MORAL AND ETHICAL ASPECTS OF THE RELATIONSHIP BETWEEN DEPRESSION AND SUICIDE

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Abstract
In recent decades, the interest in psychiatric ethics has significantly increased as a result of a number of conditions that have shaped the current framework of psychiatry, namely the change of the psychiatric care framework, anti-psychiatry criticism, controversies surrounding the treatment of mental disorders or unmasked abuses in psychiatry. Depressive syndromes represent a major nosological category due to the high frequency of occurrence, the many forms of manifestation of symptoms and especially because of their social impact. The common denominator of most depressive syndromes is the suicide risk. This is a quasi-constant phenomenon of depressive symptoms and creates a two-way relationship between depression and suicide. Suicide involves not only a moral and social dimension, but also a legal one.

Keywords: *depression, ethics, suicide.*

In its complex meanings, ethics contributes to self-knowledge and provides individual support in relation to the decision to be taken. In the psychiatrist's case, this decision goes beyond self-analysis and enters the public domain because of its consequences. However, contemporary culture inhibits moral judgment on a personal level, but encourages the assignment of moral authority to an expert (1). Thus, ethics takes an expert dimension, which society can call on whenever it feels that rights are infringed. The anti-psychiatric current had a strong social impact, with the support of the media, which led to the deinstitutionalization of psychiatry and the development of community psychiatry. This was based on a series of ethical goals such as autonomy, the right to an independent living, eliminating the abuse of admission and compulsory treatment in psychiatric hospitals (2).

The significantly increased interest in psychiatric ethics in recent decades also stems from a number of conditions that have shaped the current framework of psychiatry, namely, the change in psychiatric care, anti-psychiatry

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critiques, the controversies surrounding the treatment of mental disorders or

unmasked abuses of psychiatry. Changing the type of medical consumption increased the patient's responsibility in the provision of psychiatric care and the involvement of beneficiaries of psychiatric care in program evaluation (3). Moreover, anti-psychiatry critiques led to the creation of a favourable framework for the development of an ethical meaning for medical responsibility as regards diagnostic criteria in psychiatry, as well as re-assimilation and community reintegration. Controversies regarding the treatment of mental disorders mainly focused on the patients unable to give an informed consent for their treatment. The ethical implications extended to psychosurgery and electroconvulsive therapy, which physically manipulates the brain, up to psychopharmacology and psychotherapy, which causes behavioural changes (4).

One of the main medical ethical principles established by the American Medical Association in 1847 states that: "The principal objective of the medical profession is to render services to humanity, with full respect for human dignity" (5). Although this principle is quite explicit in psychiatry, this statement can generate a number of questions because many patients are considered to have reduced or lack of judgment and cannot be equal partners in the doctor-patient relationship. Given these conditions, psychiatrists assume full responsibility, but the decisions in their activity cannot always be subjected to a deep ethical analysis because the possibilities of intervention would be late and ineffective.

George L. Engel, the founder of the medical the bio-psycho-social model, explained the trend in recent years to compare psychiatry to the medical model, which resulted from the crisis of confidence of other medical specialties towards psychiatry. Psychiatry was considered "an amalgam of unscientific views, assorted with philosophers and schools of thought, mixtures of metaphors, propaganda of political ideas for mental health and other esoteric purposes" (6). A comparison of psychiatry with the medical model also entails new problems that can be covered by ethics. Thus, the medical model requires clear nosological delineations, whereas the boundaries of mental disorders cannot be clearly established in psychiatry because, for example, adaptive responses to stress cannot be considered actual mental disorders.

