by the decedent or precautions to avoid rescue				
8. Decedent's history of previous suicide attempt				
9. Decedent's history of previous suicide threat				
10. Decedent's history of stressful events or significant losses (actual or threatened)				
11. Decedent's history of serious depression or mental disorder				

References

[1] *Monthly Vital Statistics Report. Advance Report of Final Mortality Statistics, 1984.* Hyattsville, MD, National Center for Health Statistics, Sept. 1986, Vol. 35, No. 6, Supplement 2 (DHHS Publication No. (PHS) 86-1120).

[2] Toolan, J. M., "Suicide in Children and Adolescents," *American Journal of Psychotherapy.* Vol. 29, 1975, pp. 339-344.

[3] Jobes, D. A., Berman, A. L., and Josselson, A. R., "Improving the Validity and Reliability of Medicolegal Certifications of Suicide," *Suicide and Life Threatening Behavior.* Vol. 18, No. 1, 1988.

[4] Dublin, L. I., *Suicide.* Ronald Press, New York, 1963.

[5] Suicide in the United States, 1950-1964, Publication 1000, Series 20:5, National Center for Health Statistics, Public Health Service, Hyattsville, MD, Aug. 1967.

[6] Litman, R., "Psycho-Legal Aspects of Suicide," *Modern Legal Medicine: Psychiatry and Forensic Science.* W. Curran et al., Eds., Davis, Philadelphia, 1980, pp. 841-853.

[7] Jobes, D. A., Berman, A. D., and Josselson, A. R., "The Impact of Psychological Autopsies on Medical Examiners' Determination of Manner of Death," *Journal of Forensic Sciences.* Vol. 31, No. 1, Jan. 1986, pp. 177-189.

[8] Spelman, J. W., "Suicide: A Medical Examiner's View," *Legal Medicine Annual.* C. Wecht, Ed., Appleton Century Crofts, Norwalk, CT, 1969, pp. 165-184.

[9] Nelson, F. L., Farberow, N. L., and MacKinnon, D. R., "The Certification of Suicide in Eleven Western States: An Inquiry into the Validity of Reported Suicide Rates," *Suicide and Life Threatening Behavior.* Vol. 8, No. 2, 1978, pp. 75-88.

[10] Murphy, G. E., Gantner, G. E., Wetzel, R. D., Katz, S., and Ernst, M. F., "On the Improvement of Suicide Determination," *Journal of Forensic Sciences.* Vol. 19, No. 2, April 1974, pp. 276-283.

[11] Litman, R. E., Curphey, T. J., Shneidman, E. S., Farberow, N. L, and Tabachnick, N. D., "Investigations of Equivocal Suicides," *Journal of the American Medical Association.* Vol. 184, 1963, pp. 924-929.

[12] Mercy, J. A., Davidson, L. E., Goodman, R. A., Rosenberg, M. L., and Berkleman, R. L., "Alcohol and Intentional Violence: Implications for Research and Public Policy," background paper prepared for the National Institute on Alcohol Abuse and Alcoholism's Conference on Research Issues in the Prevention of Alcohol-Related Injuries, March 1986.

[13] Schmidt, C. W., Jr., Shaffer, J. W., Zlotowitz, H. I., and Fisher, R. S., "Suicide by Vehicular Crash," *American Journal of Psychiatry.* Vol. 134, No. 2, 1977, pp. 175-178.

[14] *Diagnostic and Statistical Manual of Mental Disorders.* 3rd ed., American Psychiatric Association, Washington, DC, 1980, pp. 215-216.

[15] Shneidman, E., *Definition of Suicide.* Wiley, New York, 1985.

[16] Gantner, G. and Gantner, T., "Coding of Forensic Factors and Circumstances Surrounding Disease, Injury, and Death," *Role of Informatics in Health Data Coding and Classification Systems.*

R. A. Cote, D. J. Protti, and J. R. Scherrer, Eds., Elsevier Science Publishers, New York, 1985, pp. 107-128.
[17] *Suicide Surveillance*, Centers for Disease Control, Atlanta, 1985.
[18] Resnik, H. L. P. and Dizmang, L. H., "Observations on Suicidal Behavior Among American Indians," *American Journal of Psychiatry*, Vol. 127, 1971, pp. 58-63.
[19] Pesiosalido, M., "Social Construction of Suicide: An Investigation into the Social Organization of Official Rates," *American Sociological Review*, Vol. 51, 1986, pp. 80-100.
[20] Bailey, W. B., "Suicide in the United States, 1897-1901," *Yale Review*, Vol. 12, 1903, pp. 70-89.
[21] Rosenberg, M. L., Smith, J. C., Davidson, L., and Conn, J., "The Emergence of Youth Suicide: An Epidemiologic Analysis and Public Health Perspective," *Annual Review of Public Health*, Vol. 8, 1987, pp. 417-440.
[22] Kreitman, N., "The Coal Gas Story, United Kingdom Suicide Rates, 1960-71," *British Journal of Preventive and Social Medicine*, Vol. 30, 1976, pp. 86-93.
[23] Tsuang, M. T., "Suicide in Schizophrenics, Manics, Depressives, and Surgical Controls," *Archives of General Psychiatry*, Vol. 35, 1978, pp. 153-155.
[24] Berglund, M., "Suicide in Alcoholism: A Prospective Study of 88 Suicides," *Archives of General Psychiatry*, Vol. 41, 1984, pp. 888-891.
[25] Roy, A., "Risk Factors for Suicide in Psychiatric Patients," *Archives of General Psychiatry*, Vol. 39, 1982, pp. 1089-1095.
[26] Centers for Disease Control, "Vietnam Experience Study—Postservice Mortality among Vietnam Veterans," *Journal of the American Medical Association*, Vol. 257, No. 6, 1987, pp. 790-795.
[27] Salk, L., Lipsett, L. P., Sturner, W. Q., Reilly, B. M., and Levat, R. H., "Relationship of Maternal Perinatal Conditions to Eventual Adolescent Suicide," *The Lancet*, Vol. 1, 1985, pp. 624-627.
[28] Centers for Disease Control, "Alcohol and Fatal Injuries—Fulton County, Georgia, 1982," *Morbidity and Mortality Weekly Report*, Vol. 44, 1983, pp. 573-576.
[29] Centers for Disease Control," Alcohol and Violent Death—Erie County, New York, 1973-1983," *Morbidity and Mortality Weekly Report*, Vol. 33, 1984, pp. 226-227.
[30] Centers for Disease Control: "Suicide and Suicide Attempts by the Nonmedical Use of Drugs," *Morbidity and Mortality Weekly Report*, Vol. 34, 1985, pp. 570-571.
[31] Murphy, G. E., Armstrong, J. W., Hermele, S. L., Fischer, J. R., and Clendenin, W. W., "Suicide and Alcoholism—Interpersonal Loss Confirmed as a Predictor," *Archives of General Psychiatry*, Vol. 36, 1979, pp. 65-69.

