



Why are people with mental illness excluded from the rational suicide debate?

Jeanette Hewitt*

Centre for Philosophy, History and Law in Healthcare, College of Human and Health Science, Swansea University, UK

ARTICLE INFO

Available online 7 July 2013

Keywords:

Rational suicide
Mental illness
Suffering
Autonomy

ABSTRACT

The topic of rational suicide is often approached with some trepidation by mental health professionals. Suicide prevention strategies are more likely to be seen as the domain of psychiatry and a wealth of psychiatric literature is devoted to identifying and managing suicide risk. Whether or not suicide can be deemed permissible is ostensibly linked to discussions of autonomy and mental capacity, and UK legislation directs that a patient's wishes must be respected with regard to treatment refusal where decisional capacity is intact. In the context of the care and treatment of those with physical disorders, extreme and untreatable physical suffering is likely to be accepted as rational grounds for suicide, where the person possesses cognitive coherence and an ability to realistically appreciate the consequences of his or her actions. In the case of those with serious mental disorder, the grounds for accepting that suicide is rational are however less clear-cut. Serious mental illness is typically conceived of as a coercive pressure which prevents rational deliberation and as such, the suicides of those with serious mental illness are considered to be substantially non-voluntary acts arising from constitutive irrationality. Therefore, where an appropriate clinician judges that a person with serious mental disorder is non-autonomous, suicide prevention is likely to be thought legally and morally justified.

There are arguably, two questionable assumptions in the position that psychiatry adopts: Firstly, that psychogenic pain is in some way less real than physical pain and secondly, that mental illness invariably means that a desire to die is irrational and inauthentic. If it can be shown that some people with serious mental illness can be rational with regard to suicide and that psychological pain is of equal significance as physical suffering, then it may be possible to conclude that some persons with serious mental illness should not by definition be excluded from the class of those for whom rational suicide may be a coherent choice.

© 2013 Elsevier Ltd. All rights reserved.

1. Introduction

The question of how best to respond to suicidal persons creates an ethical quandary for the medical profession and the wider public alike. For some, the notion that suicide could ever be rational is a contradiction in terms, and the desire to enact a self-inflicted death is interpreted as clear evidence of mental illness. Traditionally, preserving life rather than causing death has been the province of medicine and the permissibility of suicide within this value-structure is not easily reconciled with the healing goals of medicine. Where sympathy has been shown towards the notion of rational suicide, this has been primarily in relation to physical disease, terminal states and chronic pain (Hewitt, 2010). It has not been considered to be a coherent or genuine choice for those who are deemed to be suffering from irrational desires arising from the controlling forces of mental illness (Beauchamp & Childress, 2009).

Suicide has not been a criminal offence in the United Kingdom since 1961, when the common law felony of self-murder was repealed

(Williams, 1997). However, psychiatry has maintained its position that suicidal persons often suffer from some form of disease or irrational drive towards self-destruction, which must be prevented, as it is the result of a confused and distorted assessment of their life prospects (Beauchamp, 1986; Clark, 1992; Nicki, 2002). Although suicide is not illegal in the UK, it is still lawfully preventable where it is considered to stem from mental disorder.

The current response from mental health services to people with serious mental illness who attempt suicide is typically determined by the disease or medical model (Rich & Butts, 2004; Werth, 1996), which views mental illness as a dysfunction of the brain. Problems in brain chemistry, rather than problems in living are seen to be the remit of psychiatry, where treatment seeks to correct deviation from the norm. Psychiatric responses towards persons who exhibit 'symptoms' of suicidality are often adopted on the basis of a disease paradigm and seek to 'fix' the faulty organism rather than relate to the person's experience of suffering. People with a psychotic disorder are often considered to lack insight into the presence of the disorder itself and the ways in which the disorder influences reasoning abilities and judgement (Nordenfelt, 2007). Within this view, psychopathology which gives rise to irrationality in denial of the illness precludes an understanding of one's realistic life prospects.

* Tel.: +44 1792 518559.

E-mail address: j.l.hewitt@swan.ac.uk.

Therefore suicidal desires are considered to be a symptom of illness, rather than the result of rational deliberation.

Quality of life issues have increasingly been discussed in relation to rational suicide (e.g. [Farsides & Dunlop, 2001](#)) and are often linked to concepts of suffering, which are conceptualised as physical in nature ([Wilson et al., 2000](#)). Quality of life arguments contend that life is only valuable in so much as it retains value for the holder. Suicide may therefore be morally permissible where quality of life has become so reduced, that the person would rather be dead than continue with a life of suffering. The suffering associated with terminal illness and physical pain has been viewed as legitimately influencing a person's desire to die (e.g. [Warnock & MacDonald, 2008](#)). Suicidal desires in these circumstances have been accepted as both rational and morally permissible ([Fairbairn, 1995](#)). Psychological suffering¹ is however rarely given equal weight. It is typically seen as transitory and irrational; the person's distress is only the product of current cognitive distortions, which can either be reasoned against or treated with psychotropic medication. This disparity appears to stem from physicalism, which [Blackburn \(2005\)](#) defines as:

[The view that the real world is nothing more than the physical world ... Physicalism is opposed to ontologies including abstract objects, such as possibilities, universals, or numbers, and to mental events and states, in so far as any of these are thought of as independent of physical things, events or states (p.277).]

Within this view, only physical pain is real as all pain is physical, therefore only physical suffering can lead to unendurable states of being. Although this may allow for real mental states, these are dependent on and explainable by reference to brain-states. If biomedical claims that mental disorders are caused by neuro-structural or neuro-chemical dysfunction are true (and such claims have become increasingly frequent), then these illnesses are brain-based and therefore physical – pain which is physical has validity therefore brain-based pain is real. However, it is difficult to conceive of mental states such as anguish, despair or grief as being simply brain-based pain. Few would however deny that such mental states are possible, but they are not easily reducible to brain-based dysfunction. If physicalism is false and there are indeed mental phenomena that cannot be directly explained by corresponding brain-states, then it is plausible to suggest that both mental and physical suffering should at least *prima facie* be accorded equal status.

This article seeks to answer the question of whether some people with mental illness should be included in the class of cases in which rational suicide is a justifiable option. Two key perceptions are explored that may potentially influence judgements regarding the legal and ethical permissibility of suicide for some people with serious mental illness: Firstly, an apparent dualism in public attitudes towards suicide, which accepts the rationale of physically caused suffering whilst rejecting the reality of psychogenic pain. Secondly, the converse position of psychiatry, which posits an association between constitutive irrationality and psychiatric diagnosis rooted in physicalism. In exploring the growing debate about rational suicide in contemporary culture in the UK, this article then examines the rationale for the current status quo with regard to suicide intervention for those with serious mental illness within psychiatry. This exploration appears to show that the influence of physicalism in psychiatry and the public ignominy of mental illness prevent any acceptance that suicide can be a rational decision for any person with serious mental illness. Such assumptions about the constitutive irrationality of mental illness have effectively silenced those with mental illness who suffer existentially. The conclusions of this work are that only a unified view of persons, which is accepting of self-knowledge as epistemically important, can resolve the current disparity between the weight

awarded to physical in contrast to psychological suffering and challenge the dominant discourse of physicalism in relation to rational suicide.

