

## Case Consultation

### Nicole: Suicide and Terminal Illness

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The terminally ill person who plans suicide poses a clinical dilemma in suicidology. Issues of rational suicide are complicated. Although experts (Battin, 1991; Hoff, 1989; Motto, 1972; Pretzel, 1984; Saunders & Valente, 1988) recognize rational suicide, the prevailing paradigm of suicide prevention rests on an assumption that suicide is an irrational response to a temporary crisis. This bias may interfere with serious responses to terminally ill patients who plan suicide. The purpose of this case is to invite dialogue and thoughtful debate about responses to people who contemplate suicide because of terminal illness.

#### CASE SUMMARY

At age 58, Nicole was a successful consultant and a private person who loved art, editing, gardening, and travel. Watching her lover die from cancer, Nicole told her support group that she would commit suicide rather than suffer unrelieved cancer pain. After her lover's death, she avoided physicians and assumed bereavement caused her fatigue, weight loss, and abdominal distress. Upon her friends' insistence, Nicole consulted a physician. His treatment helped, but his diagnosis of malabsorption syndrome was incorrect.

Nicole distrusted physicians generally, partially because they had not relieved her lover's intense pain or symptoms. Again at her friends' insistence, she sought further consultation only after her symptoms intensified. This oncologist told Nicole she had advanced, terminal colorectal cancer with obstruction and he advised surgical reduction of the tumor to reduce symptoms. In choosing palliative surgery, Nicole chose life.

Surgery reduced the tumor mass. However, Nicole's pain relief was inadequate. Her continued complaints were discounted by physicians and nurses. Although she thought the idea was silly, she did effectively use a hypnosis tape to alleviate pain. After a stormy postoperative period, her condition stabilized and she went home. A teenage cousin who had lived with her for 2 years provided home care with assistance from Nicole's ex-lover until Nicole's sister arrived. A pain consultant helped reduce Nicole's pain.

Nicole's psychotherapist, seen since her lover's illness, effectively used cognitive therapy to treat Nicole's major depression during, and major depression and grief after, her lover's death. After resolving her painful grief, Nicole did not again experience a serious depression but continued therapy. Earlier, the therapist had encouraged Nicole to explore possible un-

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conscious death wishes to explain her avoidance of medical treatment. Once the cancer was diagnosed as terminal, therapy emphasized issues related to (a) If your time is limited, how will you use it? and (b) What do you want? After several months of feeling better, intense pain interrupted Nicole's work and her energy diminished. Concurrently, Nicole revived talk of suicide; she finished projects and planned her funeral.

Nicole had loved life and enjoyed humor. As fatigue continued and energy waned, she rushed to finish her important projects—organizing a library, settling family and business matters, arranging her will, and visiting people she loved. She had a number of pets in her care. She made arrangements for the comfort and welfare of a duck and cat, animals with special meaning. She found good homes for the other animals but worried when the dog barked too much and escaped.

Nicole realized a dream as she took her sister and cousin to her family's ancestral home in Europe. Planning was shared; Nicole assigned homework so everyone could learn the necessary currency, culture, and language. A couple of nights weekly they practiced counting change, ordering meals, and watching foreign films. The trip was ideal and Nicole returned with renewed energy and desire to work.

She was not private about her diagnosis, friends and family knew. She delegated tasks, worked during periods of maximum energy, and conserved energy at other times. She was a detailed and organized person who accomplished much and asked for help. Her routine included work, family time, psychotherapy, and other important relationships. Friends came and visited. She selectively accepted invitations. She enjoyed film festivals and concerts but avoided activities that required painful, prolonged sitting. Her finances were adequate if she were careful.

Physical deterioration continued slowly; she reached a plateau where the idea of dying seemed unreal as she ate well, enjoyed quality time, and worked. Confused and

impatient, she asked, "When do I get on with this business of dying?" and "How do I make sense of impending death when I feel OK?" Having focused so much energy on preparing to die, she had trouble focusing on living. Uncertainty was a problem. She managed life by deferring intense feelings until she knew and comprehended situations.