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Those of you with any interest in Foster state of mind/death issues likely will find the attached draft report by Dr. Berman worth reading.

Brett

Report to the Office of Independent Counsel

The Death of Vincent W. Foster, Jr.

Alan L. Berman, Ph.D.

September 4, 1996

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Report to the Office of Independent Counsel
Death Investigation: Vincent W. Foster, Jr.

Introduction

In the summary of a March, 1996 Office of Independent Counsel (OIC) "State of Mind" analysis by the FBI, the need for a "suicide expert" was raised regarding the apparent suicide of Vincent W. Foster, Jr. Several specific questions were addressed: e.g., Was Vincent Foster suffering from depression?, Why was there no suicide note?, Were indications of his impending suicide given?, etc. In addition, divergent on-site observations, investigative lapses and inconsistencies had given rise to alternative (cover-up and conspiratorial) theories and questions (e.g., the Sprunt report), necessitating a behavioral scientist's review of available evidence.

Between May and July, 1996 this author was given access to an array of documentary evidence (see below). In addition, a site visit to Fort Marcy Park was made on May 24, 1996 in the company of two FBI agents [redacted] Independent interviews, as requested, of Foster family members, however, were blocked by attorneys for surviving family members; thus, none were conducted. The following analysis and conclusions, therefore, are based entirely on the sources of information listed below.

Case Synopsis

Between 5:00 pm and 6:00 pm on Tuesday, July 20, 1993, Deputy White House Counsel Vincent W. Foster, Jr., age 48: D.O.B.: 1-15-45, was found dead of an apparent self-inflicted gunshot wound to the mouth. His body was located by a passerby some 700 feet from his parked car in Fort Marcy Park, VA, lying face up on his back on the slope of a berm near the northernmost cannon (cannon #2). His eyeglasses were located 13' down the berm. In his right hand was found a 38 caliber, six shot Colt, Army Special revolver. There was one live round of ammunition in the gun. An exhaustive search of Ft. Marcy Park, in an arc of 90° to a distance of 175 meters, failed to produce the fatal bullet.

Foster was last seen leaving the White House shortly after 1:00 pm. His whereabouts on the afternoon of July 20-- from the time he left the White House till when his body was discovered-- remain unknown.

Investigative Procedures and Sources of Information

The following sources of information were supplied by the OIC and reviewed for this report:

U.S. Park Police Investigative Reports and Exhibits; Site pictures and Maps/Plats, the "Fiske Report" (6/30/94);*The Wall Street Journal* articles of 6/17, 6/24, and 7/19/93; transcripts of Foster's torn note found after his death in his briefcase, and his University of Arkansas Law School Commencement Address of May 8, 1993; the Autopsy Report, a report of Fort Marcy Park Artifacts Inventory; 1/30/96 Summary of Fort Marcy Park Search; the Blackbourne and Lee Forensic Pathology Reports; Dr. Henry Lee's Forensic Report (vols. I&II); Ballistics Test results (8/29/95); Citizen's Independent Report (Sprunt: 7/31/95); Reports drafted by Alexander Magnus and

Christopher Ruddy; Time Line written by Jim Bell; Medical Records from Dr. Watkins, "State of Mind" Summary, and videotapes of the Law School Commencement Address and "Unsolved Mysteries" (3/22/96).

In addition, interview summaries, FBI "302s," depositions, and/or Grand Jury Tesimony transcripts from the following individuals were made available and reviewed:

Crime Scene Evidence/Site Investigation

Standard operating investigative procedures at Fort Marcy Park were not followed. As noted in Dr. Lee's report, a number of limitations in the available data made death reconstruction difficult. The lack of certain records and photographs, moreover, presented more of a Rorschach card for analysis than is typical, particularly in a death of this import. The relative inexperience of U. S. Park Police officers and Fairfax County Fire and Rescue paramedics/EMTs in death investigation procedures, and the lack of sufficient photographic documentation, made for an extraordinary divergence of reported and validated observations. For example, witness statements (numbers of witnesses in parentheses) allegedly referring to Foster's car in the parking lot described: a white Honda (2), a brown honda (1), a gray Honda (2), a blue Toyota Corolla (1), an older model Subaru (1), and a Chrysler Corporation K-car (1). Moreover, Foster's suit jacket was either: on the front passenger side seat (3), on the rear seat (2), hanging behind the driver's seat (1), or neatly folded over the passenger seat back (1). Furthermore, the lack of x-rays taken at the time of autopsy and the lack of identifiable fingerprints on the textured handle of the gun added to the absence of confirmatory data regarding the manner of death.

