SOME ETHICAL CONSIDERATIONS IN THE PREVENTION OF SUICIDE

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Abstract

The prevention of suicide is often discussed alongside the ethics of suicide itself. The ethics of prevention often centres around the use of ethical principles in the context of dilemmas and problems. The limitations of this approach are highlighted by focussing upon the concept of the moral community. Relational virtues arising from this community suggest important strategies for both client and carer alike.

Key Words: Ethics, Autonomy, Beneficence, Paternalism, Community, Virtues

> Where she was destined for exactly, I never knew .... Wherever it was she was supposed to be going, she never arrived. Instead she went to a canal and drowned herself.
> Sayers *(1988)*

> Wasn't it a basic need, for man, to belong to a community? If his father had formed the habit of going to the cafe every day at the same time, it was less for the sake of drinking in order to take his place among other people.
> Simenon *(1963)*

> I thought of all the joys the house had known ... all this I realised was more than I could ever abandon .... And just as powerfully I realised I could not commit this desecration upon myself.
> Styron *(1991)*

This paper seeks to explore some of the ethical dimensions within current approaches towards the prevention of suicide. This debate is closely tied to the ethics of suicide itself and its tendency to focus around the issues of duty, rights and obligations. (Bogen,1980) Although the central issue of autonomy is crucial and deserves to be debated in full, one result of this approach is to narrow the focus of ethical reflection somewhat and to downplay other important perspectives. One alternative is to view the prevention of suicide from the *relational* perspective of the moral community. (Hauerwas, *1977)* In doing so, a number of examples shall be given to illustrate our theme.

The Problem of Suicide

On a variety of measurement scales, suicide is a challenging and, potentially damaging, phenomenon. Around 5,500 people per year taking their own lives in Britain. (H.M.S.O., *1991)* Additional features include a predominance of male over female suicides (in the order of *3:1:* Safer *Services,1999),* strong links with levels of social deprivation (Gruer and Morrison, *1999)* and specific geographical features. (Hall *et a1,1998)* A recent *public* response to such trends has been to include suicide prevention targets within overall mental health promotion programmes. (H.M.S.O., *1991)* This report set targets of a 15 per cent general population reduction alongside a corresponding *33* per cent reduction amongst mental health service users. Durkheim, explored it in sociogenic terms of altruism, egoism and anomie. (Durkheim, *1897)* Others have added more existential, or personal, interpretations. According to Camus *(1955),* the act of suicide "is confessing that life is too much for you or that you do not understand it". As Hauerwas *(1977)* points out, there appears to be a broad consensus about the ethically problematic nature of suicide. However, despite two millenia of largely theistically-inspired disapproval of suicide, there appears to be much less agreement over *why* suicide should pose so many problems.

Conceptual Issues

One obstacle lies in the lack of clarity about what constitutes a suicide. Fairbairn (1995), argues that the plethora of terms used to describe suicidal behaviour (e.g. attempted suicide, para-suicide, failed suicide,

gestured suicide and `rational' suicide) distorts, rather than clarifies, the picture:

> the way that intentional self harming actions are at present common construed and discussed, limited as it is by the language we have available, fails to account of *the range of meanings* that actually or potentially lethal self harming may have *for those who enact them* and of the range of different communications that those actions may represent. (emphasis added)

Two points can be drawn from Fairbairn's observation. The first is to note our *objectifying* tendencies in our descriptions of suicide. All our definitions of suicide are value-laden and expressive of particular sets of values and goals. As the narratives at the beginning of this paper indicate, our understanding of suicide can never be merely `factual'. The `facts' of unemployment, isolation, poverty, physical illness, alcohol abuse and depression must of necessity be viewed within the context of a life lived with all its particular values and meanings and connected within a single narrative. (Hauerwas, 1977) The `range of meanings' for those attempting suicide and reasons attributed by others for that behaviour, needs to be seen as an integral part of a framework which is open, flexible and constitutive of a range of interpretations. The second point is to suggest, amidst the plethora of terms used to describe suicidal behaviour, a rather specific definition of what constitutes a suicide. There may be suicidal *behaviour* of different types e.g. the person who overdoses but plans to be found or the gestured `suicidal' act designed to punish, or manipulate, significant others. Such persons, of course, may *end up dead* but, arguably, these can be distinguished from those who intend to take their own lives. Fairbairn (1991) offers a specific definition of the act of suicide:

