CHAPTER ONE

ETHICAL AND PHILOSOPHICAL ISSUES IN SUICIDE

Each individual, including mental health professionals, has an ethical and philosophical stance on suicide. Perceptions and bias, which are not made explicit by the practitioner, undoubtedly will influence professional conduct (Frankena, 1980). Thus, this chapter presents ethical and philosophical issues and concerns from multiple perspectives. Specific attention is given to the issues of philosophical perspectives related to suicide, rational suicide, suicide and the law, euthanasia and physician-assisted suicide, professional ethics and suicide, media and suicide ethics, and ethics in the aftermath of a client suicide. Personal and professional conflicts are explored in relation to clinical practice throughout this chapter.

GOALS AND OBJECTIVES

An understanding of:

- The importance of personal ethical, moral, and value beliefs regarding end-of-life care in clinical practice
- The meaning of rational suicide
- The practitioners' legal and ethical responsibilities
- The professional standard of care
- The four types of euthanasia: passive, active, voluntary, and involuntary
- The implications of physician-assisted suicide (PAS)
- The professional ethical principles of autonomy or self-determination, informed consent, duty to protect, beneficence, nonmaleficence, and confidentiality in relation to end-of-life decisions
- The role of the media in suicidality
- The ethical issues related to professional conduct following the suicide of a client
- The importance of ethics when working with clients at risk for suicide

What do you think, feel, or believe when considering the concept of suicide? Your ethical, moral, and philosophical conceptualization of suicide will have direct and indirect influences on your clinical practice. While the act of suicide itself may be readily defined, it raises challenging and complex problems due to the numerous situations, conditions, and circumstances that can lead to it (Carasevici, 2016). Suicide has been considered noble, an important freedom, unacceptable, morally wrong, an indication of mental illness, a crime,

From: Suicide Assessment and Treatment, Second Edition
DOI: 10.1891/9780826135155.0001

and an offense against God (Mishna, Antle, & Regehr, 2002). In working with suicidal individuals, it is essential to candidly consider and openly understand your own ethics, morals, values, and beliefs relating to suicide, and the impact of those thoughts and attitudes on your own practice.

These questions could remain relegated to a hypothetical, theoretical, or intellectual argument if suicides or suicide attempts were uncommon occurrences rarely experienced by practitioners in their clinical practice. Although it is hoped that suicides are scarce and all can be prevented, the reality is most mental health professionals will experience at least one client suicide over the course of their careers. Studies have begun to research the phenomenon of client suicides. In survey research, 86% of community mental health teams, 46% to 67% of psychiatrists, 35% of social workers, and 22% to 40% of psychologists have reported experiencing one or more patient suicides (Alexander, Klein, Gray, Dewar, & Eagles, 2000; Chemtob, Hamada, Bauer, Kinney, & Torigoe, 1988; Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Kleespies, 1993; Linke, Wojciak, & Day, 2002; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004).

Research has also found that experiencing a client suicide during professional training is common (Coverdale, Roberts, & Louie, 2007; Dewar, Eagles, Klein, Gray, & Alexander, 2000; Kleespies, 1993; Ruskin et al., 2004). Consequently, it is fundamentally important to be aware of your ethical and philosophical beliefs and conceptualizations, as well as the direct and indirect impact of these beliefs on your practice. While this chapter focuses on ethical and philosophical considerations and perceptions, the implications of surviving a client's suicide are explored in Chapters 20 and 21.

Individual Exercise 1.1

1. Develop a list of your personal values and beliefs as they relate to suicide (i.e., always unacceptable, acceptable under certain circumstances). In considering this list, do you feel people close to you (e.g., colleagues, peers, family) would recognize these values and beliefs in you?
2. How do you think these values and beliefs will influence your clinical practice, both positively and negatively?
3. Have your personal values remained constant over time, or have they evolved or changed over time? If they have changed, based on what?
4. Should a practitioner's values change as a result of his or her work with clients? Why or why not?

CAN SUICIDE EVER BE CONSIDERED AN ACCEPTABLE ACTION?