Depressive syndromes represent an important nosological category, both due to their frequency and the wide range of symptoms involved, but especially because of their social impact. The common denominator of most depressive syndromes is the suicide risk. This is a quasi-constant phenomenon of depressive symptoms and creates a two-way relationship between depression and suicide. Suicidal behaviour involves various etiological, semiological and sociological aspects, hence it is very difficult to obtain a unified perspective on this phenomenon. The depression-suicide relationship should be removed from within a medical model and be placed at the crossing of psychiatry, normative and moral ethics. However, no clear distinction can be drawn between pathological and rational suicide, but rather an emphasis on the individual and variability of suicide behaviour. For society, suicide is not only a medical issue but a moral one, which is reflected in the social attitude of a given historical period. This attitude stems from the religious, political and philosophical

concepts of that era. Contemporary society is under the imperative of human rights. Psychiatry is one of the areas concerned in this regard, being even accused of abuse (7). Thus, in some states, psychiatry has today precise rules on admissions and differential treatments based on the voluntary or non-voluntary condition of admission. Nevertheless, the suicide, just as euthanasia is a legally disputed issue and in some countries, the right to a dignified death is already provided by law. As for the psychiatrist's position towards potentially suicidal depressive patients, it should not depend on the general concepts that govern society at a time, but must comply with professional standards. However, practice offers various specific situations that can become real dilemmas regarding the optimal attitude to be adopted and which cannot be solved only by compliance with regulations (8).

The word suicide was created in 1737 by Abbot Desfontaine and comes from the words "sui" meaning self, and "caedere" meaning to kill, that is, kill oneself (9). The introduction of this term was then followed by numerous attempts to define it. E. Durkheim considered suicide "all cases of death resulting directly or indirectly from a positive or negative act of the victim himself, which he knows will produce this result." He even attempted a classification of suicide and his categories of egoistic, altruistic, anomic and fatalistic suicide are taken into consideration even nowadays (1). In a more general approach, J. Baechler defines suicide as any behaviour that seeks and finds the solution of existential problems by attempting to the subject's own life (10). Suicide is a side of human behaviour, it is not just an isolated act and therefore philosophers, sociologists, theologians, psychologists and psychiatrists were particularly attracted by the attitude that the individual himself or society have towards suicide. Thus, the concept was defined, but the complexity of the term suicide was never understood. In fact, suicide cannot be explained, so all definitions range between descriptive marks and attempts to be as useful as possible to epidemiological methodology. Consequently, suicide, according to Beauchamp's criteria-based definition is the action taken by a person to intentionally cause his own death, there is no coercion in this respect from other people and death is caused under circumstances specifically designed for this purpose (2). The more widely the phenomenon is studied, the more new facets are discovered that require other assessment criteria and a more complex approach. JD Douglas addresses the definition of suicide from a double perspective, psychological and sociological, which results rather in a concept than a classical definition, revealing five dimensions of the suicidal act: initiative, motivation, intention, will, desire (11). A prospective study on survivors of suicide attempts showed that one in eight attempts is followed by death. Also, during one year, only 1% of them will have a new attempt and successfully complete it and within 15 years, 5 to 15% commit a new attempt and complete the suicide act. This study tried to find a relationship between suicide and impaired mental status, as well as between attempted suicide and the change of the human relations in the subject's group (12).

Many studies have demonstrated an approximately 11 times higher suicide rate among people diagnosed with psychiatric disorders compared to the general population. Among the mental disorders, perhaps the highest rate of suicide occurs in affective disorders,

namely 30.3% of all suicides recorded among patients hospitalized in psychiatric hospitals, compared to 21.9% in patients with schizophrenia and 24.6% in patients with personality disorders (13). Any depression may present, at some time, suicide risk. This risk is higher in the presence of comorbidities of anxiety or substance abuse. A problem occurs when trying to demonstrate reciprocity in the depression-suicide relationship, because not everyone who has attempted suicide is diagnosed with depression. Thus, the suicidal act may be medicalized, with forensic consequences. This attitude also has historical roots, if one considers the period when the legislation in many countries severely condemned the suicidal act, except for the cases of mental disorders (4). The consequences of giving the suicidal act a psychiatric dimension are visible at the social level, the stigmatization and labelling of mental disorder resulting in social exclusion. From a forensic point of view, the attitude towards a person with suicidal risk involves emergency, including non-voluntary hospitalization. Predicting and preventing suicidal risk are possible under the conditions of permanent clinical observation and are determined by depressive symptoms. The following elements of the depressive syndrome can alert on suicide risk:

- depressed mood;
- anhedonia, awkwardly, acknowledged;
- emotional anaesthesia;
- psychomotor inhibition;
- thought content with negative connotation;
- distorted view of the future and the world;
- reduced volitional capacity and initiative.

