

**RATIONAL SUICIDE IN THE MENTALLY ILL**

# **RATIONAL SUICIDE IN THE MENTALLY ILL**

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## ABSTRACT

In this thesis I assume that suicide can be a rational and a moral action in certain circumstances. However, I argue that the traditional arguments in favour of rational and moral suicides that exclude the mentally ill are mistaken. I begin with an examination of the usual arguments for rational suicide. This examination includes the criteria used to test for rationality, the constituents of rational decision making, and the types of cases usually accepted as rational or rejected as irrational. I discuss alternate perspectives to the equation of mental illness with irrationality and irresponsibility. I criticize the 'medical' model conception of mental illness, its practice, and its communications model. I propose that an alternative model could provide different information and different conclusions as to rationality. I introduce J, a person who has committed suicide. I apply the usual criteria for rationality both to the general case of persons diagnosed with schizophrenia and to J's experience in particular.

In the last chapter, I examine the concept of a right to suicide and suggest the conception of suicide as a component of a fundamental right to life. I conclude that the 'mentally ill' are not incapable by virtue of being mentally ill and can sometimes make rational and moral decisions including the decision to commit suicide. I also conclude that they hold the same fundamental rights as any other person, including a fundamental right to suicide.

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I dedicate this thesis with love and respect to my sisters; to Lisa, who suffered greatly and made, what I believe was a rational decision to end her life, and to Judy, who, although she also has suffered greatly, made the decision to struggle on and live.

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## INTRODUCTION

In recent years in Western cultures it has become popular to challenge the historical, largely religiously based and almost total moral and social taboo against suicide. These moral, social and political challenges as well as challenges to legal prohibitions are usually based on the idea that suicide can be a rational choice under certain circumstances or conditions. Sometimes arguments are also based on ideas of rights; that we have a 'right' to die or a right to 'die with dignity', and some argue for a corresponding right to assistance with our deaths. For example, Prado argues for the rationality of 'preemptive' suicide for the frail elderly and those who become aware of impending deterioration and death before actual deterioration in one's reasoning ability occurs<sup>1</sup>. Barrington argues that improved technology continues to extend the length of life and consequently also extends the length of the period of living with deterioration and disease. She therefore suggests that acceptance of 'surcease' suicide for the terminally ill and the elderly will inevitably become the rule rather than the exception<sup>2</sup>. Rachels argues for acceptance of suicide based on the value of a "biographical life", rather than mere biological life. Biological life alone may be a life that

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<sup>1</sup> Prado, Carlos. The Last Choice: preemptive suicide in advanced age. New York: Greenwood Press, 1990.

<sup>2</sup> Barrington, Mary Rose. "Apologia for Suicide" In Battin and Mayo eds. Suicide: The Philosophical Issues. New York: St Martin's Press, 1980.



never could be or may become what one cannot value<sup>3</sup>. Peter Singer proposes five 'new ethical commandments', which include respecting a person's choice to die<sup>4</sup>.

The first new commandment, according to Singer, is 'all human life is not of equal worth'<sup>5</sup>. Singer proposes considering, rather than mere biological life itself, the 'ethically relevant' characteristics of a person when determining whether life is worth living and when comparing the worth of one life against another. Singer proposes that such characteristics might include having consciousness of oneself as a being existing through time. It might also include having the capacity to have wants, desires and plans for the future, and "the capacity to have enjoyable experiences, for interacting with others, or for having preferences about continued life."<sup>6</sup> Mere membership in the human species would not be the sole criterion of importance. While he does consider and include intelligent animals as 'persons' with such ethically relevant characteristics and who along with humans deserve not to be killed against their will, and while his proposals do not appear to automatically exclude the mentally ill and might be usefully applied to the mentally ill, nowhere does he consider what our response should be in the case of a person who expresses a wish to die because of the painful or unbearable nature of living with a mental illness.

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<sup>3</sup> Rachels, James. The End of Life. Oxford: Oxford University Press, 1986.

<sup>4</sup> Singer, Peter. Rethinking Life and Death. New York: St Martin's Griffin, 1994.

<sup>5</sup> Ibid., p 190

<sup>6</sup> Ibid., p 192

Legal challenges include Sue Rodriguez' recent challenge of Canadian criminal law prohibiting assisted suicide. Her challenge was based on the assumption that since suicide has been decriminalized, persons have a 'right' to take their own lives. She claimed that this is a right that is denied to some persons due to the particular *physically* disabling nature of their illness. I can find no similar legal challenge that exists concerning a claim or denial of a mentally ill person's 'right' to suicide or assisted suicide. In fact Judge John Sopinka, writing for the majority in the Supreme Court's denial of the Rodriguez' claim, stated that the position of the legal system and of society with respect to suicide is essentially one based on a sanctity of life principle: 'suicide is not accepted by society but society recognizes that appropriate therapeutic tools should be used to treat it rather than criminalizing it. Criminalization is thought to be both ineffective and inappropriate in dealing with it. Judge Sopinka further pointed out that: the state has an interest in protecting the vulnerable', and that, [It is the] " state's policy that human life should not be depreciated by allowing life to be taken."<sup>7</sup>

The state does not condone the taking of one's life, either by oneself or with the assistance of others, but it is more likely to see it as a matter for 'therapeutic' intervention rather than criminalization. This legal position is borne out in mental health laws that provide for police apprehension, involuntary committal and provisions for applications that may result in psychiatric treatment without one's consent, in the case of a person who is 'a

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<sup>7</sup> Sue Rodriguez v The Attorney General of Canada and The Attorney General of British Columbia, Canada. Supreme Court Reports, Part 4, 1993, vol.3, pp 519-632

danger to him/herself [or others]<sup>8</sup>. Those who wish to commit suicide are a 'danger to themselves' and are considered by the state to be mentally ill and in need of treatment. The mentally ill are included in those that society deems as 'vulnerable' and in need of protection. The state protects its interest in human life by preventing suicide and further by criminalizing assisted suicide, thereby reducing the probability that a person will be found to assist one in committing suicide. In liberal democratic thought, this tradition of the *deprivation* of liberty of those thought to be insane, can somewhat surprisingly be traced back to Mill. In his famous and oft quoted statement from "On Liberty" he says:

"That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self protection. That the only purpose for which power can rightfully be exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because in the opinions of others, to do so would be wise, or even right."<sup>9</sup>

In attempts to defend a person's right to commit suicide, many note and make use of Mill's statement and the fact that it restricts the right of the state to interfere with a citizen's liberty 'even for his own good'. What they fail to note, because they have already either deliberately rejected it or do not consider the case of the mentally ill, is that in another work, Mill also *excepts* the 'insane' from such freedom from interference:

"... the doctrine that individuals are the proper guardians of their own interests, and that government owes them nothing but to save them from being interfered with by

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<sup>8</sup> The Ontario Mental Health Act 1990 and amendments to 1993. Chapter M7 Part II Section 15. p 8

<sup>9</sup> Mill, John Stuart. "On Liberty". In J.M. Robson ed. Collected Works of John Stuart Mill, Vol X. Toronto: University Of Toronto Press, 1977. p 223

other people ... can never be applicable to any persons but those who are capable of acting on their own behalf."<sup>10</sup>

Mill mentions infants, *lunatics*, and imbeciles as specific exceptions. The important point is not whether the insane *do* not act for their own good in making irrational decisions but that they are not even considered capable of acting for their own good.

In spite of Judge Sopinka's remarks about suicide and the need for the state to protect the vulnerable, incompetence to make autonomous decisions is not assumed in the legal system, even in the presence of mental illness. The law instead presumes competence. Neither mental illness, irrationality nor commitment to a mental institution are conclusive proof of incompetence. The difference in meaning between competence for the purpose of consent to treatment, and competence for the legal determination of criminal responsibility and appropriate punishment, has become blurred. In criminal cases the legal system relies on the medical profession to testify in court as to the 'mental' competence of the person. Excusing a person from responsibility from criminal behaviour is, however, not the same as saying that he cannot be responsible for him or herself or for his decisions about himself. Decision making about the responsibility or irresponsibility of an agent, particularly with regard to suicide, is complicated by the values of the profession that makes the judgements.

"Value conflicts such as the extent to which saving life takes priority over preserving autonomy complicate evaluation and decision making about irrationality and

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<sup>10</sup>

Mill, John Stuart. "Principles Of Political Economy". In J.M. Robson ed. Collected Works of John Stuart Mill, Vol X. Toronto: University Of Toronto Press, 1977 p 803

competence. When the patient makes a decision contrary to the professional value of saving lives, their decision is likely to be seen as irrational."<sup>11</sup>

When the decision is about suicide, the courts are likely to agree, as Judge Sopinka's remarks appear to indicate.

With few exceptions most political, legal, social and philosophical positions, if not directly as in the examples of Mill and Judge Sopinka, then at least implicitly or through omission, reject the rationality and the morality of suicide and assisted suicide for the mentally ill. Exceptions amongst bioethicists could include Joseph Fletcher who argues that an action is right generally if it helps human beings and if it is a response to human need<sup>12</sup>. Robert Martin argues that paternalistic suicide intervention is unjustified if based on the notion of potential future regrets since no person can suffer regrets or harm after having committed suicide<sup>13</sup>. Eliot Slater argues that mental illness involves extreme suffering and that suicide, *even when irrational*, can be in the best interests of the patient, his relations and society<sup>14</sup>. Margaret Battin, who advocates extensively the moral and rational nature of suicide, also does briefly address the possibility of acceptable suicide among the mentally ill. She says:

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<sup>11</sup> Abernethy, V. "Compassion, Control and Decisions about Competency." American Journal of Psychiatry. January 1981, p 53

<sup>12</sup> Fletcher, Joseph. "In Defense of Suicide" In Donnelly ed. Suicide right or Wrong. Contemporary Issues in Philosophy. Buffalo: Prometheus, 1990. pp 61-73

<sup>13</sup> Martin, Robert. "Suicide and False Desires" In Battin and Mayo eds. Suicide: The Philosophical Issues. New York: St. Martin's, 1980. p 144

<sup>14</sup> Slater, Eliot. "Choosing The Time To Die" In Battin and Mayo eds. Suicide: The Philosophical Issues. New York: St. Martin's, 1980. p 199

"while we are beginning to develop some practical although still inadequate moral rules for recognition of the rationality and moral permissibility of euthanatic suicide in cases of painful terminal illness and old age, there are many areas where we still have no rules only the strict taboo and that these areas amongst others, include mental incapacity and mental illness."<sup>15</sup>

and she further states:

"while we are beginning to recognize terminal physical pain as grounds for suicide, we do not yet recognize emotional pain in the same way."<sup>16</sup>

and she allows that:

"suicide in mental as well as physical illness may be the prudent and rational choice."<sup>17</sup>

In this thesis I would like to begin with the assumption that suicide can be both a rational and a morally acceptable choice. I assume that suicide may be a rational act if the decision meets some set of criteria for rationality such as Battin's; criteria that include a measure of non impairment of reasoning ability or of 'competence'. Since the decision is irreversible, I suggest that such criteria should be applied not in some general way but in particular to the process used in the decision to die. Such decisions will have taken into consideration the interests of both the individual wishing to die and others. I recognize that amongst philosophers the issue of the nature of rationality is a large issue and a matter of controversy, and that whatever the criteria for determining the rationality of a decision process or act, they will be subject to criticism. I assume the Battin criteria as acceptable conditions for rationality, and as Battin herself says, they will have to be 'mostly' if not all

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<sup>15</sup> Battin, Margaret. The Death Debate Ethical Issues In Suicide. Prentice Hall, 1996. p 206. Hereafter referred to as TDD.

<sup>16</sup> Battin, TDD. p 128

<sup>17</sup> Ibid., p 129

met in order for a decision to be considered rational. I also accept that rational suicide may be a moral act. I do so on the basis of a fundamental principle that a lived human life<sup>18</sup> has immense but not unconditional value and on two derived principles: i) the importance of maintaining every person's need for dignity through self-determination or autonomy, which I take to be necessary in order for a person to realize the value of their life and ii) a principle of mercy, and the need for alleviating suffering.

In Chapter 1, I begin by outlining the basics of the usual positions held by those who defend the rationality of suicide in the physically ill. I review and criticize several of the developed criteria for rational decision making. While I concur with views that promote acceptance of suicide as an option or choice for the terminally ill and aged, I depart from them in restricting the acceptance of suicide to the fatally ill who are physically suffering and to the deteriorating aged. Two important questions that I try to answer in the following chapters are: *i) what makes us reject the rationality or morality of suicide in the mentally ill* and *ii) can a mentally ill person make a rational and moral decision to commit suicide?* I will try to show that if we accept that suicide may be a rational and moral choice then we are wrong to deny such rational and moral options to a person just by virtue of their being mentally ill. I will defend my view on the basis of the same principles underlying many positions defending suicide in the physically ill, namely its *potentially rational nature*, an acceptance of the *value of a life* that is not just a biological life and the value of *autonomy*, all in relation to their potential application to the case of the mentally ill. I hope, as Battin

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<sup>18</sup>

or a 'biographical life' as Rachels terms it.

has suggested that we have not yet done, to contribute to the development of those 'practical moral rules' in a way that includes the mentally ill as well as the physically ill.

In Chapter 2, I proceed to try to answer the above two questions by challenging some popular and common misconceptions and false assumptions of the nature of irrationality or 'thought disorders' in the mentally ill. I will consider other interpretations of the thinking and behaviour which are commonly considered as signs of irrationality. It is often taken for granted that the mentally ill are irrational by virtue of being mentally ill. Since I assume that suicide can be a rational decision, I reject the argument that choosing to commit suicide automatically makes one irrational. I argue that many mentally ill persons, even those who are considered amongst the most seriously ill and are sometimes labelled 'psychotic' and who do have thought processes which show some signs of disorder and irrationality, still can make some rational decisions, including decisions to die. I argue that a rational decision to commit suicide made by such a person, like many important life and death decisions made by anyone, may contain both rational and emotional elements.

Since a major factor resulting in the rejection of the mentally ill as capable of a rational suicide decision is the equation of irrationality and mental illness, two of the major topics I consider in Chapter 3 are the meaning of the term 'mental illness', and the process of decision making by which a person becomes labelled as mentally ill or defined as legally incompetent due to mental illness. I will discuss the problems presented by a lack of conceptual clarity of the term 'mental illness' and the newer terminology 'mental disorder' as used in the field of psychiatry. I will present the problem, as I see it, that this creates for



consideration of rationality or irrationality. I also consider the problem presented by the communication method utilized in medicine to gather information; the method which forms the basis of the subsequent diagnosis of mental illness. One's concept of mental illness and the process used to gather information and formulate a diagnosis can both affect one's ability to see or discover the rational thinking capacities of the mentally ill. Both the concept and the process can affect one's idea of the similarity of or difference between (the rationality or irrationality of) the so called 'mentally disordered' person and those that are not so 'disordered'.