Her energy faded, symptoms worsened, and her liver enlarged making it impossible to drive. The best efforts at pain relief failed. Episodically, intense symptoms precluded work and rest. She talked more about suicide as her quality of life was increasingly unacceptable.

She had three severe episodes of pain, difficulty breathing, and fluid overload that were corrected after a week. She took copious amounts of drugs and morphine for symptom relief. The last episode so debilitated and frightened her that she said, "I can't go through this again and I won't be hospitalized." She feared similar episodes might leave her unable to enact her suicide plan according to the Hemlock Society directions.

As her symptoms worsened, Nicole debated when to commit suicide. She had discussed suicide with her family and took particular care that her teenage cousin understood that suicide was not all right if there were any other options. She prepared for death. She preferred not to die alone, but feared her suicide would jeopardize anyone present. She planned to consume medications and alcohol but was unsure of lethal doses.

## COMMENT

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It has been said that one's mode of death is related to one's philosophy of life. When the mode of death is suicide, it presupposes an unwillingness to accept life on its own terms, which includes, as Maris (1981) has noted, a finite life span, un-

avoidable sickness, fatigue and pain, an unpredictable life course, and ultimate aloneness. Even within this context, it is difficult to fault Nicole, a 58-year-old terminally ill woman who demonstrates such commendable resilience and vigor while simultaneously preparing to take her own life rather than face a painful and seemingly inevitable death from a progressive disease. In her case history are numerous examples of Nicole's proactive use of physicians and mental health professionals, support groups, friends, and family. She was apparently open with others about her condition, stayed as active as she could, fulfilled previously unrealized dreams, sought out relationships, put her affairs in order, managed her pain as well as possible, and carefully prepared family members for her impending suicide.

What is a therapist to do with such a patient? I tend to agree with Kaiser (1955), who suggested that responsibility is interactional, that once a patient is diagnosed as treatable psychologically, a therapist is responsible for developing the patient's sense of responsibility. My commitment with all my patients is to listen and help them move into a relationship with reality that has greater breadth and more options than the constricted view of the world they experience. Nicole's perception of reality was circumscribed by her diagnosis, but within those boundaries her therapist seems to have effectively helped open up her life to greater possibilities.

There are at least four categories of therapeutic intervention that are relevant to treating seriously suicidal individuals such as Nicole: engaging in therapy, ventilating feelings, developing alternative coping responses, and intervening with family and social networks.

### **Engaging in the Therapeutic Process**

I am reminded of Milton Erickson's response to the depressed woman who claimed that no one had been able to help her yet and that she would now give her new therapist 3 months before she killed herself (Watzlawick, Weakland & Fish,

1974). Going with the resistance, Erickson suggested to this experientially starved woman that the task before them was for her to experience as much of life as was possible in the 3 months they had together, encouraging her to have her hair restyled, take a trip, and do other things of which she had deprived herself, indirectly giving her a reason for prolonging life. Similarly, once Nicole's cancer was diagnosed as terminal, her therapy focused on setting priorities and initiating and completing important projects and pleasurable activities. In general, a therapist attempts to obtain a "no suicide" contract that is inclusive and comprehensive from patients at risk, but one sometimes settles for firm contracts over shorter periods of time, a more realistic approach to working with Nicole.

### **Ventilating Feelings**

It appears that cognitive therapy was effectively used to help Nicole manage her depression after her lover's death. Loss of a loved one can often lead to suicidal fantasies and wishes. It seems likely that Nicole's own avoidance of physicians to deal with her initial symptoms was related more to her distrust of doctors and her fears of identification with her lover's suffering than to the "death wish" hypothesized by her therapist.

A second set of feelings experienced by Nicole was the intense pain as a result of her disease. A hypnosis tape and a pain consultant were used to reduce Nicole's pain and enable her to maintain work and activities.