In spite of these issues, the following incontovertible facts appear established and developed in the Blackbourne and Lee reports:

1. Vincent Foster died from a single gunshot wound to the mouth.
2. Residue on his hands, glasses, etc. and blood and tissue matter taken from the gun describe this as a contact wound.
3. No signs of a struggle, e.g., other trauma, or evidence for the body having been moved to the location where it was discovered were in evidence. Furthermore, alternative access to this site, e.g., through the Rt. 123 access to the Park, was highly unlikely without being observed or recorded by a security camera from the Saudi compound.
4. Trace materials strongly suggest that the gun was transported from the Foster home, first in the oven mitt found in his car and, subsequently, in his pants pocket to the site of his death.

Psychological Autopsy

Basic Personality and Character

Descriptors used by interviewees with regard to Vincent Foster's basic personality were extraordinarily consistent in describing a controlled, private, perfectionistic character whose public persona as a man of integrity, honesty, and unimpeachable reputation was of utmost importance. The following verbatim remarks reflect these and related themes [numbers refer to multiple reporters using the same descriptor]:

Private: kept own counsel; not open; did not engage in casual conversation; very private [4]; tough to read; laconic; taciturn; carried confidentiality to extreme [2]; inward; introverted [4]; an internalizer; did not openly display emotions; strong, silent type; close to the vest; shut off; uncomfortable talking about personal feelings; kept distance from associates; difficult to get close to;...to get to know; quiet.

Always in Control; used to being in control [4]; rigidity; no resilience; (too) responsible; intellectual/thoughtful [2]; reflective; not given to rash judgments; disciplined; mild-mannered; calm; reserved [5]; sober/serious [3]; cautious [2]; restrained [2]; careful; never effervescent; an anchor, a rock; a Rock of Gibralter.

Perfectionist [7]; demanding; not tolerant of mistakes or sloppiness [2]; intense [6]; focused [2]; meticulous/methodical [2]; a detail man; lacked experience at failure; never seemed to have any difficulties; **Thin-skinned , not used to criticism**; did not like having honor questioned; moody; took too much to heart; paranoid.

Persona: Reputation (unimpeachability) [2]; Impecccable reputation [3]; lived his life to maintain his reputation; man of high principle, high honor; integrity/honesty [3]; ethical [2]; loyalty [2]; the perfect family.

Hobbies/Interests;Typical Patterns of Coping with Stress/Change

Foster's life, since arriving in Washington, was filled with long, intense and demanding hours of work. The relative comfort of his lifestyle in Little Rock and his civic/social involvements, theater, etc. were no longer in evidence. As well, his retreat in Michigan was not replicated in DC [neither was his advice to the University of Arkansas Law School graduation class to "Take some time out for yourself. Have some fun...Take an occassional walk in the woods...Learn to relax"] . Where he once exercised daily in the RLF gym, he now only had/took time to read and jog to "relax." Until the week before his death, he appears not to have taken time off. Religion as a protective factor was not significantly in his life.

Significant Relationships

Driven, self-reliant men value their autonomy and tend to avoid intimate relationships. Foster was an intensely private man whom few felt close to. His most significant relationships were with his wife, Lisa, and his three children. Since coming to Washington, and until early June when they arrived to stay, these relationships were strained by distance and the demands of his work; as were those with his working associates at the Rose Law Firm. Most significant among these was a falling out with a father figure at the firm, Phillip Carroll, and the change in his relationship to Hillary Rodham Clinton, a partner and friend, who now was in a conflictual role as a superior whom Foster was to protect.

In addition, he was close to his sister Sheila and her husband Berl Anthony, with whom he lived upon coming to DC. Marsha Scott may have been a confidante.

Communication Style

As noted above, Foster generally was not open with others. His role as a protector, as responsible and serious, was more important to him than his comfort with others as an emotionally vulnerable and communicative person. Significant changes in this controlled style were evident beginning in 1993 and escalated as he neared his death.

Note should be made here of his two written communications: (1) his Commencement Address, delivered in early May, which is a study in regret, and (2) the "Torn Note," allegedly written within two weeks of his death, which highlights his preocupation with themes of guilt, anger, and his need to protect others (see below).

Method/Familiarity/Knowledge/Frequency of Use

Foster was not known to use guns, to hunt or target shoot. The lethal weapon, however, was known to him and, most probably, was one (of several) confiscated from his parents' house in 1991, when there was some anxiety that his father might suicide with one of them; and packed in his suitcase when he moved to DC. Within two weeks of his death, his wife twice told him to remove the guns from their house. Upon learning of her husband's death, she reportedly went to a closet and found a gun was missing. Her behavior suggests an awareness of her husband's potential for suicide.

History and Recent Status:

Marital History/Children

Vincent Foster met Lisa while he attended Vanderbilt Law School; they married in April, 1968. This was the first marriage for both. There is a strong implication that there was considerable marital strain during the last several months after his move to DC. Lisa Foster's interview reported in the September 11, 1995 *New Yorker* quoted her as "unreserved about

voicing her feelings," "angry with Vince about 90% of the time," and "that it was not easy for us to console each other." Moreover, it is probable that his intense and stressful work life, in addition to their separation, had significantly and negatively impacted their sexual relationship.

Foster was described as "family oriented." His children, two sons and a daughter: Vincent W. Foster, III, Laura Foster, and John Brugh Foster, were born, respectively, in 1972, 1973, and 1975. The two oldest children described their relationship with Foster as "excellent" and "great." He appears to have been least close with Brugh. Foster was described as most anxious about the effect of the family's move on [redacted] Moreover, he felt responsible for his son, Brugh's unhappiness about being in DC.

Educational History

Foster graduated Davidson in 1967, entered law school at Vanderbilt, graduating from the University of Arkansas Law School in 1971. He graduated first in his class and had the top score on the Arkansas bar exam.