There appears the question whether an individual commits suicide merely as a depressed person or as a subject involved in the search for permanent solutions. Psychoanalysts even speak of the existence of a death urge, but the onset of a suicidal act involves other circumstantial factors too. This attitude of assimilating suicide with depression, of psychoanalysing the suicidal act, of prescribing a treatment and prophylaxis as in the case of any disease is a convenient, but ineffective approach. Moreover, the psychiatrist occupies a vulnerable position in front of the suicidal patient and cannot therefore adopt a detached attitude, medicalizing this relationship (14). On the other hand, there is the concept of rational suicide, where the intrapsychic conflict or the conflict with society is replaced by a conflict at the level of values. The psychiatrist will always consider the value of life itself, but suicidal patient sees only the meaning of his own life and his decision, even rationally deliberated, according to his own life quality. Obviously, it would be simplistic to accept that there are two categories of suicide, those caused by depression or other psychiatric disorders and those attempting suicide as a rational decision to repudiate the values of life itself. The laws of our country do not provide a very clear framework in this situation; they authorize psychiatric interventions within certain limits, but also allow the freedom of choice. Although in some countries, a special regulation of the right to die was requested, with situational variations, based on the argument of dignity of death, suicide becomes more liberalized, with the abrogation of the law that prohibits it (15). Thus, a suicide prevention program must take into account both the ethical and moral implications, as well as the legal issues that become more complex given the autonomy and freedom of the individual.

The rationale for suicide prevention is based on the value of life itself because life must be morally respected and must be enriched to have meaning. Suicide was often treated either in a negative manner, as an immoral act or a mental disorder or in a positive manner, as a rational choice of a free individual. Disputes on the morality of this act were generally consumed in the realm of philosophy, which sought to address three specific dilemmas related to suicide, namely, its definition, whether it is always immoral for a mentally competent person to commit this act rationally and the attitude that should be adopted by the members of society towards those who commit suicide (16).

Suicide involves not only a moral and social dimension, but also a legal one. Thus, until recently the British law considered suicide to be a crime against oneself and punished it as such. Ever since the sixteenth century, judges have objected to suicide, considering it an act that threatens the natural tendencies of self-preservation, a violation of the divine command or even the equivalent of an attack against the king. In modern law, these arguments might translate into concepts related to the value of life itself; life is not personal property and the state's function is to protect life and the public opinion to restrain from encouraging suicide. Both the legislation and the church have always considered disease as an exculpating factor in committing suicide. The Church regards psychiatric disorders as manifestations of the general damage of sin on human nature. It is unreasonable to consider psychiatric disorders as manifestations of demonic possession, which would entail performing exorcism without cause and, in turn, not all spiritual disorders should be treated by clinical methods. Mental disorder does not diminish human dignity and the Church "testifies that a mentally ill person, too, is a bearer of the image of God, remaining our brother who needs compassion and support", as stated in the "Bases of the Social Concept of the Russian Orthodox Church" (17).