It is not clear how much of the therapy was spent dealing with Nicole's feelings about her impending death. There are, of course, well-known stages to the dying process (although they are not as clean and distinct as many believe) and the skillful therapist must be prepared to accept denial and rage as well as sadness and fear. Certainly the question, "What do you want?" is a key one for therapists to pose at all stages of the therapeutic process. It is one thing to take seriously the perspec-

tive of a person who is trying to cope with an untenable situation in a self-destructive manner; it is something else to over-identify with our suicidal patients. No one can justify life or rationalize suicide by using as evidence the circumstances of someone's life. The temptation to do so by therapists may lead to countertransference blunders of the worst sort. The justifications that people give for ending their lives are never adequate nor inadequate, right nor wrong; they are simply compelling or not, based on our own values. With terminally ill patients there is also the risk of offering unrealistic reassurance and false hope. Such patients may have insatiable needs for reassurance. In turn, therapists need to use benevolent restraint, be free of pity, and treat their patients with utmost respect.

### **Developing Alternative Coping Responses**

Most suicidal individuals experience a very limited sense of viable options. For Nicole, who did not feel in charge of the unfolding events of her life, the idea of suicide may have given her a sense of control over her own destiny. A therapist needs to be aware of and acknowledge the role of suicidal impulses and self-destructive behaviors as compelling, albeit generally misguided, methods of coping.

Any therapeutic strategies that help extend the patient's coping repertoire may be helpful with the issue of suicide. At one level, this may mean encouraging patients to avoid stressful stimuli. Nicole learned to avoid activities that required prolonged sitting and to become selective in accepting invitations. Preparatory rehearsal, both behavioral and cognitive, can be usefully taught by a therapist as a means of confronting predictable major stressors, such as increasing pain and disability. In many cases stress can be reduced through environmental or lifestyle changes, such as Nicole's use of home care and her trip to her ancestral home in Europe.

### **Intervening with Family and Social Networks**

The use of social networks and personal support systems is critical in working with suicidal patients. Nicole was encouraged to accept the support of others and to reach out and involve others in her activities rather than become increasingly withdrawn and estranged. Unlike many seriously suicidal individuals, she seemed adept at using a support system. She was actively involved in relationships, even to the point of openly discussing her disease and her plans with family and friends.

Suicide is rarely an individual act; it is most often an interpersonal act. The sensitive therapist will attend to the communication value of suicidal ideation as well as to the predictable impact of suicide on others. Nicole seemed well aware of the possible impact of her suicide by taking care to discuss her situation with her young cousin. She was also apprehensive of the effect of her intended action on others and seemed in a quandry as to whether to die alone.

Family and couples therapy may be especially useful for suicidal patients. It is not clear that such intervention was attempted with Nicole. Many suicidal individuals are seriously enmeshed in very destructive relationships and it becomes important to know the functions that self-destructive behavior may serve in the family. Although it appears that Nicole's family relationships were warm and supportive, the patterns of the relationships among family members were not so clear. It would be important to explore thoroughly feelings, thoughts, and actions of family members regarding Nicole's suicide plan as well as her own perceptions and fantasies about their responses. I do believe that no matter how well informed and prepared family members may be for Nicole's eventual suicide, they will carry much of the burden of being survivors of suicide and require postdeath intervention to deal with their own grief.

In closing, one cannot forget that a case study is, by definition, someone else's

view of a person. In this instance, the assessment of Nicole's thought processes and state of mind has been inevitably filtered through the lens of the writer. The role of our subjective perceptions in shaping and coloring our judgments is vividly brought home in Baechler's (1979) observation that someone could commit suicide because he or she *has* an incurable disease or *thinks* he or she has an incurable disease. The point bears repeating.