Military History

After 1 and ½ years at Vanderbilt Law School, Foster dropped out to enter the New Jersey National Guard, during the Viet Nam War, but decided to return to the study of the law at the University of Arkansas, during which time he was defered from military service..

Occupational History

Foster began employment at the Rose Law Firm (RLF) in 1971, upon his graduation from the University of Arkansas Law School. Until President Clinton's election, Foster's entire professional life was spent with the RLF. In January, 1993 he resigned his partnership with the RLF, arriving in DC for the innauguration. In Little Rock, he was on a pedestal, well-respected and admired. His work style was pressured by self-imposed demands for perfection; however, he generally had the luxury of a measured pace. At the RLF, "20 drafts" were possible. His May 8th (1993) Commencement Address to the University of Arkansas Law School graduates is replete with reflections upon and regret regarding the changes wrought by his experiences in Washington.

At the White House, Foster was second in command to Bernard Nussbaum with primary responsibilities for issues affecting the first family and their finances. Upon his death, several files were found in his office regarding open cases on which he was working. In addition, during early 1993 Foster had responsibilities relating to Whitewater, the White House Travel Office firings, various nominations, and the remodeling of the White House; all issues of considerable stress.

Medical/Physical Health History

Dr. Larry Watkins in Little Rock was Foster's personal physician since 1979. His records are relatively unremarkable. However, beginning in late 1992, there are signs of increased stress and complaints of insomnia, for which a prescription for Restoril (30 mg PRN) was ordered. Foster's weight ranged from 200# in 1987 to 207# in August, 1990 to 194# on 12/31/92. [Reports of Foster having lost weight during the spring of 1993 are not verified in these, or any other records; Foster's weight at autopsy was 197#]. Foster's blood pressure appears to have been mildly elevated, ranging as high as 140/90 in 1990; no treatments are noted.

Most notable is Watkins' characterization of Foster's insistent telephone call of July 19th as "unprecedented." Over the phone Watkins prescribed trazadone (Deseryl), a heterocyclic antidepressant, for what he referred to as symptoms of a mild depression (insomnia and anorexia), "lots of stress, criticism, and long hours." Watkins did not ask Foster about suicide ideation, nor did he refer him to a local (DC area) colleague for further evaluation, monitoring of medication effects, or psychotherapy. Watkins appears not to have any records regarding Foster's family medical history and did not know that Foster's daughter had been treated psychologically for her eating disorder.

Foster took only one (of 30 available) Desyrel (50 mg) the night prior to his death. One pill would have had no significant therapeutic effect as the majority of those prescribed this drug do not report benefit for at least two weeks' treatment.

The Friday before his death Foster admitted to his sister Sheila that he was depressed. This was most uncharacteristic of him. She passed three names of DC area psychiatrists to him. Foster attempted to call one of the three, but never connected. His lack of follow-through reflects his ambivalence about help-seeking and, perhaps, his feared vulnerability and paranoia about the confidentiality of mental health treatment.

Mental Health History -none; see above.

FOIA(b)(6)

Family Mental Health History

Both sisters (Sheila and Sharon)

Sheila believes both parents were depressed. Foster's father hinted to "family members that he might use a weapon to end his ...life" before his death from cancer in June, 1991. Vincent Foster expressed concern and removed multiple firearms from his parents' house.

Financial History

The Fosters lived well in Little Rock on his salary reputed to be almost $300,000 per annum. Foster took a sizable pay cut in moving to his White House position (see Commencement Address reference) and downsized his personal lifestyle in a more expensive

Washington, DC. References to a possible overdrawn credit union account appear to be unsupported.

Religious Involvement

Foster's religiosity was low. There are no references to church-related activity during his days in Washington.

Alcohol and Drug Use (licit and illicit) History

Foster was a social drinker and collected fine wines. No increase (in 1993) in his alcohol use was reported.

Evidence of Thought Disorder

None; although signs of paranoia in the late sping, 1993 were evident (see below).

Cognitions/Hopelessness/Negativity

Foster's drive for perfection masked his fear of failure and criticism. When criticism came, Foster responded to the public scrutiny and criticism with anger and anxiety. He feared these issues would "never die." The publicity "ate him up." He no longer was in control. He felt trapped and talked of resigning, but considered a return to Little Rock to be a "humiliation." But, his wife pressured him to stay ("You can't quit; I just got here."). He "saw no light at the end of the tunnel." He and his wife "compromised" that he would not leave his job until Christmas (1993), but Foster had too much guilt and sense of failure to last that long.

His admission to his sister that he needed help was a profound expression of his depression. Concurrently, he had concerns about the confidentiality of therapy.

Foster appears to have lost perspective in his thinking, "blowing [things] out of proportion" according to observers. Indeed, a reading of the *New Yorker* editorials does not lead the disinterested observer to anywhere near the same level of sensitivity or outrage.

Stressors: Anticipated/threatened changes/losses/transitions

1. The Move to Washington:

Foster missed his life in Little Rock (his house, being able to walk to work). In addition, the move was costly financially--Foster was living in a more expensive city on a lessened income in a "cramped house."

2. Family/Marital problems:

Foster's separation from his family in the early months of his job, then the increasing pressure from and demandingness of his wife about his long working hours led to

marital tension and an unavailability of each to the other, as well as probable sexual distance, etc. As a responsible family man these demands would have placed a burden on Foster and concomitant feelings of conflict (between work and home) and role failure. It is unknown what, if any, problems were surfacing with his children; however, there is clearly an emotional shift in his Commencement Address when he talks of his children ("The office can wait..."). That his [redacted] moreover, strongly indicates family conflicts.

