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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

TRACY RIFLE AND PISTOL LLC; MICHAEL BARYLA; TEN PERCENT FIREARMS; WESLEY MORRIS; SACRAMENTO BLACK RIFLE, INC.; ROBERT ADAMS; PRK ARMS, INC.; JEFFREY MULLEN; IMBERT & SMITHERS, INC.; and ALEX ROLSKY,

Plaintiffs,

v.

XAVIER BECERRA, in his official capacity as Attorney General of California; and MARTHA SUPERNOR, in her official capacity as Acting Chief of the California Department of Justice Bureau of Firearms,

Defendants.

Case No.: 2:14-cv-02626-TLN-DB

COMPENDIUM OF EVIDENTIARY DOCUMENTS REFERENCED IN PLAINTIFFS' REPLY BRIEF IN SUPPORT OF MOTION FOR SUMMARY JUDGMENT

Hearing Date: Feb. 23, 2017
Time: 2:00 p.m.
Courtroom: 2
Judge: Troy L. Nunley

Action filed Nov. 10, 2014

Pursuant to Local Rule 260(a), Plaintiffs Tracy Rifle and Pistol LLC, Michael Baryla, Ten Percent Firearms, Wesley Morris, Sacramento Black Rifle, Inc., Robert Adams, PRK Arms, Inc., Jeffrey Mullen, Imbert & Smithers, Inc., and Alex Rolsky submit the following compendium of evidentiary documents in support of their Motion for Summary Judgment.

1. A true and correct copy of Clinton E. Rhyne, et. al, *Dimensions of Suicide: Perceptions of Lethality, Time, and Agony*, 25 Suicide & Life-Threatening Behavior 373 (1995) is attached as Exhibit K.

Dated: February 14, 2017

BENBROOK LAW GROUP, PC

By s/Stephen M. Duvernay
STEPHEN M. DUVERNAY
Attorneys for Plaintiffs

EXHIBIT K

Dimensions of Suicide: Perceptions of Lethality, Time, and Agony

Clinton Ernest Rhyne, PhD, Donald I. Templer, PhD, Lillian G. Brown, PhD, and Noel B. Peters, PhD

Two hundred ninety-one lay persons and 10 forensic pathologists rated the lethality, time, and agony for 28 methods of suicide for 4117 cases of completed suicide in Los Angeles County in the period 1988–1991. Whereas pathologists provided consistent ratings, lay persons demonstrated extreme variability and a tendency to inflate ratings of all three dimensions. Significant gender differences emerged, with females rating frequently used suicide methods more similarly to pathologists than the males did. Males who suicided used the most lethal and quickest methods whereas females selected methods varying in lethality, duration, and agony. African Americans were overrepresented in the use of the most lethal and quickest methods.

Epidemiological studies of suicide have relied upon death certificate information to relate factors such as age, gender, and ethnicity to frequency of completed suicides (Robins & Kulbek, 1988). Preferred suicide methods have been found to vary by gender, age, and ethnicity (Chipuer & von Eye, 1989; Peck, 1986; Stafford & Weisheit, 1988).

Investigations of suicide methods have addressed lethality in an effort to link intent to die with the medical probability that a given method will cause death (Peck, 1986). The lethality of commonly used methods has been defined either on the basis of the actual physiological processes or degree of bodily damage created by a given method, or by comparing methods used in completed suicides against those employed in thwarted attempts. Regardless of definition, there is general agreement regarding the lethality of most methods. Inferences have generally been drawn that those who use methods with low medical lethality did not truly intend to cause their own deaths (Handi, Amin, & Mattar, 1991). That individual perceptions of lethality may differ from reality and that it is perceptions, and not actual lethality, influencing the choice of method has not been addressed in the literature.

The choice of method in most cases of completed suicide is probably deliberated (Lester, 1992). Lethality, perceived length of time to die, and the amount of agony presumed to be associated with the terminal act may be among the factors considered. Ethnocultural characteristics influence the choice of method, with some groups demonstrating a preference for more painful methods than others (Chipuer & von Eye, 1989).

Although a great deal has been written about the lethality of suicide methods in the psychological and psychiatric literature, much less has been written about the delay before death occurs or the pain and suffering involved. Although lethality and time to die are empirically determinable, agony is indeterminate and data can be obtained only indirectly. This material has been dealt with or implied to some extent in religious, historical, and legal literature, and in the humanities. However, quantitative methods have not been applied.