## COMMENT

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What shall one say about Nicole? My immediate answer is an easy one-liner: If there ever were a case in which a choice of suicide appears both rational and rationally made, this seems to be it. I can't help but admire Nicole for her perseverance, her stamina, her thoughtfulness, her clear-sightedness, and her courage. She has, I think, every right to end her life in preference to what will be a very much worse death and to expect society to respect her choice. Indeed, I would want to help her, both by providing the information she requests about lethal dosages, and if she were to ask me, by helping her obtain the drugs, bringing them to her, and holding her hand while she took them.

But, of course, there are a few questions I would want to ask Nicole first – not just questions, but issues I would want to discuss with her just to see if my initial perceptions of her sincerity and rationality were trustworthy. I (Battin, 1991) have devised a little list of questions for use by mental health professionals in counseling prospective "rational" suicides but which can also be used by a friend or confidante to explore with a person in circumstances like Nicole's what it really is he or she has in mind. This list presupposes that the person is capable to a substantial degree of rational self-inspection, as Nicole clearly is, and it will not work and should

not be used with people who are clearly agitated, disoriented, seriously depressed, out of touch with reality, or otherwise mentally ill, as Nicole clearly is not. There is a great deal of overlap among the various questions; this is intended to encourage continuing consideration of the most basic issues, and I can imagine talking with Nicole about them on a series of occasions. Here's the list, adapted for Nicole's case:

### *Rational Suicide? How Can We Respond to a Request for Help?*

1. *Is Nicole making a request for help?* Is it a request for help in committing suicide, either in obtaining the means for suicide or in carrying out the act? Is it a request for help in justifying the suicide to others? Is it a request for help in avoiding a suicide one has already decided to commit? Is it all of these? Does it cloak some other request? Or is it not a request for help at all?

2. *Why is Nicole consulting a mental health professional?* Has Nicole been referred by another physician or urged by a family member or friend? Has she been forced to see a mental health professional (e.g. through involuntary commitment)? Or is she seeking the services of a mental health professional because the professional has specific training and skills, and if so, what does she perceive these to be? Does Nicole seek reassurance that it is "normal" to have thoughts of suicide in such circumstances? If she simply wishes to communicate her thoughts and intentions to "talk it out," why has she picked a mental health professional for this purpose?

3. *What has kept Nicole from attempting or committing suicide so far?* Is it fear of death or fear of violent means of death that discourages such action? Fear of afterlife consequences? Or is it the case that she does not fear suicide, but, given advanced illness or the physical limitations of severe disability, simply cannot obtain the means of causing death? Or does she think the time for suicide is not yet right?

Does Nicole seem to need approval for the act, either from other persons or from the mental health professional in this consultation? What are the deterrents to suicide so far?

4. *Is the request for help in suicide a request for someone else to decide?* If so, who? The clinician or mental health professional? Family members? The doctor? If so, why is the decision being displaced? Does Nicole characteristically displace major decisions, or only this one?

5. *How stable is the request?* Is it a solution to Nicole's problem that she has been considering or planning for a long time? Or is it a response to the recent death of her lover? Does Nicole change her mind about suicide a lot? Only sometimes? Never?

6. *Is the request consistent with Nicole's basic values?* Does it reflect her general outlook on moral values? For example, does she support self-determination in, say, reproductive matters or political policies, or does she have more conservative views about self-determination that would seem at odds with a choice of suicide? If there is a discrepancy, does this mean suicide cannot really be her own choice? If the choice of suicide is incompatible with the tenets of a religious group with which Nicole continues to identify, how does she come to terms with this?

7. *How far in the future would the suicide take place?* Is the request preemptive or reactive? That is, is it intended to solve a future problem, for instance, the eventual onset of intractable pain or mental deterioration, or to put an end to problems already occurring? If the suicide is seen as occurring in the future, how does she expect to know when the time for suicide has come? If the suicide is planned for now, is it premature? Could a suicide planned for now be postponed and, if so, for how long?

