Existential suicide and pathological suicide: historical, philosophical and ethical aspects

Suicidio esistenziale e suicidio patologico: aspetti storici, filosofici ed etici

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Summary

The complexity of suicide problems stimulates interpretations that can be compared not only with biological, physiological and/or psychopathological questions, but also with the sensitive universe of moral, philosophical and personological choices of the individual. More than once in history the value of life was faced with that of freedom, arousing many testimonies that support the inaccessibility or, on the contrary, the admissibility to use life as extreme assertion of one's own supremacy to decide. Additionally, in the difficult connection between the principle of benefit and that of self-determination, sensitive problems arise about the legitimacy of discouraging interventions, even if compulsory. By analysing the possible connection between existential choices and probable psychopathological disorders in suicidal behaviour, the authors wish to provide suggestions that can help to tolerate pain and prevent self-wounding behaviour.

Key words

Existential suicide • Pathological suicide • Historical aspects of suicide • Suicide interpretations • Philosophical representations of suicide • Ethical interpretations of suicide

Non saprai mai se ciò che hai fatto l'hai voluto …
Ma certo *la libera strada ha qualcosa di umano*, di unicamente umano.
Nella sua solitudine tortuosa è come l'immagine di quel dolore che ci scava.
Un dolore che è come un sollievo, come una pioggia dopo l'afa, silenzioso e tranquillo,
pare che sgorghi dalle cose, dal fondo del cuore.
Questa stanchezza e questa pace, dopo i clamori del destino, sono forse l'unica cosa che è nostra davvero.
Cesare Pavese, *I dialoghi con Leucò*

Suicide, mass media and science

Recent dramatic facts reported on by the press have drawn attention to different historical, philosophical and ethical interpretations about suicidal behaviours. The dramatic death of the famous director Mario Monicelli (he threw himself out of the balcony of the hospital where he was admitted because of prostate cancer) did not give rise to any doubts in the media reporting. In unison and not without a certain rhetoric and a categorical-dogmatic tone, this behaviour was seen as a free choice connected to an ethic of dignity of death without even considering a psychopathological element, in spite of his advanced age (93 years old) and the risk of a depressive reaction, which is frequent in the elderly, especially when coinciding with serious pathology [1].

Another solicitation comes from the death of Lucio Magri who went to a country where assisted suicide is permitted. His decision was commented on by the press in a very similar way and ignoring the possible effects of a previous depressive illness of which the journalist and politician suffered many years before when his wife died.

Even the recent suicide of the director Carlo Lizzani (died after throwing himself out of his flat on the third floor in Rome), only existential reasons were hypothesised.

These events mirror other episodes of people who died in similar situations, such as the great psychoanalyst Bruno Bettelheim in 1990 or the French philosopher Gilles Deleuze in 1995. Even in these cases, press explained and interpreted these facts from a point of view that was predominantly existential.

In addition, the debate recently developed from the in-

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creasing number of suicides following the economic crisis seems relevant. The widows' procession in Bologna in 2012 claimed: 'Husbands were certainly desperate but not mad …'. These deaths press for a reflection on the possible relationship between existential choices and probable psychopathological illness in suicidal behaviour.

Philosophical and sociological interpretations of suicide

In the choice of willingly ending one's own life, aspects regarding both philosophical representations of reality in a pessimistic direction (on this subject *the meaningless existence and cause of pain and boredom* of Giacomo Leopardi is noted) and descriptions of the impossibility to realize one's own ethical ideal (such as Seneca's case) cannot be ignored.

There are also sociological factors (related to the dynamics of the individual with the community one belongs to) sometimes affecting even suicidal behaviour. From this point of view, Durkheim [2] described suicide by pointing out an *altruistic* typology characterised by a sure and full adhesion to the aims of one's own group and by the moulding of the behaviour according to the culture one refers to; an *egoistic* model due to a nearly complete dissolution of societal models and to the consequent and dramatic isolation of an individual; an *anomic* configuration for the sudden break of social circumstances, relationships and points of reference; and finally, a *fatalistic* form trusted to a deep fate of personality.