Can suicide be an act of competency, or is every suicide a result of a client's lack of competence (Pinch & Dougherty, 1993)? Does an individual ever have a right to die by ending his or her own life? Can suicide or suicide intervention be moral (Lester & Leenaars, 1996)? When, if ever, is suicide ethically acceptable? What is our professional duty to protect a client from himself or herself? Each practitioner will have different responses to these questions, and those responses may be subject to change over time, raising some important ethical and practical considerations.

PHILOSOPHICAL PERSPECTIVES RELATED TO SUICIDE

Philosophers have strived to conceptualize and define suicide. There are two dominant philosophical paradigms in suicidality: the Kantian and the Utilitarian perspectives (Hill, 1983; Maris, Berman, & Silverman, 2000; Mayo, 1984; Regan, 1983). According to the *Kantian perspective*, a person is a rational agent with autonomy of will, and suicide is a violation of one's duty to himself or herself (Maris et al., 2000). Therefore, individuals who complete suicide are acting in violation of the moral law and their duty to protect themselves (Brassington, 2006; Maris et al., 2000).

The *Utilitarian perspective* considers the consequences of the suicide, including the impact on family members, others, and larger society in determining the moral or ethical judgment of the action (Maris et al., 2000; Mayo, 1984; Schramme, 2013). A client's suicide that reduces pain or suffering to self and others may be morally acceptable; however, if the suicide causes more harm than good, the act is construed to be morally wrong.

These philosophical perspectives are generally thought to be in opposition, rather than on a spectrum. In clinical practice with suicidal clients and their families, it is important to consider how your philosophical perspective impacts your work.

Individual Exercise 1.2

1. Which philosophical perspective, Kantian or Utilitarian, resonates more with your personal values and beliefs?
2. Which philosophical perspective, Kantian or Utilitarian, resonates more with your professional values and beliefs?
3. How may your personal and professional philosophical perspectives conflict?
4. How might this conflict influence your work with clients expressing suicidality?
5. How would you work to resolve this discrepancy?

RATIONAL SUICIDE

Depending on their philosophical and ethical stance, individuals may argue that suicide is morally wrong and that allowing an individual to suicide or failing to prevent suicide is no different from killing that individual (Donagan, 1977; Hendin, 1982; Heyd & Bloch, 1999; Ho, 2014; Mishara & Weisstub, 2013; Schwyn, 1976). Such individuals would argue that under no circumstances is suicide an acceptable solution. Furthermore, suicide is generally perceived as an act committed by irrational individuals affected by psychiatric illness or by those under the influence of an illicit substance. Several studies, in fact, found that as many as 90% of those who committed suicide were mentally ill at their time of death (Barraclough, Bunch, Nelson, & Salisbury, 1974; Brent et al., 1993; Hendin, 1982; Isometsa et al., 1995; Kaplan & Harrow, 1996; Robins, 1981; Strakowski, McElroy, Keck, & West, 1996). Additionally, research indicates that there tends to be a great deal of ambivalence among individuals who attempt suicide (Daigle, 2005; Erazo, Baumert, & Ladwig, 2005; Litman, 1996; Lynch, Cheavens, Morse, & Rosenthal, 2004) and that a suicide attempt is often a means to communicate a problem (Lizardi et al., 2007; Organization, 2007; Paris, 2002). Is it not imperative, then, to intervene in every instance of attempted suicide, given the chance that mental illness may have influenced the decision to commit the suicidal act or that some ambivalence may be present in the individual? Should we not explore the ambivalence and support problem-solving and coping skills?

Despite the evidence, some still argue that suicide may actually be a rational decision and should be a matter of individual choice (Brock, 1985; Fintzy, 1993; Leeman, 2004; Maris, 1982; Motto, 1999; Szasz, 1999; Werth, 1999). The case of Nico Speijers is often used

to exemplify the concept of *rational suicide*. In 1981, Speijers, a suicidologist and suicide prevention advocate, committed suicide, leaving behind a suicide note expressing his decision to end his life in the face of terminal illness and debilitating pain. Speijers had just the year prior published a (1980) book, *Aiding Suicide*, detailing circumstances under which suicide should not be prevented (Motto, 1999). These conditions are the following:

1. The decision to commit suicide is not made under pressure but rather as a result of free will.
2. The individual is suffering from unbearable pain with no relief expected.
3. The wish to end one's life is ongoing.
4. The individual is competent at the time the decision is made.
5. No unnecessary or preventable harm to others is caused by the act.
6. The helper should be a qualified health practitioner or MD if drugs are utilized.
7. The helper should seek advice/consultation from colleagues.
8. The process of the suicide should be documented and the documents submitted to the proper authorities.

