ETHICAL CONSIDERATIONS OF ADOLESCENT SUICIDE

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ABSTRACT

Suicide is a complex and a poorly understood phenomenon, especially with regard to adolescents. From an ethics perspective, attitudes toward suicide have paralleled societal evolution. Among mental health practitioners, suicide is not easily solved, multifaceted problem that requires a multi-disciplinary approach for its prevention. In western countries, the ethical debate about suicide is centered on issues of personal autonomy and freedom instead of mental health professionals/responsibility towards suicidal individuals, while in developing countries the issues are connected to macro-level dilemmas like equity, justice and social condition related to psychological distress and suicidal acts. This chapter is meant for mental health and other professionals whose work is concerned with youth who are suicidal. Youth suicide within the context of broad ethical concerns include: the evolution of ethical concepts in relation to youth; autonomy versus societal responsibility toward others; clinical and ethical issues in management of suicidal clients and problems related to suicide prevention in diverse cultural settings. The author’s focus is on intentional death rather than euthanasia (active or passive) or assisted suicide.

INTRODUCTION

Suicide is one the most personal acts in which a young person can engage that is beyond the control of adult management. Youth suicide affects not only the youth but family, friends, and

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communities, especially schools. Schools are particularly vulnerable to youth suicide as schools are the places that youth spend most of their time.

Unfortunately, youth suicide is not an uncommon phenomenon. According to the World Health Organization (WHO), the mean suicide rate for this age group is 7.4/100,000 youth (1). Globally, suicide was the fourth leading cause of death among males and the third for young females. Since the reliability of suicide statistics is often questioned (2), it should be noted that the number of suicide deaths per 100,000 youth is grossly underestimated. This underestimation is secondary to cultural and religious phenomenon, as well as different classifications and ascertainment procedures. Additional factors that can also distort reported suicide prevalence data include other mortality diagnoses and misclassification of death by the coroner or medical examiner.

Since youth suicide is considered a public health crisis, youth suicide is studied by various academic disciplines. It has proven difficult, however, to develop a neutral definition of youth suicide that is relevant to all world countries. There is no neutral definition of suicide and in many societies, youth suicide has moral aspects that are difficult to legislate or fully understand (3).

Because youth suicide, as a phenomenon, is complex, different societies approach suicide in various ways. On the one hand, youth suicide can be conceived as being morally unacceptable and to be prevented if at all possible. In the United States, for example, governmental and private efforts are supported by prevention efforts against suicide. Alternatively, a United States District Judge ruled that ‘like the abortion decision, the rights of the terminally ill person to end his or her life involves the most intimate and personal choices a person can make in a lifetime and constitutes a choice central to personal dignity and autonomy’ (4). This same District Judge, however, fails to comment on an adolescent’s desire to intentionally kill themselves.

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**SUICIDE ETHICS FOR CLINICIANS**

Within different clinical cultures, there exists specific ethical beliefs and understandings about adolescent suicide work. Explicit and implicit decisions concerning the clinical approach, including assessment, interpretation as well as clinical training in suicidology affect ethical resolution in clinical work. It should be noted that these resolutions cannot be based on direct application of ethical guidelines for all situations involving youth. Therefore, the moral premises subscribed to by individual clinicians are essential in determining how common ethical issues in youth suicide work are resolved. Nonetheless, this chapter describes three philosophical positions upon which clinicians may base their clinical decisions when working with suicidal youth.
Presented below are general ethical perspectives that are described in greater detail by Mishara and Weistubb (5). These diverse perspectives are meant to challenge clinicians to understand better the moral premises upon which many mental health clinical decisions are made.

**The Moral Perspective**

Those mental health clinicians that work from a moralistic perspective contend that suicide is unacceptable; the overriding moral obligation is to protect life and prevent suicide (5). Arguments that disallow suicidal behavior among all youth dates back to Plato (427-347BCE) who considered suicide disgraceful and an offense against society with four exceptions. Suicide was permissible when the individuals’ mind was “morally corrupt,” self-killing by judicial order, as a response to severe adverse events, and because of shame secondary to participating in unjust actions. Whereas Plato provided leeway for suicide to occur under certain conditions, Aristotle (384-322 BCE) clearly condemned suicide as a “cowardly act” that was wrong for the “state” or the community in which the individual lived (6).

