



*Rock Drill*, by Heather S. Englehart, acrylic on tent canvas, Iraq, 2004.  
Art: Courtesy of the Army Art Collection, US Army Center of Military History



# Chapter 9

## THE HISTORY AND CURRENT USE OF PSYCHOLOGICAL AUTOPSIES IN THE US MILITARY

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## INTRODUCTION

Psychological autopsies in the military have evolved over the past 40 years. This chapter is co-authored by the forensic psychiatrist who initially helped define the current use of psychological autopsies in the military and the forensic psychiatrist who presently coordinates psychological autopsies for the Department of Defense (DoD). In this chapter, the authors will:

- cover the background and history of the psychological autopsy;
- describe how psychological autopsies and other types of death investigations are conducted and used in the military with reference to applicable instructions;
- discuss manner of death determinations and provide examples of common causes of death that may require psychological autopsy along with case vignettes;
- outline the format for a psychological autopsy; and
- provide remarks on the role of psychological autopsies and other suicide death investigations in understanding and preventing suicide in the military.

The cause of death is the mechanism of illness or injury that results in death. A standard medico-legal autopsy determines the cause of death by examining the physical condition of the body. The manner of death is either natural or unnatural. Unnatural deaths occur as a result of accident, homicide, or suicide. From time to time, evidence found at an autopsy does not reveal the manner of death so it is considered “undetermined.”

A psychological autopsy may assist the medical examiner in cases in which the manner of death is not apparent. In some cases grieving family members find it difficult to accept that their loved one

committed suicide. They insist that the death must have been a homicide or accident. In other cases a command may want to better understand the underlying factors in a suicide. These cases may result in a request for a psychological autopsy that usually comes through the command or the casualty affairs office to the Armed Forces Medical Examiner (AFME), who then decides whether a psychological autopsy is appropriate. Manner of death reviews and behavioral analysis reviews are other types of suicide investigations in which the manner of death is ruled suicide but more information concerning the cause of the suicide is requested.

The psychological autopsy is a procedure for investigating a person’s death by reconstructing what the person thought, felt, and did preceding his or her death.<sup>1</sup> This reconstruction is based on information from personal documents; investigative reports; medical and mental health records; and interviews with families, friends, and others who had contact with the person in the days or weeks preceding the death. The psychological autopsy constitutes one of the main investigative tools for better understanding the suicide and the circumstances surrounding one’s death.

The current policy for the Armed Forces Medical Examiner System (AFMES) is for a forensic psychiatrist to conduct a psychological autopsy upon consultation with an AFMES forensic pathologist in cases in which the manner of death is unclear but may have been suicide. The current policy is in accordance with DoD Instruction (DoDI) 5154.30/2003: The AFMES “shall maintain a psychological autopsy registry supporting medico-legal death investigations that require a behavioral analysis, such as selected suicides, when approved by the AFME, and cases where the manner of death has not been determined and suicide is a possible manner of death.”<sup>2</sup>

## BACKGROUND AND HISTORY

The Los Angeles Medical Examiner’s Office first described psychological autopsies in 1958.<sup>1</sup> It is unclear when they were used for the first time in the military. The 1968 Army Medical Department bulletin, “Suicide Prevention and Psychological Autopsy,” described how to conduct a psychological autopsy.<sup>3</sup> In the 1970s the Army used psychological autopsies. Dr Joseph Rothberg at the Walter Reed Army Institute of Research (WRAIR) compiled data from the Army psychological autopsies in a series of papers in the 1980s.<sup>4-6</sup>

The Department of the Army pamphlet 600-24,

similar to the 1968 version, was published in 1988 to explain policies and procedures for the Army Suicide Prevention Program and for psychological autopsies. It recommended that a psychological autopsy be performed in all cases of suicide or suspected suicide and described the purposes of one in broad terms:

- Provide the victim’s commander with information;
- Enable the Army to develop prevention programs and lessons learned;
- Promote the epidemiological study of suicide;

- Bring mental health officers into contact with survivors of a suicide victim to facilitate bereavement counseling;
- Provide a thorough retrospective investigation of the intention of the victim; and
- Answer the questions of why the victim committed suicide and what was the most probable manner of death.

