

Therapeutic Response to Assisted Suicide Request

N. Gregory Hamilton, MD, *clinical associate professor of psychiatry, Oregon Health & Science University, Portland, OR*

Catherine A. Hamilton, MA, *mental health counselor*

Bulletin of the Menninger Clinic, 63 (2), 191-201; Spring 1999

The Menninger Foundation

The authors review the first publicly reported case of legal assisted suicide in the United States and discuss possible clinical responses other than assistance in suicide. Psychiatric observers have noted that acceptance of assisted suicide or euthanasia as a medical option has resulted in loss of knowledge about how to respond to suicidal ideation in the seriously ill. The authors discuss specific therapeutic interventions that may be appropriate for seriously ill patients requesting suicide..

By late afternoon, March 25, 1998, reporter after reporter had already asked the same question: “How would you have responded differently to the first patient publicly reported to die by doctor-assisted suicide?” Legalization of assisted suicide in Oregon has forced psychiatrists and other mental health professionals in that state and elsewhere to rethink their clinical responses, taking into account whether they believe offering suicide might ever be a helpful option or whether they share our view that willingness to consider any patient’s life as no longer worth living inevitably devalues and harms the patient (Hamilton, Edwards, Boehnlein, & Hamilton, 1998).

The response to the media was short and simple: Patients who are discouraged and have suicidal ideation should be given hope and treatment, not suicide. Clinically, however, the answer is not so simple. How might a psychiatrist or other clinician respond in a way that offers hope and treatment as an alternative to suicide? In a country where one state has legalized doctor-assisted suicide, this question becomes especially complex and deserving of discussion. Such discourse is particularly important in light of the fact that, once assisted suicide and euthanasia were allowed by the Dutch government, the medical profession and the general population have had little conceptualization of any response to the elderly or seriously ill other than assistance in suicide (Hendin, 1998).

This article will explore some possible clinical responses to an assisted suicide request. As a case illustration, comments attributed to the first publicly reported legal assisted suicide case in the United states (Gianelli, 1998; Hendin, Foley, & White; Hoover & Hill, 1998) will be provided. Proposed clinical interventions will be made in response to these statements of the patient, who died by oral “lethal overdose, legally prescribed,” as it will be termed on Oregon death certificates. Of course, these brief remarks will only illustrate the point that there are alternatives to framing suicidal ideation in the medically ill solely in terms of the question of whether the patient is “competent” and if and when the request should be implemented. This

discussion makes no pretense of providing a comprehensive text on the treatment of hopelessness or suicidal despair. It is merely intended as a needed reminder that there are alternatives to acceding to a request for assisted suicide.

The case

An 84-year-old woman with a more than 20-year history of breast cancer developed metastases in her lungs (Hoover, 1998). Her physician told her that these metastases might eventually prove fatal. In the context of a state deluged with favorable assisted suicide media exposure, she reportedly requested assisted suicide, but her regular physician declined to participate in any such course of action (Hoover & Hill, 1998). The patient sought the opinion of a second physician, who was philosophically open to the notion of assisted suicide, but who concluded that she was depressed and needed treatment for her depression (Gianelli, 1998); therefore she was not a candidate for lethal overdose under the Oregon law.

Her family then called the Compassion in Dying Federation, a politically active group promoting legalization of assisted suicide, which had just moved to Oregon a few weeks after the assisted suicide law finally became effective in late 1997. The Federation doctor determined over the telephone that the patient was rational. This doctor gave the patient a series of referrals to other doctors, most likely with similar philosophies and political views about suicide within the doctor-patient relationship. These doctors, including a psychiatrist who saw the patient only once (Gianelli, 1998), apparently deemed her request for suicide reasonable and gave her an overdose in barely more than the minimum waiting period of 2 ½ weeks the law requires.

The audiotapes

On March 22, 1998, a doctor, apparently from the Compassion in Dying Federation, recorded a conversation with the patient for the purpose of presenting this case as an ideal example of assisted suicide. After the patient's death a few days later, the tape was released at a press conference orchestrated by the Compassion in Dying Federation. The patient began her comments by describing the normal dying process in negative terms, depicting patients helplessly staring at the wall in the hospital. She said, "I've seen people suffer, they give them artificial feeding and stuff, which is really not doing anything for them in the long run" (Hoover & Hill, 1998, p. A1). There was no recorded attempt by the doctor to discuss with the patient a more realistic and interpersonally meaningful view of the natural dying process.