The purposes of the present research were to: (1) ascertain the "actual" lethality

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Suicide and Life-Threatening Behavior, Vol. 25(3), Fall 1995

and time to die of various suicide methods as empirically determined by forensic pathologists, operationally define agony as judged by pathologists, and compare these with ratings provided by lay persons; (2) analyze the interrelationships of these three dimensions; (3) explore gender differences in lay persons' perceptions of suicide methods; and (4) with actual cases of suicide, determine the relationship between the three dimensions and ethnicity, age, and gender.

METHOD

This research was conducted in two phases. The first phase compared the judgments of forensic pathologists with those of lay persons regarding the dimensions of time, agony, and lethality of suicide methods. The second phase applied the lay judgments to 4117 completed suicide cases in Los Angeles County, California.

Subjects

Two hundred ninety-one students, 183 male and 108 female, from Fresno City College, Cumberland County College (Vineland, NJ), and the California School of Professional Psychology – Fresno, voluntarily participated in this study. One hundred ninety-seven were Euro-American, 52 African-American, 21 Asian-American, and 21 Hispanic-Latino. Lay subjects, whose consent was obtained prior to their participation, ranged in age from 18 to 61, with a mean age of 24. Additionally, 10 board-certified forensic pathologists, all of whom were male, accepted an invitation to participate.

Instrument

Through a questionnaire, participants provided demographic information and rated 29 methods of suicide identified by the Los Angeles Coroner's Office in terms of the following characteristics.

1. Lethality. How likely is the method to cause death. Please express your opinion relative to the lethality of each method in terms of the percentage of time you feel the method is likely to cause death from 0% (no chance) to 100% (absolute certainty).

2. Time. The length of time the method will require to produce death. Please express your opinion relative to the time required in terms of the number of seconds, minutes, hours, or days.

3. Agony. The amount of pain and discomfort you would expect from the use of the particular method. Please express your opinion relative to agony on a scale of 0 to 100 with 0 equating to no pain or discomfort and 100 equating to the most pain and discomfort possible.

Procedure

Consent forms, along with a disclaimer describing the nature of the study and cautioning that the content of the questionnaire might be objectionable, were distributed to the participants in the classes. Oral definitions of lethality and agony accompanied directions printed on the questionnaire.

Questionnaires were distributed by mail to the forensic pathologists after their cooperation was solicited and the purpose of the study was explained by telephone. Self-addressed, stamped envelopes were provided for their convenience in returning the questionnaires.

In the second phase of the study, method of suicide, and age, gender, and ethnicity were identified for the 4117 suicide cases available in the archival data obtained from the Los Angeles County Department of the Coroner. This information was examined using the ratings of perceived lethality, time, and agony provided by the lay subjects.

RESULTS

Table 1 presents the means and standard deviations of lethality, time, and agony ratings provided by lay persons and pathologists, and the chi-square values associated with the Kruskal–Wallis test. It is apparent that the standard deviations are much smaller for the pathologists than for the lay persons. Pearson correlation coeffi-

TABLE 1
Lethality, Time (in minutes), and Agony:
Rater Means and Standard Deviations as a Function of Rater Group