2. Public perceptions of rational suicide

Historical debate regarding the moral permissibility of suicide may be traced back at least as far as the time of Plato. From the general attitude of tolerance in ancient Greece to the opposition of the Christian church, suicide has been seen as an act of honour, a transgression against God and a legally punishable offence ([Rich & Butts, 2004](#); [Werth, 1996](#)). Since the decriminalisation of suicide in many Western nations, there has been progressive change in the way in which suicide is viewed within Western society. Religious condemnation and vilification of a would-be suicide is no longer a norm in most Western cultures and it is no longer common to think of suicide with strong moral disapproval ([Glover, 1977](#)).

[Glover \(1977\)](#) observes that contemporary (Western) society typically views the issue of suicide in one of two ways: the first view is concerned with freedom of choice, which may be conceived of as a Libertarian perspective, and the second view is concerned with irrationality (suicide as a medical problem), which may be conceived of as the psychiatric perspective. There may of course be problems in categorising societal views so succinctly. The context of suicide is also likely to affect societal views on the moral permissibility of suicide; suicide may cause harm to others, through bereavement, survivor guilt or material loss, as when the suicidal person leaves behind dependents unable to support themselves ([Cvinar, 2005](#); [Margolis, 1975](#)) and as such may violate moral duties to others or cause harm to the community as a whole ([McLaughlin, 2007](#)). However, it is issues of choice and rationality that are typically raised in discussions of rational suicide and therefore Glover's distinction is of relevance here.

The view that suicide is a matter of free choice for a person is typically conceived of as Libertarianism. This is the view that rational persons have a moral right to liberty, which can only be limited by the liberty rights of others. Persons may freely choose the ways in which they exercise their right to liberty and others have no licence to interfere with the legitimate exercise of that liberty ([Regan, 1986](#)). This perspective is consistent with Mill's conception of liberty, wherein interference with another's actions is only permitted to prevent harm to others.

The libertarian view on suicide supports a right to suicide and prohibits others from interfering with that right. This view is supported by [Hume \(2005/1777\)](#) for reasons of suffering, by [Szasz \(1999\)](#) as a right of freedom and by [Battin \(1994\)](#) as a defence of human dignity. [Fletcher \(1998, p. 65\)](#) contends that '... the values of self-determination and liberty weigh in the suicide's favour', and argues in a similar way to Szasz that suicide is the signature of freedom. Such positions are often predicated on assumptions of individual body ownership, which confer absolute property rights to the disposal of the body by persons, and do not accept the sanctity of life arguments maintained by moralist perspectives.

[Cutcliffe and Stevenson \(2007\)](#) have observed a growing trend towards the libertarian position on suicide in the UK and speculate that this may be linked to societal changes that have increasingly valued individual freedom of choice and personal emancipation. [Cholbi \(2011\)](#) attributes progressively more morally permissive attitudes towards suicide to a secularisation of Western values and longer life-spans. This growing trend towards a more permissive attitude is illustrated in recent attempts to legalise assisted suicide, through individual challenges to UK courts and private members' bills, by the growth of suicide tourism and by medical and philosophical literature that argues for the legalisation of voluntary euthanasia (e.g. [Warnock & MacDonald, 2008](#)). Libertarian claims of a right to die have become gradually more insistent.

Suicide is not however always practically possible for some persons and a right to die does not include assistance to die within the UK and many other Western countries, whatever the person's circumstances.

¹ I use the term psychological suffering here to describe an enduring experience of profound existential sadness, anhedonia and despair, which cannot be explained by simple reference to physical or mental pathology.

It has been argued by individuals who desire to die but who require assistance to do so, that the current law is essentially unjust and enforces unbearable suffering (Nicklinson v MoJ, 2012).² The notion that persons have a right to die in circumstances of unendurable physical suffering has increasingly come to the fore over the last decade in Britain, with certain highly publicised cases such as Diane Pretty, (a motor-neurone sufferer who lost her legal case in the UK to prevent prosecution of her husband should he assist her suicide) and more recently, Tony Nicklinson, who was left paralysed with locked-in syndrome following a catastrophic stroke and who sought High Court authorization of a medically assisted suicide.

Although these cases (and others publicised by the media) have yet to successfully change the law with regard to assisted suicide in the UK, they have galvanised public debate on the rational nature of suicide in certain circumstances of unendurable suffering. These high profile cases have challenged primacy of life claims based on moral or religious grounds and prohibitions advocated by those who fear potential abuses that may arise if certain lives are deemed not worth living by external judgements sanctioned by law. Continued media attention given to 'right to die' cases has led to discussions about quality versus sanctity of life and body ownership versus state interference, in a wider arena outside of the privileged domain of medicine. The widespread reporting of such cases has challenged the public to engage in a hitherto taboo subject and has opened up discussion into the reasonableness of terminating life in circumstances of catastrophic and irreversible physical impairment. There appears to be growing sympathy with the claim that patients who wish to die because of irreversible and likely terminal physical suffering, should be allowed to do so, without interference from medicine or state.

Despite the growing media attention and commensurate body of literature debating rational suicide in physical illness (e.g. Farberman, 1997; Hietanen & Lonnqvist, 1991; Mayland & Mason, 2004), there has however been little discussion in the public domain of the views of people with mental illness with regard to a right to die. It is possible to pick out at least three possible reasons for this omission: The first two reasons are closely linked and stem from public misconceptions about the mentally ill and a consequent reluctance on the part of mental health service-user advocates to potentially reinforce negative stereotypes of mental illness. The third reason may be attributable to a prevailing dualism in public opinion and following a brief discussion of the first two reasons posited this view will be explored in greater detail.

European studies of societal attitudes towards people with serious mental illness show significant levels of intolerance and stigma (Angermeyer & Matschinger, 1996; Crisp, Gelder, Rix, Metzler, & Rowlands, 2001; Huxley, 1993; Rose, 1998) and increasing concern about the risk of dangerousness or riskiness of those who have been discharged into the community (Coid, 1996; Cutcliffe & Hannigan, 2001). Media reports in the UK often depict people with severe mental illness, particularly schizophrenia, as highly likely to be violent as a consequence of their mental illness (Ward, 1997) and this has contributed to an ongoing alienation of people with serious mental illness from society (Hewitt, 2008). Misconceptions about the general irrationality and riskiness of people with serious mental illness may well have resulted in a view that the desires and actions of people with mental illness are likely to be incomprehensible and therefore such people are best left to the care of psychiatry.

