Letter to the Editor

On the Relationship Between Suicide-Prevention and Suicide-Advocacy Groups

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Largely in response to contemporary medicine's advancing technological capacities to extend the process of dying to extraordinary lengths, recent years have seen the emergence of numerous advocacy groups concerned with what is often called "death with dignity." For instance, the New York-based group, Concern for Dying, distributes the Living Will as a means for individuals to secure their right to refuse unwanted, life-prolonging medical treatment. Another New York group, the Society for the Right to Die, lobbies for passage of "natural death" legislation, and has seen passage of Natural Death Acts in California and ten other U.S. states, and legislative consideration of similar bills in another twenty-seven. The Los Angeles-area group, Hemlock, led by a British writer who helped his cancer-striken wife drink a lethal potion, argues for societal recognition of assisted suicide as an option in terminal illness. Britain's Voluntary Euthanasia Society, once renamed EXIT: The Society for the Right to Die with Dignity, has published and distributed to its members a booklet of suicide methods for use by terminally ill persons; a similar book has become commercially available in France. Nor are such groups a local phenomenon; they are emerging world-wide. Although their views range from quite conservative insistence on passive refusal of treatment to radical suicide-advocacy, there are new voluntary euthanasia societies in Australia, Norway, Sweden, Japan, Denmark, New Zealand, South Africa, Holland, Germany, France, Colombia, Zimbabwe, Canada, India, and Switzerland.

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The emergence of these groups, however, may seem to pose an uncomfortable issue for both professionals and layworkers in suicidology and suicide prevention. Although their views are far from uniform, all of these groups counsel a more active role in one's own death. Some view suicide with tolerance. Some advocate suicide under certain circumstances, and some stress the importance of legalizing suicide assistance from physicians, family members, and other persons. Thus, it is very tempting to view these groups as inimical to the cause of suicide prevention, and to assume that they will seriously undermine the efforts of suicidologists and suicide-prevention workers in understanding and preventing self-destruction. But it is also possible to view this relationship between what we can loosely call suicide prevention and suicide advocacy groups in another, very different way.

It may be a mistake to view the aims of these two groups as conflicting, inasmuch as their aims are focused on two very different kinds of cases. It is easy to assume that the one group aims to prevent suicide, the other to promote it. This assumption is over-simplified. Of course it is true that some suicide-prevention professionals have seen their mission as the prevention of suicide in any circumstances at all. It is also true that suicide-prevention professionals often speak as if their objectives were simply to lower the rate of suicide in general, without reference to the particular facts of individual suicide cases. But these postures are comparatively rigid, and it is probably a mistake to assume that suicide-prevention groups have sought to root out *all* suicide. In particular, they give remarkably little attention to preventing suicide in terminal illness. But the fact that suicide-prevention groups are rather less zealous in working to reduce the incidence of suicide in terminal illness cases is not to be attributed to any special charity or approval of such acts. It is, rather, a function of a particular statistical fact. Such cases typically are not reported as suicide, either by the physician or by the coroner, and so do not appear in the suicide statistics at all. Suicide-prevention workers have concentrated considerable energy on understanding and reducing suicide among, say, adolescents or blacks or Indians, but not among the terminally ill. This is not from any greater sympathy for the terminally ill than for adolescents, Indians, or blacks, but largely because the facts of suicide among the terminally ill are rarely brought to our attention at all.

Of course, it is precisely these cases to which the suicide-advocacy groups direct their attention. Most repudiate suicide for (in the words of the Hemlock manifesto) "any primary emotional, traumatic, or financial reasons in the absence of terminal illness," and all insist that they do not wish to encourage suicide among young and healthy

individuals. Rather, their focus is on suicide, rationally chosen, as a means of avoiding intractable pain in terminal illness. Generally speaking, terminal illness is the only situation in which they would find suicide an act to be approved. Of course, they readily admit that the distinction between "rational" suicide and other cases is not always clear. By and large, however, they have been less concerned with the difficulties which arise when one tries to draw this distinction in actual cases, where depression, anger, or frank psychopathology may compound terminal illness, and more concerned to arouse our sentiments by pointing to cases of ideally rational suicide as a means of "self-deliverance" from the cruelties of death.

Thus, suicide-prevention and suicide-advocacy groups have quite different cases in mind. Suicide-prevention workers typically do not notice the existence of suicide cases of the sort which suicide-advocacy groups support. Suicide-advocacy groups regard the kinds of cases suicide-prevention workers strive hardest to prevent as simply not relevant to their concerns. However, to point out that these groups have different cases in mind, while it perhaps shows that they need not be enemies, does not yet convince us that they must somehow coordinate their efforts. It is this that it is most important to do.