Religious forbiddance of suicide originates from Aquinas who believed that suicide is sinful because it is contrary to natural law and charity, represents an injury to the common good, and is a sin against God (7). Spinoza continued this position into the seventeenth century stating that the “basis of virtue is the endeavor to preserve one's being (3). One of the most well-known arguments against suicide originates from Immanuel Kant’s philosophy and, in particular, his central concept of “moral philosophy,” the categorical imperative. Kantian philosophy is built around the tenet that ‘to annihilate the subject of morality in one’s person is to rot out the existence of morality itself from the world….Consequently, disposing of oneself as a mere means to some discretionary end is debasing humanity in one’s person’ (8).

These philosophical views are integral to the contemporary clinical practice of mental health care and are often seen in the suicide-related law of many countries. In 2015, there still exist several countries (India, Singapore and Lebanon) where aiding and abetting suicide is illegal. In the former Soviet Union, for example, ‘suicide’ was absent from clinical discourse and the official position of the government was that suicide could not exist in Socialist society (9).

**The Libertarian Perspective**

The libertarian perspective contains a spectrum of views and is very diverse. This perspective is in agreement with an individual’s right to die by suicide. Libertarians consider suicide to be a reasonable and calculated act to avoid pain. It is, in short, the right of a person to determine whether they live or die. As far back as 400BC, philosophers emphasized living in harmony with nature and freedom based on rational choice (7). During this period, suicide was defended as an act worthy of respect, often a choice to avoid being forced to perform an unlawful act, extreme poverty or chronic physical or mental illness. Hume (10) supported this
ancient understanding of suicide. Hume maintained that the act of suicide receives its meaning from the circumstances, characters, and purpose of those committing it and also from the consequences of their actions (3).

Though the freedom to assist someone else to die by suicide might seem like a natural extension of the freedom to die by the actions of one’s hands. For those holding the libertarian perspective, the moral challenge that assisted suicide presents is not clear. Assisted suicide raises the issue of coercion. Libertarianism does not argue for bans on assisted suicide, however, but for informed consent and a requirement that assisted suicides have third party monitoring. If those safeguards are in place, the most likely libertarian perspective will point out that the benefits of legalizing assisted suicide almost certainly exceed any costs (11).

There exists a more radical libertarian approach that promotes suicide under certain circumstances, including physical suffering and illness (12). Regardless of whether it concerns an obligation to avoid pain or simple neutrality with respect to life and death decisions, those coming from a libertarian perspective have no specific obligation to intervene and prevent a suicide (13).

THE RELATIVIST PERSPECTIVE

Ethical relativism is the skeptical view that there is no objectivity to ethical judgments. The relativist perspectives (14) determine the “rightness” or “wrongness” of suicide and the extent to which there are obligations to intervene to prevent suicide based upon either contemporary situational and cultural variables or the anticipated consequences of action or inaction. The relativist believes ethical judgment is merely a matter of opinion and views vary from culture to culture, person to person. As there is a multitude of different moral beliefs and practices, but there is no objective procedure to determine which beliefs are more or less correct.

The clinician who practices relativism may support different answers to the question, “Is suicide among youth permissible or ethical. In one instance, youth suicide is permissible and under different circumstances, it is not permissible. Mishara and Weistubb (5) discuss the principles of utilitarian approaches to ethics?.” These authors suggest that for the relativist, decisions about suicide are made by determining the best interests of the affected community. Often, relativist will employ a cost/benefits analysis of the utility. Ultimately, the maximum social utility should be considered when deciding the appropriateness of suicide among youth or any other age group.

CLINICAL AND ETHICAL INTERSECTIONS

Managing suicidal youth poses difficult ethical dilemmas for mental health clinicians. Some clinicians use bioethical principles such as beneficence (to do or promote good, or prevent harm or remove harm), autonomy (right to self-determination) and non-maleficence (minimizing or preventing harm) (15) to guide their actions without compromising the therapeutic alliance with the client.
It is important, however, to make a distinction between the chronically suicidal youth who may have a long history of life-ending attempts and the acutely suicidal adolescent. The adolescent in an acute crisis may give rise to a compromised mental state and competence. The acutely suicidal youth is vulnerable and, therefore, may not have the capacity to make a decision about their welfare. In cases such as this, the ethical principle of beneficence can guide the clinical decision-making process and would dictate that aggressive measures be used to prevent the patient from coming to harm (16).