The pamphlet also covers operational criteria for suicide, motivation, lethality, and the role of intent. Suicide was classified into different categories based on intent and lethality. The procedure for conducting a psychological autopsy was delineated in detail, but it did not call for specialized training for mental health workers.<sup>7</sup>

As was commonly done in the military from the 1990s until 2001, local mental health providers who often had little or no specific training on performing forensic evaluations and writing reports conducted psychological autopsies and submitted long, type-written reports to the command and Dr Rothberg at WRAIR. Although commanders appreciated the in-depth detail of the reports, the originals often ended up in a desk drawer because the command had little background in interpreting and using the information. Other than the summaries of the report from WRAIR, minimal actionable intelligence existed on preventing suicides in the Army.<sup>8</sup>

Two circumstances contributed to the change in policy for psychological autopsies. In 1996 a reporter for the *Fayetteville Observer* requested copies of psychological autopsies from Fort Bragg, North Carolina,

under the Freedom of Information Act and published articles about the reports. In 1989, following an explosion in gun turret two aboard the *USS Iowa*, the investigation conducted by the Navy and the Federal Bureau of Investigation included an equivocal death analysis (psychological autopsy) of one of the sailors. The psychological autopsy directed blame for the explosion on an act of sabotage by one of the sailors because of a homosexual relationship gone awry. A panel of 14 psychologists reviewed the case and found problems with some of the claims made in the report. Although the psychologists did not totally reject the findings, they did not feel that the evidence supported the confidence with which the conclusions were drawn.<sup>9</sup>

As a result of these incidents, the DoD Inspector General asked that the DoD revisit the processes of confidentiality, training, and implementation of the psychological autopsy. In June 2001 Dr Ritchie wrote a letter from the Department of Health Affairs stating that psychological autopsies should only be done in equivocal cases in which it is not clear whether the death was a result of accident, suicide, or homicide.<sup>10</sup>

The DoD Inspector General mandated that statistical data on suicides should still be gathered. The military moved to develop a standardized database on suicides; however, September 11, 2001 and the subsequent invasion of Afghanistan and Iraq delayed some of those efforts. Nevertheless, the Army Suicide Event Report, a web-based effort designed to obtain information about suicides, evolved into the DoD Suicide Event Report and is now used by all services.<sup>11</sup>

## PSYCHOLOGICAL AUTOPSIES

In 2003 a navy billet was created for a psychiatrist at the Office of the Armed Forces Medical Examiner (OAFME), then a part of the Armed Forces Institute of Pathology. Lieutenant Commander Gerald Donovan first held this position, and Commander Rosemary Carr-Malone succeeded him. Captain Janis Carlton (co-author) currently is the Chief Deputy Medical Examiner for Psychological Investigations, which is now a part of the Military Research and Materiel Command.

All requests for psychological autopsies go through OAFME. When consulted by the AFME, the forensic psychiatrist reviews all available information and gathers additional collateral information. Fellows in the Forensic Psychiatry and Psychology Fellowship programs at Walter Reed National Military Medical Center and the Medstar Georgetown University Hospital's Department of Mental Health Forensic Psychiatry Fellowship Program learn the methodology

by conducting a psychological autopsy and preparing the report under the supervision of a forensic psychologist or psychiatrist with training and experience in psychological autopsies.

The primary use of psychological autopsies in the DoD is for cases in which the medical examiner questions the manner of death and considers suicide as a possibility. Cases in which the manner of death is not clear upon physical autopsy, equivocal cases, are infrequent (about 16 per year in all the services). The Psychological Investigations Division was established by the DoDI 5154.30 in 2003 and continued in 2007.<sup>2</sup> This DoDI is being updated to reflect the change of command structure from the Armed Forces Institute of Pathology to the Military Research and Materiel Command. The policy for psychological autopsies is not expected to change significantly. The AFME delegates authority regarding psychological autopsies

to the Chief Deputy Medical Examiner, Psychological Investigations Division. The role of the forensic psychiatrist assigned to OAFME is to maintain a registry of psychological autopsies and other reports of manner of death investigations in cases in which the manner of death is undetermined and suicide is considered a possible explanation. Psychological autopsies or other investigations may also be requested in cases in which the manner of death has been determined to be natural or an accident or homicide, and additional objective evidence is found that raises the possibility that the manner of death may have been suicide or vice versa. Select cases, in which suicide has been determined to be the manner of death but questions arise about the precipitating causes, are addressed in a manner of death analysis or a behavioral analysis review. All of these analyses are conducted in response to a consult request from the AFME. Psychological autopsy materials cannot be used or disclosed for any other purpose such as research or publication unless pertinent statutory or regulatory authority requires use or disclosure.