Recent years have seen an increased tendency to consider a person who has attempted suicide or is suicidal as having mental disorders. Under these circumstances, suicide falls outside criminal law, but is subject to the law on admission in psychiatric hospitals (5). The permissiveness of some philosophers related to the attitude towards suicide was completely obliterated by the Christian Church dogma. Seneca claimed that life depends on the will of others and death only on one's own will. In contrast to the total prohibition of suicide imposed by the Church, Montaigne argued that God gives us a dispensation when we are in a situation when life is worse than death. However, he did not want to adopt an offensive attitude toward the Church and tried to answer the question on accepted cases to justify the act of suicide (16). Physical and mental suffering, as well as the lack of any hope can be appropriate reasons, but it is difficult to classify them because of the diversity and subjectivity entailed. Christian religion itself gives the example of St. Paul who wanted to die to be with Christ, so Montaigne finds a motivation for suicide other than despair. Thus, one can wish for death in hope of finding greater happiness in the afterlife and not to escape the troubles of this life. Hume argued against the idea that suicide would be a crime against God, against the society or against oneself. His famous statement, "the life of man is of no greater importance to the universe than that of an oyster", put him in conflict with the religious principles (18). With regard to one's duty toward society, it

ceases when the person is unable to bring something good and even becomes a burden and prevents other members of society from being useful. Thus, nobody would give up life as long as it is worth keeping it, but when it becomes a burden, Hume considers that life is worth giving up. Conversely, according to Kant's view, man is not only an animal creature, who has the duty of self-preservation and reproduction, but also a moral being, bearer of human dignity. The duty to preserve life becomes an ethical concept, part of a code of moral obligations. Sometimes, suicide may be a moral alternative, which presented a challenge to supporting Kant's argument against suicide, such as for persons sentenced to death or those who suffer from an incurable disease. Kant also raised the issue of heroic suicide and deliberate martyrdom, which can be regarded as acts of suicide. The approach to suicide went to extremes over time, from civil and religious condemnation, to exclusively pathological assessments as, for example, Esquirol considered all suicidal people as mentally ill. Suicide was anathema and viewed as a crime, was considered mysterious, scandalous or anguishing at the same time (19). Today, however, it could become just a statistical rate without individual value. Therefore, there is an attempt to identify the process itself that leads to the suicidal act and this act must be viewed from a broader perspective, with its philosophical and ethical connotations. Referring to the right to life, to the value of the human being and to the intrinsic value of life (20), life should be seen as a good thing and should be lived, regardless of the negative experiences that may occur. These aspects will provide a motivation, including to those trying to save the life of a suicidal person, even if dominated by pain. Moreover, according to the doctrine of the Catholic Church, which gives pain and suffering a spiritual value, the only rational choice is to face suffering. But these issues can sometimes be too subjective to be judged or evaluated by others. Suicide as sacrifice or religious martyrdom, when a fundamental purpose links the personal interest to a particular cause and motivates one to die for it, even on a psychopathological background, cannot be irrational. But, if one actually thinks that the events cannot be modified by the suicidal act and the future is unpredictable, then the sacrifice is useless. If the ultimate aim pursued by that person, such as living a moral life, cannot be achieved, then the impossibility to achieve this goal can motivate rationally the suicidal act. Preferring suicide under these circumstances is not only rational, but it also acquires a moral dimension. The moral aspect of any suicide is difficult to assess because morality involves a series of rules or principles underlying the game of life and suicide is a decision to ignore them. The decision to die lies beyond the impact of arguments. However, one can speak of the potentially suicidal person's moral obligation toward others. This can shape the idea of general obligation to assist those under the influence of negative emotional states and who want to give up life. This attitude becomes clearer given that in most countries suicide is not encouraged. However, this general situation does not prevent one from considering how great this obligation to intervene in the suicidal act is, who bears the obligation to intervene and especially what this obligation entails. Much more difficult and perhaps more subtle is the role of advisor which a professional can assume toward the suicide attempt or suicidal ideation. All one can ask from a

suicidal person is a reconsideration period in which he or she could examine all perspectives and should receive strengthened moral support. But, in terms of the physician-subject relationship, any moralizing attitude should be avoided, using careful and exploratory evaluative listening of the issues and personal motivations of the subject (21).