Are these conditions sufficient to suggest that intervention should not be taken when a client expresses suicidality? Who should decide the answers to these questions, the client or the practitioner? In considering the concept of rational suicide, it is imperative to understand the legality of suicide and one's legal responsibility as a helping professional. Further review of one's professional code of ethics should also contribute to determining an answer to these questions.

Case Vignette 1.1

As a mental health clinician within the Crisis Team in a large and busy urban hospital, you are frequently called into the Emergency Department to conduct mental health assessments. After being paged to the emergency room (ER), the attending physician informs you that the referred patient has been medically cleared after a significant overdose attempt. The patient, a 64-year-old male, has no prior reported psychiatric history or past suicide attempts. The attempt would have been lethal had not his adult daughter and son-in-law, with whom he resides, unexpectedly returned home early from visiting friends in a nearby town and discovered the patient, unresponsive in his room, wearing a suit. Beside him on his nightstand were sealed letters to each of his family members, his organized bank records, and his will. The ER doctor noted that the patient is stable and oriented. He has slept off the effects of the overdose and charcoal he received upon admission. His blood results are fine and his toxicology report is clear, with no trace of alcohol or illicit narcotics.

In reading his medical chart and receiving a complete update from the attending physician and ER nurse, you learned that the patient has a chronic and deteriorating pain condition. The patient has managed his condition for 21 years. Over the years, his ability to work or engage in functions of daily living has continued to worsen. He is now on exceptionally strong pain medications and can rarely manage to leave his room to eat, watch television, or interact with his family. His condition is terminal and will continue to decline, perhaps for many years. His constant level of pain will continue to escalate. His wife passed away 8 years earlier due to cancer, at which time he moved in with his daughter and her family. The ER nurse stated that the patient, Lee, is a nice and gentle man in a tremendous amount of physical pain. The doctor noted that Lee is a very strong and dignified individual who has managed his pain well over the years. The doctor also stated that, beyond his pain condition, Lee is in good health and that he expected him to live for many more years. However, the doctor did think Lee would have to be placed in a nursing home within a year. The doctor noted that if the patient had not been brought to the hospital, he would not have survived another hour or two.

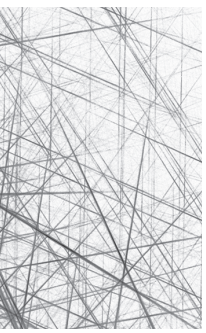
In the examination room, you find Lee in a hospital bed, sitting up with his hair combed, gently talking to his adult daughter, who is sitting in a bedside chair. After introducing yourself and describing your role of conducting an assessment, the daughter, Karen, recounts that her father has

always been a strong and independent person until recently. She tells of finding him yesterday after returning early from visiting friends. She notes how fortunate it was that her friend's son had become very ill during their visit, and that she and her husband had come home hours before they had intended. Both report that he has never attempted suicide nor experienced any psychiatric or mental health problems. While it is clearly observable that he is in pain, Lee contributes to the assessment. After a few minutes, Lee states in a quiet voice how much he loves his daughter and her family and then requests continuing the assessment alone. Karen, holding back tears, kisses her father on his forehead and leaves the room.

Lee states that he had fully intended to die and was disheartened that his daughter had returned unexpectedly early and found him. In fact, he had carefully planned his death for nearly 3 months. He describes suicide as a morally and personally repugnant idea, but it was best for everyone. Twenty-one years ago, when he was diagnosed with his condition, he knew this moment would come. Over the years, he struggled to maintain a normal and productive life, but, with each passing year, his condition deteriorated and his pain increased.

When his wife was diagnosed with cancer, they had agreed that he would continue to support their children and grandchildren until he became a burden. After she died, he noted that he wanted to end his life, but was determined to honor his wife's request to support and care for the family. Four months ago, his treating doctor had informed him that he would soon have to be placed in an expensive nursing home. Also, his pain medications, which were becoming increasingly stronger, were no longer blocking much of the pain. Recently, his daughter spoke of quitting her job to be better able to care for him. Lee states that she has her own family to look after, and while he loves his daughter, the time has come for him to die. Lee tells you that he understands your job is to assess him and prevent his suicide. He agrees to accept any treatment options; however, he also notes that regardless of what you plan, he would quietly and effectively complete suicide over the next few weeks.