3. Job Stress:

Foster was excited about and wanted an influential role in the Administration; but, soon was overwhelmed with the demands of his job: its long hours and seemingly never-ending emergencies; a lack of felt success as evidenced by the problems listed below; the immediacy of the White House pace, so different from the luxury of time afforded most of his work at the RLF where time and pace allowed his meticulousness to flourish. He now was "forced to fire at the hip" with the added demand to be correct all the time. Where he once was "the guy in charge;" he now was always on call to others. According to his wife, he "lost control once at the White House."

4. Role Failure:

Foster was known both as a star and as a protector of others. There were readily apparent cracks in the dike (see below): the failed nominations, Travelgate (and consequent blame shouldered by associate counsel Kennedy whom Foster felt was "scapegoated"), Hillary Rodham Clinton's upset with him, his wife's apparent unhappiness, etc., that placed in question his sense of self. According to his wife, he took these failures personally and hard. Foster reportedly was angry about the cost overruns in remodeling the White House, blamed himself as responsible for the failure of various nominations, e.g., Zoe Baird as Attorney General, and for the Waco Branch Davidian raid. It is probable that Whitewater issues also weighed heavily in the background.

5. Anticipated Hearings:

As an intensely private man, Foster was alarmed by the possibility of Congressional Hearings regarding Travelgate. He "thought the worst was yet to come," and was observed as "brooding" and "consumed." He told his daughter that a Congressional investigation might be "rough on the family" (see #4 above).

6. Tarnished Reputation:

As evidenced in his Commencement Address, Foster considered his reputation to be his "greatest asset" and "dents to [his] reputation...[to be] irreperable." Beginning with the June 17 *Wall Street Journal* editorial, public criticisms of him and his performance caused him "severe distress." He "hated to be on display; he was now being questioned in public. He viewed these articles as "trashing" him and attempting to "ruin the administration," again speaking to his failure as protector. He told his sister, Sheila, "We can't stop the bleeding."[see Role Failure, above]. He was angry and constantly tense. The "Torn Note," again, speaks eloquently to these foci.

7. Loss of Support:

Foster increasingly felt alone, responsible for failures, and untrusting to the point of an increasing paranoia. To Webster Hubbell he "would not speak openly over the phone," and "did not trust the walls of the White House." He told Jim Lyons that he "would not talk with him at the White House."

Evidence of recent change in behavior, mood, life style

There is little doubt that Foster was clinically depressed (see below) in early 1993, and, perhaps, sub-clinically even before this. Additionally, signs of intense anxiety (insomnia, "absently wringing his hands, pacing, tension, profuse sweating) appeared, perhaps reactivating earlier experienced panic attacks. He increasingly started his sentences with, "I just can't handle..." Numerous observations are documented of changes in his last few months, e.g., "His sense of humor wasn't quite as available;" "He was more reserved than usual;" " In last 2 weeks his tone of voice changed...he wasn't participating; he just wasn't there." He called in sick for two days during the week before his death. His morning call to Dr. Watkins on the 19th was "unprecedented." He did not get up to greet Marsha Scott, as usual (in their meeting on the 19th): He "seemed preoccupied; quieter than usual." On July 20th he "was very quiet;" "He was more reserved and non-responsive;" He was uncharacteristically anxious to get his lunch and seemed rushed to eat; He was distracted; the newspapers on his office table were left in "uncharacteristic disarray."

Future Orientation

Foster had a scheduled meeting on Wednesday, July 21 with Jim Lyons, his personal attorney, on legal issues related to "Travelgate." Telephone calls were placed to Lyons on Sunday night, the 18th, upon returning from the Eastern Shore and again on the morning of the 20th. It was understood that Foster was anxious about his vulnerability.

Foster's sister, Sharon Bowman, had arrived in town on the 20th. It is not known what or if they had any plans scheduled, although his calendar listed a dinner date with her later in the week.

Talk of Death or Evidence of Suicide Ideation

None known; however, in the last two weeks of his life his wife wanted the guns removed from their house. References to death are noted in two circled passages found among his belongings.

Evidence of Exposure

Foster recently (date unknown) watched the movie "A Few Good Men," which involved a

scene involving a gunshot wound suicide in the mouth. Foster's father was allegedly suicdal shortly before his death from cancer.

Specific Description of Behavior in Last Four Days Before Death

Foster's last 96 hours show clear signs of crisis and uncharacteristic vulnerability: He admits his depression to his sister, Sheila, and asks for help. His ambivalence about help-seeking is evident in his not following through to reach the one psychiatrist to whom he placed a call, and making no attempt to reach either of the other two names given him by his sister.

The weekend getaway to the Tidewater Inn was intended to relax him, but appears to have been a disappointment. He was stressed; tears welled in his eyes when he talked of feeling trapped. At the Cardozo's he was non-interactive and withdrawn. It is not known if there was any attempt at a sexual interaction (and possible performance failure) with his wife during the weekend. It is not known what the content of their discussions were, for example, in the car upon returning to DC. [Here it would be most helpful to have his wife's further observations and recollected verbalizations both during this weekend and in the car while in transit]. The night of his return to DC (Sunday), he evidently was immediately focused on (and anxious about) a possible Congressional inquiry. Immediately upon returning home he called his attorney, Jim Lyons.

By Monday, he turns, uncharacteristically, to Dr. Watkins and discloses enough to get medication, but not enough to alarm his physician to insist he be evaluated in person. He meets with Marsha Scott for what appears to be longer than usual. She has not been forthcoming about this meeting.

On Tuesday, he uncharacteristically asks about his wife's plans. Awaiting lunch he shows signs of impatience. It is unknown what he might have read in the paper, however the *Wall Street Journal* column regarding the FBI director's replacement appeared the day before and Freeh was presented this morning. Out of character, he leaves the White house in mid-afternoon (and leaves the newspapers in disarray on his table). It is probable that he developed his plan to suicide before this date and was ambivalent to the end about carrying it out. He knew his family's schedule on the 20th, most probably secreted the gun from his house in the early afternoon, and drove around for some time before arriving at a secluded, pastoral setting, at which he killed himself.

