Ethical Issues in the Assessment and Treatment of a Rational Suicidal Client

Rosetta M. Snipe

The Counseling Psychologist 1988 16: 128
DOI: 10.1177/0011000088161011

• PROFESSIONAL FORUM

Ethical Issues in the Assessment and Treatment of a Rational Suicidal Client

Rosetta M. Snipe
University of Denver

A rational client's decision to suicide may present particularly complex ethical issues for a therapist. This article presents and discusses a 3-month account of therapy with such a client, from the perspective of the ethical values and principles upon which assessment and treatment decisions were made, and the complex ethical dilemmas encountered as the therapist juxtaposed the client's autonomy with the irreversibility of her potential death by suicide.

The preamble of the *Ethical Principles of Psychologists* states: "Psychologists respect the dignity and worth of the individual and strive for the preservation and protection of fundamental human rights. . . . While pursuing these objectives, they make every effort to protect the welfare of those who seek their services."

Respect for the dignity and worth of the individual is implicit in the concept of autonomy: that is, "The autonomous person determines his or her course of action in accordance with a plan chosen by himself or herself. Such a person deliberates about and chooses plans and is capable of acting on the basis of such deliberation" (Beauchamp & Childress, 1983).

In the course of assessment or treatment a psychologist may determine that the mandate to protect the client's welfare takes precedence over the client's autonomy. The concept of "diminished autonomy" is implicit under such circumstances. "A person of diminished autonomy, . . . is controlled by or highly dependent on others and is in at least some respect incapable of deliberating or acting on the basis of such deliberations" (Beauchamp & Childress). Yet other clients may not consistently function as "autonomous" persons or as persons of "dimin-

I wish to thank Karen S. Kitchener, Ph.D., for her comments on an earlier draft of this article, and "Mrs. Phoenix," who made it possible. Requests for reprints should be addressed to Rosetta M. Snipe, 4400 East Iliff Ave., Denver, CO 80222.

THE COUNSELING PSYCHOLOGIST, Vol. 16 No. 1, January 1988 128-138

ished autonomy." They may, intermittently, vacillate between these two states of autonomy. These concepts form the nucleus of the ethical issues involved in both the assessment and the 3-month course of treatment of the rational suicidal client discussed in the following case presentation.

THE CASE

The case involved a 39-year-old quadriplegic, "Mrs. Phoenix." Mrs. P's disability resulted from a car accident that had occurred 4 years prior to entering therapy. She had been accompanying a group of children to a party when the driver lost control of the vehicle in which they were riding and the accident ensued.

Ultimately, following extensive medical treatment, Mrs. P, her husband, and her teenaged son (wheelchair-bound due to a congenital birth defect) moved from their home state to their current residence, so that she could avail herself of what her physician had described as the superior rehabilitation programs in the city where they currently lived.

Subsequent to the move, Mrs. P continued to experience medical complications for which hospitalization was frequently required. Although she received comprehensive rehabilitation services, her depression remained persistent. When it became clear that she was suicidal, the rehabilitation center she attended referred her to the mental health center for treatment.

Mrs. P was described by the mental health center intake therapist as an attractive woman, casually dressed, who was able to sit up in her motorized wheelchair without assistance, and operate it with the very limited function remaining in her right hand. She was intelligent, introspective, and determined. She stated directly that she had a plan for suicide that she could carry out, that she would not share it, and she would not contract not to suicide. A judgment was made that hospitalization was not indicated because her plan to suicide was not an imminent one and her husband provided close supervision.

The process of Mrs. P's initial session ultimately resulted in our contracting to work on the quality of her life. My position was that life was a necessary condition to allow for her finding new meaning in it. With some skepticism, she reluctantly agreed to think about some degree of reinvestment in life. Thus some of her initial weekly sessions were devoted to talking about how life was for her in the present, and how it used to be.