Cholbi (2011) has observed that because of the stigma that mental illness carries, mental health service-user advocates have been careful to avoid highlighting associations between suicide and mental disorder, in order to avoid reinforcing 'the popular misconception that mentally ill people are untreatable, "crazy," and need to be locked up' (p. 165). There has been increased emphasis on the recovery model of mental illness in the last decade, which focuses on the strengths, hopes and

achievements of people with serious mental illness (Gillam, 2006) and rightly enforces the view that serious mental illness need not follow a chronic relapsing course. However, the recovery vision is not necessarily the reality of experience for all people with serious mental illness and there is evidence to suggest that certain serious mental disorders, such as schizophrenia continue to carry an associated high risk of suicide (Fenton, McGlashan, Victor, & Blyler, 1997; Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Meltzer, 2001; Shields, Hunsaker, & Hunsaker, 2007). Cholbi (2011) argues persuasively that ignoring the wealth of data which links suicide to mental illness does not necessarily serve the interests of those with mental illness, even though this is motivated by good intentions to reduce stigmatization; it is, he argues, better to overcome misconceptions about the nature of mental disorder and suicide through 'knowledge and understanding, rather than more ignorance' (p.166).

The third factor that affects which kinds of disorders and experiences are generally held to be relevant to discussions of rational suicide appears to be a general privileging of physical pain above psychological distress. Discussions of rational suicide have typically focused on pain associated with physical suffering; rarely has psychological suffering been seen as a reasonable inclusion either because it is seen as being insubstantial and ephemeral or because it is attributed to an underlying mental illness which is remediable. It is to this first assumption, the insubstantiality of psychological suffering that discussion turns to next.

3. Classic dualism and suffering

Substance dualism is the view that the mental and the physical, or mind and body are, in some sense, radically different kinds of thing. Pain has traditionally been dualistically divided into organic (largely dependent upon irritation of nerve endings or nerves) and psychogenic (pain which is independent of identifiable cause and due to emotional factors) (Bendelow & Williams, 1995). The idea that pain is either real (physical) or imagined (mental) is one that is widely held within public perception (and by some healthcare professionals). Consider for example, such commonly used phrases as 'all in the mind', 'the worried well' or 'professional time-wasters', which have been used by lay persons and medics alike to refer to patients whose complaints are not objectively verifiable.

Medical theories of pain usually rest upon neuro-physiological determinants (Bendelow & Williams, 1995). Faith in empirical science has grown since the full flourishing of the Enlightenment, privileging that which is observable and objectively knowable. Physical suffering is seen as something concrete, frequently attributable to a clearly definable cause, often observable and therefore understandable and worthy of compassion. Physical pain is equally deserving of our sympathies; where it is intense and untreatable, it is understood to be insupportable. There appears to be much agreement that certain physical states of suffering cannot and should not be borne – there are limits to what the physical self can endure in terms of pain and incapacity. Certain cancers, motor neurone disease and paraplegia have been some of the most prominently referred to examples of unendurable physical states of suffering. Our understanding of pain is however to some extent constructed socially, in that we adopt a cultural narrative of suffering that is based on non-clinical notions of the rightness of courage and stoicism (and where the end points of these should be). As such, judgements about pain may have moral determinants, despite overtly resting on physiological conditions.

The experience of pain is never however exclusively situated in an individual's embodied being; it is better understood as an interaction between body, mind and the situation of the whole person (Morris, 1991). Sullivan (2001) has questioned the validity of dualistic notions of pain on both physiological and philosophical grounds. Sullivan argued that to understand the person's experience of pain, one must first come to an appreciation of the inescapable synergy between the

² Nicklinson v Ministry of Justice [2012] EWHC 304 (QB).

mental and physical. Even where pain can be clearly traced to an observable physical location (e.g. a malignant mass), the mind must experience aversion to the sensation produced if the phenomenon is to be categorised as pain. Therefore, Sullivan (2001) concluded that despite the physiological basis of physical pain it still does not originate solely in the body (or mind), but synergistically between minds and bodies.

The distress that arises from the experience of pain is usually conceived of as suffering. The concept of suffering is not however easy to define, since it is dependent on individual perception and circumstance (Cassell, 1999). Weir (1998) identified particular forms of suffering, those that are primarily physical: nausea, dyspnoea, fever, hunger, thirst, diarrhoea and pain, and those that are partially or primarily psychological in nature: anxiety, depression, denial, loneliness, helplessness, anger and fear (p. 259). One definition of suffering may therefore be any enduring experience of pain or distress that significantly impairs a person's subjective satisfaction with his or her quality of life.

Cassell (1991) defined suffering as 'the state of severe distress associated with events that threaten the intactness of the person', occurring when 'impending destruction of the person is perceived' (p. 33). Cassell contended that physical pain is but one source of suffering. He argued that dualism is responsible for the often held belief that suffering is either exclusively physical (i.e. bodily pain) or not truly real because it is mental. Suffering is however something which is experienced by persons and persons are both mind and body. Cassell asserted that there are multiple non-physical causes of suffering, including loss, powerlessness, hopelessness, loneliness and fear. Therefore, a person devoid of any physical pain may still experience suffering:

[People can suffer from what they have lost of themselves in relation to the world of objects, events and relationships. Such suffering occurs because our intactness as persons, our coherence and integrity, come not only from intactness of the body but from the wholeness of the web of relationships with self and others (Cassell, 1991, p. 40).]

Mental states of chronic suffering have not however generally received the same sympathies or credibility as physical conditions of suffering. Depression, anxiety and obsessive compulsive states have alternatively been seen products of an affluent but disaffected society, personality disorder, weakness of will or a remediable biochemical brain abnormality. Kendell (2001) observed that the dualistic separation of mind and body is partially responsible for the ongoing stigmatisation of mental illness:

[... the mind/body distinction ... still encourages many lay people, and some doctors and other health professionals, to assume that the two are fundamentally different. Both are apt to assume that developing a 'mental illness' is evidence of a certain lack of moral fibre and that, if they really tried, people with illnesses of this kind ought to be able to control their anxieties, their despondency and their strange preoccupations and 'snap out of it' (2001, p. 492).]

Historically, states of 'melancholia' and 'hysteria' were diagnosed within the medical category of neurosis, or nerve disorder, and later, as a way of differentiating them from mental illnesses associated with psychotic phenomena. The word 'neurotic' has become part of our general language and is frequently used as a pejorative term to describe those who are judged lacking in psychological robustness. The notion that these states of experience are common (to some degree or other) treatable through relatively benign methods (counselling) or possible to overcome through an effort of will, seems to be pervasive both within and without medicine. As such, the idea that mental, internal experiences produced by maladaptive ways of thinking may equate with unendurable suffering may be seen as hyperbole. If there is nothing physically wrong with the person, then pain has no tangible location and without tangibility, it cannot be real. There is a sense in which free-will is believed to be involved, at least in the early stages of

developing mental health problems, in a way in which cancerous tumours are not subject to choice. Kendell (2001) argued however that there is no logical reason to suppose that a person with mental illness has any more control over symptoms (or their genesis) than someone with a physical disorder such as migraine or underactive thyroid. He concludes that such perceptions damage the interests of patients and prevent them from receiving the support they need.