Indicators Signaling a Troubled Employee (Scale from Dietz)

1. Harsh criticism of others or self √
2. Difficulty concentrating, remembering, thinking, problem-solving, or decision-making
3. Ruminating/excessive preoccupation √
4. Negativity √
5. Inability to receive criticism and/or compliments √
6. Excessive vigilance and preoccupation about breach of rules or procedures √
7. Marked change in usual mamnner, patterns, or grooming √
8. Irritability, belligerence, hostility, insubordination, anger, temper tantrums
9. Excessive use of alcohol, drugs, compulsive gambling
10. Avoidance of situations and problem-solving
11. Consistently non-compliant, resistant, or uncooperative
12. Extreme mood swings, unpredictability
13. Problems with performance despite adequate training and motivation
14. Overwhelming emotional pain √
15. Blocked emotions; can't feel anything
16. Stuck feelings; can't get beyond anger, disappointment, sadness, or guilt over time √
17. Depressed, anxious, or angry mood √
18. Fatigue, exhaustion √
19. Eating and/or sleeping disturbance √
20. Inability to stand up for self
21. Strained relationships √
22. Inability to let go of a grudge √
23. Isolation; social withdrawal √
24. Consistent blaming of others √
25. Persistent unresolved conflict at work √

Indicia for Suicide

1. Depression, complicated by anxiety
2. Perfectionistic character
3. Self-blame; rage
4. Non-help seeker
5. Loss of security/connectedness
6. Cognitive rigidity
7. Work problems/stress
8. Marital stress
9. Lethal weapon accessible and available
10. Breakdown of usual defenses/coping strategies
11. Trapped/talk of quitting
12. Middle-aged, white male

Suicide Risk: Clinical Approach

1. Mental Status: Foster's judgment was severely affected by his depression and anxiety. His usual defenses and coping strategies showed signs of breakdown.

2. Presence of a Psychiatric Disorder:

A. Evidence for Major Affective Disorder (MAD)

loss of interest or pleasure ✓
loss of appetite or weight ??
insomnia ✓
trouble thinking, concentrating, making decisions ✓
reduced general activity level ✓
feelings of worthlessness ✓
perceived inability to cope ✓
loss of energy or fatigue ✓
hopelessness ? [trapped] ✓
less talkative ✓
social withdrawal ✓

Commentary: In addition to the diagnostic criteria above, there is sufficient evidence for a history of major depression in Foster's family. Affective disorders are the most important diagnoses related to suicide (Tanney, 1992), with proportional mortality by suicide as high as 26%. Males, ages 18-35, with major depression, are 32 times as likely to complete suicide as those in the general population (Boyer et al, 1992); studies have shown that up to 65% of completed suicides had a major affective disorder (Roy, 1982); suicides among those with major affective disorder are more common early in course of the disorder. (Maris, Berman, Maltsberger, & Yufit, 1992). Moreover anxiety (panic, obsessive-compulsive features, insomnia) increases acute suicidality in major affective disorder (Fawcett et al, 1990). Clear signs of anxiety and probably depression, as well, date back to 1992 (Dr. Watkins' records) and possibly to the time of his father's death.

2. Underlying Character Structure: Foster's character displayed an unyielding need for perfection in both his and other's eyes. He had self-imposed high standards, was competitive, hard-working, demanding detailed perfection of himself and others. He placed demands on himself for excessive achievement, to protect and be loyal to others, and to be strong (a "Rock of Gibralter," a "Tower of Strength"). To accomplish this he had to engage a critical self-scrutiny--in psychoanlytic jargon he had a harsh, punitive super-ego: to be "less than" was intolerable and unacceptable. He could tolerate self-criticism as a whip toward better performance, but could not accept external criticism. This type of thinking is unrealistic, but in Little Rock it generally "worked."

Most important to Foster was that he maintain his reputation, his public image for honesty and integrity, so well-achieved in Little Rock.

Commentary: Recent studies by Hewitt and his colleagues (Hewitt et al, 1992, 1994) have documented a significant relationship between perfectionism and both depression and suicidality, particularly when mediated by stress.

3. Help-seeking Interaction: Foster was not a help-seeker; he was private and fearful (paranoid?) about the consequences of seeking help for his depression and anxiety. He sought help only in his last few days and preferred the safety of his family physician, who asked few evaluative questions, to the immediacy and presence of other, unknown professionals in the DC area.

4. Behavioral: Foster was methodical and perfectionistic in character. He showed no signs of impulsivity. He was known to be moody, and, although not aggressive, was clearly angry at both others and self-blaming in his last few weeks. Generally his aggression was handled in a controlled fashion through a rigid demandingness of self and others. His history of handling stress was good. However, in his last few months there are clear and evident signs of a breakdown in his ability to cope with stress. He, uncharacteristically and unacceptably (to his ego) talked of quitting. There is no indication in his history of ever giving up or not engaging the battle.

5. Environment: A social support system, although present, was burdensome for Foster. He felt responsible for increasing family stress and was not/could not accept being supported at home. He kept his own counsel for the most part and did not have any clear intimate friendships. He disliked his living arrangements in DC. His daily routine was intense, filled with long hours of defending the fort. He did not work out physically as he used to.

A Suicide Paradigm

Death Before Dishonour

Litman (personal communication) has used the phrase "death before dishonour" to describe the suicides of executive personalities facing public disgrace, humiliation, disclosure of wrong-doing, etc. In essence, death is preferred to preserve one's identity. The suicide has an inability to tolerate an altered view of himself; suicide maintains a self-view and escapes having to incorporate discordant implications about the self. These types of suicides are typically complete surprises to others in the available support system.