Mrs. P's history revealed a "functional" biological family and loving relationships from childhood, a difficult and relatively short-lived first

marriage that ended at her initiation, and a good but also severely strained second marriage of 11 years' duration (her current one) with a caring and devoted husband. Three of her children (also products of her first marriage) were grown and had established independent and productive lives. Her teenaged son had always lived with her, and attended a special school for the handicapped. Prior to the accident, Mrs. P had been an active, lively person, enjoying life, her family, and full-time employment as an affirmative action counselor. She had been a responsible and productive member of her community, and clear thinking and mature in dealing with her life.

Mrs. P revealed that she did not currently view herself as having positive worth, nor did she perceive that she received positive regard in her daily life. She spoke of her anger when salespeople were condescending to her, assuming that she was retarded because she was confined to a wheelchair and had so little control over her body. We laughed together about their surprise when she began to talk with them. (She had a wonderful dry sense of humor at times.) And she talked about her embarrassment and her shame because of the kind of help she had to accept from her husband and others in dealing with her biological functions. She talked about her background, her childhood, her children, her hopes, and the accident, with varied and appropriate affect.

Her memory, intelligence, ability to concentrate and think on an abstract level, and her thought processing were all intact. She became affectively flat and logical only when she talked about what her suicide might mean to anyone. This was the point at which we differed immovably—she with logic about her disvalue and I with a clear knowledge of her worth to those who knew and cared about her.

During our weekly sessions, I challenged her to continue to be assertive, to disencumber her will, to reinvest in life, and worked toward confronting her low sense of self-worth by fostering her rediscovering her personhood, rather than perceiving only her limitations and her losses. I genuinely believed that she had a good deal to offer those around her and reflected back to her that sense of herself that she shared with me.

In light of her depression, antidepressant medication was prescribed. It had to be discontinued immediately, however, because it raised Mrs. P's blood pressure to a dangerous level and caused uncontrollable spasms in her legs.

Couples work was also recommended. Initially, Mrs. P was threatened by the idea of her husband's becoming involved in treatment. She feared

that somehow, through the process of therapy, he might give himself permission to leave her. Her care was extremely confining to him and many of his needs were no longer being met in the marriage. As she began to work through this fear, she gave permission for her husband to be contacted. Mr. P acknowledged the severe strain on their marriage and on him and agreed to couples work when his wife was ready. Thus Mrs. P used some of her sessions also to prepare for couples work. Then yet another hospitalization was necessitated due to medical complications.

Following that hospitalization, Mrs. P decided with clarity of thought and seemingly without anxiety or anger, to follow through on their planned visit to her family in their home state, to say good-bye to them in her own way, and suicide there. She refused to share her plan with her husband or anyone else. She was not responsive to any effort on my part to change her thinking, nor could I persuade her to talk with any family member about her intentions. She had an answer for every intervention I attempted. She seemed puzzled by my not understanding and accepting her decision as being a reasonable one.

At this point Mrs. P's request for confidentiality became secondary to protecting her welfare. I contacted her husband to let him know of the seriousness of his wife's plan and the timing of it. He was not surprised, said that his wife talked about suicide frequently, and assured me that she would not suicide. Although we talked about it at length, I was unable to understand why he was so sure that his wife was not at risk.

He was correct, however. His wife did not commit suicide while they were visiting with her family. Upon their return, Mrs. P shared with me that during their visit, all three of them received the nurturing they had so desperately needed for so long. Mrs. P found that she could talk with her mother about her grief and her suicidal feelings in a way that she had not foreseen. Her mother understood and accepted her feelings, and shared her own experiences on occasion with those very same feelings. Mrs. P's father, whom she also dearly loved, had suffered a medical illness since she had last seen him. In their talks together, she realized that he needed her. This belief gave her permission to live, and gave meaning to her life. Mr. P, who had adopted her family as his family, and who was loved by them, "was thoroughly spoiled by all of the attention given him by the women in her family, and thoroughly enjoyed every minute of it." Her son, who usually remained in his room at home, was rarely in his room during the visit. She had felt good watching him enjoy his cousins.

Mrs. P was clear that she did not need further services at that time.