Though beneficence can also be applied to those adolescents with multiple suicide attempts in their history, the principle of autonomy may be more relevant. When working with chronically suicidal teenagers, the impetus is to facilitate the clients’ assumption of responsibility for their actions (17). This bioethical principle was legally upheld in the case of Hobart versus Shin (18, 19), where the courts upheld that the responsibility for dying by suicide lay with the client and had no legitimate claim for compensation from the therapist. Later, the court ruled that the only time they would consider the client with mental illness not responsible for their behavior was ‘if he is so mentally ill that he is incapable of being contributorily negligent’ and that ‘to rule otherwise would be to make the doctor the absolute insurer of any person exhibiting suicidal tendencies’ (20).

To be sure, the application of ethical and moral principles to the successful management of suicidal patients requires a flexible and creative approach rather than rigidity.

**YOUTH SUICIDE PREVENTION**

In mental health treatment best practices, the concept of suicide as a public health dilemma, has become well established in the clinical literature. Mental health clinicians are now expected to prevent death by suicide among youth for whom they are providing care. Once a mental health professional accepts responsibility for the assessment, evaluation, and treatment of potentially suicidal youth, it is reasonable to hold that professional liable should their practice fall below accepted standards of care (21). In fact, failure to prevent youth suicide is one of the leading reasons for successful malpractice suits against mental health professionals and institutions (22).

Though mental health treatment of suicidal youth in an out-patient setting is prevalent, the issue of negligence and standards of care is mostly applicable to hospitalized patients, where the duty to protect is high. Regardless of the treatment setting, a mental health professional can be held liable for an adolescent’s suicide if the youth’s conduct could have been reasonably foreseen and the profession failed to take reasonable preventive measures (22).

It is important to differentiate between the clinician’s use of reasonable standards of care to prevent suicide and the ultimate goal of absolute suicide prevention. While it is within the realm of good practice standards to assure clients that they will receive state-of-the-art care, the prevention of suicide is not entirely predictable or preventable, and should be communicated as such to the client and the client’s family or responsible party.
CULTURE AND SUICIDE PREVENTION

Because the act of suicide has different meanings in various cultures, it presents clinical and ethical challenges for professionals involved in suicide prevention. In Japan, for example, suicide may be perceived as desirable because ‘the values underpinning it are directly related to a socially pervasive moral belief that any act of self-sacrifice is a worthy pursuit’ (23). The perception of suicide as being morally favorable challenges the mental health practices of western practitioners when attempts are made at preventing suicide among youth.

In India, cultural factors and gender role expectations often lead to widows throwing themselves on the funeral pyre of their husbands (sati) and in many cases is passive, if not, actively encouraged. There is little evidence to suggest that such women suffer from a form of mental illness (24).

In some countries of the Middle East and Central Asia, self-immolation by young Muslim women has become a significant cause of death and disability (25). Suicidal behavior by this highly lethal method is closely associated with low levels of female education and gender discrimination, and a lack of health and mental health services in many of these countries. In some Islamic countries, suicide is considered a criminal offense legally (26), the prosecution of suicide attempters raises numerous ethical issues. One ethical question that the practitioner is often left with is, Is it ethically justified for governments to prosecute and punish individuals for an act that may have been precipitated by social conditions directly related to the systems that handle the prosecution of the young suicide attempters?

Clearly, the ethical issues associated with suicide prevention extend well beyond the individual practitioner level of liability of negligence to macro-level social and economic factors that impact mental health care rendered to young persons. These examples illustrate the difficult ethical problems encountered in different societies and the importance of addressing specific religious, social and cultural factors while developing and implementing suicide prevention programs.

CONCLUSION

Suicide is a complex and a poorly understood phenomenon, especially in regard to adolescents. From an ethics perspective, attitudes toward suicide have paralleled societal evolution. Among mental health practitioners, suicide is a not easily solved, multifaceted problem that requires a multi-disciplinary approach for its prevention.

In western countries, the ethical debate on suicide is centered on issues of personal autonomy and freedom instead of mental health professionals/ responsibility towards suicidal individuals, while in developing countries the issues are connected to macro-level dilemmas like equity, justice and social condition related to psychological distress and suicidal acts.

In clinical practice, management of the acutely suicidal adolescent requires a different approach from those teens who are chronically suicidal. Acutely ill adolescents are more vulnerable, and aggressive management of the stated suicidal intentions, including involuntary hospitalization, may be appropriate. For chronically suicidal adolescents, recommended mental health interventions are focused on assisting clients to take responsibility for their actions. As clinicians and adolescents alike struggle with their host
countries cultural beliefs on suicide and negotiate ways to open discourse about youth suicide, future suicide prevention strategies must take into account the complexity of the ethical landscape surrounding suicidal acts.

REFERENCES