In Chapter 4, I introduce J, a person labelled as schizophrenic, who commits suicide. I utilize Battin's criteria for rational suicide as a method of evaluating rationality in both i) the diagnostic category of schizophrenia generally and ii) the specific personal example of this suicide by J. I will try to show through careful attention to the personal experiences of J, that important factors that detract from the value of life include not only physical suffering and deterioration but mental suffering, and that in fact suffering and illness may not necessarily or reasonably be separated into physical and mental components. Paying attention to the perspective of the person having the subjective experience of pain may permit us to see in an empathic fashion the nature of the suffering under consideration. I will question why we have such difficulty, as Battin suggests, in empathizing with mental anguish. Permitting suicide where chosen by a mentally ill individual may prevent the greater harm of living in a deprived or disvalued fashion. Such a deprived existence may include either the degradation and loss of dignity and autonomy that treatment often involves

or the poverty, loneliness, social rejection and mental suffering that often occurs with non-treatment. Allowing suicide may be in the 'best interests' of that person from his own individual perspective, whether or not it appears to others to be 'for their own good'.

Chapter 5 represents an attempt to assess the concept of a right to commit suicide. I conclude that if there is a fundamental right to suicide for anyone including the terminally ill and those facing impending physical deterioration, pain and death, then there is also a right for the mentally ill.

Finally, as a feminist I cannot help but note that labels of 'mental illness' and 'mental disorder' along with the general cultural stereotype of irrationality are applied unequally to men and women. The Broverman and other longitudinal studies referred to in this chapter provide enduring evidence that in the clinical setting, the normal woman's role is equated with what is mentally unhealthy. Evidence gathered from the "Specific ...[culture, age and] gender features" sections and the "Prevalence" sections, for each diagnostic category of the Diagnostic and Statistical Manual of Mental Disorders IV, when read collectively, indicate that women are diagnosed mentally disordered more often than men and more women are treated in the clinical setting for 'psychiatric' reasons.<sup>19</sup> Women predominate in diagnostic categories that include: Major Depressive Disorder [3: females

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<sup>19</sup> American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition. Washington, D.C.: American Psychiatric Association, 1994. pp 353, 360, 399, 403, 408, 414, 433, 434, 447, 451, 455, 460, 485, 524, 542, 554, 581, 594, 612, 619, 652. Hereafter referred to as DSM IV.

to 1 male], late onset Schizophrenia, Bipolar II, the majority of the "Mood Disorders" [where estimates of incidence in the community range from 30-50%], the Sleep disorders, the Eating disorders, and most of the Personality disorders. Patients with Borderline personality disorder which are estimated to constitute 30-60% of the patients seen in clinical settings are 75% female. Patients with major depressive disorder and borderline personality disorder have high rates of suicidal desire and behavior. These figures do not include those disorders where only women can be affected such as premenstrual disorder. Elaine Showalter has traced the history of the connections between women and psychiatry and has demonstrated 'that since the turn of the century, women have increasingly taken the lead as psychiatric patients.'<sup>20</sup> Since the primary focus of treatment efforts consists in the use of psychopharmacological measures, women as a group are being prescribed psychopharmacologic agents more than men. Five times fewer women than men currently commit suicide even though three times more women than men attempt it and fail.<sup>21</sup> Reasons for this difference in attempt and success rates are complex but may include such factors as women having traditionally less access to lethal means, women tending to be less physically aggressive, or women being more likely to share their plans with another person and thereby 'invite' intervention. Regardless of the reasons for the differences, and because I am advocating a permissive attitude towards suicide in the mentally ill which may increase the

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<sup>20</sup> Showalter, Elaine. The Female Malady: Women, Madness and English Culture, 1830-1980. London: Virago, 1987. p 52.

<sup>21</sup> Battin, Margaret. The Death Debate: Ethical Issues in Suicide. Upper Saddle River, New Jersey: Prentice Hall, 1996. p 1.

number of women choosing suicide, I have to ask, how would a permissive attitude differentially affect women? Would it be better or worse for women if suicide were to become a socially sanctioned choice? Throughout the paper my examples often point to gender issues. My intention is that these examples draw attention to more general problems with the concepts of mental illness and practice of psychiatry and as well to this particular issue. I recognize that the concerns that I raise are pertinent not only to women but to all vulnerable members of society. I discuss the problems that permissive suicide could present for vulnerable persons.

## CHAPTER 1 The Usual Arguments For Rational Suicide

### 1.1 The Principles.

Arguments for the potentially rational nature of suicide are often based on a moral principle that life has value but does not have absolute intrinsic value. The absolute sanctity of life position assumes a person in the abstract and cannot account for the concrete particulars of an individual life. Advocates of rational suicide do not totally reject the notion of the sanctity of life but instead modify it in favour of a principle that allows that it is the quality of life that is of importance to a particular person and not mere biological existence. The important question is the question of benefit of continued living to the person. When continued life cannot be of benefit to the person who lives it, such a life has lessened value or may be eventually of no further value to the person her or himself. Two questions in the case of suicide arise at this point. *What sorts of conditions make one's life of no further benefit to oneself? And who can make that decision?* In the case of the mentally ill whose autonomy is not respected, these questions are often answered paternalistically by caregivers and relatives who do not have the same perspective as the mentally ill person.

### 1.2 The Criteria For Rational Decision Making.

If we accept that a person's life might reasonably be judged to be of no benefit to that person, then we must attempt to define the criteria in terms of which the

reasonableness or rationality of such judgements can be assessed. A definition or set of criteria is required that will enable us to separate out the rational or reasoned decision and act from irrational ones. Some criteria which have been proposed address the process of decision making, others address the result of the process, still others attempt to separate rational persons<sup>22</sup> from those who are not. Choron, for example, defines rational suicide in the following way:

"Rational" here implies not only that there is no psychiatric disorder but also that the reasoning of the suicidal person is in no way impaired and that his motives would seem justifiable or at least "understandable," by the majority of his contemporaries in the same culture or social group."<sup>23</sup>

In this definition, the "psychiatrically disordered" are automatically excluded from consideration even before the process of judging the rationality of a decision begins. But Choron's criteria tell us nothing about who the "psychiatrically disordered" are. Battin argues that Choron's criteria are inadequate in light of our strong historical taboo against suicide. The suicidal person's motives are automatically questioned and she is labelled as insane or immoral. Battin also claims that the majority of contemporaries in such a culture will therefore not agree with or understand the motives and will, as a result, assume that the reasoning process is inadequate or faulty. Our culture is one with a strong historical taboo against suicide. The Rodriguez challenge of the Charter of Rights in Canada and public discussion raised as a result of Dr. Kevorkian's activities and several other widely publicised cases, provide evidence that we may be beginning to move away from this traditional

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<sup>22</sup> as opposed to process or acts.

<sup>23</sup> Choron, Jacques. Suicide. New York: Charles Schreiber's Sons, 1972. pp 96-97

position. In Choron's formulation, all of the "psychiatrically disordered", whether capable or not will be excluded from the possibility of rational suicide. Anyone who wants to commit suicide will be excluded automatically because they will automatically be considered "psychiatrically disordered". In addition to historical taboos, other factors including traditional values, mores, cultural forms, and practices such as sex role and gender stereotyping may also impact on the justifiability or understandability of reasons, and also on the assessed moral value of an act of suicide. As I have already indicated above, it will be critical to ask who is included in the category of the "psychiatrically disordered"? If our concept of mental illness has expanded to include categories of persons who were not included as disordered in the past, and if, as some clinicians believe, everyone has some form or degree of psychiatric disorder, then we must face the danger that everyone will be eliminated from consideration as rational even before the process of assessing the rationality of the decision to commit suicide ever begins.

Prado proposes<sup>24</sup> what he considers three more neutral criteria for a rational suicide, criteria that may not automatically exclude the mentally ill:

- i) that the decision be unimpaired,
- ii) that the motivation be understandable by others and
- iii) that it be in the agent's interests.

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Presented at speaker series McMaster University, Philosophy Department, 1997.

Prado's condition "that the motivation be understandable by others" is problematic. It may, as Battin suggests about Choron's, exclude the mentally ill precisely because they are not understood by many or most others. Prado's criteria do not specify who the acceptable "others" might be. If mental illness is equated with irrationality and mental pain is either misunderstood or devalued, then the motivations of a mentally ill person will not be understandable to others. If saving life is valued over autonomy, then the decision of a mentally ill person to commit suicide will be devalued. It is also unclear what Prado means in saying that the "decision must be unimpaired". Does he mean the decision process or the outcome or both? He appears to mean the decision itself. In that case Prado's criteria may also violate the liberal value of freedom of the competent person to decide, even when others judge the decision not to be reasonable, rational or good for him.

Battin proposes five criteria for rational suicide. These criteria do not automatically exclude the mentally ill from consideration. Nor do they automatically include the mentally healthy<sup>25</sup>. The first three of these criteria Battin groups under the heading: "*non impairment criteria*". These include not only a person's "ability to reason", but also a "realistic world view" and "adequacy of information". The last two of the five criteria, "avoidance of harm" and "accordance with fundamental interests", she calls "*satisfaction of interests criteria*". In order for a decision to commit suicide to be considered rational, it must meet "most or all" of these criteria. Battin does not clarify what she means by "most". She is perhaps clearer than Prado about her "ability to reason" criteria. It does not demand that

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the process or the outcome actually be reasonable or rational, but speaks instead to the capacity of the suicidee for reasoning. However, her demand for a 'realistic world view' may present problems for assessment of the rationality of the mentally ill in precisely the same way that the previous types of criteria failed them, since the mentally ill do not always have the same world view as their assessors and since the concept of a world view appears to be value laden. The assessment of what is 'realistic' may be as subjective and as value determined as the assessment of rationality.

### **1.3 Constituents Of Rational Decision Making.**

The sets of criteria for rational decision making considered above, all make reference in some way to 'unimpaired', or (more positively) 'adequate', reasoning powers. The difference between 'unimpaired' and 'adequate' is not merely a semantic difference. It signals a difference in the standard against which reasoning powers are assessed. Different standards will be even more important where there is already some known degree of impairment, as measured by others, in the person's competence or ability to reason. While the reasoning powers of some 'severely'<sup>26</sup> mentally ill persons' may be 'impaired', for example by hallucinations, delusions or depression, a particular decision by such an "impaired person" may still meet the criteria for 'adequate' reasoning, even if it does not meet the criteria for 'unimpaired' reasoning.

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<sup>26</sup>

I use this term to refer to those with traditional psychoses and severe depressions.

In the health care setting, ability to reason is usually conceived as 'competence'. When used in reference to consent issues the term 'capacity' is sometimes used. Typically, in the health care setting, "competence may be limited or complete, chronic or intermittent and it may be due to one or more of a diverse set of medical disorders ..."27 Mental illness may or may not result in incompetence thus understood, and patients cannot be assumed to be incompetent by virtue of having a mental illness28. In other words, it is quite possible that a mentally ill person is competent to make rational decisions, if not always, then at least sometimes. In psychiatry the issue of competence tends to arise when a patient refuses hospitalisation or treatment29 or when he or she expresses a desire to commit suicide and has both a plan and the means. But if a person is competent to consent to hospitalization and to treatment for example, than he must be competent to refuse. Both competent consent and competent refusal would necessarily involve reasoning which requires an understanding of the other as the alternative decision. A choice is not a choice at all unless it is the result of a procedure where alternative options are considered. If a person is incompetent to refuse, he must also be incompetent to consent and so his willingness to accept hospitalisation and treatment cannot be considered valid consent. Should a fundamental right to suicide be

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<sup>27</sup> Buchanan and Brock. "Deciding For Others". The Millbank Quarterly. Vol.64, Suppl. 2. 1986.

<sup>28</sup> Sprung, C. & Winick, B. "Informed Consent In Theory and Practice". Critical Care Medicine, 17, 1989. pp 1346-1354

<sup>29</sup> Lippert, G. & Stewart, D. "The psychiatrist's role in determining competency to consent in the general hospital". Canadian Journal of Psychiatry. 33, 1988. pp 250-253

established, incompetence might disqualify one from exercising the right, or allow others to abridge the right. But a competent person has the ability and the right to shape his or her life (and perhaps death) according to her own wishes, values and concepts of the good life.

Tests of competency to make medical decisions for oneself closely resemble Battin's and other's criteria for rational decision making. They typically include having the ability to understand the relevant information about one's condition, being capable of making a choice and having rational reasons for the choice made. Another standard might describe ability to understand the nature, including the risks, benefits and alternatives, and the consequences of treatment and refusal. A third more stringent standard would require that the patient not only have the ability to understand but actually understand the particular circumstances in question. Having the ability to understand and actually doing so, are different matters. The patient may be perfectly capable of understanding some alternatives to treatment for example but not want to hear about them. In Ontario, The Enquiry On Mental Competency recommended that capacity should "reflect the functional requirements of a particular decision [by] testing the individual in the decisional context."<sup>30</sup> The committee seems to be recommending the adoption of the third fairly stringent type of standard. However, the standard normally accepted in Canadian courts is a less stringent standard. It requires of adults only that they have the ability to understand, and not that they actually do understand. These are the types of standards of competency to make decisions

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Weisstub, D.N. Enquiry On Mental Capacity: Final Report. Toronto: Queens Printer for Ontario. 1990.

for oneself involving one's health care that Canadian courts have used<sup>31</sup>. Although these are tests of competency to consent to or refuse medical treatment, I am assuming that these tests or something very similar would be equally adequate tests for the rational decision making capacities of a person with respect to the decision to end his or her life.

Even though the argument here does not concern itself with anything other than autonomous suicide decisions, it is informative to refer to the standards that are used by Canadian courts in cases involving substitute decision making. The Consent to Treatment Act<sup>32</sup> requires substitute decision makers to attend first to the recently expressed wishes of the patient. The best interests of the patient can be invoked only when the expressed wishes are not known. "By giving wishes priority over best interests the Consent To Treatment Act fulfils the requirements of section 7 of the Charter."<sup>33</sup> It also reflects the principle "that what people want for themselves takes precedence over what others may think is best for them"<sup>34</sup>.

As we have seen, having an understandable motive, and coming to a conclusion that is in one's best interests, and that does not seriously harm others, are generally accepted as conditions for thinking rationally. The 'mentally ill', in so far as others cannot understand

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<sup>31</sup> Rozofsky & Rozofsky. The Canadian Law of Consent To Treatment. Toronto: Butterworths, 1990; and also Roth, Meisel & Lidz. "Tests of Competency to Consent to Treatment". American Journal of Psychiatry Vol. 134, 1977. pp 279-284

<sup>32</sup> Bill 109 Consent To Treatment Act, 1st Session, 35th Legislature of Ontario, 1991.

<sup>33</sup> Singer, P & Choudrey, S. "Ontario's Proposed Consent Laws". Editorial in The Canadian Medical Association Journal. 1992;146 (6). p 830

<sup>34</sup> Ibid., p 830

them, are therefore frequently assumed to have impaired or inadequate reasoning powers; often they are considered totally irrational and 'out of touch with reality'. They are also assumed to have unreasonable or incoherent motives, and not to know what is in their own best interests. If death is thought to be undesirable and almost never in one's best interests, and if the pain experienced by the mentally ill is viewed as tolerable, whatever its nature, and within the capability of the person to manage or eliminate, then a mentally ill person's wish to die will always be viewed as irrational.