Rather, she planned to concentrate on her son, who "needed to be more involved with life." She thought that she might also get in touch with Vocational Rehabilitation to see if they could help her find something to do during the day. She said that she would let me know if she needed to talk with me again.

DISCUSSION

A rational client (such as Mrs. Phoenix) who plans to suicide may engage the very core of a therapist's values and guiding principles in life, as well as their human frailties. Thus important and complex issues regarding the autonomy of both the client and the therapist may arise in the process of assessment and treatment.

Assessment Issues

This case illustrates that a central question for the therapist may be how to gain the objectivity to evaluate such a client's competence, and thus how to judge the degree to which the client's autonomy may be impaired.

For instance, Mrs. P triggered "like-me" issues in myself and in many of the staff, both male and female. Essentially, she was seen as living proof of the unfairness of a life in which "bad things could happen to good, lively and productive people." She was basically a warm, sensitive, and intelligent person, able to ponder deep questions and articulate important issues. And her goals and values in life were very similar to many of the staff's and to my own. She was, essentially, like "one of our own" who had been blindly and viciously struck down, facing a lifetime of no hope of even regaining some control of her own bodily functions. She aroused the question, "Would I want to live under those circumstances?" Her not wanting to live under those circumstances made sense in an important way; and her fundamental rage with life and with her condition was all too understandable. Heyd and Bloch (1981) state the dilemma succinctly:

> The possibility of suicide is considered by almost every human being at some stage in his life and this makes it harder for the doctor to take a balanced and objective view of his suicidal patient. As a result, there is the danger of an unsympathetic or unduly paternalistic attitude replacing rational evaluation and humane understanding of the patient's situation.

Thus enmeshment, based in shared ethical values and the shared myths about the positive payoffs one "should" receive for good,

productive living, was difficult to resist. By definition, in the face of enmeshment, one's ability to perceive and evaluate the autonomy of the other, is, at best, at risk. For example, it was difficult to perceive Mrs. P's manipulations and confront her with her responsibility for them.

A related issue that may impair a therapist's assessment ability is that a client such as Mrs. P may, knowingly or unknowingly, confront the therapist with his or her own unexplored reasons for valuing (or not valuing) life; and, in so doing, may propel the therapist into an existential crisis. For example, a therapist may not have come to terms with his or her own "irrational bias for life," or may not be aware that it may simply be a bias. Such therapists may find themselves in a personally vulnerable position as well as an ineffective professional position when required to clearly assess a suicidal client such as Mrs. P: For example, such a client's logical thinking process may confront a therapist with a sense of groundlessness. Adhering to APA principle 2f, by requesting competent consultation or supervision at such a point, is a valid decision.

In addition to the kinds of issues discussed above, there is the mandate to evaluate the client's autonomy in such circumstances. Powell (1984), addresses the issue of evaluating a client's autonomy in right-to-die dilemmas. He states that a client's decision to suicide may grow out of a distorted perception of life (as evident in depression) and that it is that very distortion that affects such a client's competency. That is to say that cognitive distortion calls into question the client's right to full autonomy in making decisions about suicide. I agree. My point, however, is that although a therapist may know that a client is depressed, when that client's depression is a reactive one that makes sense under the circumstances, and, when the client seems competent in the other areas of his or her functioning, the client may appear to be fully competent when this is not necessarily the case. Mrs. P was *intermittently* limited in competency in her thinking regarding suicide for the most part—which called for a complex ongoing assessment of her competency (autonomy) throughout treatment.

Treatment Issues

Suicidal ideation, expressed by a client such as Mrs P, is generally considered to be a manifestation of an existential crisis. Death, defined in the existential sense as one of the ultimate undeniable givens of existence, carries the connotation of an inevitable and unwelcome confrontation. May and Yalom (1984) state that in the existential view, the inner conflict regarding death is "between the individual's awareness

of inevitable death and the simultaneous wish to continue to live." Mrs. P was struggling with the wish to die *and* with the wish to live. From time to time in therapy sessions and with her husband, Mrs. P expressed the wish to die. At home with her biological family she experienced the kind of emotional healing that changed her diminished sense of self-worth and her negative assessment of the value of her life in positive ways. She experienced her readiness to live: the other side of her intermittent readiness to die.

