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Title: Does the Goal of Preventing Suicide Justify Placing Suicidal Clients in Care

Book: CONTROVERSIAL ISSUES IN SOCIAL WORK - ETHICS, VALUES & OBLIGATIONS

DEBATE 6

Does the Goal of Preventing Suicide Justify Placing Suicidal Clients in Care?

EDITOR'S NOTE: Suicide is an emotional topic. Religious organizations view it as wrong, even sinful. Clients can be legally incarcerated against their will if professionals believe they are a threat to themselves. Consider the following quote from the 1995 draft of the NASW Code of Ethics: "Social workers may limit clients' right to self-determination when, in their professional judgment, clients' actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others." What are the ethical issues here? Who is to say that suicide is not a basic right? Can we predict suicide? If we cannot predict it, on what ethical grounds can we exercise undue influence or coerce people into unwanted "care"? Although both debaters agree that there is no evidence that suicide can be predicted (and thus prevented), they take quite different views about the role of professionals.

Andre Ivanoff, who argues the YES side, is Associate Professor of Social Work at the Columbia University School of Social Work. Recent publications include *Involuntary Clients in Social Work Practice* (with B. Blythe and T. Tripodi), and "Clinical Risk Factors Associated with Parasuicide in Prison" in the *International Journal of Offender Therapy and Comparative Criminology.*

Tomi Gomory presents the NO case. He is finishing his doctoral studies at the School of Social Welfare, University of California, Berkeley. His research activities include a critical review of outcome claims of well-accepted programs for the severely mentally ill and a conceptual and situational analysis of the historical changes in the public mental health system.

YES

ANDRE IVANOFF

The Issue and Assumptions

Involuntary care is acceptable when it may prevent the taking of human life. Is preventing suicide ethical? For practitioners who believe that it is not, the remainder of this argument is without meaning. When clients admit to acute suicidal ideation, verbalize suicidal intentions, or attempt suicide, the question of hospitalization may arise. Mental health professionals across disciplines must know where they personally stand on this issue before their clients become suicidal: the middle of a suicidal crisis is no time to begin sorting one's feelings on this critical topic (Ivanoff & Smyth, 1992; Linehan, 1993). To hold individuals behind locked doors against their will is a serious matter calling for a great deal of consideration in which the risks must be weighed against the benefits. Many suicidal crises do not require hospitalization if the practitioner can stay in close touch with the client, monitoring suicidal thinking and feelings; indeed, hospitalization may not offer the most effective treatment and may even promote barriers to treatment with some clients. The least restrictive treatment alternative and voluntary admission are always preferable options.

What constitutes providing care to a suicidal client? Suicide prevention often involves involuntary intervention, far short of inpatient hospitalization. When does action agreed to by a desperate, distressed individual technically become involuntary? Involuntary care ranges from seeing a clinician at the insistence of family members, taking medication because you are too depressed to argue against taking it, to confinement in various settings. Involuntary psychiatric hospitalization often represents only the final step in a hierarchy of involuntary intervention, not the first.

Does hospitalization prevent suicide? There is little research examining short-term suicide rates among those hospitalized or not hospitalized for suicide risk. The only randomized intervention trial (Waterhouse & Platt, 1990) assigned relatively low-risk parasuicides (suicide attempters) to either brief (24 hours or less) inpatient treatment or to ambulatory care and found no differences 1 and 16 weeks later on repeated parasuicide or other psychological measures. Most other research is based on long-term follow-up studies and is equivocal in outcome. The difficulty associated with constructing randomized intervention protocol for individuals at immediate or imminent suicide risk makes shorter-term studies less likely. The following sections detail the clinical, professional, and structural conditions that may necessitate involuntary care or hospitalization of a suicidal individual.