The concept of unimpaired reasoning powers is often equated with having the ability to reason in a logical fashion without logical errors. Suicidologists such as Shneideman<sup>35</sup> who analyzed notes left by successful suicides, consider all suicides to be irrational on this basis. However, several questions immediately arise from this conclusion that logical error is *always* involved in suicidal decisions. For example, how do we know, after the fact, that logical error was involved in the many cases where the person did not leave a note or express any reason? Further how do we specify what is an acceptable level of logical reasoning? Does the degree or level of logical facility demanded in ordinary or personal decision making have to be of the same high standard demanded by a university philosophy professor in an academic setting? Does the logic have to be more rigorously applied because of the complexity and serious nature (irreversibility in this case) of the decision, or if the decision involves others as opposed to a purely personal decision?

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Shneideman E.S. - The Psychology of Suicide. New York: Science House, 1970.

Many extremely important decisions made by many people do not involve perfect logic and involve various mixtures of rational and irrational, cognitive and emotional processes. Decisions about having children, getting married, and having or refusing medical treatment for physical ailments are all obvious examples. For instance, decisions about having children are decisions that have a profound effect upon both the parent(s) and someone else's life (the child's) and yet these are quite often made on bases other than an ideal rational one. The expression "we are not having children until we can afford them", sounds suspiciously similar to the expressions, "we can't afford a new car, a house or a TV". In other words, it is like a decision to buy consumer goods. A child is neither a consumer good, nor a possession, nor merely another expensive acquisition, and yet people sometimes put the having of children in the same list of priorities as the acquisition of material objects. While being poverty stricken or unable to financially care for a child seems like a good reason not to have a child, being able to afford children may not necessarily be the only or even necessarily the most important reason for having children. Wanting to have children in order to have someone who will love the parent, or to please a spouse, are other frequently expressed reasons for having a child. Sometimes having children is expected to fix problems in the marriage relationship. This is a profoundly important life decision that affects not only oneself but others, but it is often made for the wrong reasons, or for irrational reasons, or with some mixture of both right and wrong, rational and irrational, cognitive and emotional components. Irrational decisions such as these do not result in loss of the right of self-determination of the person. Judging from these examples, neither the importance of the

decision, nor its complexity, nor its effect on others, appear to be sufficient conditions for demanding that the decision be purely rational.

Additionally, assessment of the logic of a piece of reasoning can be affected by the assessor's point of view, personal experience, ability to empathize, and by whether one allows for consideration of such factors as emotion within the process of logical calculus. How do we take these factors into account? Can one assess the logic of reasons after the fact when one cannot clarify what was actually on the mind of the suicidal person? In a later section on the discussion of the concept of mental illness from the medical model/psychiatric point of view, I will discuss these problems further. The point to be made here is that allowing for variation in the degrees of logical reasoning required for the determination of rationality, and recognizing the role played by the bias of the assessor in judging the cogency of a person's reasoning, may result in our either widening or narrowing of the range of persons or thinking judged to be rational.

Rationality is generally thought to involve being able to understand and predict the consequences of one's behaviour, or being able to understand and predict the outcomes. Someone is thought to act rationally when they logically weigh the options according to the information that is relevant and reasonably available, consider the harms, and choose actions that are most likely to result in maximizing their interests. Battin claims that her second criterion, "having a realistic world view", is also related to reasoning logically, having information and weighing options. Having a realistic world view includes not only *not* having bizarre beliefs about the nature of the world, beliefs which are incongruent with those

of other people in one's own culture. More importantly it also includes correct or "realistic" perceptions or beliefs about oneself, including "her own life situation, including her identity, her position in the world and her particular talents and disabilities"<sup>36</sup>. Having a poor self-image or being depressed can narrow one's ability to see alternatives or future possibilities for oneself in a way that is often thought to impair one's reasoning ability. It can also impair one's estimation of the effects one's action has on others, or the importance of oneself to others, and therefore one's estimation of the harms to others. Having a better self-image is thought to allow one to expand the range of one's options and alternatives as well as to positively develop and assess one's abilities and disabilities. Having a realistic perception of one's life situation, position in life and abilities and disabilities, supposedly also assists one in weighing possible interests and harms both to oneself and others.

Battin's third criterion involves having adequate information. All that any person can ever do is act on the basis of the information that is available at the time he acts. It would be a mistake, therefore to judge the rationality of a decision in light of information which later comes to light. For example, it would be a mistake to judge a suicide based on a mistake or mix up of laboratory data as irrational if previously unavailable information came to light *ex post facto*, but rational if the true data were never made available. The same is true for the case of a person who commits suicide the day before the completely unexpected discovery of a cure for his illness. Such a suicide would be considered rational on the information reasonably expected to be available at the time, and our judgement should not

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change ex post facto when the new discovery is made. Information that is unavailable cannot make one's suicide irrational after the fact. Decisions can only be made on the basis of one's best estimate as to future probabilities. How far into the future the probable outcomes are thought to occur, may be weighed against an individual's more immediate needs. The effects of waiting, even for a desirable outcome, and the consideration of what has to be endured while waiting, will affect the rationality of decision making.

#### **1.4 Which Suicide Decisions Are Rational Given These Criteria?**

What decisions will usually satisfy the "non impairment" and "satisfaction of interests" criteria? Many people can readily empathize with and accept the decisions of persons with certain conditions. These persons most obviously include the terminally ill and the aged. While many persons fear death they nevertheless grasp its inevitability, and realize its possibility at any time. This knowledge combined with a general or overall sense of happiness, and an enthusiastic grasp of life whatever its troubles or unhappiness, enables them to understand how they would feel themselves if faced with the knowledge of a sure threat to their physical continuance. Physical terminal illness such as some forms of cancer or long term debilitating illnesses such as Lou Gehrig's Disease or extreme old age and the health problems that go with it, are easily recognized as an absolutely certain threat to one's personal continuance and to the quality that makes life worth living. In such a case, sympathising and empathising are easy. We can imagine not only how we would feel and

what choices we might also make in these situations, but also how others must also feel. At least we can imagine the feelings of those with whom we share the same experiences and values. We recognize the bases on which they might make their own choices, even if different from our own. In spite of widespread developments in diagnosis and treatment of many disease conditions, and in spite of the fact that scientific advances have prolonged life to a considerable degree, many conditions, including the deteriorating conditions attached to aging, persist. In fact, since the length of life can now be prolonged, the length of time that one might likely live with deteriorating conditions is also prolonged<sup>37</sup>. Many of these are conditions we find horrifying because they result in pain, physical deterioration, social isolation, loss of autonomy and finally death; death in a manner that none of us wants for ourselves. Dying itself is not always a dignified process. In spite of all our progress, and the fact that death sometimes occurs in a shockingly short time, sometimes the process of dying is prolonged over agonizingly long periods of time.

In addition medicine has become a complicated, specialized body of knowledge of disease and treatment, and except in a very limited way, it is beyond the ability of many people to comprehend. Moreover, scientific opinion is valued highly over the subjective knowledge that an individual has of her or himself. The processes of deterioration due to disease and aging, combined with the perceived need for dependence on a medical professional or other caregivers along with the experience of diagnosis and treatment, removes control of his body and his being from the patient. In a society in which self-

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<sup>37</sup>

This is Barrington's basic argument.

definition is so wrapped up in the value of personal autonomy and control, people feel helpless, lost and fearful of losing their sense of self in the face of the inability either to understand and more importantly to control their bodies and their lives. It is often this very real lack of current control and perceived loss of control in the near future, coupled with a strong desire to regain a measure of control, that drives some to consider suicide. It is these facts of and fears of loss, that enable the rest of us to understand the motives and reasoning of people who in such circumstances choose to end their own lives..

The high cultural value placed on the wholesomeness and attributes of youth, beauty and bodily perfection, as contrasted with the attributes associated with aging, difference and disability, also contributes to the need to feel in control. Physical illness and deterioration take away from us the things that we value most. We understand this relatively easily because we are part of a culture in which autonomy and control are amongst our primary shared values. We expect to lead lives that follow a plan of our own choosing and our own making. In many respects we share the horror of deterioration involved in the process of dying, whether brought about through disease or old age, because we lose control. Slowly losing control can involve a pretty massive and horrifying picture. In spite of assertions that we can now always medically control pain, we do not seem to consistently do so. We have all heard horror stories of those who have experienced unrelieved acute pain and whimpered, groaned or screamed away the last moments of their lives. The debilitating effects of chronic pain are well known. Drugged stupor does not seem like a realistic or happy alternative to many.

Many of those dying of terminal disease and as a result of old age also suffer from loss of control of the most basic bodily functions: bowel and bladder control, the ability to feed oneself or swallow food, the capacity to perform the most simple self care functions. In addition old age, whether complicated by disease or not, can result in loss of one's hair, skin elasticity and colour, weight changes, height changes, and loss of body image. The elderly and the ill, whatever they do, cannot measure up to the standards of the beauty myth prevalent in our culture. Loss of jobs and economic prospects also is a factor in illness and old age. Women particularly continue to be vulnerable to living in extreme poverty in old age and women live longer than men so are more likely to be subjected to the debilitating effects of aging.<sup>38</sup> Loss of social respect and loss of a feeling that one's contribution and one's life is valued are felt by both aging and ill persons. Disvalue may be multiplied many times and not in a simple way, by being a female and old and sick. Patients institutionalized in nursing homes and hospitals or isolated in their private homes, often report the experience of loss of love and the comfort of simple gestures of human touch. Loss of long time friends, older siblings and spouses is the reported experience of many before their own deaths occur. The aged and the ill often face feelings of '*infantilization*' and of loss of basic human *dignity* as a result of these multiple actual or potential losses and as a result of society's devaluation

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Government of Canada. House of Commons. Special Committee on Pension Reform. Women and Pensions: Women in Poverty. 1983.

Canadian Advisory Council on The Status of Women. Women and Labour Market Poverty. 1990.

of them.<sup>39</sup> As noted by Overall, paraphrasing Klinefelter, "it [disrespect] is a not-infrequent experience of very elderly people, who may be regarded by younger adults as inept, incapable, ignorant, and incompetent."<sup>40</sup> It is not surprising that people are able without much difficulty to conjure up sympathy and an understanding that a choice of suicide is a potential rational choice or option in such a situation. In the face of all these possibilities, the results of a process of weighing and balancing all the potentials, the probabilities, and the harms, can easily result in weighing death as the preferable alternative for the sufferer. As one experiences all these losses one's duties and obligations to others if one has any left, seem to fade into relative unimportance. In the final analysis, we seem to share some sense and to accept for others that it is oneself that may rightly be considered first and foremost at this point in one's life.

### **1.5 Which Suicides Are Irrational According To The Criteria?**

The losses described in the preceding section are fairly easy for us to understand. We can grasp these losses if they occur through terminal physical disease processes or because of physical deterioration such as might occur for example in Alzheimer's Disease. Things are different, however, if the loss occurs through 'mental illness'. Mental illnesses

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<sup>39</sup> Overall, C. "Reflections of a Sceptical Bioethicist" In Sumner and Boyle (eds.) Philosophical Perspectives on Bioethics. Toronto: University of Toronto Press, 1996. p 174-176.

<sup>40</sup> Ibid., p 176. n 61. Klinefelter, D.S. "Aging, Autonomy and The Value of Life". In Smith. D.H. ed. Respect and Care In Medical Ethics. Lanham, MD: University Press of America, 1984.

are not terminal illnesses in the usual sense. Death is the direct result of a terminal physical disease process or of age, but the losses incurred in mental illness are often not believed to be terminal or irretrievable or irremediable losses. The mentally ill person who chooses suicide is not just 'hurrying up' death that will occur inevitably from the disease or because his biological life span is near its end. The person who 'loses his mind' and wants to commit suicide is often thought to be somehow more responsible for his condition and his pain than the one who suffers loss through physical disease. If he 'chooses' or if he 'accepts' or 'responds to' treatment, it is commonly believed, the mentally ill person can regain at least a measure of his mental health and with it his reason. The label of 'irrationality' is often used in such cases in a pejorative sense, the label being derogatory of those who somehow are responsible for their own situation and who don't try hard enough to correct it. Since we prize reason so highly and correlate mental illness and responsibility for it with unreason, we do not want to, and perhaps cannot, imagine ourselves in such a situation. We cannot as a consequence, put ourselves into the situation of the other as is required in order to empathize well. Since we see the cause as internal, whether or not we see it as biologically based, rather than as imposed on the person from some external source, the cure for the problem is also seen to lie within the individual himself. This common view is reinforced in the professional practice of psychiatry. While the trend in psychiatry is to view mental illness as biologically based, most therapy (other than psychopharmacology) is cognitive or behavioral type therapy which is directed at having the patient control or change himself. If the patient chooses to refuse therapy he is in 'denial' and does not accept his illness. In depression for example,

even though many professionals believe both that depression has a biological basis and that in women particularly it can have social roots, treatment is often still oriented towards individual therapy. The individual is said to have a 'narrowed' horizon due to depression and not to be able to see future possible opportunities and alternatives for happiness and satisfaction. Such an optimistic view of another person's future possibilities does not negate the fact that in certain cases of chronic mental illness, including some forms of depression or psychosis, one's future possibilities may be a very largely diminished version of what they once were or could have been without the handicaps of the illness.

In addition, in mental health care, treatment itself often results in or involves loss. The mental patient's treatment more resembles that of a prisoner than that of a physically ill patient. The mentally ill person, unlike the physically ill person, may be subjected to unwanted confinement and treatment, important losses of basic freedoms and of personal autonomy. Such losses can include loss of the freedom to decide what to wear, what visitors to have, when and what to eat, and whether one can even move about freely. One can potentially be restrained mechanically, chemically or even touched physically by other persons, all without one's consent. In all the most important and fundamental senses, one's autonomy may be lost or taken away by others without one's consent, as is not the case in any physical illness. One may be able to make the most foolish and apparently irrational decisions for oneself when physically ill, even decisions that will certainly result in one's death when treatment would have been simple and prevented death, yet one is not deprived of the right to make such a decision and the right to carry out one's wishes. When it comes

*Ernest  
From  
Example.*

to the mentally ill however, suicide is a choice that is rarely seen as reasonable or rational since we believe we can think of alternatives that would be acceptable and bring happiness, and because we think that the suicidal person could see his life as acceptable if only he chose to do so.

The suicides of persons who think that they will be able to gain satisfaction after death from the pain they have caused to another person will usually be seen as irrational. These so called "get even"<sup>41</sup> suicides are often judged irrational because thinking that one can act, or feel ( be gratified by the other person's response) after one's death, involves the logical error of thinking of oneself as a subject or as an experiencing individual after death. Expecting to know how another person will feel after one is dead is not rational. Except if it turns out to be the case that a belief in an afterlife was correct, one will not feel or know anything after one's death. This includes not feeling satisfaction that one has succeeded in hurting, punishing or otherwise affecting another person. One also may be able to predict with some confidence, but not to definitely determine or control, how others will feel after one is dead. Those left behind to cope with a suicide may not feel responsible, they may feel anger instead of grief, relief, or even happiness that the event or relationship is over or they may have no feeling at all.