Through the imposition of human rights and the promotion of the concepts of freedom, autonomy and individual responsibility, the freedom to decide over one's own life is opposed by the law protecting life. All these dilemmas on the complexity of an approach to suicide are highlighted by the medical ethics of suicide and open the way for future legislative changes. The reservations expressed by the majority of legislative instruments toward suicidal acts are based on the negative social consequences, the negative example that it provides to confused people or the abandonment of family members. The existence of fundamental freedoms, such as the freedom of speech or belief, does not involve as yet the same status for suicide, as long as its acceptance is not a product of collective consciousness and is not a fundamental element for law (10).

A justification of suicide-related legislative measures can be found in the following aspects:

- the impact of suicide on survivors, who feel guilty and some even commit suicide;
- preventing self-inflicted injury through suicide;
- the obstacles that arise from confirming a link between suicidal behaviour and mental disorder derive both from the diversity of approaches to human behaviour, and the lack of consensus on psychiatric diagnosis.

In the case of attempted suicide, on the verge of the act, the person experiences a state of ambivalence and may give an actual cry for help. Often, the suicidal act is not an end in itself, but a way to draw attention, an attempt to communicate with others. This ambivalent dimension of the suicidal act and the fact that only one in ten suicide attempts are completed show the importance and need to prevent suicide. However, one should not believe that the prevention or interference by hospitalization or treatment under supervision one can resolve the ambivalence preceding the suicidal act. At the same time,taking into account the impulsive dimension with extreme consequences of this act,following the coercive intervention,the actual rational choices should be reconsidered. Hospitalization and treatment under supervision are justified by a series of symptoms that characterize the severe depressive syndrome,such as impairment of rational thinking,extreme negative emotional burden and sometimes even the presence of psychotic elements. These methods of prevention and intervention are limited by the risk of incorrectly assessing the suicidal risk or behaviour. This risk is amplified by internment for a longer period of time, loss of civil rights, separation from family and double stigma as person with mental disorders and suicide attempt. Therefore, the law should spell out the time frame necessary to intervene in case of suicide risk and the criteria for assessing this risk (6). In many countries the possibility to retain a person involuntarily in the hospital is limited to only 24 hours, a time period called reconsideration period, after which the suicide risk can be reassessed. These measures also involve risks, because there remains the possibility of failing to

identify a continuity of the suicidal tendency or, conversely, the suicidal ideation can be overestimated and individuals will be retained in the hospital for a longer period of time. The legal framework for prevention and intervention in cases of attempted suicide should also include specific measures relating to persons involved in these situations. These include family members, friends, strangers or medical staff. Except for health professionals who are bound and responsible for intervention in cases of attempted suicide, there are no special legal provisions provided for the other groups of people. However, the law punishes differently the encouragement of a completed suicide and a failed attempt, while moral responsibility is equal in both cases (22). Rational suicide is a concept that begins to be accepted in the medical world, not only in philosophy, but is still searching for a legal framework. The purpose of the law is to protect the weak, so that legal measures should relate in particular to persons with mental disorders, psychotic, in crisis situations, ambivalent or undecided.

The suicide prevention approach raises the issues of influencing psychological and situational factors associated with suicide. More than moral issues, this will require a complex logistical problem. Thus, E. Shneidman considered the work to prevent human misery almost impossible. On the other hand, Jean Baechler, a supporter of the idea that suicide is a positive act that solves existential problems, discusses the inquisitorial passion with which suicide prevention policy will hunt candidates for suicide (23). Another controversial issue is represented by the intervention in case of suicide. The moment of intervention, that is, the moment of direct interference in a suicide attempt is an ethical and philosophical issue. The most popular method of intervention is known as crisis intervention or help-line. In case of such interventions, when suicide warning increases and becomes imminent, the intervention might occur warning the person in question. Nevertheless, the guarantee of anonymity and refrain from coercive interventions of rescue was recently introduced in the operational rules of these crisis intervention centres; the intervention takes place only when requested by the person concerned (24).