Method	Dimension	Lay ratings		Pathologist ratings		Chi-square (df = 1)
		Mean	*SD*	Mean	*SD*	
Carbon Monoxide	Lethality	77.55	25.35	71.00	3.16	4.89
	Time	78.75	92.46	21.50	2.42	7.86*
	Agony	23.96	20.67	18.00	3.50	3.85*
Overdose/Rx drugs	Lethality	60.81	25.27	12.30	2.06	27.26***
	Time	154.72	183.59	129.00	28.36	1.08
	Agony	28.32	29.72	8.50	2.12	2.76
Overdose/non-Rx drugs	Lethality	47.46	25.27	6.00	2.11	23.10***
	Time	208.52	182.79	456.00	57.97	18.80***
	Agony	29.78	20.75	22.50	2.64	4.60
Overdose/illegal drugs	Lethality	76.41	22.88	49.36	5.62	9.27**
	Time	90.38	114.57	116.25	19.23	13.90***
	Agony	43.93	30.42	5.25	1.75	10.24***
Household toxins	Lethality	71.67	24.58	77.50	3.54	0.02
	Time	106.36	198.95	24.00	4.59	2.80
	Agony	78.61	25.46	54.50	5.50	15.87***
Cyanide	Lethality	91.29	13.51	97.00	2.50	0.41
	Time	36.53	72.83	1.80	0.41	26.37***
	Agony	64.70	27.69	51.50	3.28	4.31*
Gunshot of head	Lethality	85.13	17.21	97.00	1.76	4.85*
	Time	10.41	27.15	2.50	0.53	0.004
	Agony	65.35	35.46	13.00	4.83	20.90***
Gunshot of chest	Lethality	75.20	20.41	89.50	2.84	4.14
	Time	64.33	164.83	7.00	2.58	2.58
	Agony	82.03	27.62	21.70	2.36	33.62***
Gunshot of abdomen	Lethality	64.49	24.21	65.00	3.33	0.09
	Time	176.15	315.49	69.00	14.49	0.84
	Agony	88.50	12.68	74.00	3.94	16.06***
Shotgun to head	Lethality	91.04	14.98	99.00	0.00	0.07
	Time	31.06	148.71	1.70	0.48	6.53**
	Agony	70.36	32.86	5.50	1.58	30.84***
Shotgun to chest	Lethality	77.23	20.62	96.40	1.84	10.40***
	Time	49.78	108.78	1.40	0.52	22.90***
	Agony	75.11	24.03	16.00	6.58	37.55***
Explosives	Lethality	80.13	29.82	96.40	1.90	0.57
	Time	31.81	130.86	1.60	0.52	8.53**
	Agony	78.78	30.51	3.75	2.31	25.81***
Electrocution	Lethality	72.02	30.38	65.50	3.70	3.24
	Time	16.27	39.39	2.40	0.52	4.99*
	Agony	84.88	19.84	72.00	2.58	13.92***
Set fire to self	Lethality	72.56	27.81	76.50	2.15	1.38
	Time	41.59	95.61	57.00	6.32	13.68***
	Agony	95.14	13.61	95.00	3.33	21.45***
Structure fire	Lethality	53.97	31.37	73.00	2.58	3.14
	Time	95.12	176.76	52.50	7.91	1.68
	Agony	86.89	20.72	91.50	2.41	3.25
Cut throat	Lethality	74.31	25.91	51.50	3.37	11.40***
	Time	37.90	81.87	15.50	1.59	3.15
	Agony	79.50	20.81	86.00	3.16	0.62
Cut wrists/arms/legs	Lethality	44.05	27.76	6.00	2.11	24.57***
	Time	102.57	215.57	105.00	21.21	9.81**
	Agony	74.62	19.44	71.00	3.16	1.93

(*continued*)

TABLE 1
Continued

Method	Dimension	Lay ratings		Pathologist ratings		Chi-square (df = 1)
		Mean	*SD*	Mean	*SD*	
Stab of chest	Lethality	62.25	23.41	58.50	5.30	0.45
	Time	96.65	186.24	96.00	27.57	7.32**
	Agony	83.60	16.22	76.00	3.50	2.60
Stab of abdomen	Lethality	53.16	26.69	12.50	2.64	23.09***
	Time	98.64	139.88	252.00	37.95	17.37***
	Agony	85.52	17.98	78.00	3.50	3.24
Auto crash	Lethality	58.49	26.69	78.50	3.37	4.53*
	Time	120.40	222.41	20.50	2.84	2.32
	Agony	74.87	22.80	30.00	6.24	27.48***
Jump from height	Lethality	80.32	24.74	93.44	2.60	0.51
	Time	32.38	92.79	4.56	0.73	2.25
	Agony	61.79	31.62	17.78	4.41	22.80***
Hit by train	Lethality	98.10	20.18	96.18	2.79	1.84
	Time	9.38	18.16	17.92	39.14	3.01
	Agony	79.26	29.85	7.08	4.83	38.91***
Hit by truck/auto	Lethality	74.37	24.19	70.00	4.71	0.22
	Time	48.03	84.56	19.00	3.16	0.06
	Agony	80.66	22.46	63.00	3.50	11.45***
Hanging	Lethality	84.12	21.67	89.50	4.38	0.97
	Time	9.57	18.53	7.00	0.00	3.60
	Agony	65.74	27.17	25.50	9.56	20.89***
Plastic bag over head	Lethality	66.30	30.93	23.00	2.58	12.05***
	Time	10.06	12.40	7.00	0.00	2.55
	Agony	56.14	30.93	23.00	2.58	18.55***
Drowning/ocean/lake	Lethality	72.42	31.38	63.00	3.50	2.62
	Time	9.83	10.90	18.50	2.41	17.62***
	Agony	60.88	27.57	79.00	3.94	5.81
Drowning/bathbub	Lethality	54.53	35.67	21.50	4.74	6.92**
	Time	9.79	11.53	18.50	2.41	16.97***
	Agony	59.06	29.01	79.00	3.94	5.98**
Drowning/swimming pool	Lethality	62.79	32.99	21.50	5.50	0.33
	Time	17.51	48.93	18.50	2.41	12.23***
	Agony	57.41	28.77	79.00	3.94	6.72**