Other suicides that will not meet the criteria of rationality may include the "cry for help" type. Some suicidologists consider that they are not properly considered suicide at all. Shneideman thinks that every suicide is of this type. These types of suicide threats and

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<sup>41</sup>Battin, M. TDD. pp 70, 79, 117, 170.



successful acts are assessed as irrational by therapists such as Shneideman<sup>42</sup>, because they do not meet the 'non impairment' criteria for rationality. The risks taken may be considered too great when weighed against the benefits (getting others to change or getting the environment to respond to one's needs). The person crying out for help by threatening suicide is expressing a 'false desire'. Although they often are unaware of this fact, death often does not represent the actual wish of the person at all<sup>43</sup>. Such suicides are thought to fail to accurately imagine future consequences that is, their own 'deadness' and also therefore have an "unrealistic world view".

Also judged irrational might be some of the suicides of those like one of Dr. Kevorkian's patients who had received false test results and who had been wrongly diagnosed with a terminal illness but who had never asked for a second opinion or a repeat test. The same might be true of another of his patients who had chronic pain but no diagnosis at all. Her suicide might be considered irrational because her condition might still have been diagnosed and her pain might have been treated. Patients who imagine a fatal illness but are too afraid to have the facts confirmed by medical diagnosis and who then commit suicide are also acting irrationally. Without any diagnosis, or without confirmation of tests or second opinions, all such suicides might be counted as irrational because they are

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<sup>42</sup> see note 34.

<sup>43</sup> Martin, R. "Suicide and False Desires" In Battin and Mayo eds Suicide: The Philosophical Issues. New York: St Martin's Press, 1980, p 144. Martin argues however, that whether these desires are false or not is irrelevant and that we should not interfere with such suicides since a person cannot suffer harm by realizing that his desires were false after he is dead.

not based on full and accurate information or on a process of careful enough information gathering and assessment. Suicides resulting from seriously impaired 'reality testing' such as that of a psychotic who believes that he can fly and jumps off the roof of a building in an attempt to do so will be disqualified as an irrational choice under Battin's criteria<sup>44</sup>.

On Battin's criteria, a less obvious case, but still a case of irrationality due to an unrealistic world view, will be the suicides of those whose self-image is seriously impaired but in a way that might have been repaired or redefined (from the perspective of others). Take, for example, the patient who thinks, feels and acts as though her life is worthless, or that she is not worthy of love and respect. On this concept of rationality the suicides of many patients who are depressed will fall into this category. Depression is said to narrow the range of possibilities that one can see as available for oneself. It narrows a horizon full of pain to only the present and the near future and it makes the importance of the present assume a disproportionately larger role in the decision making compared with the importance of future potentials for changed feelings or circumstances. Jerome Motto, a psychiatrist [who does not automatically reject the rationality of suicide for some of his patients] argues that the only standard of acceptability from which he can judge the adequacy of a patient's view is his own<sup>45</sup>. If he can see that the patient's view is like his own, then he can consider it rational.

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<sup>44</sup> It might be argued that in a sense this action does not constitute a suicide at all because it is neither the desire nor the intention of the person to die even though the outcome is death.

<sup>45</sup> Motto, J. "The Right To Suicide: A Psychiatrist's View". In Battin and Mayo eds. Suicide The Philosophical Issues. New York: St. Martin's Press, 1980. p 212

If he can see more acceptable possibilities than the patient can, then what he sees is the irrationality or unrealistic nature of the patient's decision. If Motto thinks that his patient's possibilities are few, he will agree that suicide may be a rational choice. If he cannot see that the patient's options are actually narrower than they once were, then he may think the patient irrational and take steps to prevent suicidal action. I will argue that this requirement that a person's view of reality match the view of others, is precisely one of the problems with how we judge rationality, and in particular the rationality of the mentally ill.

## CHAPTER 2

### Problems With The Usual Perspective On Rationality/Irrationality

#### 2.1      **The Equation Of Mental Illness With Irrationality And Irresponsibility.**

The notion that mental illness and irrationality are the same thing is common in popular culture and in psychiatry. Fingarette, a philosophy professor puts it succinctly: "The insane are madmen bereft of reason. Their conduct is irrational because they themselves are irrational persons."<sup>46</sup> When we do not understand or cannot comprehend the reasons for a person's behaviour or thoughts we call them, both the person and their thoughts, irrational. Sometimes we call them irrational to excuse their behaviour when calling them perverse or mean might work just as well. When a person appears to lack rationality we also see them as having something less than the attributes of a full human being and as being different from ourselves and as undeserving of the right to act autonomously. Like children, we do not consider them 'agents' of their own destiny; in Kantian terms they are not moral agents or 'ends in themselves'. Szasz points out that one problem with this equation of irrationality with mental illness is that it deprives the person of agency on the basis of the inability of the observer to understand. Furthermore the person judging another as irrational not only does so from his own perspective and with his own ability or lack of ability but more importantly

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<sup>46</sup> Fingarette, H. "Insanity and Responsibility" *Inquiry* 15 (1972): 6-29, 7. Quoted in Szasz T. *Insanity. The Idea and Its Consequences*. New York: Wiley and Sons, 1987, n 45 p 62. Hereafter referred to as "Insanity".

using his social and political power to name the observed person's condition without his agreement.<sup>47</sup> Szasz also points out that in various times and places children, foreigners, slaves and women have all been considered 'crazy' because, by the standards of the observer, their thoughts were incomprehensible. Szasz maintains that the equation of mental illness could just as easily be made and sometimes is made with failure to obey authority, lack of social adjustment or impiety as with irrationality. He also claims that "the connections of mental illness with irrationality are similar to the connections with irresponsibility."<sup>48</sup> Such connections are demonstrated in the history of legal insanity defences such as The Durham rule and the McNaughton rules which, although pertinent to criminal law and criminal responsibility rather than civil law, exhibit the legal system's search for a necessary connection between mental illness and irrationality and which seek to excuse a person from responsibility for his (criminal) acts.

If the definition of mental illness is elastic and expands to include disorders not previously considered mental disorders but immoral acts, crimes, developmental problems and even problems of normal physiology then equating irrationality with mental illness is too sweeping a generalization. The nature of irrationality in personality disorders, for example, will not be the same as the nature of irrationality in schizophrenia or major depression. The problem with some concepts of 'disorder' and of the 'wrong' conditions for rationality is that, in the case of the mentally ill, the 'right' conditions are generally thought of as internal

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<sup>47</sup>Szasz T. Insanity. p 63<sup>48</sup>

Ibid., p 64

and not external to the individual and hence the solution sought is also internal and not external. Individual behavioral, emotional or cognitive change is the desired and sought after outcome. On this view the patient can change himself internally and so can change the circumstances that may have led him/her to consider suicide. However, if any alternative perspectives<sup>49</sup> have any merit then the patient's response may be a response to external conditions that could be judged 'irrational' or inhumane and the solutions will involve not individual treatment but social and cultural change. According to sociological theory such as labelling theory, the labelling process as well as the individual's collusion in his own labelling are both a basis for problems. The focus for making the conditions 'right' will be both the individual and the society.

The problems of equating irrationality with mental illness and the resulting oppression (including tangible negative social effects such as economic loss, unemployability, social isolation and potential loss of liberty) attached to the label 'mental illness', can be usefully explained by the sociological concept of social labelling identified and elaborated upon in sociological theory. According to labelling theory, labelling and denial are two opposite poles on a continuum. Denial is the deliberate social avoidance or even valuing of certain kinds of problematic behavior. Since we do not value or admire mental illness, denial is perhaps irrelevant to this discussion. Labelling is "a public event in which an individual is denounced by an authority as being essentially deviant... civil

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<sup>49</sup> such as a sociological perspective or the 'antipsychiatry movement' or more recent feminist criticisms of psychiatry.

commitment of the mentally ill [has] been taken as [an example] of labelling"<sup>50</sup>. The process of labelling is circular, the deviant is both defined and co-operates in some way in the defining of his own identity as deviant, and then his identity is confirmed and reinforced by the social definition. The problem with the labelling /denial continuum is that the process defines the person "*essentially*" or most importantly as a deviant and the effect is that other actual qualities of the individual are ignored.

"The attitude of labelling is to reduce a complex individual with many attributes and an eventful biography to a single descriptive trait. A person is defined exclusively by some single, actual aspect of his character or behaviour"<sup>51</sup>. (My emphasis).

In the case of the mentally ill person, the process is enabled by psychiatric 'authority' ('denouncement' might be symbolized by diagnosis and forced hospitalization might be construed as the symbol of authority). The patient cooperates, in as much as he defines himself by his craziness. The process is reinforced by social definition of the mentally ill as 'crazy', incompetent and so on.

The mechanism of stereotyping also works to the disadvantage of the mentally ill. It differs from labelling in that it results in the erroneous definition of a person based on a supposed or even imagined characteristic of a group to which he belongs, rather than an actual aspect of his own character or personality. It also differs from labelling in that the characteristics defined are not necessarily deviant but can (even when the definition is erroneous and misguided) be intended positively. Stereotyping results in familiar mistaken

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<sup>50</sup> Scheff, T. "Labeling, Emotion, and Individual Change" In Labeling Madness. Englewood Cliffs, New Jersey: Prentice Hall, 1975. p 76

<sup>51</sup> Scheff "Labeling, Emotion, and Individual Change" In Labeling Madness. Englewood Cliffs, New Jersey: Prentice Hall, 1975. p 76

(and racist) beliefs, for example, that all black people are musically inclined or good athletes. Labelling of the mentally ill, or other deviant population, does not result in anything that might be construed as a flattering description. Grouping all persons who are mentally ill together, results in each mentally ill person being defined by supposed or imagined characteristics of this one group to which he belongs. In this case, an example of an assumed characteristic of mentally ill persons as a group might be increased potential for violence. This process explains, for example, the common assumption, even though contrary to some social data available<sup>52</sup>, that mentally ill persons are more likely to be dangerous to others, than members of the 'normal' population. If all mentally ill persons are assumed or imagined to be violent, then each mentally ill individual must also be violent.

The concept of 'infantilization'<sup>53</sup> also may give insight into the nature of oppression experienced by the mentally ill; oppression that results in their characterization as generally irrational and incompetent. Overall defines "systematic infantilization" as "the social construction and invidious deployment of the category 'child' ". Infantilization may result from the "inappropriate attribution of adult versus child distinctions which are also distinctions of powerful and privileged vs. powerless and disadvantaged, to other than children". The attribution of incompetence in reasoning and or rationality, to all of the mentally ill may fall in this category. To some degree in our society all 'patients' suffer or

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<sup>52</sup> Zembatty, J.S. "Introduction: Mental Illness and Individual Liberty." In Mappes and Zembatty eds. Social Ethics New York: McGraw-Hill, 1982.

<sup>53</sup> term coined by Christine Overall in "Reflections of a Sceptical Bioethicist" In Sumner and Boyle (eds.) Philosophical Perspectives on Bioethics. Toronto: University of Toronto Press, 1996. pp 176-177



benefit from this process. Perhaps the mentally ill patient suffers most since he alone is at risk of losing all of his freedoms and rights to autonomy and since he may not agree to, nor feel benefited by, nor have his suffering relieved by paternalistic interventions. "Infantilization of patients", says Overall,

"is not a social anomaly but an enactment of one of our deepest held values: those who are weak, vulnerable, frail or helpless deserve to be treated like (the cultural stereotype of) children. The knowledge, experience, emotional stability, and capacity to decide of patients of any age- but especially those who are female and/or very young or very old - are consistently underestimated."<sup>54</sup>

I would add the mentally ill to Overall's list of those patients who are "consistently underestimated". Overall points out some of the ways that patients in medical institutions are infantilized, including 'the use of a gown that resembles a child's bib, the use of first names or diminutives such as 'dear', the provision of non demanding amusements, the requirement for regular naps and the restriction of visitors'. In psychiatric institutions patients are similarly the subject of routine infantilizing, demeaning and liberty depriving procedures such as having their belongings searched, sometimes secretly, being placed in hospital gowns for 'observation', having visitors restricted and in addition having their own movements about the unit or building or their own room restricted by such procedures as locked unit doors and systems of 'privileges'. Sometimes patients are restrained physically, deprived of beds, bedding or clothing and also drugged against their will. They are required to attend 'occupational therapy' and to make crafts or do other simple, generally unskilled

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Christine Overall in "Reflections of a Sceptical Bioethicist" In Sumner and Boyle (eds.) Philosophical Perspectives on Bioethics. Toronto: University of Toronto Press, 1996. p 177

activities and sometimes work regardless of their particular skills, talents or needs and without payment for their work. Non-cooperation or protest is regarded as an indication of illness. As well 'case conferences' regularly take place where the patient is talked about by "the team" without being present, or ignored or condescended to if he is present. Treatment plans are made for his care without his input or his consent and his progress is discussed and evaluated also without his input whatever his ability or disability. Caroline Whitbeck suggests that what are morally justifiable acts on the basis of a principle of paternalism in relation to children, may or may not be justifiable and may limit or hinder a person's self-determination<sup>55</sup>. I suggest that many such activities inflicted on the mentally ill hospitalized not only hinder their immediate needs for self-determination but also contribute to the long term loss of both their abilities and rights.

The concepts of both 'labelling' and 'infantilization', can be used to understand and explain the popular notions that being mentally ill equates with being *entirely* irrational and that all of the mentally ill are irrational. This is plausibly also why consideration of the mentally ill is frequently omitted entirely from discussion of what is rational or moral thought and action, in this particular case the exclusion of the mentally ill from considerations of suicide as a rational or moral act. Seeing a mentally ill person's behaviour

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<sup>55</sup> Whitbeck, Caroline. "Why The Attention To Paternalism in Medical Ethics?" Review essay of James Childress. "Who should decide? Paternalism In Health Care" Journal of Health Politics, Policy and Law 10, (Spring 1985): 183. Quoted in "Overall, C. "Reflections of a Sceptical Bioethicist" In Sumner and Boyle (eds.) Philosophical Perspectives on Bioethics. Toronto: University of Toronto Press, 1996. p 177

(including his desire for or act of suicide) as determined entirely by his mental illness reduces him to an abstraction rather than seeing him as a whole person in all his complexity and in this case unnecessarily narrows the focus of possible reasons behind his suicidal behaviour to the irrational. Classifying all mentally ill persons as irrational also reduces them to the abstract and fails to allow one to see each as a unique individual in a particular context which may include the ability to make a rational suicide decision even given other problems with rational thought.

## **2.2 A Different Perspective On Rationality Affects The Judgement Of Rationality.**

If we look at which suicides will count as rational/ irrational on these different types of criteria and different perspectives, we may well have different opinions depending on whether or how we account or do not account for internal and external conditions. The key to the judgement of irrationality because of an impaired self-image for example is the perspective from which the judgement comes. A different conclusion is reached by taking a different perspective. On the internal condition view, it is the individual who is *wrong* about their opinion of themselves and who must change their perspective to the 'correct' or 'realistic' perspective. Perhaps, however, there is nothing that the suicidal person can do, short perhaps of conforming to social expectations that are damaging to her self-esteem, to change herself in a way that would result in satisfaction of her needs. Perhaps a person's view of possibilities for her life is narrowed, for example in depression, but that does not change the fact that a person's possibilities may actually not be what they once were or may

be permanently diminished from their full potential because of a mental disorder. On a view that it is the external environment that is deficient it may be social conditions that are not 'rational'. Social values, norms and cultural expectations can contribute to the definition of the self in such a way as to limit options for personal development and satisfaction. The failure of a culture to support and supply basic needs for nutrition, housing, and love or nurturing as well as failure to provide the economic opportunities for education and the possibility of jobs and the prospect of improvement for whole classes of persons merely based on membership in a particular classification (race, age, gender, mental illness) may damage a person's chances for full self-realization. Furthermore, it may not be realistic to affect social change in a way that solves the problem, at least in a reasonable period of time for the suicidal person, or in a way that will have an effect on the precipitants in the suicidal person's life.