Suicide is still a socially disturbing, universal and perennial phenomenon; although an individual act, its social resonance cannot be ignored and ranges from the attitude of the community up to social and medical preventive and support organizations. Moral problems posed by suicide continue to require ethical-philosophical judgments and reflections, referring to the ethical principles of autonomy and paternalism, free and informed consent, confidentiality and involuntary hospitalization.

Finally, we might conclude on the controversies regarding the moral and ethical attitude toward suicide, by quoting Nietzsche, who emphasized in "Thus Spoke Zarathrustra" the subjectivity and relativity of the approach to this still puzzling phenomenon:"Many die too late and some die too early." Dying at the 'right' time has meanings still hard to decode.

Bibliography

[1]. Abrams N., Buckner M.D. Medical Ethics, MIT Press, London 1983

[2]. Appelbaum P.S., Gutheil T.C. Clinical Handbook of Psychiatry and the Law, Williams and Wilkins, Baltimore 1991
[3]. Arieti S. Psychiatric controversy : Man's ethical dimension, Am J of Psychiatry 1975;132: 39-42
[4]. Beauchamps F.L., Childress J.F. Principles of biomedical ethics, Oxford University Press, New York 1980
[5]. Chiriţă R. Elemente de psihiatrie clinică şi etică psihiatrică, Edit Fundaţiei Andrei Şaguna 1989
[6]. Engelhardt N.T.Jr. The foundation of bioethics, Oxford University Press, New York 1996
[7]. Pallis D.J., Gibbons J.G. Estimating suicide risk among attempted suicides, Brit J Psychiatry 1984, 139-148
[8]. Warheit G.J. Life events, coping, stress and depressive symptomatology, Am J Psychiatry 1979, 502-507
[9]. Belis V. Îndreptar de practică medico-legală, Edit Medicală, Bucureşti 1990
[10]. Astărăstoae V., Oprea L., Vicol M.C. Responsabilitatea Socială şi individuală pentru sănătate în sistemul sanitar românesc, Raport al Colegiului Medicilor din România 2010
[11]. Battin P. Ethical Issues in suicide, Pretince Hall, New Jersey 1982
[12]. Meisel A. The right to die, Wiley and Sons, New York 1989
[13]. Bloch S., Chodoff P. Psychiatric Ethics, Oxford University Press, 1981
[14]. Ali Md Y. Understanding suicide attack: weapon of the weak or crime against humanity?, Journal for the Study of Religions and Ideologies 2011;10(30): 236-257
[15]. Olaru B. Common morality, moral dilemmas and hermeneutic ability, Revista Română de Bioetică 2010; 8(2): 124-133
[16]. Bazac A. Philosophy and Reform: a word about current philosophy–religion dialogue within the Romanian educational system, Journal for the Study of Religions and Ideologies 2011;10(28): 108-128
[17]. Iliescu A.P. The Autonomy of Morals. Two Analytic Arguments, Journal for the Study of Religions and Ideologies 2010;9(26): 3-17
[18]. Chertie D., Curşeu P.L., Schalk R. Decizii privind euthanasia explorare şi extindere a modelului de luare de decizii în comun, Revista Română de Bioetică 2011; 9(4):5-14
[19]. Marţian I. Două linii de gândire şi de acţiune privind problema legalizării eutanasiei şi evoluţia practicii în domeniu, Revista Română de Bioetică 2011; 9(2):50-62
[20]. Buta M.G., Buta L. Perspectivele teologice ale bioeticii, Revista Română de Bioetică 2012; 10(1): 27-33
[21]. Abrudan E. Ethical expertise and bioethics, Journal for the Study of Religions and Ideologies 2011;10(30):397-402
[22]. Baechler J. Suicide, Basic Books, New York 1979
[23]. Iovan M. Characteristics of the ideal of Christian education, European Journal of Science and Theology 2010;6(4):5-21
[24]. Szasz Th. The ethics of suicide, The antioch review 1971; 7-17