*$p < .05$
**$p < .01$
***$p < .001$

cients demonstrated a positive relationship between the time and agony ratings of both lay persons and pathologists. This relationship was much stronger for pathologists than for lay raters. For the lay persons, the product moment correlations were .00 between lethality and time, .18 ($p < .005$) between time and agony, and .00 between lethality and agony. Respective correlations for the forensic pathologists were .00, .67 ($p < .025$), and .00. There was no relationship between lethality and time or lethality and agony in either lay or pathologist ratings.

As reflected in Table 1, significant differences between lay and pathologist ratings ($p < .05$) were found in lethality for 10 active methods. On the dimension of time, lay raters significantly differed ($p < .05$) from pathologists on 10 of the 28 active suicide methods.

Lay raters also tended to inflate agony ratings relative to pathologists. They significantly differed from pathologists in

their estimates of agony for 23 of the 28 active methods. Although lay raters of both genders tended to give higher ratings than the coroners, females tended to provide higher ratings on all three dimensions than their male counterparts.

Cluster analysis of suicide methods yielded three distinct categories, as indicated in Table 2.

1. Cluster 1. Most lethal and quickest, with varying degrees of agony
2. Cluster 2. Moderately lethal, require the longest time, and moderately painful
3. Cluster 3. Least lethal, require moderate amounts of time, and are the most painful

It is interesting to note that the majority of Cluster 1 methods involve the head (ingestion, inhalation, and asphyxiation included here) and/or neck. In contrast, the majority of the methods contained in Clusters 2 and 3 involve the limbs or torso.

Cross-tabular examination of the Los Angeles County data (see Table 3) disclosed clearly discernible preferences for certain methods among specific age, gender, and ethnic groups. In general, males in all four ethnic groups demonstrated a definite preference for those methods falling within Cluster 1. In the vast majority of cases, males tended to use two principal method groups: firearms and hanging. Female preferences were more diverse, with all three clusters represented. Females, however, tended to prefer four principal types of methods (overdose, firearms, jumping, and hanging). An examination of cross-tabular analyses further found that there is a definite preference for Cluster 1 methods for persons within the age range of 10–29. Of particular note, there is an overrepresentation of persons in this age range who chose the methods of hanging and jumping from height. As age increases, there appears to be a gradual shift from Cluster 1 methods to methods in Clusters 2 and 3. When examined for ethnic variation, cross-tabular presentations of the Los Angels County data provided only one noteworthy observation. African-Americans were definitely overrepresented in Cluster 1 methods.

Attempts to apply logistic regression analysis via categorical modeling demonstrated the need to employ the more

TABLE 2
Cluster Analysis of Suicide Methods as a Function of Lay Ratings of the Dimensions of Lethality, Time, and Agony

Cluster 1	Cluster 2	Cluster 3
Carbon monoxide	Overdose of Rx drugs	Overdose of non-Rx drugs
Cyanide	Household toxins	Gunshot wound of chest
Gunshot wound of head	Gunshot wound of chest[a]	Gunshot wound of abdomen
Shotgun wound of chest	Gunshot wound of abdomen[a]	Explosives[a]
Electrocution	Shotgun wound of head	Structure fire
Set self on fire	Structure fire[a]	Cut wrist/arms/legs
Cut throat	Cut wrists/arms/legs[a]	Stab wound of chest[a]
Stab wound of abdomen	Stab wound of chest	Stab wound of abdomen[a]
Jumping from height	Auto crash	Auto crash[a]
Hit by train		
Hit by truck/auto		
Hanging		
Plastic bag over head		
Drowning in ocean/lake		
Drowning in bathtub		
Drowning in swimming pool		
Overdose of illegal drugs		

[a]The method was represented in more than one cluster; the footnoted listing indicates the cluster in which the method appeared with the most frequency.