The Chief of Psychological Investigations at OAFME coordinates and supervises preparation of psychological autopsies and conducts quality assurance or peer review. Each military service is responsible for conducting the psychological autopsies of their service members. A forensic mental health professional who has an active, unrestricted license and has received specific forensic training in psychological autopsies or is in training under supervision conducts the psychological autopsies. When a psychological autopsy request has been accepted, the appropriate military service is notified and the case is assigned. The Chief of Psychological Investigations tracks the report and files it in the Armed Forces Medical Examiner Tracking System when it is completed and peer reviewed. The psychological autopsy report is provided to the AFME, with a copy to the military service's criminal investigative organization. A copy of the report is provided to the next of kin upon written request.

The psychological autopsy is only one of a series of investigations by the military. The criminal investigative community also does a thorough investigation. In the Army this criminal investigative community is the Criminal Investigative Command; in the Navy it is the Navy Criminal Investigative Service; and in the Air

Force it is the Air Force Office of Special Investigations. In addition, the command conducts an investigation to determine whether the suicide is considered to be in the line of duty. The procedure is basically the same in all three services. In the Army this investigation is conducted in accordance with Army Regulation (AR) 600-8-4; in the Navy it is conducted in accordance with Judge Advocate General Instruction 5800.7E; and in the Air Force it is conducted in accordance with Air Force Instruction 36-2910.

According to AR 600-8-4 General Rule 4-11: "A member may not be held responsible for particular actions and their foreseeable consequences if, as the result of mental defect, disease or derangement, the service member was unable to comprehend the nature of such acts or was unable to control his or her actions."<sup>12</sup>

Line of duty investigations into suicide, or serious suicide attempts, are conducted to determine whether the service member was mentally sound at the time of the event. A mental health officer reviews all cases to determine bio-psychosocial factors that contributed to the suicide and opines as to the probable predisposing and precipitating factors in the suicide or attempt and mental soundness at the time of the event. If a service member is found to be mentally sound at the time of the suicide, the death is considered not in the line of duty. If the service member is found to be not mentally sound, the death or attempt is considered in the line of duty. Mental health providers at the victim's command who do not have specific training in this area often conduct these evaluations. In some cases, unless the service member was suffering from a severe mental illness such as psychosis or severe depression at the time of death, the reviewer may determine that he or she was mentally sound and the suicide was not in the line of duty; however, in AR 600-8-4, Line of Duty Policy, Procedures and Investigations, Appendix B, Rule B-10 states, "The law presumes that a mentally sound person will not commit suicide (or make a bona fide attempt to commit suicide). This presumption prevails unless overcome by substantial evidence and a greater weight of the evidence than supports any different conclusion."<sup>12</sup> Thus most suicides can be determined to be in the line of duty. This is important for survivor benefits in cases of suicide and administrative issues in suicide attempts.

## **MANNER OF DEATH CLASSIFICATION**

Manner of death classifications include natural death that results from disease or aging and unnatural death that results from suicide, homicide, or accident. An injury or poisoning that was intentionally self-inflicted to cause death is suicide. When the volitional

act of another person causes death it is homicide. Intent is not required in homicide and is a matter for the legal system to determine. Accidental death applies when the evidence points to lack of intent to cause harm or death. For cases in which there is not a preponderance

of evidence for any of the above manner of death classifications, it is considered “undetermined.” Manner of death determinations require judgment and may be changed if additional evidence or information is brought forth. Psychological autopsies most often involve distinguishing between accidental death and suicide. If there is a possibility of homicide, the case is returned to the investigative agency.

The concept of intention is critical in determining the manner of death in cases of suicide or accident. Suicide is the result of an intentional act and accidental death is unintentional. Thus, intentionally jumping from a high building with a clear expectation of death is suicide; unintentionally falling to one’s death is accidental. Each action involves similar volitional acts such as going up the stairs or standing by an open window; however, the intent in one case is to die, but not in the other. Determinations are not always so clear cut. For example, a psychotic sailor jumps overboard believing that dolphins will save him or her. Is that accident, suicide, or undetermined since we may not know what was in his or her mind at the time of the volitional act? If a person dies as a result of his or her volitional actions, and that person suffers from a mental illness so severe that he or she cannot appreciate the nature and quality of those actions or their consequences, then the act may not be considered suicide. The question becomes: does the victim have the mental ability to form intent?

