Ethical Implications of Clinical Responses to Patients Presenting with Suicidal Ideation

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Medical treatment of patients with suicidal ideation has been a long-standing ethical debate amongst healthcare professionals. A fine line must be drawn between autonomy and beneficence, two of Beauchamp and Childress's principles in *Principles of Biomedical Ethics*.[1] In many cases, however, clinicians have failed patients, and negative consequences have resulted. Too much autonomy has allowed patients to follow through with suicide attempts, but too much clinician beneficence, or intervention, has resulted in patients' unwillingness to return for care in the future.[2] These outcomes are dependent on both the patient's psychological state at the time of presentation and clinicians' inaccurate assessments. Suicidal ideation can be viewed as a spectrum of severity; some patients have passive thoughts about death, while others have a commitment to a detailed plan.[3] Though this is a generalization, and never a substitute for individual psychiatric assessment, patients presenting with suicidal ideation who have not engaged in any suicidal activity (writing suicide notes, obtaining supplies to follow through with a plan, history of suicide attempts, etc.) should be given as much autonomy as possible, in order to allow them to maintain control over their treatment, and maximize their likelihood to return for future care. This proposal considers bioethical principles, therapist responses, risk factors for suicidality, international policies related to involuntary commitment, prioritization of patients'

1. Beauchamp, Tom L., and James F. Childress. *Principles of Biomedical Ethics*. 5th ed. New York, NY: Oxford University Press, 2001.

2. Rosebrock, Hannah Y., Philip J. Batterham, Nicola A. Chen, Lauren McGillivray, Demee Rheinberger, Michelle H. Torok, and Fiona L. Shand. "Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-up Care Arrangements Following an Initial Suicide-Related Presentation." *Crisis* (2021): 1-3.

3. Van Spijker, Bregje A., Philip J. Batterham, Alison L. Calear, Louise Farrer, Helen Christensen, Julia Reynolds, and Ad J.F.M. Kerkhof. "The Suicidal Ideation Attributes Scale (SIDAS): Community-Based Validation Study of a New Scale for the Measurement of Suicidal Ideation." *Suicide and Life-Threatening Behavior* 44, no. 4 (2014): 408–19.

willingness to return for future care, and patient-controlled admission in order to make a determination that considers all aspects of involuntary psychiatric hospitalization.

Ethical Principles in Medical Care of Suicidal Patients

A person's ability to choose their medical treatment, and have their choice respected, is autonomy. Medical treatment is always a choice made by some individual or organization, but should be made by the patient when possible. There are exceptions to this, such as with minors, patients who are unconscious, and patients who have been deemed unfit to make choices about their healthcare due to mental health concerns. The latter is a complex circumstance, because the point at which a person becomes unfit to make a rational medical decision is controversial. At the heart of a person's opinion about involuntary psychiatric hospitalization is a belief about the criteria for patient autonomy. Patients should be able to make coherent, rational decisions for their medical needs, and should demonstrate ability to give informed consent.[4] Beneficence is the clinician's obligation to give treatment in order to positively affect a patient. For example, a doctor who sees a person choking in a restaurant should give CPR, because part of the responsibility to "do no harm" is to not look the other way when a person is in danger. Choosing which ethical principles to prioritize is at the root of most dilemmas in the medical field. In the case of suicidality, there are multiple points at which a person's autonomy could become secondary to clinician beneficence, but determining this point is tricky. Is it when the patient first admits to suicidal thoughts, regardless of the severity? Is it when a patient admits to worsening suicidal thoughts, or active suicidal plans? Is it when a patient seeks assessment from a clinician? Is it when a patient shows high-risk behavior? Is it at the point of a patients first suicide-related activity, like writing a suicide note? At each of these points, a new concern surfaces about the

4. Beauchamp, *Principles of Biomedical Ethics*.

patients fitness to make coherent decisions, and the clinician's obligation to act with beneficence must be reconsidered. However, the idea of beneficence is complex here, because an attempt to act with beneficence may actually be harmful to the patient, if done prematurely or in excess. This could occur if the patient is involuntarily hospitalized while at a low risk, when treatment could be done in an out-patient setting. This could also occur if too much control is taken from the patient regarding their length of hospitalization, possession of personal items, and ability to contact friends and family. For beneficence to remain truly beneficent, clinicians must tow this line with caution. As Simel Zhang, Graham Mellsop, Johann Brink, and Xiaoping Wang state in their research study, "Involuntary admission and treatment of patients with mental disorder,"