Complexity of suicidal behaviour stimulates the use of filters that can examine both the sensitive universe of the moral, philosophical and personological choices of the individual and the correlated circle of biological, physiological and/or psychopathological phenomena [3].

At least occasionally, contemporary bioethics have facilitated a simplified interpretation of the causes of suicidal behaviour, in a existential way, for the defence of the absolute priority of the principle of self-determination and that of the free availability of *the good life*.

In reality, the problem is much more complicated because, in our opinion, it refers to a conflict of two values, one of life and one of freedom. In most of history these were compared by generating many testimonies that privileged the principle of unavailability of life, that is now the admission of using life as extreme assertion of one's own supremacy to decide.

Examples in which suicide is not accepted are:

1. condemnation without reserve because of unavailability of life with Philolaus in Plato's *Phaedo* (indeed Plato, in his early dialogues, believed suicide morally unacceptable as meanness, in *Republic* and *Laws* he believed it right when it is for advantage of public utility or for defence of justice);
2. rejection as a cruel action (Aristotle);
3. close connection with the concept of sin (Saint Augustine - who compared suicide to homicide - and Saint Thomas);
4. incompatibility with suicide, because it is a self-centred attitude that is opposed to the universality of the moral law and to the unconditioned obligation of categorical imperative (Kant);
5. falsification of the authentic courage (Hegel);
6. illusion of evading the deceit of will (Schopenhauer).

Other testimonies, on the contrary, support admissibility of suicide with reference to several lines of reasoning:

1. impossibility to realise pleasure as the aim of life and the consequent pain that comes from it (Hegesias of Cyrene);
2. impossibility to realise the ideal and ultimate aim of virtue (Stoics, particularly Cleanthes and Zeno);
3. a wise man is free to kill himself because life does not deserve to be lived (Seneca);
4. assertion of a free and independent availability of one's own life (Montaigne, Rousseau, Voltaire);
5. freedom as release from nature influences (Hume);
6. free choice of will towards life (Nietzsche).

Ethical interpretations of suicidal psychopathology

A critical analysis of the problem stimulates important questions, both philosophical and scientific, on the authenticity or not of free choice in suicidal behaviour. Is suicide free from any type of psychopathological, social and cultural influence possible? Even recently, many authors have asserted that suicide is always characterised by very strict aspects of psychopathological compulsion and determination [4 5*].

An uncritical reading of the risk factors that these authors

* Considering that in the dynamics of suicidal behaviour the pathogenetic process is clear (but not the aetiology), the literature recalls the following risk factors: a) organic diseases (including epilepsy, multiple sclerosis, Huntington's chorea, AIDS, dementia, Alzheimer's, Cushing's, cancer, etc.), b) mental disorders (the scientific literature considers them as the major risk): first of all depressive disorder in which there is little aetiopathogenetic importance of environmental and social stressors; schizophrenic disorder; alcoholism, often combined with personality disorders. At the beginning psychosocial factors (mourning, poverty, loss of a social role) are only aggravation of a biological vulnerability. There is also a hypothesis of psycho-neuro-endocrine markers on anomalies of the axis hypothalamus-hypophysis-adrenal gland, hypothalamus-hypophysis-thyroid, hypothalamus-hypophysis-growth hormone, hypothalamus-hypophysis-prolactin.

indicate (it seems that they assign not only a decisive role to the brain, but even an exclusive role that explains suicidal behaviour) can produce interpretations of an extreme biological reductionism with the following loss of an existential and anthropological dimension of the person [6].

As Hewitt [7] states, the specificity and the ulteriority of mental state rather than the brain cannot be denied, even in obvious admission of its genesis from physico-chemical processes of the brain.