Vincent Foster showed a real vulnerability and sensitivity to external criticism (rigid/fragile defenses). A number of negative life-events, now opened to public scrutiny by the *Wall Street Journal* articles and the threat of a Congressional Inquiry, posed serious questions of character and exposed him to feelings of failure and the threat of punishment. Mistakes, real or perceived, posed a profound threat to his self-esteem/self-worth and represented evidence for a lack of control over his environment. Feelings of unworthines, inferiority, and guilt followed and were difficult for him to tolerate. There are signs of an intense and profound anguish, harsh self-evaluation, shame, and chronic fear. All these on top of an evident clinical depression and his separation from the comforts and security of Little Rock. He, furthermore, faced a feared humiliation should he resign and return to Little Rock in disgrace. Foster felt trapped and had no felt hope of changing his circumstances in the near term. Feelings of hopelessness increases suicide risk significantly (see Figure 1).

Aware he was in trouble psychologically, Foster, nevertheless, was reluctant to seek help. This difficulty accepting the vulnerable position is common to successful executives. By the Friday before his death he was desperate; calling for names of psychiatrists was a clear public (and personally intolerable) admission of his failure. He was ambivalent and fearful about this help-seeking. Even his call to Dr. Watkins on Monday signals his attempt to minimize while announcing his depression to someone other than Lisa or Sharon (and, perhaps, Marsha Scott on the 19th).

Specific Questions:

1. **If Foster was intent on his suicide, why did he eat lunch?**

There is no study in the professional literature that has examined eating behavior prior to suicides. Gastric contents are usually not recorded on autopsy unless there is a specific reason to look and record.

Foster was ambivalent about his death until the end. His behavior on the 20th is consistent with this: He did not need to go to work if he was unambivalent in his suicide intent that morning. I believe the fatal decision was not made until lunch-time, perhaps triggered by something read in the newspaper. However, the plan to secret the gun from the home was probably formed over the weekend. In any event, even death row inmates, knowing they are to die within a short time, eat a last meal.

2. **Does the finding of semen on his boxer shorts reflect a possible sexual liason in Fort Marcy Park?**

No: involuntary urination, secreted seminal fluid, and defecation often occur upon death from any cause.

3. **Why did this death occur in Fort Marcy Park?**

If we accept the idea that Foster was ambivalent to the end and that he may have driven his car for some time after secreting the gun from his home, the following possibilities are apparent: he may have simply and inadvertently happened upon the park or he may have purposely picked it off the area map found in his car.

We know Foster valued privacy. He spoke in his Commencement Address of taking "an occassional walk alone in the woods." Similar to the typical male physician who suicides by seeking the guaranteed privacy of a hotel room, and a "do not disturb" sign, Foster, protective of his family, would be most unlikely to suicide at home, leaving the possibility of being discovered by his children as a legacy.

4. **Why was no suicide note left by Foster?**

First, it is less, vs. more, common to leave a suicide note. Only 12-15% of suicides leave a note; 85-88% do not (Leenaars, 1992).

Secondly, Foster, again, was intensely private, protective, and loyal to his family and the president/first family. It would be out of character for him to leave a disclosure such as a note.

Thirdly, I believe Foster was intensely self-focused at this point; overwhelmed and out of control.

5. **Why did the pressure get to Foster now?**

He was under an increasing burden of intense external stress, a loss of security, a painful scanning of his environment for negative judgments regarding his performance, a rigid hold of perfectionistic self-demands, a breakdown in and the absence of his usual ability to handle that stress primarily due to the impact of a mental disorder which was undertreated. He simply could not maintain control or see a way out. Most likely, the precipitating "event" that triggered his suicide was a complex of: dashed expectations of relief from the weekend away, anxiety pertaining to the possible Congressional inquiry, highlighted by the meeting planned with his attorney, and the Freeh nomination placed in the context of the *Wall Street Journal* column the day before.

Mode of Death Determination:

In my opinion and to a 100% degree of medical certainty, the death of Vincent Foster was a suicide. No plausible evidence has been presented to support any other conclusion.

At worst, there remains a lack of **additional** validating evidence answerable by a number of yet unresolved/unanswered questions posed by the unavailabilty of family members for direct

interview, a paucity of information regarding Foster's early childhood (which would help to better understand the formation of his character structure) and, particulrly, communications on the weekend of June 16-18, and the unknowability of other evidence, including the remote possibility that other documentation was removed from his office before it was secured two days after his death.

References

Boyer, R., Lesage, A. D., Grunberg, F., Morisette, R., Vanier, C. Buteau-Menard, C., & Loyer, M. (1992). Mental illness and suicide: Psychological autopsy (pp. 250-251). In D. Lester (Ed.). Suicide '92: Proceedings, Silver Anniversary Conference, American Association of Suicidology. Denver: American Association of Suicidology.

Fawcett, J., Scheftner, W. A., Fogg, L., Clark, D. C., Young, M. A., Hedeker, D., & Gibbons, R. (1990). Time-related predictors of suicide in major affective disorder. American Journal of Psychiatry, *147* (9), 1189-1194.

Hewitt, P.L., Flett, G. L., & Turnbull-Donovan, W. (1992). Perfectionism and suicide potential. British Journal of Clinical Psychology, *31*, 181-190.

Hewitt, P.L., Flett, G. L., & Weber, C. (1994). Dimensions of perfectionism and suicide ideation. Cognitive Therapy and Research, *18*, 439-460.

Leenaars, A. A. (1992). Suicide notes, communication, and ideation (pp. 337-355). In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.). Assessment and prediction of suicide. New York: Guilford.

Litman, R. (Personal Communication, June, 1996).