Heyd and Bloch address the central treatment issue here.

> Suicide is not only a *functional* problem to which therapeutic techniques are applied but also an *existential* one—in both the literal and the philosophical senses of the word. The question is not how to achieve a better, more fruitful life, but whether to live at all. The fact that the starting point in the treatment of the potentially suicidal person is seen in such radically divergent terms by doctor and patient makes suicide a particularly difficult case: the psychiatrist's task extends beyond technically assisting his patient in attaining his own desired goals: he is required to persuade the patient to change his most basic desires and attitudes to life.

The principle of "autonomy" has been used as the nucleus of the case presentation and discussion inasmuch as it is considered a central underlying principle of the APA code of ethics. A second central principle has to do with "the preservation and protection of fundamental human rights" and with protecting the client's welfare. This mandate (and related philosophical considerations) will be discussed in the following section, within the context of five relevant ethical principles formulated by Beauchamp and Childress. These principles were used as criteria for the therapeutic decisions and interventions in the case.

ETHICAL PRINCIPLES

Beneficence

To "do good," "prevent harm," or "remove harm" by protecting a client's welfare is, perhaps, a less complex matter when the client is out of control, obviously thinking irrationally, or experiencing a severe pervasive depression or the like. It is a more complex matter to think through what *beneficence* means and how it may be actualized when a rational person makes a decision to suicide.

Although it is reasonable to believe that there is usually some ambivalence in a person's wish to die (as there was in the case of Mrs. P),

this line of thinking raises questions regarding whether there are instances in which doing good could include *helping* a rational person work through ambivalent feelings about his or her decision to suicide, say his or her good-byes, and prepare for death. My immediate response is no. Yet, on a philosophical level, the question is a tantalizing one. Acting on the principle of beneficence in Mrs. P's case resulted in my giving priority to the protection of her welfare over her request for confidentiality regarding her plan to end her life.

Paternalism

> The principle of paternalism authorizes interventions to protect the individual from the consequences of his or her choices, wishes, and actions. . . . Paternalism can be justified only if (1) the harms prevented from occurring or the benefit provided to the person outweighs the loss of independence or the sense of invasion suffered by the interference, (2) the person's condition seriously limits his or her ability to choose autonomously, and (3) it is universally justified under relevantly similar circumstances always to treat persons in this way. (Beauchamp & Childress)

Mrs. P was functioning in a state of limited autonomy, if not a nonautonomous state at the point she made her decision to suicide. One may argue that this state was produced by the intensity of both her anger and her sense of hopelessness following her last hospitalization. She was not in a position to choose autonomously because her choice was based upon a distorted view of her value as a person and the value of her life. Her self-assessment of her value was so low, so pervasive, and so intense that she could not accommodate a more objective and realistic view of herself or her value to others.

To intervene at such a point in a client's process becomes justified on the basis of the benefits that could accrue from providing him or her with the increased *time* to (1) consider, or come to understand the harms that this behavior could create for him- or herself or others, (2) allow for obtaining a more realistic view of him- or herself and the situation, and 3) allow for benefits that could accrue through unforeseen outcomes—such as the nurturing and positive resolution that occurred in Mrs. P's experience.

Nonmaleficence

The principle of nonmaleficence (to do no harm) was one of utmost importance in this case. To permit Mrs. P to possibly carry out her plan

to suicide with no attempt on my part to protect her welfare would *not* have been adhering to the principle of nonmaleficence: a fundamental principle of the APA ethical code.