What then of categories of mental illness with psychotic phenomena? Mental illnesses such as schizophrenia or bipolar disorder are increasingly categorised as brain disorders caused by neuro-structural defect or neuro-chemical malfunction³ (e.g. Berman et al., 1997; Brown & Pluck, 2000; Dollfus, 1998). Due in part to this brain-based hypothesis which has been cited with increased certainty, such states are not conceived of as so easily remediable or self-limiting and are therefore categorised as 'serious' mental illnesses. However, despite the catastrophic effects that such illnesses may have on those who are diagnosed with them, there has been little discussion of psychogenic pain and suffering arising from living with such a disorder.

4. Psychiatric perceptions of rational suicide

Since the late eighteenth century, medical perspectives have conceptualised suicide as a symptom of mental illness (Spratt, 1961). Battin (1994) has traced the historical development of attitudes towards suicide, from the moral condemnation of the pre-Enlightenment era to the scientific empiricism of the 19th Century, which sought to explain suicide through reference to underlying psychopathology. Battin (1994) argued that the medical model, which rests upon scientific empiricism, continues to be the prevailing view in which suicide is understood; suicide is largely considered to be an involuntary and non-deliberate act, if not a mental disease in itself, then the product of a mental disease (Battin, 1994). The orthodox psychiatric view is that suicide always, or nearly always results from psychological disturbance, and thus it is always necessary to intervene in suicide attempts whenever possible (Fairbairn, 1995).

In general, in order to meet any sort of rational criteria, suicide must be seen as an understandable reaction to life circumstances by others; be associated with unendurable suffering; be in accord with a reasonable appraisal of future outcomes in terms of a cost-benefit analysis; have some connection with reduced life expectancy; and be uncontaminated by psychological dysfunction (Battin, 1994; Beauchamp, 1986; Beauchamp & Childress, 2009; Brandt, 1992; Graber, 1998; Kupfer, 1998; Siegel, 1986).

Siegel (1986) has defined the characteristics of rational suicide as:

[(1) the individual possesses a realistic assessment of his (or her) situation, (2) the mental processes leading to his (or her) decision to commit suicide are unimpaired by psychological illness or severe emotional distress, and (3) the motivational basis of his (or her) decision would be understandable to the majority of uninvolved observers from his (or her) community or social group] (p. 407).

Suicide associated with psychological disturbance has thus been largely excluded from the definition of rational suicide and the plethora of suicide prevention policy documents in the United Kingdom (e.g. DoH, 1999a,b, 2001, 2002), which link suicide with mental illness, illustrate the position taken by psychiatric authority that suicide is not a rational act and therefore should be prevented. Suicide has been linked with such diagnostic labels as depression and schizophrenia, where loss of contact with reality or a negative view of self, the world and the future lead to the irrational response of suicide resulting from cognitive distortions (Katschnig, 2000).

³ I do not include a substantial critique of the brain-based hypothesis of mental illness here, but Bentall (2003, 2004) has argued persuasively that such claims are flawed empirically and philosophically.

A diagnosis of mental illness is seen as one of the most influential factors in determining suicide risk (Appleby, 1992; Kapur, 2007). However, Werth (1996) observed that healthcare professionals are predisposed to observing psychological pathology in people who express suicidal ideation. Therefore whilst a diagnostic label of mental illness may well be predictive of suicide, expressing suicidal ideation may equally be predictive of a diagnostic label of mental illness. Cholbi (2011) observed that some mental disorders even include suicidal behaviour in their diagnostic criteria, which he argues implies a troubling circular explanation of suicide in terms of cause and effect. Beauchamp (1986) described the general principles that lead psychiatry to characterise suicides as non-autonomous acts. Suicidal persons are either conceived of as ill or not in a position to act autonomously because they are 'immature, ignorant, coerced, or in a vulnerable position in which they might be manipulated by others' (p. 108). The issues of coercion and irrationality are of relevance in considerations of the suicides of people with serious mental illness. Where mental illness is viewed as a controlling influence, this is seen to prevent the person from possessing cognitive coherence, autonomous reasoning and relevant or accurate judgement (Nicki, 2002). Within this paradigm, the suicide of a person with a serious mental illness would not be considered an intentional act, but rather an action which was coerced or controlled by the illness itself. Conceiving of suicidal acts as non-autonomous then allows others to directly intervene in to prevent 'irrational' acts and protect against harm, wherein the principle of saving life is taken to be the over-riding concern (Beauchamp, 1986).

The idea that the mentally ill are in same way coerced by their illness into suicide is one to which much assent appears to be given (Beauchamp & Childress, 2009). Arguably, it may be the case that a much weaker claim is true, that people are likely to be influenced by their illness but that such influence does not necessarily amount to coercion in all cases. It is arguable whether it is ever possible to be completely free of external influence on one's thoughts and actions. People with mental disorder are not the only group of persons who are influenced by the effects of illness. Some persons with chronic conditions, complicated by physical pain and disability also lack the freedom to be able to make decisions without the enduring presence of illness or dysfunction (e.g. those with multiple sclerosis, renal failure, quadriplegia). However, such persons would not normally be categorised as non-autonomous, in that their desires and actions would not usually be seen to be necessarily resulting from the influence of their illness or dysfunction.

The experience of unendurable pain (e.g. in terminal cancer) may be conceptualised in the same way. This pain is outside of the person's autonomous control, in the sense that it cannot be turned off at will. Thoughts, feelings, desires and goals may all be affected by the presence of the phenomenon of pain, which in that sense acts as an influencing force. Yet, the presence of such a force does not usually entail that the person is characterised as being non-autonomous. Where such a person expresses a desire to die, this may well be seen as an understandable reaction to unendurable suffering rather than an irrational response to influencing forces.

Within the psychiatric way of knowing, there are however considerable barriers to any potential suicide being considered as rational, and seemingly insurmountable barriers in the case of those already diagnosed as mentally ill. Since healthcare professionals are largely disposed to observing psychological pathology in people who express suicidal ideation, the assessments and responses made are likely to reflect the norms of psychiatry, which support a disease model of mental illness (Rich & Butts, 2004; Werth, 1996). Psychiatric literature often characterises people with serious mental illness as being globally or constitutively irrational because of brain-based pathology (Hewitt, 2010). Within this paradigm, mental disorders are viewed as being due to neurostructural or neurochemical abnormalities, which means that they can be classed as organic brain diseases such as dementia. As such, irrationality is imputed since cognitions and behaviours are seen

as inevitably affected by the enduring brain pathology, and physical diseases are only remediable through physical means. The effects of serious mental illness are not however necessarily definitive or global in the same ways that some brain insults or injuries are. Capacity for autonomous thought and action is likely to fluctuate according to variable mood, the direction, intensity and fixity of psychotic thought disorder and the effects of psychotropic medication (Hewitt, 2010).