The National Association of Medical Examiners has prepared a guideline for determining the manner of death. Death by firearm is considered an accident if the gun was not fired by intentionally pulling the trigger, such as when a gun has been shown to be capable of discharge without pulling the trigger: as when dropped on the ground or picked up. Russian roulette is considered suicide because the act of putting a loaded gun to one’s head and pulling the trigger is inherently dangerous and carries a high risk of death. When a person dies by forcing police to shoot it is classified as homicide rather than suicide because the person died as the result of an intentional act of another. It may be difficult to determine the state of mind or intent of the victim but the circumstances may be described in reported details. When a person has attempted suicide but later apparently changed his or her mind, such as calling for help after an overdose, it is considered suicide. Deaths from autoerotic or consensual sex acts, such as bondage with asphyxia, are classified as accidental. Although these involve risk-taking behavior, they are not as inherently dangerous as Russian roulette. Suicide while under the influence of drugs or alcohol taken voluntarily is considered suicide; however, it may be difficult to determine

whether the person would have committed suicide without intoxication.<sup>13</sup>

Common types of manner of death investigations include drug overdose, death by gunshot, hanging or asphyxiation, cutting or stabbing, drowning, and single person motor vehicle accidents. In addition to examining the mental state of the victim at the time of death, it is important to look at the characteristics of the physical evidence, review all investigative reports, and conduct interviews. For each of the causes of death listed above, certain key elements are characteristic of suicide, accident, or homicide. In the following examples, the patterns described herein are by no means exhaustive and every piece of available evidence in each individual case must be considered.

In a death by gunshot one must consider access to the weapon, placement of the body, placement of the weapon at the scene, bullet trajectory, gunpowder residue, blood splatter patterns, stippling and soot patterns at the entry wound, neighbor or other witness reports of hearing a shot or witnessing the shooting, and all other available evidence. In a death by asphyxiation or hanging one must consider the condition of the body and the presence or absence of alcohol or drugs. Homicide by hanging is difficult to accomplish unless the victim is incapacitated or there are several assailants. Usually a homicide staged to simulate suicide by hanging involves other injuries such as strangulation, head injury, and other obvious injuries to the body.<sup>14</sup> Accidental hanging may be accompanied by signs of autoerotic asphyxiation such as specific knots, sex paraphernalia, or pornography near the body. In suicide by stabbing or cutting there is usually a lack of defensive wounds and the presence of “hesitation wounds” located on body regions accessible to the victim where he or she appears to be either testing the depth of the wounds or gathering courage to deliver the fatal injury.<sup>15</sup>

In a case of drug overdose, consider the following:

- dates of prescriptions, prescriber, number of pills, refills, and pill count;
- name on the prescription on medication bottles and a comparison with pharmacy records;
- evidence of illegal or designer drugs;
- presence or absence of alcohol;
- toxicology levels of substances in blood, urine, and vitreous humor;
- toxicology findings compared to therapeutic, toxic, and lethal levels and the therapeutic to lethal dose curves;
- drug combinations, synergy, and metabolism;
- history of substance abuse, patterns of use, central nervous system depressant use, and polysubstance abuse;

- a recent period of abstinence followed by resumed use;
- risk factors for suicide, evidence of depression, or suicidal thoughts;
- history of intentional or unintentional overdose; and
- information from family, friends, coworkers, and medical and behavioral health providers.

## CASE VIGNETTES

Below are four case vignettes involving suicides. These are composite cases and do not represent a single person.

**Case Vignette 10-1:** Specialist A was a soldier in the warrior transition battalion, with diagnoses of chronic pain and posttraumatic stress disorder after a motor vehicle accident. He had been treated for both these diagnoses. His wife had recently asked for a divorce and he was facing medical discharge from the military. He was found dead at his desk and there was no suicide note. Toxicology found traces of antidepressants, narcotics, and alcohol in his system.

**Case Vignette 10-2:** In Iraq, a second lieutenant was told that he was being investigated for war crimes after there was a shooting at a military checkpoint where a family was killed. He was found dead of a gunshot wound, apparently self-

inflicted; however, he and others had been drinking, although that violated the military rules. It was not clear whether the death was an intentional suicide or an accident.