Utility

> Utility requires that one examine the consequences of actions to determine the impact on the interests and welfare of all concerned. The interests of the person contemplating suicide, the interests of dependents, the interests of relatives, and perhaps the interests of others must all be considered in the calculation of positive values and disvalues. The fact that people love the person contemplating suicide and that they value the person's contribution to the community are relevant to a moral assessment of the contemplated action. In many cases a utilitarian calculation would show that the disvalue of the suicide, including grief, guilt, and deprivation, would be greater than the value to be gained. Hence the principle of utility would dictate that an act of suicide is unjustified in these cases. (Beauchamp & Childress)

It was quite clear that although Mrs. P could not perceive her value to others in the face of her intense anger and hopelessness, *she had worth and value* in the eyes of both her biological and marital families. Thus it was also based on the principle of utility that I determined that the disvalue of her suicide to others who loved and cared about her was greater than the values it could accrue—particularly in the face of the nonvoluntary state of her autonomy at the time.

Fidelity and Justice

The decisions a therapist makes about the promises they will keep (fidelity), and how the therapist determines what is due a client (justice), are fundamentally based on the therapist's judgment regarding the relative importance of these principles at any particular point in the process. In the case presented, these principles were given priority according to what, of greater comparative value, was at stake: for example, justice, the protection of Mrs. P's welfare, ultimately took priority over fidelity, maintaining confidentiality.

CONCLUSIONS

Several generalizations may be drawn from the above discussion. (1) A rational suicidal client has the right to autonomous thoughts and behavior to the extent that he or she is deemed competent by appropriate and valid means of assessing competency. In the process of

assessing competency, it is crucial to determine the degree to which the client's autonomy (competence) may be compromised by thoughts and feelings outside of the normal range of experience and judgment. The extent to which such a compromise exists, is the extent to which such a client's decisions and actions may be considered nonautonomous *at any point in time.*

(2) In accordance with APA *Ethical Principles of Psychologists*, there is *no* permission for a therapist to help such a client fulfill his or her goals. Nor is there permission to do nothing. Rather, and in stark contrast to the client's goal, there is the clear and consistent professional mandate to *protect the client's welfare*, based on the principle of nonmaleficence.

(3) Although a rational client's decision to suicide may make sense to the client (particularly if that decision has been made in response to a devastating and irreversible psychosocial stressor), that very rationality may at times tend to cloud his or her awareness of, and ability to express, ambivalence. Under such circumstances, the therapist may need to take an increased responsibility to explore the degree of ambivalence and the degree of resolution in the client's decision.

(4) It is of particular importance, when working with rational clients who may arouse like-me issues, that the therapist be aware of and separate out personal, philosophical, and professional values and beliefs from the client's. Enmeshment precludes a valid assessment and efficacious treatment.

Each client is unique and each client's situation and background is unique. Thus it is not possible to foresee the outcome of interventions at such a crucial point in a client's life. However, as Heyd and Bloch state with such eloquence:

> We may conclude by saying that it is better to err on the side of preserving life than on the side of letting it be lost. Although the philosophical considerations may show that there is no logically valid argument for the preference of life over death and that our bias for life is completely irrational, we should always remember that the potential suicide may, deep in his heart, share that irrational preference with us.

REFERENCES

American Psychological Association. (1981). *Ethical principles of psychologists.* Washington, DC: Author.

Beauchamp, T. L., & Childress, J. F. (1983). *Principles of biomedical ethics* (2nd ed., pp. 19-220). Oxford: Oxford University Press.

Heyd, D., & Bloch, S. (1981). The ethics of suicide. In S. Bloch & P. Chodoff (Eds.), *Psychiatric ethics.* Oxford: Oxford University Press.

Keith-Speigel, P., & Koocher, G. P. (1985). *Ethics in psychology.* Hillsdale, NJ: Lawrence Earlbaum.

May, R., & Yalom, I. (1984). Existential psychotherapy. In R. J. Corsini (Ed.), *Current psychotherapies* (3rd ed., pp. 354-391). Chicago, IL: F. E. Peacock.

Powell, C. J. (1984). Ethical principles and issues of competence in counseling adolescents. *The Counseling Psychologist, 12,* 57-67.