Clinically Necessitated Reasons

Even practitioners who believe strongly that involuntary hospitalization is unethical acknowledge they would not hesitate to place an actively suicidal patient into care during an acute psychotic episode (e.g., Linehan, 1993). Others make the case that hospitalization, regardless of level of suicide risk, and, whether voluntary or involuntary, is the immediate treatment of choice for severe phases of manic–depressive disorder, major depression, and psychotic presentations with delusions pertaining to death (Comstock, 1992; Litman, 1992). Psychotic thinking may be functional or organic in origin or the consequence of failed medication or failed medication compliance. The level of impulsiveness demonstrated or acknowledged by the client is also a factor in assessing whether hospitalization is necessary. History of highly impulsive behavior and the client's self-predicted responses to questions such as, "What do you think you would do if you left here now?" are often a useful gauge of impulsivity.

Clinically determined "failure to respond" to crisis intervention efforts is also frequently cited as a reason to consider involuntary hospitalization. Many suicidologists have written about the severe psychological pain that evokes suicide, viewing the role of clinician as one of persuading the client to cling to hope. This may be particularly difficult during critical periods in the life cycle (Yufit & Bongar, 1992). Whether the client or the practitioner is viewed as responsible for failing to attain hope or achieve a working therapeutic relationship, it is not possible to ensure the outcome of all interventions.

Professionally Necessitated Reasons

In cases in which the practitioner's professional well-being may be at stake, it is ethical to inform the client of this. For example, a practitioner may seek to place a suicidal client in care to avoid the threat of being sued or held liable if the client commits suicide (Linehan, 1993; Schutz, 1982). The practitioner may be aware that hospitalization reinforces suicidal behavior but may be afraid to take the risk of suicide if the client is not hospitalized. Clinicians should understand the relevant legal precedents and procedures necessary to admit a client into involuntary care in their locale (state or city).

Informal community norms and guidelines are also important to understand (Linehan, 1993; Schutz, 1982). The grounds under which personal philosophy against involuntary care or hospitalization may be violated must be spelled out to the client. The practitioner's position on involuntary care and probable response to threats of imminent suicide should be made very clear to the client at the beginning of treatment (Linehan, 1993). It is important to be clear and direct about the conditions under which interventions against the wishes of the client will be used. For instance, I was trained (and now train others) to always tell my clients that if they convinced me they were going to commit suicide, then I would actively intervene to stop them (Ivanoff & Smyth, 1992; Linehan, 1993).

Some practitioners are willing to take far fewer professional risks than others. Some agencies are less willing to let their practitioners take risks than others. Not all ethical interventions must be justified as designed to protect only the welfare of the

client, independent of the practitioner's own welfare (Linehan, 1993). If the client has frightened the practitioner, this should be clarified, and the practitioner's right to maintain a comfortable existence should be explained (Linehan, 1993). Realistically, most practitioners have no intention of having their professional lives threatened because a client has committed suicide when it could have been prevented.

Suicide cannot be separated from its interpersonal context. When clients enter a therapeutic relationship, their subsequent behavior has consequences within that relationship and beyond: to pretend otherwise is both dishonest and a disservice (Bongar, 1992; Linehan, 1993; Maltsberger, 1986). Helping a client appreciate the intentions of those in the community who must respond to suicidal behavior can be a useful clinical focus (Bongar, 1992; Ivanoff & Smyth, 1992; Linehan, 1993).

Structurally Necessitated Reasons

Inadequate Community-Based Supports

Although the "ideal" suicidal client is one in, or with access to, ongoing intervention and a reasonably comfortable physical existence, the reality is that many multiproblem clients of social agencies may lack shelter, food, physical safety, and access to health and mental health services. "Exterior sustaining resources" (Maltsberger, 1986) may be fractured, lost, or unavailable. Whether the sustaining interpersonal support is a practitioner or significant other, the availability of substitute supports and the client's ability to use such supports are important: some clients are not capable of switching to available substitute supports. Often, no substitute sustaining supports, either formal or informal, are available.

Inadequately Trained Practitioners

A tragic irony in the U.S. mental health care delivery system is that the least trained mental health practitioners are responsible for care of the most distressed and disordered populations. Highly trained professionals are those least likely to be involved with the daily management of suicidal individuals. Judgments of clinical risk must take into account a multiplicity of individual psychological, social, and behavioral factors, including impulsivity, willingness to accept help, and empirical risk factors for suicide. Beyond these factors, however, it is widely acknowledged that accurate assessment of suicide risk requires a global, integrative assessment including these data plus clinical experience in dealing with other suicidal individuals (Comstock, 1992). Those legally or organizationally unable to exercise clinical judgment, (e.g., crisis line workers, line staff in residential facilities or correctional institutions), may be mandated to refer for involuntary hospitalization any client evidencing suicidal intent. Less restrictive alternatives to hospitalization may not exist, and organizations may be unwilling to risk liability for wrongful death.