1. *Is this an example of rational suicide? Why or why not?*
2. *Which of Speijers's eight conditions of rational suicide are present in the aforementioned case vignette?*
3. *What action would you take as a professional practitioner in this case vignette?*
4. *Would your stance in regard to Lee change if you were his friend? His family member? If so, how?*
5. *Would your personal ethics, values, and beliefs create any potential dilemmas in regard to your professional obligation?*
6. *How would you support this practitioner, if you were his or her supervisor?*



ROLE-PLAY 1.1

Using Case Vignette 1.1 of Lee, engage in a role-play in which you would propose and present a discharge plan and treatment options to Lee.

SUICIDE AND THE LAW

The past decades have seen a dramatic shift in malpractice lawsuits regarding suicide from a focus largely on inpatient institutions and practitioners toward an overrepresentation of lawsuits against outpatient practitioners (Jobes & Berman, 1993; Litman, 1982). It

is critical to be aware of your legal and ethical responsibilities as a practitioner, particularly concerning malpractice liability (S. R. Feldman, Moritz, & Benjamin, 2005).

Determining Liability

Regardless of personal values or ethics, practitioners are legally expected to actively prevent the suicide of a client. Practitioners are expected to uphold their standard of care or duty to care, which includes making reasonable efforts to prevent suicide of a client. The standard of care is legally defined as the duty to employ the degree of skill and care as would be used by a typical practitioner in a similar circumstance (Gutheil, 1992; Jobes & Berman, 1993).

As the act of suicide is nearly impossible to predict, four key elements are often present for a claim of malpractice to be supported. These are (a) the presence of a professional relationship, (b) a violation of the standard of care, (c) the violation resulting in damages or harm, and (d) a direct causal relationship between the practitioner's omissions and the suicidal act of the client (Berman, 2006; Bongar, 2002; Bongar & Greaney, 1994; Cantor & McDermott, 1994).

In malpractice suits, the standard of care is evaluated retrospectively via review of clinical records and available testimony. There are several areas that are considered failures of the standard of care that can result in a practitioner being held liable for malpractice (Bongar, Maris, Berman, & Litman, 1992; Gutheil, 1992; Waltzer, 1980). These include failures to perform the following:

1. Assess risk as the most obvious violation of the standard of care.
2. Keep accurate, up-to-date records.
3. Assess for suicide risk at the time of the last professional contact.
4. Conduct or refer client for a psychological evaluation.
5. Secure records from prior psychiatric treatment.
6. Develop an adequate treatment plan.
7. Provide adequate treatment.
8. Refer to inpatient hospitalization, voluntarily or involuntarily, when indicated.
9. Protect patient from known danger to self.
10. Possess the training, knowledge, and skill necessary to treat and assess for suicidality.

Recommendations to Minimize Risk of Malpractice

Essential guidelines have been developed as a result of the proliferation of suicide malpractice lawsuits in outpatient care settings (Bongar, 1991). Key recommendations that should not be overlooked include the following:

1. Conduct an assessment of suicide risk with every patient. As suicidal behavior cannot be predicted, no client can be determined to be free of risk without a thorough assessment.
2. Maintain comprehensive records. A lack of documentation can be damaging to a practitioner's defense as there will be no evidence of the standard of care he or she maintained in respect to the client's treatment.
3. Seek records from client's prior treatment experiences. Proper assessment of the suicide risk must include consideration of prior suicidal behavior. Relying on a client's personal report of suicide history is insufficient when it has been established that prior treatment existed.
4. Suicide risk is increased in offspring of individuals with psychiatric illness and a history of suicidality (Brent et al., 1994; Gould, Fisher, Parides, Flory, & Shaffer, 1996; Kovacs, Obrosky, Gatsonis, & Richards, 1997; Schulsinger, Kety, Rosenthal, &

Wender, 1979; Tsuang, 1983; Weissman, Fendrich, Warner, & Wickramaratne, 1992; Wender et al., 1986). Thus, proper evaluation of a client's risk for suicide should include assessment of family history of mental disorders and psychiatric hospitalization.

