“Rational” Suicide Is a Misnomer

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Joseph Richman is a therapist who has published extensively on suicide and clinical psychology. The next piece, Richman was written in response to Derek Humphry’s viewpoint. Richman argues that even for the terminally ill, “rational suicide” is a misnomer. He contends that by its very nature the choice to commit suicide shows an inability to see alternative pathways, which by definition deviates a rational choice toward suicide. Richman argues that society’s misperception of suicidal persons clouds the distinction between rational and irrational suicide. This tendency to misperceive the needs of suicidal persons threatens the utility and efficacy of psychotherapy for such individuals.

QUESTIONS

1. How does Richman’s definition of rational suicide differ from that of Humphry’s? How does this difference affect their arguments?
2. Does Richman’s definition of rational suicide allow for any cases of legitimate rational suicide?

I write as a clinical suicidologist and therapist who has interviewed or treated over 800 suicidal persons and their families since 1965. I have been impressed by the similarities in stresses and strains among these people—similarities that cut through cultural, socioeconomic, psychosexual, and ethnic barriers. Those from diverse backgrounds who are suicidal are more like each other than different, including, I submit, those who choose "rational suicide."

A major difference between Derek Humphry and myself lies in the idea of suicide as a unified versus a pluralistic concept. Mr. Humphry postulates that there are at least two types of suicide, one emotional and irrational and the other justifiable and rational. For reasons that I elaborate upon later, I do not see this as a justifiable position.

As Humphry put it during our debate, I, Dr. Richman, am a hanker of sick people, whereas, "A person like myself goes amongst healthy people. . . . The cases of rational suicide I know of directly and indirectly are of intelligent, thoughtful, caring people, who do not need a therapist, who would not go near a therapist or psychiatrist. There are some of us in this world who can handle and work through our own problems. . . ." and so forth. Thus, "at least two types of suicide" are dichotomized into "them," the weak and the sick, and "us," the strong, the intelligent and the healthy.

Not coincidentally, is precisely the attitude expressed by those most vulnerable to suicide, because of what it means to them: to accept help. At those people and Mr. Humphry is smart, see it, those who are strong and healthy would not go near a therapist or psychiatrist; they, to go for help means that one is not strong or healthy. Such a division is itself neither rational nor healthy. It has been my experience that many of my patients are strong, intelligent, and basically healthy people who have been faced with a major life crisis, and possess the good sense to seek help. Those who perceive the acceptance of such help as a sign of weakness are not necessarily strong.

My position, therefore, is that the concept of rational suicide and its accompanying attitudes are at best irrelevant and misleading, and at worst the basis for unnecessary deaths. As a therapist, my attitude is inseparable from my effectiveness.

When someone is suicidal and fate dictates that our paths cross, it is my goal to practice my profession, not to determine whether the person should live or die.

Originally, I had thought that Mr. Humphry's work would help reduce the stigma of being suicidal by bringing the topic of suicide out of the closet. Help would then become more acceptable for those who might want it but believe that being suicidal is too much of a shame or stigma. What Humphry has said has disabused me of that belief. His attitude is simplistic, because all suicides, including the "rational," can be an avoidance of or substitute for dealing, with basic life-and-death issues.

Six other reasons why I disagree with the concept of rational suicide include the following:

1. The suicidal person and significant others usually do not know the reasons for the decision to commit suicide, but they give themselves reasons. That is why rational suicide is more often rationalized, based upon reasons that are unknown, unconscious, and a part of social and family system dynamics. I began my work as a proponent of rational suicide, but direct experiences with those who chose "rational suicide" led me to a major questioning of that concept. "Rational suicide" prevents rather than facilitates genuine understanding and decision making.

2. The proponents of rational suicide are often guilty of tunnel vision, defined as the absence of perceived alternatives to suicide. Their attitude can become a generalized narrowing of vision, in which the alternatives are automatically disregarded.

At a gathering, some supporters of the Hemlock Society asked me what, in my opinion, was the cause of suicide. I outlined my fourfold theory: the exhaustion of both individual energy and family or social network resources; the presence of a crisis felt to be intolerable by everyone; and the idea of suicide as a solution. They said, "Of course, people should commit suicide in that case." In that response lies the crux of the difference between the Hemlock Society and myself. What I see as the basis for treatment, they see as the basis for rational suicide.