Involuntary hospitalization should not be used because a mental health professional is incompetent; it is the responsibility of the practitioner to use all reasonable means to protect and ensure the safety of the client outside the constraints of involuntary hospitalization. However, given the autonomy assigned to less-trained practitioners, the complexity of variables involved in accurate risk assessment, and a significant lack of sustaining interpersonal or economic resources, few alternatives may exist.

Summary

Despite strong beliefs in client self-determination and least restrictive treatment alternatives, it is clear that there can be disadvantages to outpatient or ambulatory care. These disadvantages include the fact that the increased burden to the family or other caregivers may strain natural support networks beyond their capabilities, the practitioner's increased uncertainty about the safety of the client may weigh heavily, and the presence of actual (or judged) degree of immediate danger that exists in an outpatient setting. The family and friends of suicide victims (suicide "survivors") deserve assurance that due care and diligence are exercised to prevent suicide. They are also entitled to legally seek such assurance. In the presence of acute distress and suicidal intent, and the absence of sustaining psychosocial supports, involuntary care may be one of few ethical solutions.

There is no empirical evidence that inpatient psychiatric hospitalization has ever extended the life of a patient or prevented suicide. Despite the knowledge that it is increasingly only the most severely distressed and disordered individuals who fill inpatient beds, the high suicide rates in inpatient psychiatric facilities are cited circuitously as evidence that hospitalization may increase suicide risk. Given the ethical and other difficulties in conducting controlled studies on the efficacy of involuntary hospitalization, we may never have convincing data in this argument. However, there are convincing data on the associations between acute mental disorder and suicide: to *not* adequately protect an acutely suicidal individual violates the professional standards of the National Association of Social Workers, the American Psychological Association, and the American Medical Association, as well as community standards and expert opinion that support this intervention for the highest-risk patient (Litman, 1992). When we serve professionally in roles as health or mental health care providers, our obligation is to help safeguard the lives and well-being of others based on the best empirical and clinical knowledge available.

Case Example

S. was a 32-year-old woman with a 16-year history of major depressive episodes and repeated parasuicide (suicide attempts) of increasing lethality. After 9 months of moderate progress in treatment, S. began to experience delusions, incapacitating paranoia, and, not surprisingly, depression, suicidal ideation, and increasingly frequent suicidal urges. After two weeks of managing this in an outpatient setting, I suggested that S. admit herself for a brief inpatient stay to gain control over the delusions and paranoia (which I viewed as antecedent to the depression and

suicidal urges). S. was adamantly opposed to this notion; forty-eight hours later, after multiple expressions of concern, explanations of my view of the current situation, and extended persuasion, S. went to the hospital.

A voluntary admission? Technically, yes. However, if our relationship had been less potent, or if S.'s paranoia or delusions had been slightly more severe, I would not have hesitated to have had her involuntarily admitted. Damaging to the therapeutic relationship? Perhaps, but I have faith in the capacity for reparation and repair in ongoing relationships. And I know that all forms of intervention are ineffective with dead clients.

References

Dongas, B. (Ed.) 1992. *The assessment management treatment of suicide: Guidelines for practice.* New York: Oxford University Press.

Comstock, B. (1992). The decision to hospitalize and alternatives to hospitalization. In B. Bongar, (Ed.), *Suicide: Guidelines for assessment, management and treatment.* New York: Oxford University Press.

Ivanoff, A., & Smyth, N. J. (1992). Comprehensive treatment for suicidal clients. In K. Corcoran (Ed.). *Structuring change.* Chicago: Lyceum.

Linehan, M. M. (1993). *Cognitive-behavioral treatment of borderline personality disorder.* New York: Guilford Press.