In other words, it is not necessary to mistake the origin with the meaning and neither *quomodo* with *propter quid* (to use philosophical language).

Considering this and the changeability of answers to same stimulus, the different capacity of resilience to stressors and multidimensionality, a circular and multidimensional model that favours the correlation among several factors than simple causal explanations seems to gain reliability.

We can and have to ask ourselves if it is possible to ensure with an adequate probability rate if and when suicide can correspond to a free choice that is completely free from psychopathological influences.

Certainly for the physician and healthcare worker there is a problem of legitimacy in discouraging intervention (even compulsory) and of the difficult relationship between the principle of benefit and the principle of self-determination, considering the distinction between subjective and objective good [8].

In these ambits, although aware of the need to safeguard the right of self-determination of the patient and considering the extreme difficulty to exclude pathological components, in real terms it is required to privilege the principle of benefit (in the meaning of objective good) and the duty *prima facie* to prevent suicide when it is possible to prevent it, coherently with Hippocrates oath and the Code of Medical Ethics (2006).

What then is the breadth of the right of self-determination of the patient?

If one can only refer to a moral point of view where freedom acquaint his authentic meaning: 'the problem if freedom exists has its origin in myself who insist that it exists' [9]. And it is exactly from the point of view of the postulate of the human (Kant) that the theme of suicide needs to be discussed. If, actually, one believes in the human being as an absolute value, the defence of life is an unconditional duty. The ethical commitment, whose extreme intensity needs to be assured, must be joined up with the consciousness of a difficulty (that in no way does not mean illusion) in preventively protecting oneself from suicidal risk. In any case, a realistic direction of prevention must not be an excuse to disregard absolute duty. It is a question of encouraging a methodical prevention of suicidal behaviour to protect life as common good and freedom as subjective good.

In pursuit of operating proposals

Today, the problem of preventing suicide is particularly relevant in Italy in relation to several cases of suicide of people affected by the economic and social crisis and various famous individuals.

Concerning suicide for psychopathological reasons, on one hand the present organization of local psychiatry represents considerable progress in treating mentally-ill patients both from a clinical and ethical points of view by contrasting the action of reaching a chronic condition in isolating the patient in closed and alienating places. On the other hand, it highlights important problems related to the risk of abandon, isolation and alienation of the person who suffers [10].

However, as important researchers have noted [11], further strengthening of the measures of psychosocial rehabilitation might reduce the frequency of suicides with an organic precautionary strategy.

The clinician's ethical-deontological behaviour is that of dissuasion and prevention that tends both to guide the patient's choice to goals compatible with his authentic good and to eliminate or reduce the causes and risk factors. Therefore, communication and social skills are recommended to create empathy and to encourage *compliance* [12].

Above all, an ethic of listening and comprehension is encouraged, which is very important in a clinical setting. From this point of view, a phenomenological model that does not exhaust the reliability on a methodological level does not seem negligible, but extends it both to the comprehension and respect of the existential dimension of the psychic patient, establishing an attempt at restoring an interpersonal relationship and communication, even if compromised by the pathological condition [13 14].

Another basic ethical rule is to eliminate pain with every available therapeutic means.

Indeed, pain represents an emergency that implies priority intervention. It is something that dehumanizes; it often dulls judgement and evaluation; it provokes a fatal decrease in the quality of life.

It is thus appropriate to adopt aggressive analgesic therapy with a well-balanced examination of the parameter costs/benefits, and if and when it is necessary, the risks of side effects and controlled toxicity while protecting the patient from rash choices.

Pain therapy represents not only a success of treatment, but a binding and inalienable ethical imperative to offer an alternative (or at least a possible re-examination) to request for euthanasia from those who suffer extremely and see ending their lives the only possibility to assert themselves and their own desire for happiness [15] .

Considering existential suicide, pragmatic instructions,

particularly on preventing not only suicide but also circumstances and reasons that motivate it, can be taken into account.