3. Ageism and bias against the ill, the severely disabled, and the poor, especially those dependent upon society, is frequent. Life has become a question of dollars and cents. Rational? Age is not an illness, but ageism is a social disease, which
is also not rational. The April 1987 issue of the Hemlock Society Newsletter reported indignantly that a 103-year-old man with pneumonia was placed on a respirator for 6 days. Some members of the hospital staff thought life support systems were degrading to the patient. According to the Hemlock Society, the respirator was not giving the man enough air to breathe. However, the report did not give any other reason for not using life support systems. The report did not provide any evidence to support the claims made by the Hemlock Society.

Evidently, the same claim about some of the man's children wanted him to live and be placed on a respirator was seen by the Hemlock Society as justification for eliminating the family. The family was the treatment and decision process. That is not a rational view. It is rooted in the refusal to recognize the crisis nature of suicide and the role of others. It would be more rational to work with the divided family members, to help them resolve disagreements and deal with their anticipatory grief and other problems. It is not a reason for leaving them with their splits and differences.

4. The dying process is a complex event that includes biological, psychological, family, and social factors—both past history and current stresses. It is a systems phenomenon, in which the family is central. The proponents of rational suicide do not recognize the degree to which reactions to death are related to family presence and conflicts. An example is the extreme stress placed upon families with cancer in one of their members. In one study, 62% of the spouses of such patients described the presence of suicidal ideation. Lyons and I also found that 62% of the figures drawings of the spouses of cancer patients contained suicidal features. Many of these well spouses assist their sick spouses in what they consider rational suicide. The stress placed on the family members and other loved ones, and the wish to alleviate their suffering, are related to the decision of the terminally ill person to end his or her life. However, the Hemlock Society's wish to exclude family members when they are not in agreement with the decision to die could place formidable obstacles to the possibility of the best resolution for all. I suggest two alternatives to suicide: First, the family members are people in pain who should be offered help and counseling. Second, family members should be included, not excluded from the dying process of a family member or from the basic life-and-death decisions.

5. Other people's turning away is often more painful than dying itself. Friends and family turn away when they find the state of a dying person and the pain of losing him or her unbearable. This inability to deal with the mounting process facilitates rational suicide. The dying person may be seen unconsciously as abandoning the family. The result of such turning away and pain in the others is a dreadful loneliness in the dying person, because the need for others continues to the very end. Such a need can be the basis for a truly good death as well as a good life. Feelings of abandonment call for a restoration of cohesion, an affirmation of belonging, and a renewal of love.

6. I wish to emphasize, finally, that effective psychotherapeutic treatment is possible with the terminally ill, and only irrational prejudices prevent the greater extent to such measures. These prejudices are perpetuated by the rational suicide movement. It is true that the treatment of the seriously ill and suicidal person places an enormous strain upon everyone's resources. Major transference and countertransference issues emerge. The major one, perhaps, is the inculcation of hopelessness in the therapist or physician by suicidal and despairing patients and families. However, the proponents of rational suicide compound the problem, in that the hopelessness of those involved is not understood for what it is—a problem—and worked through. Instead, it is seen as a rational response to the real, not perceived, hopelessness of the patient. Thus, at the end, we return to the beginning, the primacy of tunnel vision.

Let me emphasize, in conclusion, that although I am opposed to suicide, I respect a person's genuine choice. Although I believe that suicide is intimately based upon family relationships and the social system, even in our individualistic society, I also believe that it is the individual's responsibility. My goal is to make a genuine choice possible. Self-sacrifice to relieve others of being burdened, for example, is not my idea of a genuine choice. Instead, I would want people who are contemplating suicide—rational, emotional, or otherwise—to feel free to go for help without being stigmatized as sick or weak, in full
confidence that they will be heard and listened to and that their wishes will be respected. Needed are: the following; a greater voice by the patients in determining their treatment program; respect for the needs of family members and other loved ones; the elimination of bias and other barriers against the realization of our common humanity; and respect for a patient's wish to live or die, with a full realization that if there is a right to die, there must be a right to live.