Litman, R. E. (1992). Predicting and preventing hospital and clinic suicides. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide.* New York: Guilford Press.

Maltsberger, J. T. (1986). *Suicide risk: The formulation of clinical judgment.* New York: New York University Press.

Menninger, K. (1938). *Man against himself.* New York: Harcourt, Brace, & World.

Schutz, B. M. (1982). *Legal liability in psychotherapy: A practitioner's guide to risk management.* San Francisco: Jossey-Bass.

Waterhouse, J., & Platt, S. (1990). General hospital admission in the management of parasuicide: A randomised controlled trial. *British Journal of Psychiatry, 156,* 236–242.

Yufit, R. I., & Bongar, B. (1992). Suicide, stress, and coping with life cycle events. In R. W. Maris, A. L. Berman, J. T. Maltsberger, & R. I. Yufit (Eds.), *Assessment and prediction of suicide.* New York: Guilford Press.

Rejoiner to Professor Ivanoff

Tomi Gomory

The good news is that Professor Ivanoff states that there is no disagreement between us about the efficacy of coercive treatment. It has none. "There is no empirical evidence that inpatient psychiatric hospitalization has ever extended the life

of a patient or prevented suicide." The bad news is that Professor Ivanoff goes on to attempt to justify coercive interventions on what she calls ethical grounds. She does not explain, however, how an intervention that does not work can be "one of [the] few ethical solutions."

I will rebut Professor Ivanoff's assertions in order of their appearance in her essay. First, she asks, "When does action agreed to by a desperate, distressed individual technically become involuntary?" Professor Ivanoff seems to view this as a difficult problem. Let me reassure her it is not. It is any course of action that is not consented to by a person.

She next argues for "clinically necessitated reasons" compelling hospitalization. The three citations she supplies are assertions by authors without any meaningful argument and no empirical evidence. A clinician's so-called clinical assessment and intervention skills are practice folk myths or subjective beliefs about what works in the absence of well-tested outcome research. Ivanoff appears to be a believer.

"Professionally necessitated reasons" turn out to be exceptionally troubling under analysis. Professor Ivanoff suggests that a suicidal client may personally scare or professionally threaten the therapist and as a result may then ethically be involuntarily hospitalized. I believe that this is a completely misguided approach and, contra Ivanoff, professionally unethical. If a clinician is too frightened to hear a client's suicidal thoughts, ideas, or fantasies, then what is ethical on the part of that clinician is to choose not to work with suicidal clients.

Professor Ivanoff's statement, "if [clients] convinced me they were going to commit suicide, then I would actively intervene to stop them [presumably by involuntary hospitalization]" is remarkable in its naivete about the process of therapy. If she makes this statement at the beginning of her work with a client, she puts the client on notice as to what problems are not acceptable to talk about. Even if suicide is the key issue for that client, serious discussion about various aspects of suicide are not allowable, unless the client is willing to risk being imprisoned on a psychiatric ward. Furthermore, the decision to hospitalize is going to be made based on what intensity of suicidal feelings, ideas, desires is enough to "convince" Ivanoff of the client's determination to commit suicide. What is being tested in this situation is Ivanoff's capacity to tolerate discussion of suicide, not the client's suicidal intentions (which are unknowable).

The correct ethical stance is to firmly place the responsibility for seeking hospitalization or other treatment in the hands of the client, explaining up front that as a practitioner all I will do is talk with them. I must make clear that this dialogue may include any and all aspects of their concerns, including self-destructive feelings, along with potential options and choices the client may have. This clarifies and signals to the client what kind of treatment he or she can expect from me. Because I know from the available scientific research that I cannot prevent or predict whether the client in front of me will commit suicide, I do not take on the unrealistic burden of suicide prevention. By making this explicit at the beginning

to my clients, I am allowing them to determine whether they want to work with me or would prefer a referral.

Her argument about "inadequate community-based support" because of the possible lack of shelter, food, physical safety, health, or mental health services for this group again is simply an assertion also true of many populations who are not suicidal. How the provision of such support prevents suicide is not discussed, probably because no empirical research corroborates this claim.