> "From an ethical perspective, the involuntary admission and treatment of patients with mental disorders are often discussed from the perspective of personal liberty. However, influenced by an increasing emphasis on individual rights, the autonomy of patients with mental disorders has been growing in importance. This viewpoint may undermine the original purpose of involuntary admission and treatment, which is to provide adequate mental-health care to those individuals whose mental disorders interfere with their rational ability to consent or decline treatment."[5]

Suicidal Action versus Ideation

Conclusions made about the treatment of suicidal patients must be differentiated between patients who have attempted suicide or have had suicidal behavior, and patients who have only had suicidal ideation. Treatment will vary significantly between these two groups, as if they were two different diagnoses. Some patients come to the emergency room after a suicide attempt,

5. Zhang, Simei, Graham Mellsop, Johann Brink, and Xiaoping Wang. "Involuntary Admission and Treatment of Patients with Mental Disorder." *Neuroscience Bulletin* 31, no. 1 (2015): 99.

developing an active plan, or high-risk behavior (abnormal substance use, writing suicide notes, impulsivity, etc.)[6] The actions of these patients give healthcare providers reason to believe that, if left alone, the patient will follow through on suicidal plans. This justifies the temporary removal of autonomy, until the patient has a decrease in suicidality.[7] Most patients in this psychological state enter the psychiatric hospital expecting to be admitted, so this is not necessarily a surprise.[8] In some cases, patients are committed "involuntarily" on paper, though they may be willing to receive in-patient treatment. This is because voluntary patients are able to leave at any point, but an involuntary patient must stay until they have clinician approval to leave the hospital. Suicidal ideation is different than this active form of suicidality, and requires much more careful assessment. Patients with this diagnosis usually seek treatment on their own, or with the help of a loved one, and are concerned about their psychological state. Though this certainly can escalate into suicidal actions, there is no guarantee that it will. In fact, a majority of patients with lifelong suicidal thoughts report that they are passive, and have not escalated into actions.[9]

Clinician Responses to Suicidal Patients

When patients report these thoughts to therapists, however, an emotional response can be evoked, which damages the therapeutic relationship, and can be "predictive of near-term

6. Schmitz-Buhl, Mario, Stefanie Kristiane Gairing, Christian Rietz, Peter Häussermann, Jürgen Zielasek, and Euphrosyne Gouzoulis-Mayfrank. "A Retrospective Analysis of Determinants of Involuntary Psychiatric in-Patient Treatment." *BMC Psychiatry* 19, no. 127 (2019): 2.

7. Zhang, "Involuntary Admission and Treatment of Patients with Mental Disorder," 99.

8. Ma, J., Batterham, P. J., Calear, A. L., & Han, J. "A systematic review of the predictions of the Interpersonal-Psychological Theory of Suicidal Behavior." *Clinical Psychology Review*, 46, (2016): 34.

9. Liu, Richard T., Bettis, Alexandra H., & Burke, Taylor A. "Characterizing the phenomenology of passive suicidal ideation: a systematic review and meta-analysis of its prevalence, psychiatric comorbidity, correlates, and comparisons with active suicidal ideation." *Psychological medicine* 50, no. 3 (2020): 11.

suicidality."[10] This was observed by Gelan Ying, Lakshmi Chennapragada, Erica D. Musser, and Igor Galynker in their study, "Behind therapists' emotional responses to suicidal patients: A study of the narrative crisis model of suicide and clinicians' emotions." This study assessed 1,001 patients using the Suicidal Narrative Inventory (SNI), Suicide Crisis Inventory (SCI), and an assessment of the long-term risk factors (LTRF). In addition, 169 therapists were assessed using the Therapist Response Questionnaire-Suicide Form (TRQ-SF). A high correlation was found between the SNI and TRQ-SF, where clinicians who responded more emotionally to a patient's disclosure of suicidality typically had patients that felt more burdensome, leading to increased suicidal thoughts. Perceived burdensomeness is "a reportedly superior predictor of suicidal behavior."[11] The association between burdensomeness and emotional therapist responses implies that the therapist made the client feel more burdensome, or affirmed their previous perception of burdensomeness, by responding with strong emotions. Patients may feel like their concerns are too heavy for the therapist to emotionally carry, which can lead to feelings of hopelessness. The possible consequences of a negative response should reinforce the importance of unconditional positive regard towards patients in a therapeutic relationship, and should cause therapists to self-reflect on their internal response when a client discloses suicidal thoughts.

Warning Signs of Need for Involuntary Psychiatric Hospitalization

In a retrospective study, German researchers observed patient-related factors that contribute to increased risk for involuntary commitment due to suicidal plans and behaviors. The

10. Ying, Gelan, Lakshmi Chennapragada, Erica D. Musser, and Igor Galynker. "Behind Therapists' Emotional Responses to Suicidal Patients: A Study of the Narrative Crisis Model of Suicide and Clinicians' Emotions." *Suicide and Life-Threatening Behavior,* 51, no. 4 (2020): 685.