Such suicides as the "get even" suicide, or the "cry for help" [that does eventually result in suicide] may be considered rational if looked at from the perspective of need for change in external conditions. If what the person really needs and wants is what they accomplish either at the moment or later perhaps their thinking is rational in a sense. Perhaps the get even suicide wishes to hurt another person in retaliation for some real harm to themselves. Since many of those who are left after a suicide are indeed hurt by it, the action may be a logical even if not moral one. Many clinicians sense that suicidal persons of the "cry for help" type are those who are unhappy with their relationships and that what they primarily desire is a change in the nature of these relationships. This is confirmed in the

arguments presented by Robert Martin who argues that the expression or threat of the suicidal desire may be the outcome of a 'false desire'. In this case the desire for death may be a false desire. Another way of expressing this thought, according to Martin, might be to differentiate between wishes and intentions. It may very well be that one's wish is to have some external change occur but that one's intention is to die if one does not see any possibility for that change to occur. In this case there is no indication of irrationality in the wish or in the intention even if they are different. For example the actual goal might be immediate pleasure or satisfaction of some kind at the mere thought or hope that someone else will feel pain in the future whether or not this actually happens, and whether or not one knows about it in the future. It is no more irrational to act in such a way that someone else experiences harm or pain after one is gone, than it is to act to produce pleasure after one is gone, for example, by leaving an inheritance. It does not make one's thinking irrational if one merely imagines oneself seeing someone else's pain in the future, if one knows very well upon reflection or when having it called to one's attention, that one will in fact see or feel nothing because one will be dead. One may wish that something different would happen but be willing to end one's life in the eventuality that what is wished for does not happen.

This also points out the interesting perspective that whether or not a conscious thought appears rational, one's thinking and actions can be rational if based on a subconscious or unconscious rational thought or knowledge which could be brought to conscious awareness if required or demanded. It could also be the case that one has subconscious or unconscious knowledge that one cannot articulate when required or demanded

by someone else or that one cannot express in a way that others can understand but that nevertheless affects one's behaviour in a way that would supply reason if one could articulate it. In this case the suicidal threat can be interpreted as an expression of the person's selfhood and the pain felt. Often what a person threatening suicide really wants and needs and sometimes doesn't get and cannot get, is for someone else to understand and to take seriously the extent of the pain that they feel and to be willing to make changes in their attitude or behaviour towards the person or in the nature of the relationship between the two persons. Threatened suicide may be a means then of changing some fundamental aspect or quality of a relationship. In this case it is the threat of suicide rather than the act of suicide that may be rational in the sense of being a way of getting one's interests satisfied. Imagining another person's response may, rather than being seen as an irrational thought, only be a means of motivating the person, perhaps through expressing anger, to act to get what they want and need and perhaps deserve. Threatening suicide may also be explained as a means of testing the likelihood of the response of another party and therefore part of the process of gathering relevant information before making a final decision rather than a sign of irrationality. Although many consider such threats irrational because they are never actually carried out, it may be the case that this is not a sign of irrationality at all. Success may be impeded by our impermissive attitude towards suicide. Interventions such as forced hospitalizations and medication may be what prevents the successful completion of such acts even if rational.

It might also be urged that such actions are not moral actions because they involve the manipulation of others for one's own ends; threatening another person is using the other

as a means and not as an end in himself in terms of the Kantian categorical imperative. Usually this kind of threatening behaviour is not seen as moral because it is by custom not acceptable in our society to manipulate another person in order to get what one wants. However, even if not moral, thought and action can still be rational. If the other person (or institution) does not respond to one's needs (or one's threats) then perhaps suicide is a rational choice because one cannot get one's basic needs and interests satisfied through one's own efforts.

Suppose we look at the external conditions that might contribute to the behaviour of threatening suicide before we decide that it is irrational? Can we say that expressing needs which have been continuously thwarted and that are essential to the threatener's life or well being is an irrational act? What would be the rational course of action? Is it rational to submit to the conditions of deprivation or oppression? We could explain the behaviour as rational if we thought of the environment as 'irrational' in its persistent denial of satisfaction of the needs of some persons. Couldn't we say that a culture, society or person that by custom treats another person as something less than human, is irrational and that a person's perhaps unusual or out of the ordinary response to this environment is reasonable and rational under the circumstances? Is it moral for some people to have their most basic needs for love, respect and personal development, as well as for autonomous action, denied and then to be labelled as irrational when they resort to whatever it takes to get their needs met? Perhaps one more reasonable alternative response is to recognize the expression of pain and to shape the environment in such a way that it is more responsive to the person's need. The solution

need not only be to deny the rationality and autonomy of the person while attempting to correct his behaviour. Recognition of the meaning of the threat and supporting the individual's attempt to get what he needs, or even supporting an eventual suicide choice should efforts fail to achieve an apparently impossible goal, might be rational alternative courses of action for the caregiver rather than interference with the suicidee's acts.



## **CHAPTER 3**

### **The Concept Of Mental Illness**

#### **3.1 Problems With The 'Medical Model' Conception Of Mental Illness.**

In his study of madness, Foucault tried to detail how the history of our concepts of madness are connected with our conceptions of reason. Since the concept of mental illness is now almost invariably equated with the notion of 'unreason' or irrationality it would appear to be prudent or even necessary to clarify the meaning of the concept 'mental illness'. It would appear important also to differentiate, if possible, 'mental health' from 'mental illness'. This is not an easy task since there is no consensus on the meaning of the term 'health' much less 'mental health' and debate rages on as to whether it is best to expand the definition of health to include anything (such as a concept of positive wellness) more than the absence of disease. Discussion of the concept of mental illness is, however, crucial, if the task of determining who has the right to suicide is ever to be determined. If it is not possible to definitively separate health from illness, mental health from mental illness, and rationality from irrationality, then it is not possible to find acceptable grounds for excluding the mentally ill from exercise of the same abilities and rights as anyone else. Within the field of expertise in mental illness, there is no agreement on what constitutes mental health or what defines mental illness. Sometimes, as in the concept of physical health, mental health is merely assumed to be the absence of disease and or disorder. The field of psychiatry has however continued to expand to include within its realm many disorders previously counted

as developmental disorders or immoral acts and not as mental illnesses at all. Some theorists and clinicians even consider that everyone has some mental disorder to some degree.

In mental health care, expansion into the realms of ordinary life presents dangers for expansion of deprivation of important freedoms of the individual. Some feminists worry that the field is expanding to include 'normal' female responses to life events and situations, for example with the Battered Woman Syndrome (BWS). Feminists have argued, that it might be better to conceive of the murder of an abusive spouse by his victim as an act of justified self-defence, for example, rather than as a criminal act punishable by imprisonment, or excusable only by the finding of 'mental illness' in the victim.

'The dilemma here is that holding that her act is an act of self defence, encourages self help as the solution to domestic abuse, and on the other hand convicting women or excusing women on the basis of mental illness treats women as inferior to men whose defensive acts are justified. Traditional "rules requiring like force, immanency of the threatened harm, consideration of only the circumstances surrounding the single encounter and use of an objective reasonable man standard, necessarily defeated [women's claims]'<sup>56</sup>

It is neither appropriate, nor is there the space here, to expand discussion of the problems of justified self-defence or to debate the issue of gender differences in self-defence and the difficulties that the legal system has in resolving such difficulties. In bringing up the question, I only wished to point out that there is an alternative to labelling the woman as mentally ill' and to saddling her with all the negative effects of that label. A further area of concern for feminists, in relation to the expansion of psychiatry into the ordinary realms of

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Rosen, C. "The Battered Woman's Defense" Chapter 7 in: Controversies in Criminal Law: Philosophical Essays on Responsibility and Procedures. Gorr, M.S. & Harwood, S. eds. Boulder, Colorado: Westview Press, 1992.

life, concerns the diagnosis of pre-menstrual disorder (PMS). Dan and Lewis<sup>57</sup> present seven research papers all of which demonstrate gross inconsistencies and inadequacy in current methodologies that purport to define PMS. Feminists also have concern over proposals such as the one to incorporate 'diseases' such as "paraphilic rapism"<sup>58</sup> into the diagnostic categories of the field, the inclusion of which would allow for the legal defence of rape. This diagnostic category was proposed and rejected by vote after protests by feminists at a conference in preparation for the publication of DSM IV. The practice of 'voting' on the inclusion or exclusion of diagnostic categories also brings into question the validity and neutrality of defining disorder and rationality.

Thomas Szasz reiterates this concern about the expansion of psychiatry into ordinary life. He cites Samuel Guze, a professor of psychiatry at Washington University in St Louis, who claims that it is proper to "gradually incorporate many personal and social problems into the concern of medicine"<sup>59</sup>. Ivan Illich questions what he calls the 'ethical status of medicalization', which includes not only the more easily recognizable invasions into

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<sup>57</sup> Dan, A.J. & Lewis, L.L. eds. Menstrual Health in Women's Lives. Chicago: University of Illinois Press, 1992.

<sup>58</sup> Szasz. Insanity p 80. Paraphilias are defined in the DSM IV as "intense sexually arousing fantasies, sexual urges or behaviors, generally involving...[amongst other things]... nonconsenting persons and that may involve the suffering, humiliation or injury of the nonconsenting partner". pp 522-523

<sup>59</sup> Guze, S.B. "Nature Of Psychiatric Illness. Why Psychiatry is a Branch of Medicine." Comprehensive Psychiatry. 19 (1978): pp 295-307, p 296

childhood, the entire female reproductive life cycle, aging and death but also physician's certification of deviance, incompetence and insanity<sup>60</sup>.

### 3.2 The DSM IV Definition Of Mental Illness.

The DSM IV is, in North America, the most widely used recent authoritative classification system for the use of diagnosticians in the field of psychiatric medicine. Classification of a mentally ill person using this system may be one of the most important factors in determining the outcome of questions concerning a person's competence to make decisions for him/herself, particularly the decision to commit suicide. The DSM IV replaces the term mental illness with the terminology "mental disorder". Russell notes that this may be "a reflection of the long-standing failure of psychiatry to respond to the conceptual challenge posed by the antipsychiatrists<sup>61</sup> or a broadening of the conceptual foundation incorporating more phenomena under the domain of psychiatry"...and she further says that..."While there may be objection to calling such difficulties mental illness', there may be less resistance to regarding them as mental disorders."<sup>62</sup>. Russell and other feminist critics

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<sup>60</sup> Illich, Ivan. Limits To Medicine: Medical Nemesis, The Expropriation of Health. London: Marion Boyers, 1976. p 103 fn 211 quoted in Overall, C. "Reflections of A Sceptical Bioethicist" In Sumner and Boyle eds. Philosophical Perspectives on Bioethics. p 167

<sup>61</sup> Most people include Goffman, Laing, Szasz and Scheff in this category although Szasz does not consider himself 'antipsychiatry'. Newer members are usually ex-patients and not professionals.

<sup>62</sup> Russell, D. Women Madness and Medicine. Cambridge, UK: Polity Press, 1995. p 28

of medicine such as Showalter<sup>63</sup>, regard this broadening trend, not as an improvement in understanding or diagnosis, nor increase in the incidence of mental disorder, but as a political manoeuvre, which principally justifies and benefits the status quo in terms of inequality and oppression as well as benefiting psychiatry itself. This trend is thought to be particularly alarming and dangerous for women since, as I have previously claimed, it is women who are the largest number of clients<sup>64</sup> of typically male ( and even when female, male trained and socialized) psychiatrists. Russell sees the labelling of mental illness as a part of the oppressive machinery of a culture that lacks respect for women and that narrows the options for their personal development.

The DSM IV conceptualises a mental disorder as:

"a clinically significant behavioral or psychological syndrome or pattern that occurs in a person and that is associated with present distress (a painful symptom) or disability (impairment in one or more areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom."<sup>65</sup>

The irony is not hard to miss since treatment for mental disorders can itself involve "significant loss of freedom". Other conditions that would fit the definition could include conditions such as slavery and conviction of a crime. Both of these would cause distress, disability in functioning (such as loss of paid employment), and loss of freedom, but are not mental disorders. The DSM IV acknowledges that the term 'mental disorder' defies definition in a way that would specify "precise boundaries for the concept of "mental

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<sup>63</sup> Showalter, Elaine. The Female Malady: Women, Madness and English Culture, 1830-1980. London: Virago, 1987. p 52.

<sup>64</sup> also see footnotes no. 19,20 21.

<sup>65</sup> DSM IV, p xxi Introduction.

disorder."<sup>66</sup> From the examples given, it appears that the problem with definition is larger than mere 'imprecision in boundaries'.

The manual points to the difficulty, which it calls "a reductionistic anachronism of mind/body dualism", of separating the mental from the physical. It acknowledges that the term "mental disorder", "lacks a consistent operational definition that covers all situations". What it critically refers to as mind/body dualism it then attempts, not entirely successfully, to reduce to a material monism; the 'body' and the 'mind' as a single physical machine with mental aberrations being the result of some pathophysical substrate. While I would agree that the concept of mind/body dualism doesn't work especially well when applied to the functioning of a human being, I don't think that reducing thought and emotion to an anatomical or physiological substrate is the only alternative. In continued efforts to align psychiatry with what is often seen as the more respectable and scientific nature of physical medicine, the manual maintains that mental disorders are *like* physical disorders. It points out that physical disorders are defined by various levels of abstraction including "structural pathology, symptom presentation, deviance from a physiological norm and etiology"<sup>67</sup>. In spite of claiming that mental disorders are *like* physical disorders in this way, the same text later contradicts this assertion when it admits that there is no known aetiology for the majority of disorders listed in the manual. In addition the evidence from the lists of characteristics of each illness indicate that symptom presentation varies widely within

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<sup>66</sup> DSM IV, p xxi Introduction.

<sup>67</sup> Ibid., p xxi

disorders and that mental or behavioral 'norms' are very difficult to separate definitively from pathology.

Mental disorders are defined by their own unique variety of somewhat abstract concepts (the symptoms) including for example, "distress, disadvantage, dyscontrol, disability and irrationality", and also by 'disabilities' and 'risks', none of which the manual admits, are equivalent to the concept of mental disorder but which are rather "useful indicators" of mental disorder. The precise definition of these particular terms is left mostly to our imagination. But there is no need to assume along with the authors of the DSM IV, that distress for example is a 'symptom' of an underlying (unknown) mental disorder or physiological imbalance. Distress is not always a problem. Distress in many forms may be a normal response to a particularly disturbing environmental situation or event. Conflict between people in personal relationships or at work may cause distress but not all conflict is a problem. Neither distress nor conflict need necessarily have underlying pathological bases. 'Dyscontrol' likewise may be evidence of what once would have been considered immoral behaviour rather than unknown underlying physical pathology and 'risks' such as the risk of imprisonment (loss of freedom) may likewise be explained as the result of illegal behaviour and not some mental 'disease'. "Irrationality", which may be only one possible symptom of mental disorder and which is of particular interest here, is left undefined by the professional classification system that is most used to label a person as mentally ill. No positive concept or norm or standard comparable to a physiological norm is specified for what are the opposites of any of these negative concepts, for example an optimum level of

stress<sup>68</sup>, advantage, control, ability or, most importantly here, rationality. This definition of mental illness and the symptoms through which it is recognised, as well as the underlying conceptions, are thus grossly lacking in any specificity or clarity. Even if we accept that there is a pathological, biological substrate for most or even all mental disorders, that does not automatically or necessarily equate with irrationality in those so afflicted.