Instead, he went on to ask the patient to explain how she felt about the prospect of dying in a few days. She was living at home and was not anticipated by anyone to be likely to die in a few days, except that she was scheduled for assisted suicide. So her suicidal ideation was no longer being explored and treated but was being dealt with instead as a *fait accompli*. She responded, "I am looking forward to it.... I will be relieved of all the stress I have" (Gianelli, 1998, pp1, 62). She particularly emphasized difficulty adjusting to decreased mobility as a cause of her suicidal wishes when she said, "because, being I was always active, I cannot possibly see myself living out two more months like this" (Hoover & Hill, 1998, p. A1).

After the patient thanked the assisted suicide doctor for helping her feel relaxed about her wish to kill herself, a family member interjected advice to doctors in general that if they are uncertain about assisted suicide, they should inform the patient initially rather than listening with open-mindedness or equivocating in their decision. The patient went on, "If somebody's saying that I'm sitting in a chair waiting to die, that's not right because I have always been able to get around and do things, and now suddenly I'm in a position I can't even walk very good" (Hoover & Hill, 1998, p. A1). She next mentioned trouble breathing, although she was able to speak clearly and apparently comfortably on the tape. She concluded by noting that she loved to garden, declaring that this hobby was a major way of coping with stress. She said, "I didn't sit and cry about it. I went out and worked it out" (Hoover & Hill, 1998, p. A1).

Therapeutic responses in place of assisted suicide

Diminished mobility

Even this small amount of clinical material allows for the presentation of an alternative style of clinical thinking and interaction, one that would not have been so passive, so "neutral" (Hamilton, 1990), or so open to, or encouraging of, suicide.

From the patient's few words, a theme emerges. She said, "I was always active." And later, she again said, "I have always been able to get around and do things." One of her coping mechanisms must have been activity, as evidenced by her statement, "I didn't sit... I went out and worked it out." Clearly, seeing herself as active was important to this patient, who had done water aerobics at least until the week before her suicide.

Since problems with movement formed a predominant theme for this patient, the doctor could have empathized with her fears of future immobility. He could have said, "I guess being active is very important to you. It sounds like it would be terribly hard for you to adjust if you ever become immobile." Such a comment, despite its obviousness, could reassure the patient, because it would address her fear of immobility. The patient would thus feel understood, less alone, and therefore more valued and sustained (Kohut, 1971, 1977) or contained (Bion, 1962; Hamilton, 1990). In addition, from a more supportive therapy viewpoint, it subtly yet clearly implies that adjusting to a new life phase is a type of activity, a good and healthy activity, one that the patient can successfully achieve.

More important, such comments create a shift from the proposed activity of committing suicide onto the clinical issue at hand, which the patient and doctor seemed so determined to avoid – what might have been causing her suicidal ideation and how to treat it. This shift would change the doctor-patient interaction from a framework in which both were preparing to act on conscious and unconscious fears of infirmity to a framework in which it was the physician's role to understand and treat the patient.

Self-image change

On closer examination, it was not merely difficulty with the function of movement that troubled this patient. Perhaps even more problematic was her self-image of having difficulty with movement. The difference between a practical, motor dysfunction and being afflicted with a self-

image or self-worth problem prompted by diminished mobility is a subtle but potentially important one (Hamilton, 19996). Her self-image problem is illustrated by the fact that after commenting on how active she had previously been, she said, "I cannot possibly see myself living out two more months like this," meaning that she could not see herself as less physically active than she had been. She went on, "I have always been able to get around and do things, and now suddenly I'm in the position I can't even walk very good." This change from seeing herself as being able to "get around" to seeing herself as not being able to walk very well was a serious problem for her, although it was clear that she could still walk. It was known that she did not have significant pain with movement.

Again, empathic paraphrase could have been a useful approach. Furthermore, such a woman might have risen to the challenge of exploring previous changes in life phases and concomitant changes in self-image. What was it like for her as a young girl? How had she coped as she grew up and changed from girlhood into young womanhood? How did she cope with the losses of freedom and of unlimited possibilities for herself that she must have experienced in rearing children, as reports indicate she did? Throughout her more than 20 years of breast cancer, she must have had other episodes of immobility and losses of cherished self-image. How did she cope with those changes? Such a dialogue would have allowed the patient actively to discover within herself her adaptive capacities and her own abilities to cope with adversity and find meaning.