The first intervention is about the so-called Werther's syndrome. In reality, it is known that the spread of news on suicides and on how they were achieves provokes mimetic behaviours. More than to appeal to any kind of censure that can be labelled as illiberal, it should be necessary to recall the press to a serious moral self-regulation to distinguish exactly between authentic freedom and rash and irrational will. On this subject, the recent hard criticism from Popper along with the composed but severe appeal by Ciompi and other important members of Swiss psychiatry towards risks and damages produced by the press not only in a younger population can serve as a model [16].

Although its realization is harder and slower, pedagogic intervention on the influence of the contemporary culture it is much more important (or at least as important). In other words, it is necessary to operate a critical reclamation of prejudice and myths, very common at the moment, that support self-imposed violence and directed towards others as response to pain.

It is extremely important to act through schools, local heath offices and the mass media to change certain identifiable risk assessments. In particular, the short tolerance to frustration strictly connected to low self-confidence and behaviours of social isolation should be highlighted. Therefore, a campaign to support socialization and to fight isolation in every age group of the population but with more care for the weaker one should be promoted for both teenagers and elders. Synergistic connection between psychotherapy and pedagogy is needed that tends to remove possible opportunities and psychosocial influences as much as that somehow encourage the tendency to suicide. This is not only in the realm of systematic, urgently-needed health education, but also in light of a cultural proposal that favours inviolable values of the human being.

References

1 Harwood Hutton K, Hope T et al. *Life problems and physical illness as risk factors for suicide in older people: a descriptive and case-control study*. Psichol Med 2006;361265-74.

2 Durkheim E. *Le suicide*. Paris: Alcan 1897 (trans. it. by Tosi MJ. *Il suicidio*. Torino: Utet 1969).

3 Bressi C, Nocito EP, Porcellana M. *Suicidio*. In: Invernizzi G, Bressi C, a cura di. *Manuale di psichiatria e psicologia clinica*. 4th ed. Milano: McGraw Hill 2012, pp. 391-9.

4 Chatzittofis A, Nordström P, Hellström C, et al. *CSF 5-HIAA, cortisol and DHEAS levels in suicide attempters*. Eur Neuropsychopharmacol 2013;23:1280-7.

5 Pavan L. *Esiste il suicidio razionale?* Roma: Ma. Gi. 2009.

6 Giannelli A. *L'evento suicidario nei suoi aspetti di ambiguità e complessità*. Psichiatria Oggi, 2/1/4. 2004.

7 Hewitt J. *Why are people with mental illness excluded from the rational suicide debate?* Int J Law Psychiatry 2013;36:358-65.

8 Schiavone M. *Problemi etici in psichiatria*. In: Invernizzi G, Bressi C, a cura di. *Manuale di psichiatria e psicologia clinica*. 4th ed. Milano: McGraw Hill 2012, pp. 667-714.

9 Jaspers R. *Philosophie*. Munchen: Il Piper 1932.

10 Pompili M. *Suicide prevention: a long-lasting Italian tradition. Toward understanding the suicidal mind*. Giorn Ital Psicopat 2010;16:1-8.

11 Chesin M, Stanley B. *Risk assessment and psychosocial interventions for suicidal patients*. Bipolar Disord 2013;15:584-93.

12 Norcross J C, Wampold BE. *Evidence-based therapy relationships: research conclusions and clinical practices*. Psychotherapy 2011;48:98-102.

13 Borgna E. *Noi siamo un colloquio. Gli orizzonti della conoscenza e della cura in psichiatria*. Milano: Feltrinelli 2012.

14 Amore M, Innamorati M, Vittorio CD, et al. *Suicide attempts in major depressed patients with personality disorder*. Suicide Life Threat Behav. 2014;44:155-66.

15 Varelius J. *Medical expertise, existential suffering and ending life*. J Med Ethics 2014;40:104-7.

16 Popper Karl R. *Cattiva maestra televisione*. Venezia: Marsilio editori 2002.