Under "inadequately trained practitioners," she states that the least trained practitioners work with the most "distressed and disordered populations." Professor Ivanoff completely ignores the fact that even a highly trained professional cannot predict or prevent a particular suicide. There are simply no such methods (see my NO essay). Paradoxically, she knows this to be the case.

She also claims that there is convincing evidence of the association between acute mental disorder and suicide, and consequently there is a duty to "adequately protect" (whatever that may mean) a suicidal patient. To not do this, she asserts, violates professional standards of several organizations, including the National Association of Social Workers. This is a curious statement from a university professor who I expect is familiar with statistics. Association by itself demonstrates nothing. Association, also known as correlation, can mean that *a* causes *b*, or *b* causes *a*, or a third variable *c* causes both *a* and *b*, or the association of *a* and *b* occurs simply by chance. I would respectfully disagree with Professor Ivanoff and assert that there cannot be any violation of professional or community standards based on associations of claimed entities because such associations tell us nothing of importance in and by themselves.

Of the case example Professor Ivanoff provides, the less said the better. Case examples of the sort included here serve little purpose beyond propaganda for any claims asserted. We have no way of evaluating the illustration or any of its claims. It is just a subjective description.

In conclusion, I believe that Professor Ivanoff, by agreeing with my contention that there is no empirical evidence corroborating that involuntary treatment is useful in preventing suicide, has conceded the essential point. The rest of her claims are without any well-tested evidence or are beside the point.

NO

Tomi Gomory

My response, in the negative, to the question up for debate is based on a very simple fact. There is not a shred of empirical evidence through unrefuted (Miller, 1994), controlled experimental research in more than 30 years of research by suicidologists (the alleged experts) showing either that suicide is preventable or that an individual suicide can be predicted (Hillard, 1995). This is so for all suicide prevention methods, coerced or consented.

Although I believe that the act of suicide is a moral and ethical, not a medical or psychiatric, issue, I have no problem with any treatment that is voluntarily requested by any troubled individual or is freely offered to such a person by any concerned professional. Such treatment may be for suicidal ideation (self-focused, scary, intense, angry thoughts) or any other minor or serious psychic pain. This seeking of help by an individual and the response by experts or others, whether they are called suicidologists, psychotherapists, clergy, relatives, or friends, is in the best tradition of what Thomas Szasz might describe as "ethical" psychotherapy (Szasz, 1965).

In this type of activity, there is a request for help from someone (the client) directed at someone (who may be a professional), who the client believes can be helpful in facing his or her problem(s). This help may be talk, medication, massage, or mahjong. Alternatively, a professional seeing that a person appears to be in some sort of difficulty, may offer his or her services for amelioration if he or she believes they are appropriate. Based on contractual consent, they work together on the problem or problems of the client until the problem has been resolved to the clients satisfaction or the participants mutually agree that the relationship has run its course. This type of therapeutic activity between consenting adults does not present any ethical difficulty. The issue becomes problematic when the alleged therapy is the confinement of so called suicidal adults in psychiatric facilities against their will or the coercive use of such treatments as electric shock, the prescribing of brain-damaging psychotropic medications (most such medications cause a high incidence of tardive dyskinesia), or various physical restraints. The debate is really about whether these coercive techniques are ever justifiable ethically or scientifically for the sake of suicide prevention (I exclude from my argument the involuntary treatment of "suicidal" children. Although a very important issue, by definition children as minors are under the coercive control of various adult authorities [parents, teachers, mental health professionals] and would require a separate argument).

I believe that the existing empirical research falsifies any claims of effective suicide prevention. Currently there are none (Hillard, 1995; Allard, Marshall, & Plante, 1992). There is only the personal decision by a "suicidal" individual to either not go ahead with the act, or if he or she is using the threat of suicide to manipulate the people around him or her, to learn to ask for what he or she needs differently. If there is no effective suicide prevention, then it follows tautologically that no targeted coercive treatments can be useful. Although people may be psychiatrically imprisoned against their will and can be forced to undergo electric shock or be medicated without their consent, this use of authority and power is not thereby a demonstration of any empirically well-tested concept of suicide prevention.