There is evidence that an alternative conception of at least some psychological problems as 'responses' to traumatic or abusive or threatening or less than nurturing life circumstances is beginning to be discussed and recognised in psychiatric circles. The concept, rather than being disease based, might be more analogous with the body's physical response to injury. The analogy might be described in this way "If I kick you in the leg, your leg will hurt and you may have swelling, pain and bruising. These are signs of inflammation, the body's normal and helpful, if sometimes painful response to trauma. You cannot be said to have a diseased or disordered shin"<sup>69</sup>. At a conference in Atlanta on Personality Disorders to be held in the spring of 1998, psychiatrists and other caregivers will discuss personality disorders from this perspective. One psychiatrist sympathetic with this perspective predicts that the personality disorders will be mostly all if not all dropped eventually from the DSM manuals. They will no longer be considered 'disorders' at all but adaptations or responses to trauma or injury which, while they are or at least have been helpful, necessary and

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<sup>68</sup> Selye's concept is 'Ustress' - the optimum level of stress and the opposite of distress.

<sup>69</sup> Private communication with Dr. T. Schofield psychiatrist.



sometimes life preserving responses to traumatic external events in the patient's life, sometimes cause the patient some problems or some pain.

In the DSM IV, cultural differences of degree in response are noted (it is perhaps instructive that gender differences are not mentioned). Suggestions as to how the clinician should treat such differences are made. There is, however, no explanation for the fact that unlike physical medicine, where a biologically based disease like AIDS is still AIDS across cultures, concepts, signs and symptoms [including concepts of irrationality] of mental disorder and diagnosis and successful treatment of mental disorders do vary widely across cultures with different histories, religions, social arrangements and social values. Notwithstanding these problems, the manual still claims that the definition serves as a "useful tool" in "guiding decisions regarding conditions on the boundary between normality and pathology". The language used here indicates that as far as psychiatric thought goes, abnormality and pathology are thought of in linear terms. A line, although admittedly difficult to draw according to the DSM IV, can conceivably be drawn between normal (whatever that is) and abnormal. As we have already discussed, alternative perspectives provide us with no such certainty concerning the difference between rationality and irrationality.

### **3.3 DSM IV Diagnostic Methodology**

If psychiatry is not value neutral in its position on the nature or the concept of mental illness, neither is it value neutral in its methods of determining diagnoses. An

important proviso is made in the DSM IV that use of the classification system is only relevant *when appended to the 'clinical judgement'*<sup>70</sup> of a properly trained and experienced professional. The confusions present in defining the concept are added to by appending the proviso regarding the use of individual 'clinical judgement' in the making of diagnoses. Such a situation in no way resembles the state of classification of and diagnosis of physical illness. The result of such lack of clarity in conception and definition is that diagnoses based on clinical judgements about the state of a person's mental health or disorder, can and do vary widely not only from culture to culture as already pointed out but more importantly from practitioner to practitioner depending on factors affecting each practitioner's 'clinical judgement'. Symptoms of physical illness like AIDS do not vary across cultures or from patient to patient depending on the 'clinical judgement' of the practitioner. Many 'symptoms' of mental illness are entirely different than the symptoms of physical illness. Judgements about and conclusions drawn from such different symptoms can be influenced by personal, social and cultural value judgements. Individual practitioners can base a diagnosis of 'mental disorder' on 'symptoms' which are indicators of some totally unknown underlying pathology and on their own definition or estimation of a level of 'distress' or 'dysfunction', 'dyscontrol' or 'irrationality' in a patient. No consideration is given to the problem presented by the fact that individual practitioners may have difficulty in, lack training in, or even lack a propensity for, identifying or taking account of their personal values, social position and perceived authority and how such values and power relations might influence both patient

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DSM IV, introduction xxiii.

presentation and response and subsequent 'clinical judgements'. No consideration is given as to how to account for differences besides culture: differences such as race, social class or gender between the therapist and the patient, and how those differences may influence the therapeutic relationship and the practitioner's 'clinical judgement' and diagnosis, especially the recognition or labelling of what is irrational.

For example, if the clinician has no way to differentiate mental health in women from mental health in men, or if he considers traditionally normal behaviour for women (including more passiveness, emotionality and dependence on relationships) as mentally unhealthy, he will likely see and assess a woman's suicide decision differently than he will see a man's decision. Women who make decisions that are contrary to the currently accepted feminine role model or that are based on behaviour more similar to the masculine model may also be seen as acting pathologically. It is interesting to recall many now old studies and to note some similar more recent ones<sup>71,72,73</sup> confirming data that have repeatedly demonstrated that the standard conception of what makes for healthy behavioral traits matches clinician's judgements of what is healthy for a male. A female can not be mentally healthy by definition, when assessed against the usual standard. Males who do not meet the

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<sup>71</sup> Broverman, I.K. et al., "Sex Role Stereotypes and Clinical Judgements of Mental Health" Journal of Consulting and Clinical Psychology.34 (1970): p 4

<sup>72</sup> Broverman, I.K. et al "Sex Role Stereotypes A Current Appraisal". Journal of Social Issues. 28. (1972) pp 59-78

<sup>73</sup> Rosencrantz, P.S. et al., "One half a generation later: Sex role stereotypes revisited" Paper presented at the American Psychological Association . Los Angeles: 1985. For a comprehensive list see Russell, Denise. Women Madness & Medicine. Chapter 2 note 18

currently accepted male standard might also be considered unhealthy. For example, men who stay home to care for children, rather than going out to work, are still the exception rather than the rule. While things may be slowly changing, many of these men are still looked on with suspicion with regards to their mental health.

The fact is that there is no way to account for 'difference' in practice, other than by resort to personal experience and personal judgement based on personal experience, and no way to standardize practice or to mitigate value differences. This means that this model of mental disorder cannot provide a basis on which to judge the rationality of personal decisions such as the suicide decision. People cannot be excluded from the possibility that their decision could be rational, by having a 'mental disorder' as defined and assessed using this model.

### **3.4 Problems With The Communicative Model.**

In addition to the problem presented by unclear and value laden concepts and communication processes, the model of communication that defines the practice of psychiatry and medicine in general as exemplified by 'the interview', and the model that results in diagnosis (and in the case in point here the potential assessment or determination of rationality) is problematic. The traditional model is one of "information transfer"<sup>74</sup> that involves collection of information and authoritarian decision making rather than one of

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Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 189

shared communication. The physician gathers what she/he considers relevant information (input) from the patient regarding his or her history, symptoms and test results and rejects what she or he considers irrelevant. The physician then manipulates the information according to his scientific knowledge and gives information back (output) to the patient about the clinical judgement (diagnosis), treatment and prognosis. The goals of this communicative process are strategic goals; goals meant to ensure rational decision making both on the part of the physician in terms of diagnosis and on the part of the patient in terms of giving informed consent. According to Farrell Smith, because communication in this model is merely a means to an end, it holds no ethical significance in and of itself. However, what is obscured by this model is the way that "speech acts guide, co-ordinate and interpret action and how speaker's power and authority remain open or closed to hearer's questions or challenge."<sup>75</sup> The model determines the kind and amount of information that is made available and this poses a difficulty for the collection of complete and context sensitive information and subsequent labelling of rationality/irrationality in this case. There is an implicit denial of equality and mutuality; the physician controls the interview. Mutual understanding and mutuality of goals, values and strategies is not required and there is no emphasis on "concerted, collective, consensual action"<sup>76</sup>, without which medicine may "cure

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<sup>75</sup> Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 190

<sup>76</sup> Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 192

the disease but kill the patient, kill his desire to live or ruin the quality of his life."<sup>77</sup> I suggest that these possibilities and this criticism are particularly applicable in psychiatry. In psychiatry the patient may have particular difficulty in expressing what she is experiencing, or the expression of feeling itself may be discounted, or the patient's speech may be typified by metaphor that the physician does not recognize or cannot interpret due to his own 'incapacity'. The picture of disorder obtained and the diagnosis and treatment of the patient can all have a profound and lasting effect on both the patient's ability and opportunity to exercise his autonomy and also an effect on the nature of his future life.

### **3.5 An Alternative Model Of Communication May Give Different Results.**

Farrell Smith proposes, an alternative model of communication based on the work of Habermas<sup>78</sup>. Such a model may be superior because it can take into consideration both needs for strategic or goal directed action and communicative action (action oriented towards understanding). The communicative action model can account for the "authenticity of patient voices"<sup>79</sup> in a way that a model only directed towards strategic action cannot. Such

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<sup>77</sup> Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 192

<sup>78</sup> I previously criticized the medical model and proposed this same communicative model in a paper for C. Beattie in an MA course.

<sup>79</sup> Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 192

discourse can take better account of cultural or gender or race (power) differences as exemplified in for example speech styles such as assertiveness.

"Under the traditional strategic communicative model and when differences are not taken into consideration, a female patient challenging a male physician for example, can be considered hostile, uncooperative and confrontative all of which might be considered symptoms of illness, whereas a male patient, exhibiting the same behaviour, might be viewed as *rational* and actively involved in his own treatment"<sup>80</sup> (my emphasis).

What I am suggesting, is that such a model and the different type of discourse generated could obviously also change the 'outcome' of the determination of the 'rationality' of a patient.

Such a model would be designed to promote discourse which can "generate the values and norms peculiar to a particular patient's situation"<sup>81</sup> within the therapeutic relationship. Such a model would satisfy a feminist demand for contextual sensitivity, and attention to the particularities of the individual, his or her relationships, and the social forces of oppression impinging on that individual. Such discourse, because it is not directed or controlled by the person with power or authority by virtue of his/her training or professional role, "allows for statements that go beyond informational exchange"<sup>82</sup>. It includes what Habermas calls "expressives", "speech acts expressing affective or emotional content which

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<sup>80</sup> Farrell Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 194

<sup>81</sup> Ibid., p 193

<sup>82</sup> Farrell-Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 193

might function as stimuli for further action"<sup>83</sup>. Such "further action" can then include exploration of alternatives or the expression of further thoughts, feelings and concerns. While the emphasis of communicative ethics is on a rational stance, such a model can include consideration of affect. In psychiatry, such a communicative model might sometimes produce a different opinion of the patient's situation and even a consensus between client and caregiver concerning the aims and goals of the relationship. It could conceivably also include then the possibility of rational suicide as a choice for the patient whether or not there is consensus about the mental health status and especially the thinking problems of the patient. At the very least, in the case of disagreement, it would produce some 'mutual understanding' and the chance of furthering a relationship that could be 'therapeutic' through the power of the relationship itself, rather than unequal, harmful, degrading and infantilizing to the patient.

Without such a model of communication, 'symptoms' are merely seen as indicators of internal pathological conditions of the patient, even when there is no known aetiology and even when there are clear indications that the environment (values or behaviour of the culture, society or family) of the individual is less than nurturing or less than optimum in some way and sometimes even outright abusive. The client is never seen as a person who is responding appropriately, rationally or sanely (if painfully), to an impossible (insane)

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Farrell-Smith, Janet. "Communicative Ethics in Medicine" In Wolf, Susan ed. Feminism and Bioethics. New York: Oxford University Press, 1996. p 195 and see Habermas, J. Theory of Communicative Action Vol.1 Thomas McCarthy, trans. Boston, MA.: Beacon Press, 1981.



situation. We fail to appreciate the insight of R.D. Laing who is reported to have said that, "madness is a sane response to an insane world" (source unknown). Conclusions are drawn without information which is perhaps obtainable only through use of a method based on a communicative model. The result is that a line cannot always clearly be drawn as to who is 'disordered' and who (if anyone) is not, or what thinking is disordered and what thinking is not. It is unclear how a decision can be made that a person's response is 'pathological' or a normal, albeit painful response to external conditions of her life. Consequently it will also not be so easy to draw the line between rational and irrational thought or behaviour.

Looked at in this different perspective, such an approach as the DSM IV and the practice of medicine takes, might also be criticized for focussing almost exclusively on the individual and her or his responsibility for the disorder and his or her responsibility for changing in a way that results in a palliation of symptoms or a 'cure.' It ignores the possibility that distress or disability may have social or relational origins or causes, and more importantly social or relational solutions. The results of such a problematic conceptual framework and communicative practice on the notion of assessment of the rationality or irrationality of decisions and actions, and also on the form and nature of the subsequent therapeutic response, then will depend on cultural, social and individual value judgements and standards and not at all on the perspective of the patient or on the relationships involved. Russell presents a proposal that the need is to focus on the social and cultural roots of such responses and on amelioration of these underlying causes of 'abnormal behaviour' rather than on individual therapies. Attention to, and amelioration of the underlying cultural roots

of responses such as suicide decisions might reduce the number or types of suicides currently practised. Attention to cultural determinants of unhappiness and despair that have traditionally led to suicide, might also conceivably uncover some situations that we are unable as a culture to change, and that are therefore candidates for social acceptance of suicide.

## CHAPTER 4

### Application Of Criteria For Rationality To The Mentally Ill

#### 4.1 J's Suicide.

I would now like to turn to the case of J as an example of a person who was mentally ill and had made a suicide decision. The purpose of introducing J's personal experience is to see if his reasoning fits Battin's criteria for rational choice and to analyze the case with the above criticisms of the traditional concepts of irrationality due to mental illness in mind.

J was a 34 year old (paranoid) schizophrenic. He was originally diagnosed at the age of 17 and since that time he had repeated re admissions to his local psychiatric hospital for management or treatment of his psychosis. When discharged from hospital J would apparently 'manage well' (according to his caregivers and relatives) on his medication and then after a while he would find that he did not want to put up with the side effects. While on medication J himself claimed that he did not feel in control of his life; he felt like he was in a "straight jacket" or as another patient described his feelings, he felt as though he had "500 pounds of lead in his head". J would stop taking his medication and his bizarre behaviours including shouting out loud at the imaginary voices that he heard in his head, would begin to escalate and he would be readmitted to hospital (sometimes taken there against his will) for medication adjustment. Even during periods when he was experiencing hallucinations [psychotic thought processes] but more especially when he was 'managing

well', J felt acutely disappointed and sad that his life situation was not what he had hoped and dreamed for himself. He could see no hope for a happy marriage and children or for the career that he had dreamed of as a psychologist. He did not relish the thought of other people telling him what to do for the rest of his life. He was embarrassed and ashamed that he did and said 'weird' things when feeling under certain kinds of stress and that he frightened people. He was in fact unable to keep any job or friends or to succeed at school because of repeated hospitalizations and because the return of the hallucinations and resulting bizarre behaviour frightened his fellow students and teachers, neighbours, employers, friends and family. He had never actually harmed anyone. His parents were unable to tolerate J living with them because they were afraid of him, so he lived with his older sister and her husband and two children. He was able to pay a small amount for room and board from his disability pension but he had not enough income to pay for many of the ordinary comforts of life and he felt indebted to his sister for her help in supporting him. He also felt responsible for being an emotional and financial burden to his sister's family and for the fact that his niece and nephew avoided him and were afraid of him. J saw little hope for anything different. He anticipated additional problems in his future because of the potential long term detrimental effects of his antipsychotic medication, such as tardive dyskinesia, and also the chronic nature of his illness and the lack of available alternative therapies.