There are also more direct ways of coping with a shift in self-image and diminished mobility. The doctor or therapist can help the patient explore alternative, substitute, or compromise activities. As an example, one of the first author's patients loved gardening, just as this woman apparently did. With a bit of encouragement, my patient quickly adjusted to the loss of her ability to work in her extensive garden by substituting an equally meaningful endeavor. She planted a smaller, potted garden and had flower baskets hung over her back porch. The challenges for my patient became how to water her hanging flower baskets from her wheelchair. She needed to learn how to accomplish this task without water dripping down her arm. Such a life-giving task as watering hanging baskets and creating a spot of beauty on her porch was just as important at this life phase as at any other (Siegel, 1993).

Instead of being helped to see that smaller creative endeavors can be just as meaningful and worthwhile as previous grander activities, however, the 84-year old cancer patient received a prescription for a lethal overdose from her doctor.

Images of others

Beyond a change in self-image, this patient may have benefited from a discussion of her views of other people. Even her few comments provide useful information about her views in this regard. Her direct statements about others are in two paired arrangements. In one scenario, she described people in the hospital as passive and staring at the four walls while receiving futile treatment. She was portrayed as the superior self looking down on others for being passive and degraded. In another interaction, the self-image and image of others was reversed. Hypothetical other people were looking down at her. She said, "If somebody's saying that I'm sitting in a chair waiting to

die, that's not right...." Here the patient had imaginary others viewing her as inferior for sitting in a chair waiting to die. She refused this imagined scenario, as if sitting would somehow be shameful.

In the first example, she seemed to project her unwanted passive self-images and her disgust with infirmity onto hypothetical hospital patients. She devalued those patients by seeing them as somewhat contemptibly accepting treatment, which she depicted as futile. In the other example, the patient saw her own image of herself as stigmatized and degraded or devalued by others. In both cases, she equated inactivity and helplessness with worthlessness.

From a cognitive (Ponzoha & Warren, 1985) or supportive therapy viewpoint, the clinician could directly challenge this patient's underlying faulty assumption that decreased physical activity implies decreased value or personal worth. Similarly, when the patient spoke of imagined others as critical of her (e.g., "If somebody's saying that I'm sitting in a chair waiting to die, that's not right"), the doctor could clarify the situation or make an interpretation. The doctor could deal with the patient's projection by commenting that she might think other people would be critical of her for decreased activity, because she was critical of herself for having a disability. In fact, many people, including the doctor, might think there is nothing at all shameful about inactivity.

Containment

As doctors or therapists, we sometimes must sit quietly by the side of the seriously ill patient, hearing and empathically feeling, actually empathically experiencing, the feelings of the patient, letting go of illusions of power and control we so heartily cling to most of our professional lives. This process can be very hard for physicians and therapists alike. For some doctors, it is not sadness or anger or even erotic feelings in relation to patients that are most difficult to tolerate, but feelings of helplessness instead.

In this case, the patient's way of dealing with her fear of helplessness and inactivity may well have engendered a similar fear in the clinician working with her. The doctor who assisted in her suicide was quoted as saying that talking to her was "like talking to a locomotive" (Hoover, 1998, p. A1). Perhaps he felt helpless when faced with the challenge of containing a patient who elicited images of locomotives, or of attempting to make a therapeutic intervention when talking with the patient seemed, as he put it, like "talking to Superman when he's going after a train" (p.A1). This feeling of helplessness may have been elicited from the doctor, when in fact, as Hendin has noted (Hamilton, 1998), helping a suicidal seriously ill patient is not more difficult than helping any other suicidal patient who comes into the office.

In terms of projective identification (Gabbard, 1989; Grotstein, 1981; Hamilton, 1988; Kernberg, 1965; Klein, 1946; Ogden, 1982), which has been so well described in psychotherapy, the patient may have behaved in such a way as to engender her unwanted feelings of helplessness in the doctor and then may have tried to control those feelings in him. In this case, the patient evidently disavowed her feelings about, and fears of, her inactivity while she adopted the hyperactive role of a speeding train---or of Superman, even faster and more powerful than a speeding locomotive.

Over the past 20 years, psychotherapists have learned to use their feelings as an effective therapeutic tool. One approach to dealing with such feelings is containment (Bion, 1962; Hamilton, 1990)---that is, accepting the feeling being thrust upon the clinician by the patient, reflecting on what the patient must be experiencing, and offering the projection, now transformed by understanding and meaning, back to the patient in a way that can be tolerated. Such an approach with this patient would have required the physician to tolerate his own and the patient's feelings about, and fears of helplessness and passivity and to use his therapeutic understanding of those feelings actively to help the patient.