So what is left then to talk about? We might ask for example, how there can be almost 8,000 (7,989) articles in the University of California's psychology database on the subject of suicide covering more then 30 years (1963–1995) of research and theorizing? A cynic might suggest that mental health researchers have

to make a living, some even at the expense of the dying. I would rather suggest that the act of suicide, which is claimed by the mental health field either to be a symptom of mental illness or to be itself mental illness, has suffered the same fate as the volitional behaviors that are asserted to embody the concept of mental illness.

Psychiatry long ago began to rename unwanted, disturbing, unpleasant, hard-to-understand purposeful human behavior and by the use of this semantic smoke screen convert acts to states of being or conditions indiscriminately called mental dysfunctions, diseases, syndromes, or illnesses. This psychiatric alchemy was necessitated by the alienists' (early institutional psychiatrists) desire to be baptized under the sacred authority of Medicine. By claiming to treat mental diseases rather than deviant behaviors, they gained in authority what they lost in truth telling.

Since the beginning of human social existence, there have been plenty of personally and socially unwanted behaviors to go around. The exercise of control over such behaviors and over the people manifesting them has varied. Before the late eighteenth century, mostly religious authorities were invested with this power. As science began to replace religion as the universal explanatory framework later in that century, medicine conformed more and more to good scientific practice, and by the mid to late nineteenth century, it could claim some explanatory power.

The prestige and authority of doctors grew as they were able to actually help physically sick people get better. Mimicking medicine, psychiatry claimed its right to control socially misbehaving people by asserting that these misbehaviors were diseases just like any others, and they (the psychiatrists) had cures for what ailed them (the deviants). Today, 150 years later, the psychiatric profession is still claiming that mental illnesses are just like any other illnesses and treating millions of people for them. Interestingly enough, we still have no unrefuted empirical evidence to corroborate this claim.

Such facts notwithstanding, suicidologists along with other members of the "helping" professions have argued that people wanting or planning to commit suicide are mentally ill. Consequently, they cannot make autonomous choices or at least are cognitively restricted from seeing the full extent of the alternatives open to them. The assumption of mental impairment articulated by the psychiatric mantra of "harm to self and others," which is invoked to justify involuntary hospitalization of anyone judged to be manifesting suicidal behavior, if taken seriously, would lead to absurd conclusions.

Involuntary hospitalization would have to be the "treatment of choice" for all people who are in danger of a lethal outcome based on many regular activities they pursue, well chosen or foolish. The habitual users of large quantities of cigarettes and liquor, for example, are far more numerous and more likely to die as a result of their behavior than are people talking about killing themselves. People undergoing any dangerous activity (construction jobs, walking the high wire, various sports, medical experiments, etc.) would have to be hospitalized if the phrase "danger to

self" was meant literally by psychiatry. The absurdity is self-evident. Why then is this obviously arbitrary selection by psychiatry of just one particular dangerous, self-harming activity (suicide-related talk, planning, fantasizing, threatening,) for the label of mental illness so well accepted?

Medical doctors by their Hippocratic oath are committed to preserving life. People choosing to end theirs are a direct threat to the belief system of medicine (psychiatrists claim they are just like any other doctors). The institutional psychiatrist's defensive reaction, in the form of imprisoning or involuntarily medicating suicidal individuals, is "ego syntonic." Coercive efforts to keep people from harming themselves are justified by a belief system that assumes human life is always above any other ethical value. This notion is false and is refuted by the many heroes of humanity (Socrates, Jesus of Nazareth, Joan of Arc, Dietrich Bonhoeffer) who chose death over life for what they believed were more important values.

The last point I wish to make is that even in what we would ordinarily call suicidal behavior, there are those acts that are assumed to be "sick" behaviors and others that are accepted as justified (we understand the reasons for them). For example, self-starvation for a social or political cause (called a hunger strike) is seen as an admirable act, whereas self-starvation, by young women, for a personal cause (called anorexia nervosa) is seen as a mental disorder commonly requiring medication and hospitalization. What is the difference between the two acts? Nothing.