Like many other severely mentally ill patients, Jay also experienced chronic depression and had almost constant suicidal thoughts. He had been offered antidepressant medication and had given it a trial several times but then refused it because he felt that it was

just another form of 'external' control. He felt that medication did not and could not give him the real happiness and kind of life that he wanted. He felt that it would be better for him to die than to endure a life of dependence, poverty, illness and unhappiness or drugged acceptance, in either case unable to fulfil any of his hopes and dreams. While his sister and her husband were understanding of his life situation and his frustration with it, they were unable to listen to him talk of suicide and tried to dissuade him from this course. He was found hanging in the basement of his sister's house by his brother in law.

#### **4.2 Application Of The Criteria For Assessment Of Rationality In Schizophrenia In General.**

Most schizophrenics are eliminated as an acceptable case of rational suicide almost immediately merely because of the psychiatric diagnosis. It is assumed that the schizophrenic's ability to reason in general is impaired by his psychotic thought process. A psychotic thought process is frequently assumed to be a constant factor in every thought both with respect to content and to process. In the same way depression is also often considered to impair a person's rationality in the sense that it may narrow one's perspective in such a way that more positive alternative choices cannot be seen. Leaving aside the conceptual problems and lack of value neutrality within the system of diagnostic classification and the method of communication earlier discussed, and assuming acceptance of the foundations of the DSM IV diagnostic categories and the method of strategic communication used in practice, such a pervasive extent of impairment is not required for the diagnosis or classification of schizophrenic behaviour or for any other mental disorder.

The DSM IV diagnostic criterion A for schizophrenia<sup>84</sup> specifies two or more of the following list of symptoms, each of which must be present over a period of six months and "for a significant proportion of the time during a 1 month period or less if successfully treated,

- 1) delusions,
- 2) hallucinations,
- 3) disorganised speech,
- 4) grossly disorganised or catatonic behaviour
- 5) negative symptoms (meaning flattened affect, alogia or avolition).<sup>85</sup>

Widely taken as the most profound evidence of irrationality, neither delusions nor hallucinations, are necessary symptoms for the diagnosis of this mental disorder. If certain types of delusions or hallucinations are present, "bizarre delusions or hallucinations consisting of a voice keeping up a running commentary on the person's behaviour or thoughts, or two or more voices conversing with each other", only one of those symptoms is required for the diagnosis<sup>86</sup>. Even where bizarre delusions<sup>87</sup> are the only symptom present, the DSM IV states that "bizarreness may be difficult to judge"<sup>88</sup>. If bizarre delusions were the only symptom of schizophrenia and the bizarreness of the symptom was difficult to

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<sup>84</sup> DSM IV, p 285

<sup>85</sup> Ibid., p 285

<sup>86</sup> DSM IV, p 285

<sup>87</sup> defined as erroneous beliefs usually involving a misinterpretation of perceptions or experiences and not defined by illogic.

<sup>88</sup> DSM IV, p 285

judge, and if the symptom were present for, say, fifty-one percent of the time (or whatever period will satisfy the condition 'most of the time' that an individual clinician considers significant) then it would be unreasonable to conclude that the person was *completely* irrational. In addition, delusions are not evidence of faulty logic. A delusion may be logical but is based on different premises than non delusional thinking.

The other single potential defining symptom of schizophrenia, and the other one most often thought to be indicative of irrationality, is hallucinations. Auditory hallucinations especially, which are the most common type experienced in schizophrenia, are according to the DSM IV, usually experienced as "distinct from the person's own thoughts"<sup>89</sup>. In other words a person can tell the difference between what the hallucinated voice says and his own thoughts. While his hallucinations may have the quality of irrationality, and may be profoundly disturbing to the individual and to his behaviour, it does not follow that his own thoughts are also irrational. J, for example, cannot be considered completely irrational just because of the presence of hallucinations.

Furthermore, some types of hallucinations are of very brief character, such as those occurring while falling asleep or waking up, or those following an extremely traumatic experience. These "are considered to be within the realm of normal experience"<sup>90</sup>. 'Normal' people whose rationality is not in question can experience hallucinations. Evidence that hallucinations can be found in the presence of rational thought is also found in the DSM IV

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<sup>89</sup> DSM IV, p 275

<sup>90</sup> DSM IV, p 275

statement, (referring to the paranoid type of schizophrenia where prominent delusions or auditory hallucinations are present) "in the context of relative preservation of cognitive functioning and affect"<sup>91</sup>. The prognosis for the paranoid type is considered better than for other subtypes and the individual may function well both in terms of independent living and occupationally. It is difficult to conceive how such a person could function in these dimensions if *completely* irrational.

It would also be difficult to judge the state or extent of rationality of a person if the two necessary symptoms found were from the list of so called negative symptoms<sup>92</sup>, for example a speech disorder and avolition. A speech disorder itself is not usually thought of as a sign of irrationality even though it may make it difficult for others to understand the speaker's intentions or meaning. Speech disorders can be present for a wide variety of reasons both known and unknown. In a discussion of the difficulty of evaluating the negative symptoms, the DSM IV recognises that grossly disorganized behaviour, disorganized speech and apathy or avolition "occur on a continuum with normality"<sup>93</sup>. It also acknowledges that "chronic environmental under stimulation or demoralization may result in learned apathy or avolition"<sup>94</sup>. The manual goes on to explain that 'it is the presence of the negative symptoms

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<sup>91</sup> DSM IV, p 287

<sup>92</sup> Ibid., p 285 no. 5 in the symptom list.

<sup>93</sup> Ibid., p 277

<sup>94</sup> DSM IV, p 277



over a period of time and despite efforts at resolving the potential causes'<sup>95</sup> that should make the clinician suspect schizophrenia and not a normal response. One problem here is that despite the sustained efforts of the clinician, the patient, or others at resolving the external contributors to avolition or apathy, such efforts may be unsuccessful and even unrealistic in terms of the chance or expectation of change. The clinician and the patient may not, in effect, have any control over the 'environment' which may resist all such efforts by an individual. It is unreasonable to suggest, for example, that a single clinician working with his individual patient can overcome the influence of a whole culture. The length of time required is also problematic for realistic expectation of accomplishing major social, familial or cultural changes and expecting those changes to have a positive effect on an individual patient's responses or even in an individual patient's lifetime. If the patient has given up believing that his actions can make any difference or given up hope of the environment meeting his needs, then even small changes in the environment will not be trusted. A great deal of time will need to pass before a relationship can be built where there is trust that changes are stable. This will have to take place before behavioral or emotional change might occur. Persistence of only the so called negative symptoms then can not reasonably be attributed to schizophrenia. And more importantly, these 'symptoms' cannot with any confidence be said to be indicators of irrationality.

Further problems for assessing the nature of irrational thought in the mentally disordered occur because symptoms of disorders such as schizophrenia are often not

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DSM IV, p 277

persistent over a continuous period of time. Although schizophrenia may be considered a chronic disease and is sometimes referred to as "the psychiatric equivalent of cancer", the patient can often have periods of apparent remission and can experience control of symptoms with medication. It cannot automatically be judged, by labelling such a person as a schizophrenic, that a person is irrational during all those periods. It appears then, from our look at the definition and nature of mental illness and particularly with respect to disorders such as schizophrenia, usually recognised as involving the most irrational forms of thought, that a diagnosis of a mental disorder or a label of mental illness may not tell us very much about the state of rationality or irrationality of any one particular decision or act of such a person.

#### **4.3 Application Of The Criteria To J's Decision.**

What is the situation then with respect to whether J's decision meets Battin's criteria? The reasoning process that J used to arrive at his suicidal choice, despite his hallucinations, involved no obvious errors in instrumental reasoning or logical errors. Perhaps there were undetectable errors, but since his caregivers agreed with his assessment of his situation and his situation supplied reasons that were the basis for his decision, his decision cannot be criticised for its faulty logic. Unlike some suicides in the mentally ill, he did not have an unrealistic world view. He did not think that he would somehow survive his attempt because of unusual or magical powers and unlike some of the "get even" suicides he did not expect to survive as a subject of experience after death, being able to see, feel or hear

what others really felt about him. He did have an understanding, as far as anyone is able to conceive, of what death is like; that he would be gone and would feel nothing after he died. In fact this was the aim of his suicide; release from the pain that he experienced as inevitable at the hands of his illness, release from his social isolation, the overall inadequacy of his life and the lack of a conceivably better future. 'His own life situation, including his identity, his position in the world and his particular talents and disabilities' were all affected by the 'labelling process' as applied to persons' with a mental illness, (the process which names a person a deviant and by which he also learns to define himself). J understood that he was labelled as a crazy person by the world and although he thought of himself as a crazy person by the world's standards, he also understood other aspects of himself as a person. J was affected by the personal, social and economic sequelae of such labelling which resulted in his being shamed, outcast (except in his sister's home), deprived of autonomy and dignity and often rejected by or locked away from society for 'his own good' or for the 'safety of others'. In addition to considering himself a crazy person, J. had a realistic understanding of himself as an inadequate man, a man who would never be able to accomplish his dreams and his hopes and who could never meet the expectations society has for a normal man. He was both acutely ashamed that he frightened others and concerned for their welfare. He worried about being a burden on his sister's family. He felt incapable of a 'normal' life and he was lonely and socially isolated as a result of his illness and the social stigma attached to it.

J had a clear understanding of his illness as it is understood by professionals and of the options for treatment and the probable outcomes. Other's evaluations of J were not much different than his own. J appears to have weighed his options and found that continuing to live was wanting. He chose the option that most suited his needs given that his preferred goals appeared unreachable. It appears that J's decision would meet Battin's criteria for rationality.

## **CHAPTER 5**

### **The Concept Of A Right To Suicide And How It May Benefit The Mentally Ill**

Society, at least in law, as Sopinka's interpretation of the Charter of Rights and Freedoms and provincial mental health statutes appear to prove, apparently does not condone the taking of life even if it is one's own by suicide, assisted or otherwise. In Canada, even though suicide is not illegal, there is no legal 'right' to suicide. In this paper I have however accepted that suicide can be a moral and a rational decision and so far have tried to show that the mentally ill may sometimes be able to make such a decision. In this chapter I will try to answer two questions. First how can we construe a right to suicide such that a person, including a mentally ill person, might have a right to suicide? Secondly if there is such a right how could or should the law provide for it?

#### **5.1 Property Rights And Simple Rights.**

In an effort to establish the basis for a right to take one's own life some people use the analogy of property rights. Our body is our own and we therefore have a right to dispose of it as we see fit or so the argument goes. Property that belongs to us can be sold, given away or destroyed and in a similar way we can destroy our own bodies if we so choose because they 'belong' to us. In some ways the analogy from property fits imperfectly, however. In some important sense that is not true of other property, our body *is us* rather than belonging to us and in this sense 'disposal' of it is disposal or destruction of something

more than an object such as a house, a car, a computer program or a story. We cannot destroy it totally and still be or exist ourselves, at least not in the form in which we have existed. We cannot give away or sell our life so it then becomes the property of someone else. The concept of disposition of property does not cohere easily with the concept of rational suicide. The ease with which a property right can be overridden by the rights of others also may present problems for the meaningful right to suicide that is needed to support the notion of rational and moral suicide. Perhaps what the analogy from property is really meant to accomplish is the sense or feeling that we are autonomous agents, free to do whatever we wish with ourselves.

Besides the sense of ownership of oneself, this sense of freedom to do as one chooses is also a frequently expressed theme by those who claim suicide as a right. What they claim is what Battin calls a "simple" right. Simple rights, says Battin, 'are based on one's right to do or not to do as one pleases providing that what one does, does not interfere with anyone else's rights and providing that there are no overriding obligations or duties'<sup>96</sup>. Battin divides simple rights into three subtypes, i) liberty rights; those of the type that Mill defended, ii) non interference rights, and iii) welfare rights. If we were to describe a right to suicide in terms of a liberty right, we would say that a person may kill him or herself because they are not obligated to exercise their right to life.<sup>97</sup>, whether or not committing suicide is good for the person. To commit suicide, is in a sense, to refuse to exercise one's

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<sup>96</sup> Battin, TDD. p 163

<sup>97</sup> Battin, TDD. p 164 Battin uses the expression "has no obligation not to exercise the right" which I find awkward and confusing.

right to life and to be free to do so. Perhaps the law is recognising and respecting this type of right when it allows for a medical patient's refusal of treatment and allows death to take place as a result of the refusal of treatment. In law, such a right is not respected for a person with a mental illness if refusal of treatment results in the person's death by suicide. If described in terms of a non-interference right, one would have the right not to have anyone interfere or stop one from committing a suicidal act. Obviously the mentally ill and anyone else who announces his or her intention does not currently have this type of right respected in law<sup>98</sup>. If thought of in more positive terms as a welfare right, one would have the right not only to commit suicide but to have assistance with one's suicide act. This right is most emphatically not recognised in law since assisting suicide is a crime. The simple rights conception as applied to suicide suffers from several problems. Most important perhaps is the problem of when or how it can be overridden either in law or by the interests of others.

The first category of problems with simple rights concerns the rights of others and when one person's rights can be overridden by them. If, for example, J had no relatives who would suffer from emotional pain at his death that might make J's suicide allowable. The simple fact of having relatives makes the weighing of harms to others versus benefit to J a more complex problem and may mean that J's right should be overridden by the rights of others. Whose interests take precedence? There does not always appear to be a way to weigh

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or at least their right will almost always be overridden since mental health law is based on the assumption that anyone that wishes to die is mentally ill in the sense that they can at least be committed even if unwilling, for a mental assessment and if they are found to be in 'imminent' danger to themselves they can be held against their will and potentially treated against their will.

and balance harms and interests and come out with a clear conclusion. Does the interest of the person who definitely will suffer from continued living have precedence over the interest of the survivor, whose interests may or may not suffer from the death? One wants to ask how can one predict the nature, degree or length of suffering of the survivor? And might not such suffering be alleviated when the suffering of the suicidee cannot? Can the suicide have consequences that can count as harms that reach down even further, for example to J's niece and nephew and the suffering that they experience as a result of their parents' suffering? Is J expected to forgo the exercise of his right in the same way as a person who is the father of two young children? Can accidental circumstances that are not of his choosing (such as having a sister or having a sister who has children) override his right? Since such weighing and balancing would occasion different conclusions for different people, even people who suffer in the same ways, it would have to be acceptable for some people and not others, even when in similar circumstances, to have simple rights to liberty of action.