Sometimes a comment may be in order, such as, "It seems that you feel it's somehow dangerous for you to slow down a bit and wait. Are you afraid something might happen if you slow down a bit?" The clinical clue to asking such a question would be in the danger, fear, or urgency the clinician would find within himself or herself when faced with the feeling of being in the presence of a speeding train.

Such a patient would very likely be much relieved by being able to talk about her fear of inactivity, a fear that may have plagued her much of her life, that might have arisen anew as her disease began to feel like a train bearing down on her, especially if the prognosis had been presented in an excessively certain, or perhaps even brutal, fashion. The assisted suicide process, with its political momentum, also could have taken on a life of its own, leading her to feel railroaded herself, as has apparently been the case with other Compassion in Dying patients who were reported to feel pressured by their family and the press (Hendin, 1998).

Empathic listening and questioning might have helped this patient feel understood and accepted in a way she never would have anticipated. By sitting with her and listening, the doctor can demonstrate the value of understanding one's impulses without taking action. However, if the doctor, instead of understanding the fears of such a patient, acts out on his own feelings of helplessness and fear, a therapeutic opportunity is missed and an irrevocable course of action is set in motion. Such "countertransference enactments" (Gabbard, 1996, p.75) usually result not only from the patient's troubling feelings, but also from the doctor's failure to come to terms with his or her own internal struggles. Such a confluence of the patient's issues and the doctor's vulnerability can result in the doctor enacting a scenario that expresses his or her own wished-for or feared denouement to a personal internal drama at the expense of the patient.

Countertransference enactments are thus the very antithesis of containment. In this case, at least as it was reported, the doctor may have been unable to tolerate his own feelings of limitation as a human being. He may have reasserted his sense of power and control by writing the patient a lethal prescription, which left him calm and in control, and left the patient utterly helpless, inactive, and, in fact, lifeless---all in the name of compassion and choice.

Antidepressant medication

Antidepressant medication can also dramatically help such patients, considered by at least one, perhaps two, doctors as depressed. All psychiatrists and most primary care physicians have heard a patient convincingly and logically describe a grim and seemingly hopeless life circumstance, only to find this perception entirely changed after the patient's depression has been treated with

antidepressant medication. Although the emphasis in this article is not on medication, such treatment, with its potential to actually cure depression, should certainly be attempted. In this case, it is apparent that no effective therapeutic attempt was even made, and there is evidence from numerous reports that the psychiatric consultants confined their role to determining whether the patient was “competent” in a narrowly defined and legalistic fashion.

Education

Finally, education about palliative treatments could have addressed this patient’s fears. It is far more likely that the fear of pain (Emanuel, Fairclough, Daniels, & Claridge, 1996) or dyspnea or loss of mobility will lead to suicidal ideation than that the actual symptoms themselves would lead to such ideas. It is our job as clinicians to allay those fears through a realistic discussion of available treatment and care. The need for such reassuring and realistic education is especially pressing in the face of political efforts to portray the natural dying process as unbearable and grotesque. Efforts to legalize assisted suicide have served a suggestive function, which has frightened many patients and often needs to be therapeutically countered.

Conclusion

This brief discussion serves as a reminder that suicidal ideation in the seriously ill requires thorough evaluation and treatment, as it does among all patients. The legalization of assisted suicide, even in one state, can create a shift in attitude and focus among clinicians nationwide, which can interfere with the appropriate evaluation and treatment of such cases (Hendin, 1998; Orr & Bishop, 1998). For example a now widely disseminated manual, *The Oregon Death with Dignity Act: A guidebook for Health Care Providers* (Haley & Lee, 1998), calls for the primary care doctor to “explore the meaning behind the patient’s request” for a lethal prescription (p. 5), yet frames the question to be answered solely in legalistic terms about whether “health care providers will choose to honor the request” (p.5). This conceptualization excludes from consideration the clinical question of how to help the patient overcome suicidal ideation. The same guidebook goes even further in the section on mental health consultation to recommend limiting any psychiatric consultation to a “competency evaluation, specifically focused on capacity to make the decision” (p.30) for assisted suicide. Competency is so narrowly defined that even major depression does not necessarily exclude the patient from being considered competent, and the authors conclude, “If the mental health professional finds the patient competent, refusal of mental health treatment by the patient does not constitute a legal barrier to receiving a prescription for a lethal dose of medication” (p. 31).