TABLE 3
Percentages of Completed Suicides by Active Methods in Los Angeles County, 1988–1991

	Euro-American (N = 2372)		African-American (N = 222)		Hispanic (N = 413)		Asian-American (N = 147)	
Method	Male	Female	Male	Female	Male	Female	Male	Female
Carbon monoxide	7.8	3.9	1.8	1.4	1.3	0.0	2.5	2.5
Overdose/Rx drugs	7.5	38.4	2.8	35.6	2.9	26.7	3.6	15.0
Overdose/non-Rx drugs	0.8	1.9	1.8	2.7	0.0	2.2	0.9	2.5
Overdose/illegal drugs	0.7	0.7	0.6	2.7	0.0	0.0	0.9	2.5
Household toxins	0.6	0.7	0.0	2.7	0.3	2.2	2.7	2.5
Cyanide	0.4	0.2	0.0	0.0	0.3	0.0	0.0	0.0
Gunshot of head	44.1	20.4	50.3	30.1	46.9	33.3	34.5	2.3
Gunshot of chest	5.2	7.0	0.0	2.7	6.4	2.2	10.9	7.5
Gunshot of abdomen	0.4	0.6	5.4	2.7	0.6	0.0	0.9	0.0
Shotgun to head	6.6	1.4	3.0	0.0	2.8	0.0	2.7	0.0
Shotgun to chest	1.3	0.9	3.6	0.0	0.6	0.0	0.0	0.0
Explosives	0.0	0.0	0.6	0.0	0.3	0.0	0.0	0.0
Electrocution	0.0	0.0	0.0	0.0	0.0	0.0	0.9	0.0
Set fire to self	0.4	0.0	0.0	2.7	0.0	2.2	0.9	0.0
Structure fire	0.1	0.2	0.0	0.0	0.0	2.2	0.0	0.0
Cut throat	0.3	0.7	1.8	0.0	0.3	0.0	0.0	0.0
Cut wrists/arms/legs	1.6	1.6	1.8	0.0	0.0	0.0	2.7	2.5
Stab of chest	0.8	0.0	1.8	0.0	0.6	0.0	0.0	0.0
Stab of abdomen	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Auto crash	0.4	0.9	0.0	2.7	0.0	0.0	0.9	0.0
Jumping	4.7	8.2	4.8	8.2	5.5	11.0	2.7	15.0
Hit by truck/auto	0.6	0.4	0.0	1.4	2.3	2.3	0.3	40.0
Hit by train	0.4	0.0	0.6	2.7	0.3	15.6	0.0	0.0
Hanging	12.9	7.3	18.6	0.0	30.0	0.0	34.5	0.0
Bag over head	1.7	5.1	1.2	0.0	0.3	2.2	0.9	0.0
Drowning	0.7	2.3	0.6	0.0	0.3	0.0	0.9	0.0

highly constrained models as these models fit the data best. This suggested that predictions regarding suicide method may be based on three or fewer predictors (age, ethnicity, and gender). Of a total of 11 models tested for this purpose, three proved to fit the data best. These were models that combined age with ethnicity. Table 4 depicts the results of regression analyses and clearly demonstrates that the best fit of the three models for predictive value is the model that considers the characteristics of age and gender. The effects of gender on suicide choice are easily discernible from Table 5, which shows the percentage of suicide victims falling into each cluster of suicide methods based upon sex and age.

DISCUSSION

The huge differences between the standard deviations of lay person ratings and pathologist ratings on all three dimensions support the assumption of the present study that the greater knowledge and

TABLE 4
Logistic Regression Analysis of Models for Categorical Variables Associated with Suicide Methods

Model	Chi-square	df	p value
Gender/age/ethnic	27.31	20	0.1268
Gender/age	0.35	2	0.8383
Ethnic/age	7.88	6	0.2474

TABLE 5
Sex and Age of Suicide Victims in Each Cluster

Gender/Age Group	Cluster 1	Cluster 2	Cluster 3
Female/Over 60 years	49%	48%	3%
Female/Under 60 years	51%	45%	4%
Male/Over 60 years	77%	21%	2%
Male/Under 60 years	78%	19%	3%

experience of the pathologists enable them to appraise the relevant variables more accurately than lay persons. Although it is acknowledged that the pathologists were not present at the time of death, it is assumed that their medical training provides them with more knowledge than lay persons to infer the admittedly subjective matter of "agony." Although consistency does not conclusively establish validity, enormous inconsistency certainly militates against accuracy.