8. *Are the medical facts cited in the request accurate?* Specifically, is the diagnosis accurate? What confirmation of the diagnosis does she have? What about the prognosis? How secure is it? Has an independent second or third opinion been obtained? Does she accurately understand

treatment options for future stages of terminal illness, such as pain control in terminal cancer? Has she been willing to try possibly effective treatments? Has she tried adaptive strategies for coping with disability? Does she trust her doctor? Is she afraid of abandonment by the doctor as the condition worsens?

9. *How accurate are other nonmedical facts cited in the request?* Does she accurately understand that, although attempting suicide is not itself a violation of the law in most jurisdictions, it may be grounds for involuntary commitment and that others who assist in an attempt may be subject to criminal penalties? That suicide does not invalidate life insurance coverage, except during the initial 1 or 2 years? Does she know whether injuries sustained in a nonfatal suicide attempt would be covered by her health insurance?

10. *Is the suicide plan financially motivated?* Is it intended to avoid catastrophic medical expenses? To avoid excessive home care expenses? To supply insurance proceeds to a survivor?

11. *Has Nicole considered the effects of her suicide on other persons?* Has she considered possible emotional trauma to survivors? What about the stigma associated with suicide? What about financial and other effects on survivors? What about co-workers, those involved in joint projects, friends, and so on? Or does she assume that others will be untouched or even relieved at her death? Would she want to try to mitigate the effects of the suicide on others? If so, has she given any thought to how this could be done? If not, why not?

12. *Does Nicole fear becoming a burden?* Is her assessment of the situation realistic? Has there been any frank and open communication between her and her relatives?

13. *What cultural influences are shaping Nicole's choice?* Are religious beliefs playing a major role, for instance, by promising a positive afterlife? Are cultural prejudices, especially against the handicapped, contributing to feelings of worthlessness? What other cultural beliefs play a role, for instance, in shaping

views about heroism, suffering, the value of life, the nature of death, and so on?

14. *Are Nicole's affairs in order?* Has she set domestic and financial matters straight? Made a will? Made funeral arrangements? Signed a living will or durable power of attorney should a suicide attempt be incapacitating but not fatal?

15. *Has Nicole picked a method of committing suicide?* If so, is it a realistic method that she is likely to be able to accomplish fully? Does she know what kinds of injuries are likely to result if the attempt is not fatal? Is she committed to one method only, or has she considered various different methods? What features of the method chosen makes it suitable for her? Would another method be more suitable? If she has not chosen a method, does this reveal ambivalence about committing suicide at all or only lack of information or resources?

16. *Would Nicole be willing to tell others about her suicide plan?* Would she be willing to confide the plan to friends or co-workers? Tell the minister, priest, or other religious advisor? Have it publicly known? Or would she want the suicide kept secret, and if so, why?

17. *Does Nicole see suicide as the only way out?* Does she have alternative plans for coping with her terminal illness and if so, how realistic are these plans? If these plans were subjected to the same previous 16 questions listed here, would the answers be more or less consistent and coherent than those associated with suicide? To which plan is Nicole most realistically and rationally committed, or is no such commitment evident at all?

How would Nicole answer? What conversations would we have? What would she get me to see that I cannot discern in the dry description of her case? Although I did not have the privilege of knowing her, from inspecting the details of the case study as it is presented here, I suspect I

would be persuaded – indeed, impressed – that she had anticipated almost all the questions I would have asked and thought of almost all these things I would want to be sure she had reflected on. I think I would see that there were no hidden agendas, no unresolved conflicts, no dark secrets, no external pressures, no grinding depression interfering with her choice. On the contrary, I think I would be humbled by the courage of a person looking directly into her own future – a future of inevitable disintegration in increasingly medicalized circumstances in the end stages of her disease – and making a clear, straightforward choice about how she wants – and how she does not want – that future to be. Of course there might be bright moments in that future, but there will also be many bad ones, and I see no adequate reason for expecting or forcing her to live out the entire terminal course of her cancer if that is not her choice.

"Goodbye, Nicole," I would have to whisper to her, "you're a lesson to us all."

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