11. Ma, "A systematic review of the predictions of the Interpersonal-Psychological Theory of Suicidal Behavior," 36.

major determinant of risk is the diagnosis of an organic psychiatric disorder.[12] Organic psychiatric disorders arise when there is a illness or injury that is causing symptoms of a diagnosable mental disorder.[13] Non-organic psychiatric disorders, also known as functional psychiatric disorders, have a presentation of symptoms without a clear diagnosis. While diagnosis was the most significant determinant of risk in this study, several demographics were compared to observe trends in voluntary versus involuntary commitment. These groups included gender, age, marital status, children, migration background, living situation, education, professional experience, employment status, income source, type of diagnosis and presence of comorbidities, suicidal tendency upon admission, previous suicide attempts, length of in-patient hospital stay, treatment prior to admission, time of admission, and history of psychiatric hospital stays. Data from the time of admission suggests that patients admitted outside of regular operating hours (8am to 4pm, Monday through Friday) are far more likely to be involuntarily hospitalized than those admitted within business hours.[14] This could be due to increased symptoms of mental illness at night, when there are fewer distractions. It could also be due to a decrease in patients' likelihood to willingly visit an emergency department after hours, so patients who visited during these times were more desperate for care, or had been brought in by a loved one, indicating a higher severity in suicidal thoughts.

12. Schmitz-Buhl, "A Retrospective Analysis of Determinants of Involuntary Psychiatric in-Patient Treatment," 4.

13. Bell, V., Wilkinson, S., Greco, M., Hendrie, C., Mills, B., & Deeley, Q. "What is the functional/organic distinction actually doing in psychiatry and neurology?" *Wellcome open research*, 5, (2020): 138.

14. Schmitz-Buhl, 7.

International Policies of Involuntary Commitment

It should be noted that international healthcare standards for psychiatric illness vary significantly. Criteria determining the necessity of involuntary admission can include combinations of mental disorder, danger to self, and need for treatment. Of the seventeen countries assessed, six countries (35.2%) required a combination of mental disorder and danger to self for involuntary commitment to occur, one country (5.9%) required a combination of a mental disorder and need for treatment, seven countries (41.2%) accepted either of the previous two combinations as criteria for involuntary commitment, and three countries (17.6%) required all three criteria to be present for involuntary commitment to occur.[15] When considering the diagnosis required for involuntary commitment, eleven countries (64.7%) had a wide range of criteria or an undefined standard, while five countries (29.4%) required severe mental illness, and Denmark alone required presentation of psychosis.[16] Because of the clear variation between countries, further assessment should be done to observe which countries have lower rates of attempted or completed suicide, and higher rates of self-reported suicidal patients. These trends imply the success of the healthcare practice in effectively caring for suicidal patients while considering patients' likelihood to return for future care. Most likely, countries that are successful in these areas have higher governmental budgets for public mental health care, high quality education of medical professionals, a variety of resources for suicidal patients to be able to seek help, and hospitals with a culture of respect and genuine care for patients.

15. Zhang, "Involuntary Admission and Treatment of Patients with Mental Disorder," 100.

16. Zhang, 101.

Unwillingness to Return for Future Psychiatric Care

Patient willingness to return for care in the future is a key consideration in this ethical debate. This is a long-term effect of the choice between autonomy and beneficence in a given case, because an inappropriate clinician response can lead to reluctance to seek future care, while a positive experience can reinforce a patient's desire for treatment.[17] "The [suicide] risk is greatest in the month after discharge from an emergency department or psychiatric ward; however, there is evidence of an elevated risk for the first year post-discharge, with rates estimated to be 55.5 times higher than those in the general population."[18] This is likely due to continual suicidal symptoms that are present once patients leave the hospital; some patients may be discharged prematurely, or may still have some level of suicidality when returning home. Patients who were involuntarily committed are more likely to be dishonest in order to be discharged from the hospital, which precludes them from receiving the help they may need, and may make them more likely to follow through with suicidal plans. Research studying patient satisfaction with psychiatric care in emergency departments reported that patients "frequently report low levels of satisfaction with both their immediate and follow-up care, which in turn impacts their willingness to engage in future help-seeking."[19] Because of the increased suicide risk in the months following hospitalization, it is crucial that patients receive follow-up, out-patient care when they are discharged. Many patients identified issues with dismissive

17. Rosebrock, "Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-up Care Arrangements Following an Initial Suicide-Related Presentation." 2.