Constitutional irrationality is therefore quite different to isolated irrationality. Irrationality of a global nature is more appropriately attributed to states of catastrophic brain injury or advanced dementia. Cholbi (2009) has argued that serious mental illness does not necessarily amount to constitutive irrationality; thought disorder and disconnection from reality are rarely global in nature and more likely to be isolated within a discrete domain. Studies of people with psychosis suggest that delusions do not point to marked abnormalities in general reasoning (Kemp, Chua, McKenna, & David, 1997; Owen, Cutting, & David, 2007; Owen et al., 2008). Abnormal beliefs tend to coalesce around certain predominant themes, but people who experience delusions are not deluded about everything or apparently at random (Kemp et al., 1997). Despite the experience of mental illness, some people can and do make decisions about their lives which are intentional and reasonable. There may of course be cases where delusional beliefs become so pervasive that all connection with reality is temporarily lost, but this is likely to be the exception rather than the norm in all but a few cases. Where illness becomes acute, psychological crisis may precipitate short-term loss of capacity, but most mental disorder (even the most severe) does not necessarily cause constant disablement. Most persons with serious mental illness are therefore not necessarily permanently and globally irrational in the sense of being completely removed from reality, but can merely be irrational with regard to certain beliefs and mental capacity should therefore be assessed in relation to specific decisions, on a case by case basis.

It is plausible to claim that most persons are not consistently rational with regard to all beliefs, but that nonetheless their irrationality rarely interferes with their liberty unless it is accompanied by a diagnosis of mental illness (or where it poses serious harms to others). Some people with serious mental illness, such as schizophrenia, are defined as irrational by virtue of a diagnostic category, which denotes serious disorder of thought and behaviour. Psychiatric labelling has important moral consequences when it is viewed *ipso facto* as being equivalent to a state of non-autonomy; these consequences seriously affect the moral standing, rights and quality of life of people with mental illness (Edwards, 1982). To conceive of a person as being globally irrational is to confer irrationality on his or her whole interaction with the self and outside world. Mental ill health and irrationality are not however synonyms. It is persons who are mentally ill, but it is the beliefs, desires or actions that are irrational; a person can be mentally ill but have few irrational beliefs or desires and perform no irrational actions (Culver & Gert, 1982).

Intervening to prevent unreflected or impulsive suicides, where the person has temporarily lost capacity for autonomy because of acute psychological disturbance is likely to be morally justified. Suicides, where contact with reality is lost or where there is an unrealistic appreciation of present or future circumstances are not likely to be rational and should not be conceived of as autonomous acts. Where a person's reasoning capacity is impaired, there are grounds for intervening to ensure that actions are not the result of confusion, coercion, misconception or even sudden desperation. There are numerous examples that may be cited of persons who, in acute psychological distress caused by crisis who impulsively wished to die, but whose desires were rescinded once the acute nature of the crisis had passed. Most moral agents would likely agree that to abandon such persons to suicidal impulses or further to assist those persons to die would be reprehensible. Even those adopting a libertarian position towards suicide would likely allow intervention in order to ascertain whether an individual was acting autonomously or not. Suicidal ideation associated with acute psychological crisis is rightly

not considered relevant to any discussion of rational suicide. Should however the same judgements be made about chronic psychological pain in the context of enduring mental illness? Chronic mental illness is qualitatively and quantitatively different to temporary psychological distress. The person may suffer repeated acute episodes of illness and also enduring changes in psycho-social functioning that have far reaching consequences for the person's quality of life. The view that we should always intervene to prevent the suicides of people with mental illness, because no mentally ill person could ever be sufficiently autonomous with respect to such a decision, is not so easily reconciled. This absolute approach to the prevention of suicides for those with mental illness is founded on assumptions about the general inability of most people with serious mental illness to be rational and is often linked to the particular physicalist explanations of mental disorder outlined above.

Is it however possible to reliably distinguish between a) those whose suicidal desires arise directly from a treatable mental illness, and whose life circumstances, were the illness to be successfully treated, would make life worth living and b) those who experience enduring suffering because of mental illness, which cannot be successfully treated in a way acceptable to the person and whose wish for suicide should therefore be accepted? Acceptance of such a delineation is likely to be dependent on first accepting three key underpinning arguments that are endorsed here: agreement that people with serious mental illness are not necessarily constitutively irrational, recognition that psychiatric treatments are not always effective or welcome to those who live with serious mental illness; and that subjective satisfaction with quality of life for those with serious mental illness is not solely dependent on the absence of psychopathology. Having explored the first premise, it is necessary to consider the second and third elements of the argument before arriving at some idea of what a delineation of rational and irrational suicide might look like in the context of serious mental illness.

5. Quality of life and serious mental illness

Despite significant advances in psychiatric treatment in the last sixty years, some people with serious mental illness do not respond to drug therapy (Bentall, 2003), find psychotropic medication ineffective and intolerable in terms of side-effects (Sharif, Ogunbanjo, & Maletz, 2003) and perceive psychiatric intervention to be intrusive and punitive (Fletcher, 1998; Jones, Ward, Wellman, Hall, & Lowe, 2000).

Many patients do not respond to psychotropic medication and neuroleptics provide little or no relief from hallucinations and delusions (Bentall, 2003). Neuroleptics do not reduce symptoms for approximately 30% of people with schizophrenia and where application of medication proves to be successful this is likely only to occur against a background of psychosocial support (Coffey & Higgon, 2001). People taking psychotropic medication often report distressing side-effects (e.g. motor restlessness, obesity, lack of energy, drowsiness, excessive salivation, speech problems) and a consequent reluctance to comply with drug therapy (Jarrett, Bowers, & Simpson, 2008; Sharif et al., 2003). Use of coercive practices in psychiatry to enforce compliance is not uncommon (Quirk, Chaplin, Lelliott, & Seale, 2012) and has been experienced by patients as humiliating (Svindseth, Dahl, & Hatling, 2007) and dehumanising (Olofsson & Jacobsson, 2001). Compulsory admission to hospital, and the use of 'special' or close observations which are often used to prevent in-patient suicides where there is perception of suicide risk, have been reported by patients as being restrictive, punishing and humiliating (Fletcher, 1998; Jones et al., 2000). The consequences of coming to the attention of psychiatric services therefore do not always prove helpful or therapeutic and may not significantly improve the quality of life of those diagnosed with serious mental illness.

Quality of life has thus far escaped precise definition, with the result that no clear consensus has been reached regarding its particular components (Hewitt, 2007). It is however widely acknowledged that the burden of a person's illness cannot be described fully by measures of disease status; psychosocial factors such as apprehension, functional

impairments and diminished cognition must also be encompassed (Muldoon, Barger, Flory, & Manuck, 1998). Components of worth have included: happiness, fulfilment, 'normality,' mental capacity, attachment, rationality, role performance, autonomy, absence of pain and material well being (Fletcher et al., 1992; Flanagan, 1978; Kaasa & Loge, 2003).