This confusion of autonomous action with apparent mental disorder can only occur when values, ethics, and science are confounded by both the controlling authorities and those controlled. The world as it exists entails tragedy. Life is problematic, and the choices to be made often invoke fear, anxiety, and pain. The human predicament consists of two conflicting desires. One is our desire for dependency. This consists of not wishing to be responsible, or wishing to be taken care of by some all-knowing authority—parents, the state, or God. The other is the desire for autonomy, to be self-possessed, self-reliant, free. This requires that we accept responsibility for our actions and be willing to live with the anxiety and ambiguity accompanying choice making. The decision of whether life under a certain set of circumstances is worth continuing is clearly a tragic human question, answerable only by the person living that life. By asserting that suicidal people are insane and that their choices are illnesses treatable by coercive psychiatric interventions, we diminish the humanity of the persons so labeled and cede authority to those who have no empirical or moral warrant for such a role.

References

Allard, R., Marshall, M., & Plante, M. (1992). Intensive follow-up does not decrease the risk of repeat suicide attempts. *Suicide and Life-Threatening Behavior, 22*(3), 303–314.

Hillard, J. R. (1995). Predicting suicide. *Psychiatric Services, 46*(3), 223–225.

Miller, D. (1994). *Critical Rationalism: A Restatement and Defence.* Chicago: Open Court.

Szasz, T. S. (1965). *The Ethics of Psychoanalysis: The Theory and Method of Autonomous Psychotherapy.* New York: Basic Books.

Rejoinder to Mr. Gomory

ANDRE IVANOFF

My opponent argues that because psychological/psychiatric intervention has not been shown to be unequivocally effective, there is largely no ethical basis for voluntary or involuntary interventions to help distressed individuals. His secondary argument is that hospitalization of potentially suicidal individuals is not ethically justified because it has not been shown that hospitalization of those individuals reduces the likelihood of their self-harm.

This forum is not the place to argue the empirical effectiveness of psychological intervention, pharmacological therapy, and other psychiatric or residential treatments. Space and focus prevent discussion of how, and under what circumstances, practitioners use methods lacking demonstrated effectiveness; suffice it to say that almost all do. I share a strong bias for interventions with demonstrated effectiveness and can identify numerous psychological or psychiatric problems for which there are empirically based interventions. It is clear, however, that the society we live in popularly expects that individually or socially defined symptoms of aberrant behavior can be ameliorated by experts traditionally, using a medical model of treatment; in other words, we place ourselves in the hands of expert caregivers who define our pathology, know what is best, and prescribe relief. Regardless of preferred treatment models or theoretical orientation, while in roles as caregivers and mental health professionals, we are called on to support and protect life, sometimes even in cases when the client has lost all hope.

Suicide is not a simple personal act in our social structure, nor do I believe it should be treated as such. Suicide has significant social, as well as personal, repercussions. Contrary to Gomory's interpretation, I view the 8,000 articles on suicide found in his university's database as a testament to the profound impact suicide has on the living. I fail to understand how the act of suicide can be viewed only as an ethical exercise in free will by anyone who has witnessed the struggle against voices ordering self- (or other) destruction, alcohol- or drug-induced loss of contact with reality, or postpartum depression so severe that the risk affects both mother and child.

Do all such affected individuals request help or voluntarily accept it? Unfortunately not. The phrase "harm to self" when used to determine individuals needing care is stated more aptly as "imminent harm to self": it is absurd to suggest that habitual users of alcohol and cigarettes are at more imminent risk of

harm to themselves than the distressed individual who plans, states full intention to carry out, and possesses the immediate means to carry out, suicide.

Suicide is a permanent, unretractable solution to what may be a temporarily unsolvable problem. The number of individuals who think seriously about suicide is far, far higher than the number who "attempt" suicide, which is far higher than the number who actually commit suicide. Most of those who engage in suicidal ideation verbalize suicidal intent, and even engage in self-harm labeled as attempted suicide, later change their minds. Are we so autonomous, so individually determined to deny this opportunity? Placing suicidal clients into care does not permanently deprive them of the right to suicide; at most, it defers a decision. Suicide is only an option for the living.