A LINE ON LIFE

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Assisted Suicide – A Rational Choice? *

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You have heard of Dr. Kevorkian and his work to help people commit suicide. Many of you may have strong opinions one way or the other. Regardless of your views, you may be interested in the psychological debates on assisted suicide.

"Like it or not,
physician-assisted suicide is already happening."

In 1995 in San Francisco, a survey was made of 118 physicians dealing with AIDS patients. Over half of them had prescribed lethal doses of narcotics to suicidal patients.

Psychologist Bob Barret, professor of counseling at the University of North Carolina (Charlotte), sees suicide as "*a normal reaction*" in some situations. He cites an example of a young man in his 20s with AIDS. Completely rejected by his family, and with most of his friends already dead, he is too sick to even get out of bed without help. After carefully considering all his options, he had an assisted suicide. According to Barret, this is an example of suicide as a **rational choice**.

Last summer, Barret and other psychologists submitted an *amici curiae* (friend of the court) brief to the Supreme Court. They see suicide as a rational act. They believe that mental-health professionals should be allowed to assist these people without fear of legal or professional penalties.

On the other hand, other psychologists have a different view. The see suicide as one symptom of a mental disorder. Helping someone to commit suicide should still be banned. In researching psychological sources, suicide is not mentioned as a reasonable option. "*There's the assumption that someone who's suicidal is depressed and is in need of hospitalization*."

Psychologist James L. Werth, Jr., is a staff clinician at the University of Arkansas Counseling and Psychological Services in Fayetteville. Werth has also authored *Rational Suicide? Implications for Mental Health Professionals* (Taylor & Francis, 1996). In 1994, he sent a survey to randomly selected psychologists listed in the *National Register of Health Care Providers*. Of the 400 selected, 125 responded to the survey. Of those who responded, 86% believed in the idea of rational suicide. In addition, 20% had dealt with patients who they thought were rationally suicidal.

The psychologists surveyed outlined three specific criteria for defining rational suicide. First, the patient's should be facing a **hopeless condition**. This includes a low quality of life with high levels of psychological and physical pain. Second, the patient's decision should be **free of coercion**. This includes internal factors like beliefs relating to aging or infirmity. Cost conscious professionals or greedy relatives are external factors to consider. Third, the patient's choice should be based on **sound decision-making** methods. The psychologists further defined the criteria for making sound decisions.

- **Mental competency** – Clients should not have a treatable depression or other judgment-clouding impairments.
- **Consider all options** – Other options should be considered like psychotherapy, antidepressants, assisted living or support groups.

- **Impact on others** – Clients need to consider the impact of their suicide on significant others.

- **Seek advice** – Clients should consult with other providers such as religious leaders, disability advocates, physical therapists or hospice personnel.

If psychologists have had long-term relationships with their clients, according to Werth, this gives them plenty of time to assess these criteria. Psychology emphasizes autonomy for each client. Werth says psychologists are not there to prevent rational clients from accomplishing their plans. However, psychologists should help them explore alternatives, discuss the possibilities with loved ones, and make rational decisions.

Psychologist David C. Clark does not accept suicide as a rational choice. Clark is professor of psychiatry at Rush Medical College in Chicago and the director of the Center for Suicide Research and Prevention at Rush-Presbyterian-St. Luke's Medical Center. From his clinical experience, Clark is convinced that some type of intervention can avoid suicide.

> *"Their physical condition and life situation haven't changed one iota, but they are no longer thinking of suicide. They are really glad that no one responded to their seemingly rational wish to die a few weeks earlier."*

In Clark's research of people ages 65-95 who committed suicide, few met the "*hopeless condition*" criterion – 95% had no significant financial problems, 90% had regular social visits, and 66% were in relatively good health.

> *"These people didn't fit the stereotype. They weren't sick, financially impoverished or alone. There's no strong correlation between circumstance and suicide."*

Even with these differences, both sides agree that any legislation about assisted suicide needs to have safeguards to prevent abuses. Psychologists can help to prevent abuse. Physicians – acting alone – do not have the time or training to screen potential suicides. Psychologists can provide the counseling to help clients deal with treatable problems. They can help clients to resist pressures from others to commit suicide. An important first step is getting the issue out in the open, where it can be discussed.

If we live long enough, we may have to deal with these very difficult questions. Would you ever consider an assisted suicide for yourself? Would you think about it for a loved one? What conditions might influence your answers?

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* Adapted from Rebecca A. Clay's "Is assisted suicide ever a rational choice?" *The APA Monitor*, April, 1997, pages 1, 43.