The subjective quality of life of people with serious mental illness has been shown to be lower than in the general population (Bengtsson-Tops and Hansson, 2001; Katschnig, 2000). Quality of life studies show that serious mental illness leads to impairments in many aspects of life, including physical and cognitive functioning, mood state, social and occupational roles, and economic stability (Hewitt, 2007). Psychopathology and the experience of side-effects associated with psychotropic medication have been significant predictors of a poorer subjective experience (Skantze, Malm, Dencker, May, & Corrigan, 1992). The experience of loneliness, daytime inactivity, unemployment, psychological distress, and difficulties with sexual expression is all associated with dissatisfaction with quality of life in people with serious mental illness (Bengtsson-Tops and Hansson, 2001).

Judgments regarding the severity of patients' psychopathology by psychiatrists do not always correlate with subjective appraisal of quality of life and its components. There is often a disconnection between the patient's narrative of suffering and the language of medicine (Cassell, 1999). Clinicians' concepts of quality of life tend to be more illness-oriented, encompassing the absence of psychopathology, whereas patients think about it more in terms of standard of living and lifestyle (Hewitt, 2007). Katschnig (2000) argues that to achieve adequate quality of life people with serious mental illness living in the community have additional needs and fewer personal and environmental resources.

The experience of chronic mental illness for some people may be one of repeated relapse, continuous psychiatric surveillance, unwanted intervention and stigma from without and within the psychiatric system. This can lead to significant impairment in psychosocial functioning, including poor social interaction, difficulty in maintaining relationships with family and friends, or function in the workplace; the inability to meet societal defined roles such as homemaker, worker, student, spouse, family member or friend (Burns & Patrick, 2007). The mentally ill may endure both the misery of the illness itself and the iatrogenic consequences of psychiatric treatment, with resulting psychic, social and interpersonal losses. Werth (1996) is among the few who have put forward the contentious view that the suffering caused by chronic mental illness is equivalent to the suffering endured by the terminally ill. He argued that both groups suffer because of a sense of deep hopelessness. High pre-morbid achievement, high self-expectations of performance and high awareness of pathology have been reported as important determinants of suicide risk (Drake & Cotton, 1986). Hausmann and Fleischhacker (2002) referred to a condition of 'chronic demoralisation,' which develops gradually for some people with serious mental illness, especially in patients who increasingly feel loss of self-efficacy. This condition they describe as a persistent state of deep hopelessness and existential distress. Suicides for such persons may be the result of fear of further disintegration of mental abilities and a choice to end life rather than live with chronic mental illness.

The experience of present suffering and prediction of future suffering may therefore lead to the state of hopelessness based on a reasonable appraisal of prospects. Psychological suffering in such circumstances is not transitory, nor can it be said to reflect a distorted view of present reality or of the future. People may become hopeless because they despair about their future lives with mental illness. Hope is necessary to human survival or at least to the desire to survive (Kylmä, Juvakka, Nikkonen, Korhonen, & Isohanni, 2006). Hopelessness experienced as a result of a realistic perspective on the course, costs and consequences of living with serious mental illness would seem a reasonable response in some circumstances where treatments have proved ineffective and remission or recovery has not occurred. Yet, despite the real losses often experienced by the mentally ill, this choice has generally been viewed as inauthentic.

In summary, the reasons suggested for an ongoing assumption that rational suicide is not possible for the mentally ill are that: 1) Psychological suffering is not 'real' in the same way that physical pain is; 2) Serious mental illness is a brain disorder which produces global irrationality and 3) Suicide in such cases is 'treatable' or at least appropriately preventable through psychiatric intervention. This discussion has attempted to show that such views may be flawed in wrongly attributing greater weight to physical pain above psychological suffering and wrongly assuming constitutive irrationality in the mentally ill. Both views ignore the important element of the person's subjective experience of quality of life.

Should all people with mental illness then be included in the class of cases for which rational suicide is considered reasonable? This is clearly not a tenable claim: where a person is in acute psychological distress, constitutively irrational, acting on command hallucinations or as the direct consequence of a delusional belief, is unable to appreciate the consequences of his or her actions or realistically appraise present circumstances or future possibilities, or where suicidal impulses are impulsive and unreflected, then such a person should not be considered rationally suicidal. Can an exhaustive list of qualities be equally constructed for persons with mental illness who can be considered to be rationally suicidal? Arguably, this would be a bold and difficult claim to make. It may however be possible to suggest that an assessment of the rationality of suicide for a person with mental illness should include at least include the following criteria: 1) That the person is not acting impulsively because of acute psychological distress or acute psychotic phenomena; 2) That suicidal thoughts are not causally linked to command hallucinations or persecutory delusional beliefs; 3) That the person is able to realistically appraise current circumstances and probable futures; 4) That the person is able to appreciate the possibility for alternative action and the costs and consequences of his or her decision; 5) That the cause of suicidality is not directly linked to an obviously treatable or remediable condition; 6) That the person perceives his or her suffering to be unendurable; and 7) That the person has a realistic perception of death. This is not likely to be exhaustive criteria and the threshold for evidence of mental capacity may be appropriately increased in the assessment of decisions where so much is at stake.

6. Conclusion

This article has attempted to show that some persons with serious mental illness can suffer equally as those with severe physical pain or disability. Claims that all persons with mental illness are inevitably irrational in their desire to die have been rejected and a rationale for unendurable suffering based on psycho-social losses has been put forward. It would seem from an examination of both monism and dualism in the context of mental illness and suicide, that neither can in effect address the suffering experienced by some persons with serious mental illness. Both, in different ways ignore the multi-faceted nature of quality of life – neither can explain the hopelessness inherent in a desire for death. There are not (as far as we are aware) any established links between specific brain neurotransmitters and suicidal thoughts (Matthews, 2007), nor are there cases of minds committing suicide without physical assistance.

What then should count as good evidence of a person's suffering and be significant to the rational suicide debate in the circumstance of serious mental illness? It would seem in answer that the only means of addressing the whole experience is to take a whole view of persons as unified in body and mind. As such, internal mental phenomena must be given equal weight as physical properties. Since subjective experience is by nature internal and individual, this can only be known fully to the person and only revealed through the person's narrative. As Matthews (2007) observed, brain chemistry can tell us nothing about the rational justification for suicide, this can only be identified through reasons and intentions. Should some persons with mental illness then be included in the class of cases in which rational suicide is a justifiable option? Arguments here have attempted to show, that in some cases they should. The only persons however who can give good reasons for

suicide in this context are those who experience serious mental illness. There are no lives that can be judged not worth living by objectively discernible criteria, only persons who judge their suffering as not worthwhile. Only a unified view of persons explains the existential hopelessness that can occur as a result of living with chronic mental illness and personal narratives are the only adequate means of assessing the reasonableness of suicidal desires in this context.

Acknowledgements

My thanks to Professor Steve Edwards and Dr Andrew Bloodworth for commenting on an earlier draft of this article and to the two anonymous reviewers who have helped greatly in clarifying the arguments in this work.