**Case Vignette 10-3:** A woman reported that she had been raped in Iraq and named a perpetrator. Two days later she was found dead of a gunshot wound, apparently self-inflicted. Her family refused to believe it was a suicide and thought the soldier she had named as the rapist had killed her.

**Case Vignette 10-4:** A sergeant served in Afghanistan for 6 months. He was treated with the antimalarial mefloquine, Lariam (F Hoffmann-La Roche, Basel, Switzerland). He came home for his mid-tour leave. On return to Afghanistan, he killed himself with his military-issued weapon. The military psychiatrist in Afghanistan opined that his suicide resulted from mefloquine usage.

## FORMAT OF THE REPORT

When the psychological autopsy report is prepared, it should contain the following information:

- **Source and reason for request:** The name and title of the medical examiner who requested the psychological autopsy and the reason for the request to assist in the determination of the manner of death. The reason may be because the medical examiner was unsure if the death resulted from suicide or another cause, or less frequently, because investigators or family members raised questions. This section also contains the victim's demographic information.
- **Disclaimer:** A standard disclaimer about limits of confidentiality explained to persons interviewed for the report and a statement that the conclusions are subject to change if additional information becomes available.
- **Sources of information:** A list of investigative reports, sworn statements, forensic evaluations, physical autopsy and toxicology reports, death scene and autopsy photographs, physical evidence reports, statements, correspondence, medical and mental health records, interviews, and all other information available for review.
- **Chronology and details of death:** Accounts of the events leading up to the suicide and events on the day of death. People who witnessed the suicide or found the body; emergency medical workers; and friends, family, and others who saw or talked to the victim in the days and hours immediately preceding the death provide these accounts.
- **Autopsy and toxicology reports:** Summary of relevant autopsy findings and the toxicology report.
- **Forensic analysis and electronics:** Transcripts, recordings, and analysis of telephones, computers, and other devices. Journals and other writings or drawings are described in this section. If a forensic investigative analysis has been conducted it is summarized here. Forensic evidence such as DNA and gunshot residue reports, firearms analyses, and trace evidence analysis is usually analyzed at the US Army Criminal Investigation Laboratory, or state forensic laboratories may be involved.
- **Physical evidence:** Death scene descriptions and photographs; materials found at the death scene such as weapons, bullets, pill bottles, and ropes; and other characteristics of the scene and surrounding areas.

- **Personality and lifestyle:** Information collected through interviews and statements of people who knew the victim well.
- **Recent stressors and triggering events:** A description of possible precipitating factors including changes in life circumstances; problems with relationships; and legal, financial, or occupational problems.
- **Significant relationships:** Important romantic relationships and relationships with family and friends throughout the victim's life.
- **Developmental and social history.**
- **Educational history.**
- **Occupational history.**
- **Military history and service record.**
- **Financial history.**
- **Legal history.**
- **Medical history.**
- **Psychiatric history:** Any history of psychiatric illness, treatment, medications, hospitalizations, and any previous suicidal threats or self-injurious behavior as well as information from interviews and statements that may indicate undiagnosed mental illness.
- **Family medical and psychiatric history:** Any relevant medical illnesses or injuries, any psychiatric illness and treatment, and any suicidal behavior among close family members including family of origin, spouse, and children.
- **Alcohol and other substance abuse history:** Misuse of alcohol, prescription drugs, street drugs, over-the-counter preparations, and supplements in the past or present at the time of death.
- **Analysis of manner of death:** Consider possible causes of an unnatural death. Describe the evidence for and against suicide, homicide, or accident. Address risk factors for suicide or homicide including static and dynamic factors. Specifically address the presence or absence of high risk factors. In the assessment of a person's risk for suicide clinical factors, interpersonal relationships, situational factors, and statistical factors should be considered and viewed in the context of the clinical presentation. If the victim suffered from a mental illness such as depression, personality disorder, or substance abuse, or had a history of suicidal behavior, this should address how these factors may have contributed. Discuss the impact of recent stressors or triggering events. Consider means, motive, opportunity, intention, and lethality. Conclude with a summary of the above, analysis of the information for and against each possible manner of death, and how the reviewer reached his or her opinion.
- **Forensic opinion:** Provide a conclusion of the analysis and state the final opinion. For example, "Therefore, it is our opinion, to a reasonable degree of medical and psychological certainty, that the manner of death was ..."