> I take suicide to be the autonomous act of bringing about one's death by one's *intentional* action when that intentional action is intended to result in ones' death.

Approaching Ethics

The method by which ethics is utilised in the prevention of suicide deserves important scrutiny. *One* route is to use the approach of ethical principles (e.g. the `four principles' of autonomy, beneficence, nonmalificence and justice: Beauchamp and Chi ldress, 1989) which can be applied universally in all situations and in all times. The context for the application of these principles is certain (highly visible) problems or *dilemmas* which confront practitioners. The roots of this principled approach lie in the Enlightenment quest for knowledge rooted in universal, detached and impartial terms. (Lutzen, 1997) One result of this approach is to view the *rational* self in isolated and individualist terms. In addition, this detached approach tends to view ethics as something done *over-and-above* everyday practice. The dominant position is to do ethics from detached and impartial stances in order to `see the whole picture' *before* making a decision. Such a cognitive perspective downgrades many aspects of our knowing which lie within, and not apart from, the range of factors which we attribute to the term *action.* In this approach, persons are seen as moral *agents* and moral perspectives are therefore placed at the very centre of our lives.

Ethical Principles applied to suicide prevention

How have the `ethical principles' been applied to the prevention of suicide? One approach has been to consider prevention in terms of the interplay between the principles of autonomy (does the client have the right to non-interference by others?), beneficence (intervening `imperfectly' in the `best interests' of the client) and non-malificence (the `perfect' duty of causing `no harm' in intervening). (Nicholson, 1994) The autonomy principle is pivotal to the discussion on suicide prevention. Is autonomy to be interpreted strictly as noninterference (allowing a person to kill themselves) or in terms of its variants (the person acting under influences e.g. ignorance, irrationality, mental distress or some other `crisis') and, therefore, not *really* autonomous? (Fairbairn,1991) Another issue is the charge of paternalism levelled against caring professionals. Long *et al* (1997) defend mental health nurses against such a charge by arguing that "in practical terms, most nurses regard their actions in terms of *doing the best they can,* rather than deliberately setting out to infringe on patients' rights to autonomy". (emphasis added) Despite Long *et al's* rebuttal, it seems hard not to see distinct limitations to the principles approach. Our ethics appears to remain firmly rooted within a 'top-down', *dilemmas* frameworks. Is this suicidal person acting autonomously or not? Are our actions, as carers, promoting, or hindering, a person's sense of autonomy? What are the grounds of our

involvement? When, if ever, can our paternalism be considered *justijied?*

To illustrate the point that our ethics need to be centred upon an action/reflection, rather than a theory/practice, axis, Fairbairn (1995) provides a revealing personal testimony. He contrasts the perspective of the `suicide liberal' (one tending to uphold a person's right to kill themselves) with that of the `suicide conservative' (one tending to argue that all interventions to prevent a person harming themselves are justified).

> I used to think of myself as a suicide liberal because I believe that taking personal responsibility for one's life is a very important feature of what it is to function fully as human person. I thought that suicide was simply a matter of personal choice, that a person had a right to do away with his life if he wished to do so, because our lives are our own and we are entitled to do with them what we will. Then, as a psychiatric social worker, I was asked to go out in the middle of the night to identify the body of a client who had jumped in front of a car. On one occasion a client swallowed large numbers of pills in my presence and on another I discovered a client lying in a pool of blood ... As I stood by Gloria's bedside the thought ran through my mind ... perhaps I should leave quietly and allow her suicide to proceed ... But then I thought about how much I would miss her in all madness, of how much poorer the world would be without her.