Consider what suicidologists and suicide-prevention workers might contribute to suicide-advocacy's concerns, and the ways in which those contributions might allay fears about irresponsibility among suicide-advocacy groups. It is true that most clinical and scientific work in the theory and occurrence of suicide has been done by research suicidologists and clinicians associated with the suicide-prevention movement. In contrast, suicide-advocacy groups, although with some exceptions, are composed largely of persons who occupy essentially laymen's roles. These include people who have met terminal illness as patients, relatives of patients, or friends of patients, and not in professional roles. Advocates of suicide in terminal illness tend, generally, not to know much about the theory and clinical characteristics of suicide behavior, and so are less able to see specific terminal-illness cases against the larger scientific background. Suicide advocates often tend to see each case as unique, and not as part of a larger demographic pattern. The familiarity with these larger patterns, and with the characteristics of various suicides, through research and clinical experience which has developed within suicide-prevention groups, should be of interest to the suicide-advocacy supporters. In particular, suicidologists, drawing on recent work in thanatology, might hope to contribute some knowledge of the psychological dimensions of the dying process and the most likely moments in the course of a typical terminal illness at which suicide attempts might occur. For instance, it may be of considerable interest to know whether suicide in terminal illness usually occurs, say, in

anger or depression, or whether it more commonly occurs as a kind of demonstrable decathexis, the ultimate leavetaking from the world. Such facts may vary from one cultural group to another, or in different types of terminal disease. Very little is known of the actual facts of suicide in terminal illness. There is a vast amount of research work to do in describing general trends and patterns of suicide in these difficult circumstances.

Each case of suicide is in a sense unique, and it is this fact which suicide-advocacy may hope to point out to the suicide-prevention groups. In suicide-prevention's zeal for effecting a decline in suicide rates, this fact is perhaps all too easy to forget. Most suicides are preventable, perhaps, but it is not so clear that each single one should be prevented. What suicide-advocacy stands to contribute to the work of suicide prevention is a new sensitivity to the issue of when suicide-prevention is no longer humane, and the reminder that one consequence of effective suicide prevention can be to force people in intolerable circumstances to stay alive. Suicide prevention has been partly shielded from this problem by the widespread practice of not reporting suicide in the more sympathetic terminal-illness cases as "suicide" at all. This shielding may border on self-deception. It is easy to think that one's work is always right, if one can avoid noticing the cases in which it may be wrong. What suicide-advocacy can bring to suicide-prevention is a reminder not only that sympathetic cases do occur, but that in certain central ways they are quite unlike other sorts of suicide cases, despite the common trends and demographic patterns, and should be treated in very different ways.

We must grant that suicide-advocacy, like suicide-prevention, is humanitarian at root. Each has, or should have, the interests of individual human beings at heart. It is this fact of underlying humanitarian aim which provides the basis for interchange between the two apparently inimical groups. But what is needed is something more than mere disinterested coexistence. Rather, what is needed is genuine interaction and exchange, in which suicide-prevention supplies the background scientific view for a careful look at suicide in the as yet essentially unexamined area of terminal illness, while suicide-advocacy supplies a particular view which insists that in doing so the individual's interests always be kept at heart. Both suicide-prevention and suicide-advocacy can be irresponsible sometimes, each in its own way. Suicide-prevention's failings in this area might be labelled callousness, those of suicide-advocacy naivete. Both sorts of irresponsibility might be avoided, if there were a closer rapprochement between the two groups.

Finally, a pragmatic reason may suggest itself for suicide-preventers to attend to the claims of suicide-advocates. It may well be that more open attitudes on the question of whether suicide is sometimes

permissible will increase the use of suicide-prevention's traditional services, particularly hotlines and crisis counseling centers, by those who are serious suicide risks. It is sometimes suggested that any attention to the claims of suicide advocacy, or any greater permissiveness in attitudes towards suicide, would weaken the efforts of suicide prevention and cause additional suicides among those who are not terminally ill. But if it is the case that some persons who are serious suicide risks do not seek help from hotlines and counseling centers because they do not wish to be antecedently dissuaded or forcibly prevented from an act they are seriously considering, then it might well be expected that they will be more likely to use such services in a less rigidly preventive atmosphere. After all, these are the persons who may need suicide counseling most, and these are also the persons hotlines and crisis counseling services seldom see. In some such cases, an openness to this possibility might make possible treatment for persons for whom suicide prevention *is* humane, and who otherwise would not present themselves. Thus, some attention to the claim of suicide-advocacy may serve not only the interests of terminal illness victims, but of serious suicide risks within the population as a whole.