Maris, R. W., Berman, A. L., Maltsberger, J. T., & R. I. Yufit, R. I. (Eds.). Assessment and prediction of suicide. New York: Guilford.

Roy (1992). Risk factors for suicide in psychiatric patients. Archives of General Psychiatry, *39*, 1089-1095.

Tanney, B. L (1992). Mental disorders, psychiatric patients, and suicide (pp. 277-320). In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.). Assessment and prediction of suicide. New York: Guilford.

Foster Suicide Paradigm

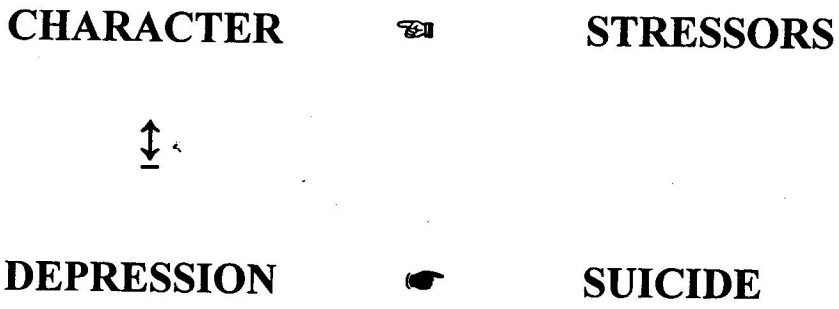

Figure 1

Addendum

Chronology of Major Events in Last Several Months

December, 1992

Foster tells Dr. Watkins he's under stress/has insomnia (post-election) and is prescribed Restoril. Weight = 194

January, 1993

Foster resigns RLF; arrives in DC on 20th for Innauguration; lives with Berl and Sheila Anthony.

March, 1993

Leases house

April, 1993

Receives buy-out from RLF building

May, 1993

Commencement Address delivered at University of Arkansas Law School: affect = flat; content = regret. Travel Office Report Issued. End of month: Dinner with Sheila, Webb Hubbell: "to cheer Vince up." Tells wife he wants to resign (two weeks prior to her arrival).

June, 1993

5th: Family moves to DC
8th Lisa notices Vince is emotionally down
2nd week: comments re seeking job with less pressure to Kennedy
17th WSJ editorial: "Who is Vincent Foster?"
24th WSJ Review & Outlook: "VF's victory"
29th Comments to Berl: "I spent a lifetime building my reputation and now I am in the process of having it tarnished."

July, 1993

2nd His sister (Sheila) last sees him at dinner, at which he confides his thoughts of resignation
Kennedy et al given formal reprimands
4th-20th: Lisa Foster twice tells him to remove guns; she and their eldest son call office to ask how he's doing (Gorham)
12th Telephone call to Berl re travel office/congressional inquiry -- asks names of

attorneys. Takes "unusual" day off

13th Talks to wife about resigning; looked "very tired" [Rutherford]

14th Talks with Susan Thomases about needing more legal help, anticipating congressional inquiry, and being unhappy. Calls Jim Lyons; pulls him out of deposition.

15th Wife expresses concern about account being overdrawn. Receives names of attorneys from Berl.

16th Telephone conversation with Sheila ("strained voice"); Admits depression, concerned about security clearance if sees Therapist; Sheila gives 3 psychiatrists' names; Foster asks re Eastern Shore getaway. Blood Pressure reading: 160/100; 10' later: 140/90. Calls/Books Tidewater Inn for weekend; Calls R. Hedaya, MD. Arrives home at 4:00 pm, leaves for Tidewater.

16th-18th: "very upset/emotional" at Tidewater; tearful. At Cardozo's: jogs with Harolyn Cardozo; not interested in watching tennis, did not want to stay for dinner, more withdrawn.

18th: At home, 6:00 pm: speaks with Jim Lyons regarding meeting on the 21st. Talks by phone with mother: "sounded unhappy"

19th: jogs in morning. WSJ article published: Review & Outlook: "What's the Rush" (re Freeh nomination). Makes "unprecedented" call (10:30 am) to Dr. Watkins, reports he is not eating well, not sleeping well, depressed. Watkins prescribes 30 tabs trazadone (Desyrel): 50 mg.

Marsha Scott spends 20-30' [afternoon] and/or 1-2 hours in a.m. with him, discusses weekend. Foster did not get up to greet her ("unusual")--seemed more relaxed. Tells her he's "going to get some rest." Sends life insurance payment

Evening: takes 1 Desyrel 50mg

20th: Does not jog

8:30 am: leaves for work: according to his wife his "mood [is] better." He, uncharacteristically, asks about her plans for the day

8:50 am: at work; has breakfast

10:00 am: attends Freeh nomination Rose Garden; makes "weak" response to Nussbaum's comment about "2 home runs."

12:00-12:30 pm: Orders then eats hamburger, french fries, coke, some M&Ms; expresses impatience with time taken to get luch); reads news clippings.

12:45 pm: appears "distracted" to Chadwick and Tripp. Tripp conjectures he's "very distressed" re an article in the paper.

1:00 pm: Leaves office, stating "I'll be back" to B. Pond; does not respond to Tom Castleton's "so long." He has his suit jacket with him.

1:10 pm: leaves the White House in his car.

3:05 pm: car possibly seen by J. Ferris making abrupt cut into Fort Marcy Park

4:15 pm: Knowlton sees Honda at FMP

5:10 pm: Wife calls ofc

5:15-5:30 pm: Doody/Feist arrive FMP - leave car @ 6:00 for walk

5:30-5:45 pm: CW discovers body
6:00 pm: 911 call from Swann
6:03 pm: US Park Police receive notice
6:10 pm: Gonzalex & Fornshill discover body
7:15 pm: Medical Examiner arrives