Fairbairn's quotation is noteworthy for indicating that our starting point for ethical deliberation *is action.* By being inextricably and inevitably involved with people who are suicidal, we cannot adopt `neutral', or detached, stances.

The Concept of Community

A central tenet of the critique of the technological-rational model of knowledge is its failure to acknowledge the social, or communal, dimensions to learning. (Glen, 1999) Knowledge creation is closely allied to *practices,* such as medicine, nursing or law and their particular social histories and traditions. (MacIntyre, 1984) Linked to this has been a critique of the philosophy of individualism, epitomised by authenticity (`be true to oneself: Taylor, 1995). By way of contrast, the concept of community affirms people *in relation to one another* and suggests that we find our *identity* as persons only in, and through, our relations with others. The task of ethics, therefore, is discover, and act upon, the shared values and understandings of this *moral* community. (MacMurray, 1949) According to Parker (1999), a simple *definition* of community is "the face-to-face close comfort of regular personal contact with valued others". This definition could be further refined to include the multiplicity of *communities* - families, neighbourhoods, work, leisure and care settings - that people fmd themselves part of. In a community approach, ethics is no longer narrowly bound to problem-solving. Instead, consideration of the `kind of people we are' (as a distinct community) takes priority over questions of `what are we to do' (in addressing particular `problems') and suggests that issues of character and identity are important factors in ethical deliberations. Such an ethics of action will attribute to each of us, as members of this moral community, such characteristics as intentionality (future-orientated), responsibility, integrity, dignity, freedom (within constraints) and mutuality.

Community and Suicide

Hauerwas (1977) turns the discussion of suicide on its head by invoking the value of life itself. He does this in an extended discussion of life in terms of gift, trust and affirmation. Such elements are constitutive of the sense of community itself. Using the example of community, Hauerwas contrasts a model of memory as *event* (focusing on the past) with a model of memory as *character* (emphasising `being present in mind' and, therefore, futureorientated and hopeful). Suicide militates against community in that "it eradicates the presence of the other and results in the other's loss in our memory". (Hauerwas, 1977) In other words, community never accepts the argument that `others would be better off without me'. Suicide erodes community of an essential part of its *raison d'etre.*

The Prevention of Suicide: Some relational examples using the virtues

In what particular ways can the moral community assist in the prevention of suicide? The virtues, or character metaphors (Dueck, 1990), can offer us a number of concrete examples which *may* contribute to the prevention of suicide. By suggesting that there is no certainty of prevention, we guard against any form of ethical `positivism'. The communal position of the

virtues apply to both client and carer. These will be illustrated under a number of key themes.

(1) *'Life is not understandable and therefore is not worth living'*

Patience and Hope

There are many instances when life shows up the limits of our ability to understand and make sense of it. The practice of patience and the exercise of hope suggest encouraging the person to look beyond present pain and past memories to a future offering the prospect of transformation and change. Hope finds its dynamic in the power of a sustaining, and unifying, narrative. It is interesting to observe Solzhenitsyn's (1975) point that the community making up Russian labour camps, in incurring few suicides, were sustained by an overall belief in their `universal innocence'.

Faithfulness

The virtue of faithfulness suggests that, despite life's vicissitudes, pains and problems, we do not give up on one another and abandon a person to their own (inevitable) destiny. Invoking the language of covenant, we `stay with one another' even if, *logically,* there may appear grounds to consider otherwise. This may place extra responsibility in the hands of a carer, especially if a client's behaviour suggests faithlessness on their part.

Trust

Lutzen and Barbosa (1996) offer an interesting example of the virtue of trust in a mental health nurse's action with a depressed patient who has become suicidal.