Secondly, if J has a right to suicide but his sister is not sure if he is thinking rationally about it or not, does she have an obligation not to interfere? On what basis would her obligation rest? Is the limitation of J's liberty right to rest on the assumed irrationality of his decision making process or because of someone else's determination of the rightness or rationality of the act itself? It would seem more likely that if the possibility of rational and moral suicide is generally accepted that we might assume the act to be rational rather than assuming irrationality. In such a case the onus for justification might change from justification for the suicide to justification for interference. Even if irrationality of the



decision did not affect the exercise of the right, does J's sister have an obligation to assist him even if she is sure that his decision is rational? What if, for example, J's sister does not accept that suicide is a moral act. Must she forego her own moral convictions in order to assist her brother in his welfare type right to commit suicide? It is possible that some others may have duties to assist him brought about by professional obligation rather than familial relations. But suppose that even those professional obligations can be waived or overridden by someone's personal moral position. If J needs assistance but cannot find anyone to assist him what would be the point of his having a right which cannot protect him or help him and which he cannot exercise? What if J lives in a part of the country where he cannot find anyone to help him, but someone else with a comparable right lives where they can find help easily due to differing social climates or local cultures?

As Battin points out, even constructing some complex system of rights, overriding obligations and duties "does nothing to identify the grounds on which such a right is based."<sup>99</sup> Battin claims that,

"... establishing such a right on the grounds of a freedom to do what one chooses will almost always result in it being overridden by others rights and claims to harm and will provide for no real obligation for assistance on the part of others who can always decline on the basis of their own right to free action. At best it would provide for a very weak claim to a right to commit suicide if nobody else objected."<sup>100</sup>

Such a conception of rights is not what is needed to support the notion of suicide either as a rational or a moral act or to provide for provision for assistance for those who need it.

<sup>99</sup> Battin, TDD. p 166

<sup>100</sup> Battin, TDD. p 166

## 5.2 A Fundamental Right.

A stronger claim to suicide as a right could come from conceiving of suicide as a natural right. Even though as Battin points out, there are no precedents for it in various charters of human rights, she proposes that we might conceive of suicide as a fundamental human right<sup>101</sup> in the same sense that we conceive of a right to life. “A fundamental right would be a right based on the idea that persons have a right to do something or to have something because those things promote human dignity.”<sup>102</sup> In the same way that the notion of a fundamental right to life promotes the value of human worth, a fundamental right to suicide might do the same.

In this ‘fundamental’ sense of rights, the discussion by Battin and others of a ‘right’ to die is often accompanied by, and compared and contrasted with, discussion of a sort of corresponding and complementary right to live as if the two ‘rights’ were distinct. The idea of suicide as a fundamental right might work particularly well if we viewed death as a part of life and not as something apart from or separate from life. We do not for instance view birth as something apart from or separate from life and so there may be no good reason to view death as separate from life. We could then conceive of the right to death through suicide not as a separate right but as a part of our right to life. If our right to life includes not just our right to biological existence but a right to conceive, plan for and carry out our lives as we see fit and to construct a self-ideal, then it might also include the right (since we,

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<sup>101</sup> Battin, TDD., pp 170-172

<sup>102</sup> Ibid., p 170

unlike other animals, are capable of conceiving our own deaths), to plan for any carry out our own death. In other words our death may form a part of our self-ideal and a plan for it and an act of suicide, may preserve or be part of our definition of ourselves. In addition to 'timing' other aspects of our life, we might, if fate didn't intervene, time our own deaths by committing planned suicide. A person would have a right to suicide if it promoted his dignity through the promotion of his freedom to define his self-ideal or through protection of their self-ideal. One's right might be abridged only if one's suicide did not promote human dignity through the promotion of one's self-ideal.

Battin says that most suicides would still not meet the criteria for promotion of dignity. She says that the "get even" suicide committed for the purpose of hurting someone else and the suicide committed out of loneliness and despair would not count as promoting human dignity. While some current suicides would no doubt not meet the criteria, that is not to say that many suicides in an atmosphere of permissive suicide would not do so. Perhaps the "get even" suicide would no longer be practised because it could no longer accomplish its intended purpose in the same way in a culture that accepted suicide. I also suggest that it is a mistake on Battin's part, to write off such suicides as the 'lonely isolated old man' as a "tragedy" and as not constitutive of or promoting of human dignity. Given conditions that he is not able to change, for example the existence of a cultural attitude of devaluation and denigration that society often inflicts on its aging members, unremitting grief over losses of his spouse and lifelong friends, loss of economic status, meaningful work or other productive activity, and that therefore result in living conditions that do not 'fit' with his fundamental

values or plan for his life, one might say that the suicide of the old man removes him from what is an 'undignified' life and so preserves the values that he has held important.

To say that a suicide is tragic or sad is not to say that it does not promote human dignity. What might not be dignified about this actual suicide might be the means that he had to use because he was denied assistance and comfort, or the fact that unsuspecting others had to take responsibility after the fact for his actions. That is not to say that human dignity might not have been better preserved by the offering of assistance and support and perhaps planning of the death and aftercare such as funeral arrangements. In that case it was the lack of social support that failed to promote human dignity not the man's suicide. What might be considered tragic are the social conditions that make his suicide a rational and dignified act.

In addition, the claim that such suicides do not promote human dignity can only be made by clumping individual cases into a classification such as "lonely old men who commit suicide" and to consequently be insensitive to the specifics of the context or the particulars of the situation which may very well be different for different people. Whether or not one's suicide promotes one's dignity may be a very subjective decision. As Battin herself points out, to say that certain types of suicide do not promote human dignity, is not to say that no suicide can do so. Battin says further:

"One's values may sometimes take precedence over the continuation of one's life. One might consider whether some self deaths could not be understood, paradoxically, as a kind of 'self preservation', a kind of self respect and protection of one's fundamental

interests ... They are based, as it were, on a self ideal: a conception of one's own value and worth beneath which one is not willing to slip."<sup>103</sup>

Besides an ideal self as the bearer of dignity, the subject of self-respect and self-preservation, I suggest that an important and related notion is the notion of an ideal life or an approximation of it, as lived by the self. Perhaps these two ideas are in fact inseparable since the notion of a self without a life is unimaginable. And so not only may one be "unwilling to slip beneath" a certain sense of one's value and worth, but one may also be unwilling to live a life that cannot be demonstrative of those choices and that worth. What may be profoundly troubling about such a suicide and the fact that it does promote dignity may be the fact that it might not have occurred in a different social climate and given improved social supports.

Mill's argument for liberty was based on his concept that well being and happiness were necessary components of human dignity. He did not just argue for a liberty right in terms of personal decision making, but argued that such decision making and the exercise of such choices, regardless of the approval of others, and regardless of the irrationality of the outcome, were necessary for the development of individuality which he considered essential for well being and human happiness<sup>104</sup>. Mill considered the use of a person's rational faculties to be necessary for the continued development of the capacity to reason and the capacity to reason essential for the development of one's individuality. So

<sup>103</sup> Battin, TDD. p 171

<sup>104</sup> Mill, J.S. "On Liberty". In Robson, J.M. ed. The Collected Works of John Stuart Mill. Vol III Toronto: University of Toronto Press. 1977. p 226

liberty or autonomy is important for its role in developing and maintaining human dignity through the development of one's individuality.

Individuality is not a single achieved or static state, and the nature of what constitutes individuality and what is necessary for the maintenance of dignity of the individual also may change over time and with different experiences. Human autonomy and dignity is not achieved or maintained only by the making of 'right' decisions or by just staying alive. Dignity can be developed and maintained, and important learning for the individual and for others can also take place through the making of mistakes and perhaps even sometimes through loss of dignity and shame. While learning for the individual cannot take place through suicide, dignity and autonomy can be preserved in death. In western liberal society, where individuality is prized perhaps above all other values, the notion of autonomy is invariably intermingled with the concept of dignity. Loss of autonomy including deprivation of autonomy through forced hospitalization and suicide prevention measures can be a source of loss of ability and dignity. Since one's self-ideal is not only a part of the definition of what one essentially is, but perhaps also how one is seen or remembered after one's death, that would seem to make the preservation of that ideal, in both life and death, important for the notion of human dignity. The fundamental right to die then is the right of persons,

"to decide in certain circumstances that their quality of life is so diminished that continued existence is humanly pointless and may therefore be ended by themselves."<sup>105</sup>

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<sup>105</sup>Charlesworth, Max. Bioethics in a Liberal Society. New York:

(continued...)

More fundamentally one might even say that the fundamental right is the right 'to choose', including the right to choose the length of one's life, for oneself. The 'mentally ill' have the same needs for self-definition and for dignity in this respect as anyone else and mental illness, particularly chronic mental illness, no less than poverty, isolation, loneliness or physical illness, can grossly and permanently interfere with one's achievement of or progression toward one's self-ideal and one's ideal life.

According to the conception of suicide under discussion here as a fundamental right either in itself or as part of a fundamental right to life, a person has the ability to exercise his right by virtue of his ability to or capacity for reason. A person who doesn't have the capacity for reason, does not lose but cannot autonomously exercise his right. The outcome of a specific decision, whether judged "foolish, perverse or wrong"<sup>106</sup> according to Mill, is not a criterion to be used in restricting an individual's liberty in the pursuit of his own goals, values or self-definition. Instead the only acceptable criterion is a person's inability or "incapacity for making rational decisions independent of any specific health decision."<sup>107</sup> A decision which a caregiver considers wrong cannot be considered proof of

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<sup>105</sup> (...continued)  
Cambridge University Press, 1993. p 33

<sup>106</sup> Ibid., p 226

<sup>107</sup> Culver, C. and Gert, B. "The Inadequacy of Incompetence". The Millbank Quarterly 68: 1990. pp 619-643

a patient's mental incapacity'<sup>108</sup>. If suicide were conceived of as a fundamental right, the right might be abridged but only because of incompetence in the use of reason.

In answer to the question asked earlier, "how can or should the law provide for a right to suicide?", the Canadian Charter of Rights and Freedoms<sup>109</sup> provides some possibilities. Section 7 provides not only for a right to life, which I have argued might include a right to suicide, but to "liberty" and "security" of the person. This section of the charter, although it does not specifically define a right to suicide, protects a person's right to personal autonomy and self-determination. This protection is of major importance where it concerns important decisions or actions that are part of a person's 'private' life. We have already discussed the importance of self-definition for a person's well-being and also the personal and 'private' nature of the experience of pain. Section 7 therefore would seem to provide the necessary protection of a right to decide to commit suicide, defined as a right to "liberty" and "security"(security in this case being protected from interference). Section 15 of the charter also provides for the equal right of persons before the law, "without discrimination and in particular, without discrimination based on...mental disability". How else can this be read except to say that like any (disabled) person, the mentally ill have the same rights to 'equality' before the law as any other person. No one has the right to interfere with the actions of the mentally ill person just because he is mentally ill, except perhaps to

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<sup>108</sup> Culver and Gert argue however that sometimes a wrong decision should be overruled even if the patient is competent and especially when the decision is dangerous to the patient himself without compensating benefit.

<sup>109</sup> Canadian Charter of Rights and Freedoms. Constitution Act, 1982.



ensure, when competence is in question, that the person is capable of making his own decisions. The section prevents 'discrimination' on the basis of personal characteristics or characteristics that are part of a group to which a person belongs. Discrimination would have the effect of imposing disadvantage on the individual or on the individual as a member of the group. Denying the right or freedom to commit suicide to a mentally ill person, and thereby denying him something that anyone else has a right (or at least the freedom) to do could be interpreted as constituting discrimination. It has been suggested by mental health system survivors, that the proposed institution in Ontario of community treatment orders (enforced acceptance of treatment even when not hospitalised) might constitute such discrimination and might be subject to a Charter challenge.

## **PROBLEMS AND CONCLUSIONS**

Several times I have approached the problem here from a kind of sociological perspective and suggested that it might be the environment, the culture or the society that is considered irrational and incapable of promoting human dignity, not the act of suicide of a mentally ill, depressed or schizophrenic person. I have suggested that some such persons can very acutely see and feel and reason about the circumstances within which they find themselves and can come to rational conclusions that suicide is the most appropriate solution. This is precisely the issue that is perhaps the most troubling with my proposal for permissive suicide in the mentally ill. It appears to place the onus for correcting the effects of what are essentially social problems on those that are the most vulnerable to those effects. It makes suicide an acceptable individual solution to a social problem. While it allows for 'autonomous' decisions to be made in order to provide for preservation of dignity in circumstances that are beyond the capacity of an individual to resolve, it appears, in some respects, to absolve the community of its responsibility for care and concern. Human dignity is not promoted by the failure of the community to provide for the fundamental needs of selected members of the community. Nor is it promoted by measures such as current proposals in Ontario, for forced treatment of the mentally ill (community treatment orders). It is communal attitudes that result in poverty, joblessness, homelessness and inadequate nutrition and care for members of the community such as the mentally ill who fail to conform to community norms and expectations. The failure of society to seriously address issues such

as sexual abuse that result in lifetimes of mental health problems, problems of poor self-esteem, problems in holding jobs and problems in intimate relationships with others, is an example of the failure of society to promote human freedom, equality, and dignity. Permitting the suicide of individuals cannot be the only solution to these failures of society. Unless and until these basic needs are provided for, so that every person's capacity for development of the ideal self is nurtured and every person has a real opportunity to develop as an autonomous person, we will never know what a completely rational and moral suicide would look like and who would commit it. Permitting the suicide of individuals can only be accepted as one of many reasonable alternatives and choices and cannot come to be seen as an expectation or even an obligation, otherwise the choice may not truly be autonomous. For example, women have a tradition of defining the self in terms of care for and sacrifice for others and the suicide of a woman, on the basis that she relieves others of a burden, perhaps should not be accepted. Neither aging, nor mental illness, nor disability can be the determining factor in permitting a person's suicide. The only acceptable basis for the decision is that it be an autonomous decision made by a competent person.

### **Conclusions.**

I have discussed the usual positions on rational suicide including several different sets of criteria for measuring rationality and the concept of competence. Using specific criteria, I have analyzed suicides that are usually considered rational and those that are considered irrational . I have also applied the criteria to one category of severely mentally

ill persons (schizophrenics) and to the suicide decision of J who was severely mentally ill. I have considered potentially different conclusions as to rationality based on different views. The medical model has been shown to have problems for the definition and assessment of mental illness and of rationality and irrationality because of fuzzy concepts for both mental illness and its symptomatology. The model also presents problems because of the emphasis placed on 'clinical judgement'. Additionally, the traditional method of communication has too narrow a focus on strategic objectives. I demonstrated how a different communication process might result in different information exchange and in different conclusions about rationality of the patient. Additionally, I discussed various concepts of 'rights' and found that a conception of suicide as a fundamental right might be defended based on its promotion of human dignity. On the basis of 1) the assumption initially made that suicide can be a rational and a moral choice; 2) the evidence that mental illness and irrationality are not equivalents and that some mentally ill persons, even the most severely mentally ill can make rational decisions; 3) the establishment of a right to life as a fundamental right constitutive of human dignity, a right that may be exercised and the exercise of which may include suicide if the decision is made by a competent person, I conclude that the rationally able or competent 'mentally ill person' has the same right to suicide as any other person. Mental illness is not a criterion for exclusion from the right to determine one's own life including one's death by suicide.

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