Legalistic, either-or action decisions, rather than nuanced clinical thinking, can hamper good medical evaluation and treatment. Even the case discussed in this article, which was promoted as an “ideal” assisted suicide case, demonstrates lost opportunities for understanding and helping a patient overcome suicidal ideas and feeling. Clinicians have numerous available interventions, such as those mentioned earlier, as well as other possibilities. In order for such therapeutic activities to be effective, however, the clinician must approach the task with a commitment that the seriously ill patient’s life is as valuable as any other suicidal patient’s life---that his or her life

is worth living, just as any other human life is worth living, and that the therapeutic endeavor is therefore hopeful and meaningful. If the doctor or therapist does not consider the patient's life equally valuable, this covert devaluing of the patient under such fragile circumstances could jeopardize his or her life.

In a country where assisted suicide is now approved by one state government, it is vital to remind ourselves that all suicidal patients deserve equal therapeutic intervention, regardless of their health status.

References

- Bion, W.R. (1962). *Learning from experience*. London: Heinemann
- Emanuel, E.J., Fairclough, D.L., Daniels, E.R., & Clarridge, B.R. (1996). Euthanasia and physician-assisted suicide: Attitudes and experiences of oncology patients, oncologists, and the public. *Lancet*, 347, 1805-1810.
- Gabbard, G.O. (1989). Splitting in hospital treatment. *American Journal of Psychiatry*, 146, 444-451.
- Gabbard, G.O. (1996). *Love and hate in the analytic setting*. Northvale, NJ: Aronson.
- Gianelli, D.M. (1988, April 13). Praise, criticism follow Oregon's first reported assisted suicides, *American Medical News*, 41, 1, 62.
- Grotstein, J.S. (1981). *Splitting and projective identification*. New York: Aronson.
- Haley, K., & Lee, M. (1998). *The Oregon Death with Dignity Act: A guidebook for health care providers*. Portland, OR: Center for Ethics in Health Care.
- Hamilton, C.A. (1998). Assisted suicide and mental illness: Herbert Hendin at PCC spring lecture. *Physicians for Compassionate Care Newsletter*, 1 (2), 1-2.
- Hamilton, N.G. (1988). *Self and others: Object relations theory in practice*. Northvale, NJ: Aronson.
- Hamilton, N.G. (1990). The containing function and the analyst's projective identification. *International Journal of Psycho-Analysis*, 71, 445-453.
- Hamilton, N.G. (1996). *The self and the ego in psychotherapy*. Northvale, NJ: Aronson.
- Hamilton, N.G., Edwards, P.J., Boehnlein, J.K. & Hamilton, C.A. (1998). The doctor-patient relationship and assisted suicide: A contribution from dynamic psychiatry. *American Journal of Forensic Psychiatry*, 19, 59-75.
- Hendin, H.E. (1998). *Seduced by death: Doctors, patients, and assisted suicide* (Revised and updated). New York: Norton.
- Hendin, H.E., Foley, K., & White, M. (1998). Physician-assisted suicide: Reflections on Oregon's first case. *Issues In Law and Medicine*, 14, 243-270.
- Hoover, E. (1998, March 27). Two deaths add new angle to debate. *Oregonian*, pp. A1, A18.
- Hoover, E. & Hill, G.K. (1998, March 26). Two die using suicide law. *Oregonian*, pp. A1, A14.
- Kernberg, O.F. (1965). Notes on countertransference. *Journal of the American Psychoanalytic Association*, 13, 38-56.
- Klein, M. (1946). Notes on some schizoid mechanisms. *International Journal of Psycho-Analysis*, 27, 99-110.
- Kohut, H. (1971). *The analysis of the self*. New York: International Universities Press.
- Kohut, H. (1977). *The restoration of the self*. New York: International Universities Press.
- Ogden, T.H. (1982). *Projective identification and psychotherapeutic technique*. Northvale, NJ: Aronson.
- Orr, R.D., & Bishop, L. (1998). Why psychiatrists should not participate in euthanasia and physician-assisted suicide. *American Journal of Forensic Psychiatry*, 19, 35-48.
- Ponzoha, C., & Warren, R. (1985). Self-acceptance techniques for structured groups. *Journal of Rational Emotive Therapy*, 1, 36-43.
- Siegel, B.S. (1993). *How to live between office visits*. New York: HarperCollins.