18. Geulayov, G., Casey, D., Bale, L., Brand, F., Clements, C., Farooq, B., Kapur, N., Ness, J., Waters, K., Tsiachristas, A., & Hawton, K. "Suicide following presentation to hospital for non-fatal self-harm in the multicentre study of self-harm: A long-term follow- up study." *The Lancet Psychiatry*, 6(12), (2019): 1021.

19. Wan, Y., Chen, R., Ma, S., McFeeters, D., Sun, Y., Hao, J., & Tao, F. "Associations of adverse childhood experiences and social support with self-injurious behaviour and suicidality in adolescents." The British Journal of Psychiatry 214, no. 3, (2019): 146–152.

emergency department staff, stigmatization of mental health in the emergency setting, longer triage wait times, and inadequate follow-up care.[20] This broadens the scope of what clinicians must consider in treating patients; autonomy is not the only consideration for willingness to return, and even an ideal balance of clinician beneficence and patient autonomy does not guarantee a patient's return.

Patient-Controlled Admission

Clinical nursing research performed by Trine Ellegaard, Vibeke Bliksted, Mimi Mehlsen, and Kirsten Lomborg aimed to understand patient goals in seeking psychiatric hospitalization, and to identify ways that clinicians can positively or negatively affect patient experience.[21] The researchers observed and interviewed twenty-six mental health patients. Safety was identified as a "focal point," and was "associated with the attitude and behavior of the mental health professionals."[22] Four goals that patients had for their care were observed through this study: reversing the downward spiral, being self-determining, receiving care, and achieving calmness. Treatment in these areas increased an overall feeling of safety, while experiences of feeling overlooked or uncertain reduced perceived safety.[23] Participant 14 spoke to the self-determination aspect of patient admission by saying, "All this about you having a say in your admission – it means a lot. Because at some point, it's of course me who's the expert in my own life. It's of course me who knows best how I'm feeling, but then I can seek support, advice and

20. Rosebrock, "Nonwillingness to Return to the Emergency Department and Nonattendance of Follow-up Care Arrangements Following an Initial Suicide-Related Presentation," 5.

21. Ellegaard, Trine, Vibeke Bliksted, Mimi Mehlsen, and Kirsten Lomborg. "Feeling Safe with Patient-Controlled Admissions: A Grounded Theory Study of the Mental Health Patients' Experiences." *Journal of Clinical Nursing* 29, no. 13-14 (2020): 2397.

22. Ellegaard, 2399.

23. Ellegaard, 2400.

guidance through the hospital. So, in this way, it's good that I have a say."[24] This study ultimately showed that patient-controlled admission tends to result in a more optimistic perspective of psychiatric care from the patient, decreased stigmatization of mental health, and less uncertainty relating to the treatment plan.[25] Because of these factors, patient-controlled admission is ideal whenever possible.

Conclusion

Individuals who are able to seek out care on their own should be given appropriate respect and autonomy over their admission, because they showed enough rationality to acknowledge their need for help. This is more common in patients with suicidal ideation than suicidal activity, because patients who have taken action are more often required by a concerned party to seek help, or brought to an emergency room after an attempt.[26] After assessing risk factors such as initial presentation, clinician response, perceived burdensomeness, and psychiatric diagnosis, healthcare professionals should be able to make a determination on the level of autonomy given to a patient. Rather than always erring on the side of caution in cases of suicidal ideation, clinicians should prioritize patient autonomy more, because of the long-term benefits. It is essential that patients feel safe and in control, because a lack of those feelings can result in increased suicidality. Patients who have taken suicidal action, on the other hand, have proven to be a danger to themselves, which justifies the prioritization of clinician beneficence. Of course, there is risk associated with this proposal, because a poor assessment of a patient's psychological state could result in suicide. However, the act of self-disclosure in a suicidal

24. Ellegaard, "Feeling Safe with Patient-Controlled Admissions: A Grounded Theory Study of the Mental Health Patients' Experiences," 2402.

25. Ellegaard, 2406.

26. Ellegaard, 2406.

ideation case proves the patient's desire for some level of treatment, and should give clinicians some reassurance that the patient will not be in danger. Patients with suicidal ideation who do not want treatment are highly unlikely to self-disclose to any healthcare professional. The increased risk of suicide after an involuntary hospitalization is another argument for patient-controlled admission, because feelings of safety and care will decrease suicidality upon discharge. The concerns expressed within this literature review reflect the difficult nature of medical treatment of suicidal ideation, but should ultimately give rise to self-reflection within healthcare professionals about how they can balance beneficence and autonomy in these cases.

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