References

- Angermeyer, M. C., & Matschinger, H. (1996). The effect of violent attacks by schizophrenic persons on the attitude of the public toward the mentally ill. *Social Science & Medicine*, 43, 1721–1728.
- Appleby, L. (1992). Suicide in psychiatric patients: Risk and prevention. *The British Journal of Psychiatry*, 161, 749–758.
- Battin, M. (1994). *The least worst death: Essays in bioethics on the end of life*. New York: Open University Press.
- Beauchamp, T. L. (1986). Suicide. In T. Regan (Ed.), *Matters of life and death* (pp. 77–124) (2nd ed.). New York: Random House.
- Beauchamp, T., & Childress, J. (2009). *Principles of biomedical ethics*. New York: Oxford University Press.
- Bengtsson-Tops, A., & Hansson, L. (2001). Quantitative and qualitative aspects of the social network in schizophrenic patients living in the community. *Relationship to sociodemographic characteristics and clinical factors and subjective quality of life*. *International Journal of Social Psychiatry*, 47(3), 67–77.
- Bendelow, G., & Williams, S. J. (1995). Pain and the mind–body dualism. *Body and Society*, 1, 83–103.
- Bentall, R. P. (2004). Sideshow? Schizophrenia as construed by Szasz and the Neo-Kraepelinians. In J. Schaler (Ed.), *Szasz Under Fire* (pp. 301–320). Chicago: Open Court.
- Bentall, R. P. (2003). *Madness explained*. London: Penguin Books.
- Berman, I., Viegner, B., Merson, A., Allan, E., Pappas, D., & Green, A. (1997). Differential relationships between positive and negative symptoms and neuropsychological deficits in schizophrenia. *Schizophrenia Research*, 25, 1–10.
- Blackburn, S. (2005). *Oxford dictionary of philosophy* (2nd ed.) Oxford: Oxford University Press.
- Brandt, R. B. (1992). *Morality, utilitarianism and rights*. Cambridge: Cambridge University Press.
- Brown, R., & Pluck, G. (2000). Negative symptoms: the 'pathology' of motivation and goal-directed behaviour. *Trends in Neurosciences*, 23, 412–417.
- Burns, T., & Patrick, D. (2007). Social functioning as an outcome measure in schizophrenia studies. *Acta Psychiatrica Scandinavica*, 116, 403–418.
- Cassell, E. J. (1991). *The nature of suffering and the goals of medicine*. New York: Open University Press.
- Cassell, E. J. (1999). Diagnosing suffering: A perspective. *Annals of Internal Medicine*, 131, 531–534.
- Cholbi, M. (2009). Tonkens on the irrationality of the suicidally mentally ill. *Journal of Applied Philosophy*, 26, 102–106.
- Cholbi, M. (2011). *Suicide: The philosophical dimensions*. Peterborough, Ont: Broadview Press.
- Clark, D. (1992). Rational suicide and people with terminal conditions or disabilities. *Issues in Law & Medicine*, 8, 147–166.
- Coffey, M., & Higgin, J. (2001). Auditory hallucinations. *Mental Health Nursing*, 21, 18–22.
- Coid, J. W. (1996). Dangerous patients with mental illness: increased risks warrant new policies, adequate resources, and appropriate legislation. *British Medical Journal*, 312, 965–966.
- Crisp, A. H., Gelder, M., Rix, S., Metzler, H. I., & Rowlands, O. J. (2001). Stigmatisation of people with mental illness. *The British Journal of Psychiatry*, 177, 4–7.
- Culver, C. M., & Gert, B. (1982). *Philosophy in medicine: Conceptual and ethical issues in medicine and psychiatry*. New York: Oxford University Press.
- Cutcliffe, J. R., & Hannigan, B. (2001). Mass media 'monsters' and mental health clients: The need for increased lobbying. *Journal of Psychiatric and Mental Health Nursing*, 8, 315–321.
- Cutcliffe, J. R., & Stevenson, C. (2007). *Care of the suicidal person*. Edinburgh: Elsevier.
- Cvinar, J. (2005). Do suicide survivor suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care*, 41, 14–21.
- Department of Health (1999a). *Saving lives: Our healthier nation*. London: HMSO.
- Department of Health (1999b). *National service framework for mental health. Modern standards and service models*. London: HMSO.
- Department of Health (2001). *Safety first: Five year report of the national confidential inquiry into suicide and homicide by people with mental illness*. London: HMSO.
- Department of Health (2002). *National suicide prevention strategy for England*. London: HMSO.