Lay persons tended to overestimate the lethality of overdoses with prescription drugs, overdoses with nonprescription drugs, and wrist cutting. It has long been established that overdoses of medication and wrist cutting are low lethality methods, are among the most frequently used methods in attempted suicides, and are among the most frequent methods in incomplete suicides.

Our findings suggest that to attribute these incomplete attempts to "mere" cries for help may be inaccurate. Persons who overdose may do so wanting to die, overestimating the lethality of the method.

Lay persons underestimated the lethality of the methods of gunshot wound of the head, gunshot wound of the chest, and shotgun wound of the chest. This lack of knowledge may well account, in part, for the fact that so many suicide attempters survive. It also suggests that some suicides may not be serious attempts but may result in death because the lethality of the method was underestimated.

The tendency of the lay rater to overestimate lethality, time, and agony for the majority of suicide methods, especially for the more widely used methods of gunshot wounds, hanging, drug overdoses, poisonings, and jumping from height; and their tendency to underestimate in a few of the lesser used methods such as drowning, lead one to examine the process of selection of a suicide method and the expected outcome of a suicide attempt. It would appear that many of those who choose to use the more popular methods may be aware of the suffering they will experience and in some cases may actually intend to create suffering for themselves in the process of dying.

In general, female lay raters provided higher ratings than male lay raters and than coroners on all three dimensions. It is interesting to note that females seem to be more accurate in assessing male-preferred methods (gunshot wounds), and that males seem more accurate in assessing female-preferred methods (drug overdoses). These two types of methods accounted for more than 60% of completed female suicides in Los Angeles County during the period 1988–1991, and 78% of female suicides nationwide. It is also noteworthy that females have shown a trend toward the increased use of firearms in recent years (Lester, 1991). With all of this considered, it may well be that women who attempt suicide may have more lethal intent than previously thought. In this study, ratings of the lethality of overdoses of medication among females were unexpectedly high. Although the rating for this method is among the lowest given by females for the active methods, it implies perceived probable death.

Attempts to ascertain ethnic and age differences in the choice of suicide methods, based upon perceptions of the identified dimensions of suicide, were inconclusive. Although there appeared to be some predictive value in these demographic variables, all ethnic groups and age groups showed a definite preference in completed

suicides for those methods that were the most lethal and required the least amount of time, with only minimal variability between groups. This is not surprising considering that the archival data examined did not include information relative to incomplete suicides.

The findings of the present study appear to have implications for the practical matter of suicide prevention. Perhaps it would be useful for hot line counselors and other professionals and paraprofessionals to inform persons threatening suicide that the agony and time may be considerable, that success is far from certain, and that the injuries inflicted could be consequential and permanent. On the other hand, persons who appear only to be threatening suicide may be told that suicidal gestures or ploys are sometimes fatal.

Future research surveying mental health professionals and comparing their impressions of the dimensions of lethality, time, and agony against those of the lay population and the pathologists would prove enlightening. If their ratings differ appreciably from those of pathologists, it would be advisable to provide more training to mental health students in the realities of suicide and perceived suicide.

Obtaining phenomenological or other qualitative data from persons who have attempted suicide—regarding the nature and intensity of their judgments and feelings regarding lethality, agony, and time at the time of their attempts—would also add immeasurably to our understanding of the process of a suicide attempt.

It is further suggested that research be conducted that specifically addresses the dimension of agony, the most complex and problematic for conceptual and methodological considerations. Lethality and time are objective and, at least theoretically, can be placed on a ratio scale. Agony is not only a subjective experience of the person undergoing the suicidal experience but must be indirectly inferred by the external rater. Also, a differentiation should be made between the maximum intensity and the duration of the agony. In the present study directions for such differentiation were not given and we, therefore, do not know whether the positive correlations on these two judged dimensions are a function of maximum intensity or duration, or both.

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