## CONCLUSION

The psychological autopsy may be used in several ways. In the civilian area, a common use is to determine whether insurance claims should be paid in cases in which suicide is excluded from payable claims. In the military, the results of psychological autopsies are used for classifying the manner of death as homicide, accident, or suicide. A psychological autopsy's primary use is to assist the medical examiner in determining the cause of death in equivocal cases, and thus, it is not a first-line research tool.

Psychological autopsies can be a useful method to help the military understand the reasons for suicide in individuals. Appropriately trained practitioners must conduct these autopsies with a clear understanding of how the results will be used. The information should be integrated into other suicide data gathering systems working to decrease suicides in the military.

The psychological autopsy provides a great deal of information about the death of an individual. The primary information is qualitative. Because

these reports are in-depth and time consuming, and because they are performed only in select cases, they have limited utility in providing the type and amount of data that are needed to statistically analyze information about suicide in the military. Many of the same risk factors for suicide in the general population apply to military personnel; however, certain factors may be more or less represented in military populations. The kind of quantitative data needed for analysis is more likely to come from an instrument like the DoD Suicide Event Report or the data maintained by the OAFME's Mortality Surveillance Division. The Defense Suicide Prevention Office and the Suicide Prevention and Risk Reduction Committee of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury are developing methods to obtain data including suicide death reviews that can help foster a better understanding of suicide in the military and be applied to suicide prevention efforts.

## REFERENCES

1. Botello T, Weinberger L, Gross B. Psychological autopsy. In: Rosner R, ed. *Principles and Practices of Forensic Psychiatry*. 2nd ed. London, Great Britain: Arnold; 2003:89–94.
2. US Department of Defense. *Armed Forces Institute of Pathology Operations*. Washington, DC: DoD; 2003. DoD Instruction 5154.30.
3. US Department of the Army. *Suicide Prevention and Psychological Autopsy*. Washington, DC: DA; 1968. Army PAM-600-24.
4. Rothberg JM, Bartone PT, Holloway HC, Marlowe DH. Life and death in the US Army: in corpore sano. *JAMA*. 1990;264:2241–2244.
5. Rothberg JM, Jones FD. Suicide in the US Army: epidemiological and periodic aspects. *Suicide Life Threat Behav*. 1987;17:119–132.
6. Rothberg JM, Rock NL, Jones FD. Suicide in United States Army personnel, 1981–1982. *Mil Med*. 1984;149:537–541.
7. US Department of the Army. *Suicide Prevention and Psychological Autopsy*. Washington, DC: DA; 1988. Army PAM-600-24.
8. Ritchie EC. Army suicides and the legacy of Dr. Joseph Rothberg. 2013. <http://www.nation.time.com/2013/03/15/army-suicides-and-the-legacy-of-dr-joseph-rothberg/>. Accessed August 1, 2013.
9. Otto RK, Poythress N, Starr L, Darkes J. An empirical study of the reports of APA's peer review panel in the congressional review of the USS Iowa incident. *J Pers Assess*. 1993;61:425–442.
10. Ritchie EC, Gelles M. Psychological autopsies: the current Department of Defense effort to standardize training and quality assurance. *J Forensic Sciences*. 2002;47:1370–1372.
11. Ritchie EC, Morales W, Russell M, et al. Suicide prevention in the US Army: lessons learned and future directions. In: Ritchie EC, ed. *Combat and Operational Behavioral Health*. Textbooks of Military Medicine. Fort Detrick, MD: Borden Institute; 2011;403–421.
12. US Department of the Army. *Line of Duty Policy, Procedures and Investigations*. Washington, DC: DA; 2008. Army Regulation 600-8-4.
13. Hanzlick R, Hunsaker JC, Davis GJ. National Association of Medical Examiners: a guide for manner of death classification. *Med Sci Law*. 2002;1:1–29.
14. Sharma L, Khanagwal VP, Paliwal PK. Homicidal hanging. *Legal Med*. 2011;13:259–261.
15. Karger B, Niemeyer J, Brinkmann B. Suicides by sharp force: typical and atypical features. *Int J Legal Med*. 2000;113:259–262.