- Dollfus, S. (1998). The measurement of negative symptoms. *European Psychiatry*, 13, 145s.
- Drake, R., & Cotton, P. (1986). Depression, hopelessness and suicide in chronic schizophrenia. *The British Journal of Psychiatry*, 148, 554–559.
- Edwards, R. B. (1982). Mental health as rational autonomy. In R. B. Edwards (Ed.), *Psychiatry and ethics* (pp. 68–78). New York: Prometheus.
- Fairbairn, G. J. (1995). *Contemplating suicide: The language and ethics of self-harm*. London: Routledge.
- Farberman, R. K. (1997). Terminal illness and hastened death requests: The important role of the mental health professional. *Professional Psychology: Research and Practice*, 28, 544–547.
- Farsides, B., & Dunlop, R. (2001). Measuring quality of life: Is there such a thing as a life not worth living? *British Medical Journal*, 322, 1481–1483.
- Fenton, W., McGlashan, T., Victor, B., & Blyler, C. (1997). Symptoms, subtype, and suicidality in patients with schizophrenia spectrum disorders. *The American Journal of Psychiatry*, 154, 199–204.
- Flanagan, J. C. (1978). A research approach to improving our quality of life. *American Psychologist*, 33, 138–147.
- Fletcher, J. (1998). Attitudes towards suicide. In J. Donnelly (Ed.), *Suicide: Right or wrong?* (pp. 57–66) (2nd ed.). New York: Prometheus Books.
- Fletcher, Gore, S., Jones, D., Fitzpatrick, R., Spiegelhalter, D., & Cox, D. (1992). Quality of life measures in health care. 1: Applications and issues in assessment. *British Medical Journal*, 305, 1074–1077.
- Gillam, T. (2006). Positive approaches to schizophrenia. *Mental Health Practice*, 10, 30–33.
- Glover, J. (1977). *Causing deaths and saving lives*. London: Penguin Books.
- Graber, G. C. (1998). Mastering the concept of suicide. In J. Donnelly (Ed.), *Suicide: Right or wrong?* (pp. 150–161) (2nd ed.). New York: Prometheus Books.
- Hausmann, A., & Fleischhacker, W. (2002). Differential diagnosis of depressed mood in patients with schizophrenia: A diagnostic algorithm based on a review. *Acta Psychiatrica Scandinavica*, 106, 83–96.
- Hawton, K., Sutton, L., Haw, C., Sinclair, J., & Deeks, J. (2005). Schizophrenia and suicide: Systematic review of risk factors. *The British Journal of Psychiatry*, 187, 9–20.
- Hewitt, J. (2007). Critical evaluation of the use of research tools in evaluating quality of life for people with schizophrenia. *International Journal of Mental Health Nursing*, 16, 2–14.
- Hewitt, J. (2008). Dangerousness and mental health policy. *Journal of Psychiatric and Mental Health Nursing*, 15, 186–194.
- Hewitt, J. (2010). Rational suicide: Philosophical perspectives on schizophrenia. *Medicine, Health Care and Philosophy*, 13, 25–31.
- Hietanen, P., & Lonnqvist, J. (1991). Cancer and suicide. *Annals of Oncology*, 2, 19–23.
- Hume, D. (2005/1777). *On suicide*. London: Penguin.
- Huxley, P. (1993). Location and stigma: A survey of community attitudes to mental illness. Part 1. Enlightenment and stigma. *Journal of Mental Health*, 2, 73–80.
- Jarrett, M., Bowers, L., & Simpson, A. (2008). Coerced medication in psychiatric inpatient care: Literature review. *Journal of Advanced Nursing*, 64, 538–548.
- Jones, J., Ward, M., Wellman, N., Hall, J., & Lowe, T. (2000). Psychiatric inpatients' experiences of nursing observation. A United Kingdom perspective. *Journal of Psychosocial Nursing*, 38, 10–19.
- Kaasa, S., & Loge, J. H. (2003). Quality of life in palliative care: Principles and practice. *Palliative Medicine*, 17, 11–20.
- Kapur, N. (2007). Reducing the suicide rate in people with mental health problems. *Sixth latest advances in psychiatry symposium, London*.
- Katschnig, H. (2000). Schizophrenia and quality of life. *Acta Psychiatrica Scandinavica*, 102(Suppl. 407), 33–37.
- Kemp, R., Chua, S., McKenna, P., & David, A. (1997). Reasoning and delusions. *The British Journal of Psychiatry*, 170, 398–405.
- Kendell, R. E. (2001). The distinction between mental and physical illness. *The British Journal of Psychiatry*, 178, 490–493.
- Kupfer, J. (1998). Suicide: Its nature and moral evaluation. In J. Donnelly (Ed.), *Suicide: Right or Wrong?* (pp. 162–174) (2nd ed.). New York: Prometheus Books.
- Kylmä, J., Juvakka, T., Nikkonen, M., Korhonen, T., & Isohanni, M. (2006). Hope and schizophrenia: An integrative review. *Journal of Psychiatric and Mental Health Nursing*, 13, 651–664.
- Margolis, J. (1975). *Suicide, negativities: The limits of life*. Columbus, Ohio: Merrill.
- Matthews, E. (2007). *Body subjects and disordered minds*. Oxford: Oxford University Press.
- Mayland, C. R., & Mason, S. R. (2004). Suicidal intent in the palliative care setting. *Journal of Palliative Care*, 20, 119–120.
- McLaughlin, C. (2007). *Suicide-related behaviour*. Chichester: John Wiley and Sons, Ltd.
- Meltzer, H. (2001). Treatment of suicidality in schizophrenia. *Annals of the New York Academy of Sciences*, 932, 44–60.
- Morris, D. B. (1991). *The culture of pain*. Berkeley: UCal Press.
- Muldoon, M., Barger, S., Flory, J., & Manuck, S. (1998). What are quality of life measurements measuring? *British Medical Journal*, 316, 542–545.
- Nicki, A. (2002). Feminist philosophy of disability care ethics and mental illness. *Nursing Philosophy*, 3, 270–272.
- Nicklinson v Ministry of Justice (2012). *EWHC 304 (QB)*.
- Nordenfelt, L. (2007). *Rationality and compulsion*. Oxford: Oxford University Press.
- Olofsson, B., & Jacobsson, L. (2001). A plea for respect: Involuntarily hospitalized psychiatric patients' narratives about being subjected to coercion. *Journal of Psychiatric and Mental Health Nursing*, 8, 357–366.
- Owen, G., Cutting, J., & David, A. (2007). Are people with schizophrenia more logical than healthy volunteers? *The British Journal of Psychiatry*, 191, 453–454.
- Owen, G., Richardson, G., David, A., Szmukler, G., Hayward, P., & Hotopf, M. (2008). Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: Cross sectional study. *British Medical Journal*, 337, 448.
- Quirk, A., Chaplin, R., Lelliott, P., & Seale, C. (2012). How pressure is applied in shared decisions about antipsychotic medication: A conversion analytic study of psychiatric outpatient consultations. *Sociology of Health & Illness*, 34, 95–113.
- Regan, T. (1986). Introduction. In T. Regan (Ed.), *Matters of life and death* (pp. 3–34) (2nd ed.). New York: Random House.
- Rich, K. L., & Butts, J. B. (2004). Rational suicide: Uncertain moral ground. *Journal of Advanced Nursing*, 46, 270–283.
- Rose, D. (1998). Television, madness and community care. *Journal of Community and Applied Social Psychology*, 8, 213–228.
- Sharif, S. A., Ogunbanjo, G. A., & Maletc, N. H. (2003). Reasons for non-compliance to treatment among patients with psychiatric illness: A qualitative, South African study. *South African Family Practice*, 45, 10–11.
- Shields, L., Hunsaker, D., & Hunsaker, J. (2007). Schizophrenia and suicide: A 10-year review of Kentucky Medical Examiner cases. *Journal of Forensic Sciences*, 52, 1–8.
- Siegel, K. (1986). Psychosocial aspects of rational suicide. *American Journal of Psychotherapy*, 40, 405–418.
- Skantze, K., Malm, U., Dencker, S. J., May, P. R., & Corrigan, P. (1992). Comparison of quality of life with standard of living in schizophrenic out-patients. *The British Journal of Psychiatry*, 161, 797–801.
- Sprott, S. E. (1961). *The English debate on suicide: From Donne to Hume*. Illinois: Open Court.
- Sullivan, M. (2001). Finding pain between minds and bodies. *The Clinical Journal of Pain*, 17, 146–156.
- Swindseth, M. F., Dahl, A., & Hatling, T. (2007). Patients' experience of humiliation in the admission process to acute psychiatric wards. *Nordic Journal of Psychiatry*, 61, 47–53.
- Szasz, T. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport, Connecticut: Praeger.
- Ward, G. (1997). *Mental health and the national press*. London: Health Education Authority.
- Warnock, M., & MacDonald, E. (2008). *Easeful death: Is there a case for assisted dying?* Oxford: Oxford University Press.
- Weir, R. (1998). The morality of physician-assisted suicide. In J. Donnelly (Ed.), *Suicide: Right or wrong?* (pp. 247–264) (2nd ed.). New York: Prometheus Books.
- Werth, J. L. (1996). *Rational suicide? Implications for mental health professionals*. Washington: Taylor and Francis.
- Williams, M. (1997). *Cry of pain: Understanding suicide and self-harm*. London: Penguin.
- Wilson, K., Scott, J., Graham, I., Kozak, J., Chater, S., Viola, R., et al. (2000). Attitudes of terminally ill patients toward euthanasia and physician-assisted suicide. *Archives of Internal Medicine*, 160, 2454–2460.