EDITORIAL

Ethical Issues in Psychotherapy with Suicidal Clients

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Suicide is an indiscriminate killer that claims the lives of individuals from all walks of life. According to the World Health Organization, 703,000 people lost their lives to suicide in 2019.[1] The act of attempting suicide was widely considered a criminal offense until the start of the 19th century. With a change in these patterns of thought and law being observed in the last 50 years, a greater understanding of how to ethically assist suicidal clients in a psychotherapeutic environment has become paramount.[2]

The very first question in discussing the question of ethically working with suicidal clients is that of competence. When it comes to psychotherapy the attitudes held by the therapist toward the topic of dying and suicide are as important as the ideas held by the client. According to Hendin et al., "A therapist who is threatened by the fact that a patient may kill himself while under his care is in no position to be a therapist to the patient".[3] The ethical principles of the American Psychological Association (APA) delineate that "Psychologists recognize the boundaries of their competence and the limitation of their techniques. They only provide services and only use the techniques for which they are qualified by training and experience".[4]

One of the most vital considerations that comes into play while working with suicidal clients is countertransference. It is paramount that counselors learn to scrutinize and address their reactions to the thoughts or actions of their suicidal clients. If the anxieties held by the therapist in question start dictating the boundaries of the relationship with the client, then it is not conducive to the needs of the client and ultimately more gratifying for the therapist's desire to help than their ethical duty of upholding the autonomy of the client.

Discussions surrounding suicide almost always have the suffix 'management' associated with it and suicidality management is almost synonymous with keeping a watchful eye on the client, coming up with a contingency plan, and signing a no-suicide or anti-suicide pact. A discourse of this nature also promotes the idea that therapy should be limited to the management of suicidality. Moreover, the use of treatment modalities that encourage clients to consider the emotions of others or are built on promises that better times will come their way, is inherently based on manipulation.[3]

Researchers have suggested that the inclusion of relevant study material in the curriculum, clinical supervision and formal didactic training in understanding and managing suicide must be made mandatory to set basic standards of knowledge and practice in managing clients who are suicidal.[5] The entire concept of intervention in case of suicidality should not be hinged solely on preventing suicide by any means possible. Rather, the essence of these interventions should be creating more sustainable alternatives that actually assist with the quality of life of the clients.

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Informed consent is the backbone of all the ethical practices that are in play in modern-day psychotherapy. This ethical principle is also at the core of working with suicidal individuals. Psychotherapists are ethically duty-bound to provide their suicidal clients with a complete and unambiguous discussion about the risk and benefits of the treatment, the consequences of discontinuing therapy, and the inclusion of any specific considerations that arise due to the particular dimensions of their diagnoses or of the treatment process.[6] Informed consent in these instances needs to be a process that evolves along with the requirements of the client; is direct and honest in its scope and supplemented with empirically sound material that brings clarity to the client and makes them more likely to be forthcoming and supportive of the treatment process.[7]

The American Psychological Association's Ethical Principles and Code of Conduct,[8] laid out ethical principles that are meant to nurture an understanding and desire for having an ethically sound therapeutic relationship. This text is based on the primary principles of beneficence and nonmaleficence, fidelity and responsibility, integrity, justice, and respect for people's rights and dignity. Historically, the principle of beneficence and nonmaleficence took precedence over other principles and was considered the goal of not only mental health professionals but physicians on average, to the extent that these principles were often given more importance than the wishes of the client.[9] However, autonomy has overtaken beneficence as the primary principle of medical ethics over the course of the last 25 years and has become extremely intertwined with the concept of beneficence.[10] Autonomy can be thought of as the "capacity to make autonomous choices, with the underlying claim being that people who are capable of making autonomous choices are worthy of respect whereas people who lack this capacity are not".[11]

The subjectivity faced by mental health professionals when it comes to assessing the autonomy of an individual's ability to retain their ability to make rational, autonomous choices in the presence of fluctuations in thought processes, the influence of psychiatric conditions, medications, etc., has renderer the act of understanding what is beneficial for the clients an extremely ruminative decision. To further complicate matters, sometimes, carrying forward with treatments is not a decision that actually does the client much good. The concept of rational suicide is one that often leaves psychotherapists divided.

A 1995 paper studied the opinions of psychotherapists of the APA. This study found that a small number of psychotherapists refused the existence of rational suicide and claimed that the terms 'rational' and 'suicide' are contradictions. This opinion was based on two stances, the first being that such a harsh decision is invariably based on strong emotions and therefore inherently irrational. Others believed that the decision to die by suicide was reached because of a lack of options and borne out of desperation, once more bringing the rationality of the client into doubt.

If suicide is an inherently irrational act, then it warrants the evocation of diminished autonomy or sanction of paternalistic intervention.[12] Paternalism can be defined as limiting the autonomy or freedom of an individual to protect them from the negative consequences of their decisions. These actions are often undertaken against the will of said individuals and can be linked to acts such as forcing patients to take blood transfusions despite religious beliefs, governmental policies about indiscriminate nudity, or the sale of drugs, etc.[13] Such an action regarding suicidal patients could include, coercing the client into heavy doses of medication, limiting access to places where they might have the means to end their lives, and forcing psychiatric hospitalization among others. Engaging in these acts renders the application of autonomy obsolete, with the power of decision-making resting squarely in the hands of next of kin or mental health professionals. Individuals that advocate for these measures typically believe that acting on suicidal ideation, despite all circumstances is a violation of morality.

A second group of respondents believed that suicide can be conceptualized as rational because people have the right to die by suicide when stuck in a hopeless situation.[12] Suffering from insidious and chronic conditions or extremely debilitating and excruciating conditions such as HIV/AIDS, cancers of the brain and spinal cord, and Multiple Sclerosis among others are associated with high rates of suicide risk. In these cases, quality of life might be low and treatment might only provide slim chances of improvement. In these cases, the principle of beneficence and autonomy both support the decision to come to a peaceful end of life.

The final group of respondents believed that suicide could be considered rational only if it involved informed decision-making. These psychotherapists detailed that the process of coming to this conclusion should be well informed and every other option must've been explored as well. Additionally, the individuals in question must continue experiencing satisfaction with this decision and not simply act out of impulsivity. Researchers examined the conditions that are required to be met before the act of dying by suicide can be considered rational. The very first of these requirements is being in a state of hopelessness in terms of a cure or meaningful improvement in the quality of life. The individual in question must be undergoing extreme and chronic physical or mental anguish.[14] Perhaps the most important part of reaching such a conclusion is that there should be no coercion involved in this decision. Such a decision should only be taken after a lengthy discussion with a mental health professional to allow them to detangle any desire to die by suicide from side effects of medication or psychological conditions such as depression or anxiety, which can cloud one's judgment and be possibly managed. It is the ethical responsibility of the mental health professional to ensure that the client does not act impulsively or in a way that is out of character from their personality and personal belief systems.[14]

A truly ethically oriented therapist will prioritize the well-being of their client above all else. While the idea behind this statement is straightforward, the application of ethics can be a cumbersome enterprise because of the different understanding of what behavior and actions are truly destined for the well-being of the clients. I believe that an individual's decision to die by suicide is indisputably a question of autonomy, but it is a decision that cannot be taken lightly. Loosening the rigidity surrounding the idea of suicide can perhaps lead to normalizing the act to an extent where it might seem commonplace and cause individuals who could've survived suicidality due to temporary lapses in judgment, to lose their lives more frequently. Any misgivings about the idea of death and dying held by the psychotherapist should not interfere with the conclusion of whether the suicidality of a client is rational or not. The well-being of the client should be at the core of the ethical standards when it comes to the concept of suicide.

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