> She didn't directly say she wanted to kill herself and didn't want me to call her doctor, even when I asked her. There was conflict for me. I felt that she trusted me: it had taken a long time to build up a good relationship with her. What should I do? My choice was either to call the doctor anyway ... or waiting until the next day. I couldn't go behind her back, she would never have trusted me again. What I decided to was to *tell her of my dilemma,* be firm but kind and tell her I was going to tell the doctor. In the end she agreed to this and eventually was brought in by a relative.

By utilising the dimensions of the trust built up between nurse and patient, the nurse was able to be honest with her client and bring a difficult problem towards some kind of solution.

(2) *'Suffering and its alleviation'*

Humility and Self-Denial

A community approach suggests seeing suicide less as an event and more as part of the story, or narrative, of a life. In this way, Long *et al* (1997) aptly describe suicide as a `statement of suffering'. The practice of the virtues of humility and self-denial go some way to showing the cost of commitment in caring for a suicidal person. McFadyen (1990) observes that communication with suicidal person may involve suffering for that carer and necessarily involves `following the path of death oneself for the sake of life'.

(3) *'Everyone else would be better off without me'*

Loyalty

Consideration of the practice of this virtue reverses, in part, the relationship direction hitherto discussed and focuses upon the responsibilities of the person considering suicide. The virtue of loyalty challenges the person considering suicide with this question: `what would be the effect of my suicide on others?' There is considerable evidence as to the effects of a suicide on `those left behind to their shame, guilt and grief. (Hauerwas, 1977) These `survivors' (Wertheimer, 1991) attest to their helpless-ness, enduring sense of guilt and the eradication from their memory of a significant proportion of the deceased's value and worth.

Invoking a client's sense of loyalty and responsibility towards others is one of the most complex aspects of suicide prevention. The evidence of `survivors', however, suggests that rarely would no-one be unaffected by someone taking their own life. (Fairbairn, 1991) Social isolation and lack of meaningful relationships may be valid `predictors' of suicide. However, as Palmer (1983) indicates, each person is a `community in micro-cosm' and, as such, still exists within a nexus of relationships, even to strangers. If a suicidal person's *identity,* however tenuously perceived, is still to be found in relation to others, no less is their *integrity* bound up, in part, with the effects of their actions on others. However, given the acute sense of despair that suicidal people often find themselves in, perhaps it is expedient to balance the above statement with one suggesting that the `burden' of responsibility for a

completed suicide lies elsewhere. As Hauerwas (1986) reminds us:

> suicide is not first a judgement about the agent, but a reminder that we have failed to embody as a community the commitment not to abandon one another. We fear being a burden for others, but even more for ourselves.

Conclusion

It is important that we do not neglect fruitful perspectives emerging from an `ethical principles' approach. However, the prevention of suicide needs to focus less on a single (or repeated) event and more on consideration of a `narrated' life in all its action and shades of meaning. The practice of the virtues focus on the transformation of the self. Although this transformation is, in part, open to change in its *hope-ful* orientation towards the future, there also needs to be *acceptance* of the limits and constraints of living itself. The prevention of suicide for some may not necessarily result in the cessation of suicidal ideas, but lead instead to an altered perception of their own limitations and new ways of addressing `old' problems. We return to our three narratives at the beginning of this paper. Sayers (1988) indicates to us the *unpredictability* of life itself. Ultimately we cannot legislate in the area of the action of persons. Simenon (1963) indicates the importance of *people-in-relation:* the multiplicity of communities which sustain men and women by giving life a purpose and a framework to help in times of health and illness. Where these are lacking (and they appear to be in many areas of our lives today), we need to be bridge-builders and facilitators of community at a whole range of different levels. The final narrative (Styron, 1991) suggests that life lived in community - with all its values, memories and symbols - is a potentially far greater factor in efforts to prevent suicide than we may have hitherto realised. In the end, it is not the perfectibility of our ethical systems or preventative strategies that is the most important issue. It is, rather, our living of life itself and our willingness to bear each other, and ourselves, up in the living of it in all its variety.

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