5. Establish relevant *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5;* American Psychiatric Association, 2013) diagnoses. There is a differential risk of suicide associated with psychiatric illnesses (see Part IV). Comprehensive assessment of *DSM-5* psychiatric disorders will shed light on the degree of suicide risk in relation to other psychosocial characteristics with which the client presents.

Small Group Exercise 1.1

1. In groups of four to five, use Case Vignette 1.2 (later in the chapter) to discuss whether the prescribing physician could be considered liable for malpractice.
2. What violations of the standards of care (listed earlier) might apply, if any?
3. If you were a mental health practitioner on the physician's team, what steps could you have engaged in to prevent Sam's action (use Case Vignette 1.2 provided later in the chapter)?

EUTHANASIA AND PHYSICIAN-ASSISTED SUICIDE

There are four types of euthanasia: passive, active, voluntary, and involuntary. *Passive euthanasia* involves the withdrawal or withholding of artificial life-support or medical treatments that may prolong life, whereas *active euthanasia* is an act taken to shorten life (Smokowski & Wodarski, 1996). An individual requesting assistance from anyone in ending his or her life is considered to be engaging in *voluntary euthanasia*; however, intentionally causing the death of an individual, whether, competent, incompetent, or unaware, without informed consent or explicit request, is considered *involuntary euthanasia* (Csikai, 1999). Only passive euthanasia is widely accepted by health care practitioners, family members, society, and the law. *Physician-assisted suicide (PAS)* is the provision of suicidal means, such as prescribed medications, to an individual who is otherwise able to suicide (Csikai, 1999; Smokowski & Wodarski, 1996). If a physician administers the lethal dose following the request of the patient, this is considered active voluntary euthanasia (Smokowski & Wodarski, 1996).

Euthanasia, PAS, and the Law

Across the United States and throughout the world, the increasing legalization of euthanasia and PAS has challenged the attitudes and practices of health care providers and the larger public. In the United States, as of 2016, five states (California, Oregon, Montana, Vermont, and Washington) have passed laws supporting PAS, but not euthanasia. Globally, euthanasia or PAS can be legally practiced in Canada, Colombia, Belgium, Luxembourg, and the Netherlands, with Switzerland allowing only PAS (Emanuel, 2016). Reportedly, fewer than 20% of U.S. physicians described having received requests for euthanasia or PAS, whereas in the Netherlands and Belgium, over 50% of physicians reported receiving such requests (Emanuel, 2016). Beyond the five states of the United States, countries that have discussed, debated, and have passed laws related to euthanasia and PAS currently include Argentina, Australia, Chile, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, India, Israel, Italy, Poland, Spain, Sweden, Taiwan, Uganda, United Kingdom, and West Indies (Bendiane et al., 2009; Gielen, 2008; Giese, 2009; Levene, 2011; Rosenfeld, 2004; Schoonman, van Thiel, & van Delden, 2014; Snijdewind,

2014; Sorta-Bilajac, 2008; Tamayo-Velazquez, Simon-Lorda, & Cruz-Piqueras, 2012; Trankle, 2014).

In 1997, the U.S. Supreme Court unanimously ruled (*Washington v. Glucksberg; Vaccpo v. Quill*) that there is neither a constitutional prohibition nor a constitutional right to euthanasia and PAS (Breitbart & Rosenfeld, 1999; Emanuel, 2002). The Ninth and Second U.S. Circuit Courts of Appeals in Washington State and New York State have also ruled in lawsuits brought before them that laws prohibiting PAS are unconstitutional (Drickamer, Lee, & Ganzini, 1997). In 1998, Oregon passed the Death With Dignity Act legalizing PAS for state residents with a terminal illness who voluntarily request these actions (Quill, Meier, Block, & Billings, 1998; Sullivan, Hedberg, & Fleming, 2000).

Euthanasia, PAS, and Attitudes

In their analysis of opinion polls between 1936 and 2002, Allen and colleagues (2006) found that Americans supported euthanasia and PAS. Since 1973, the majority of polled Americans, when asked "when a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?" supported this position (Allen et al., 2006). In a similar survey study among terminally ill patients and their caregivers, a majority supported PAS, but only a small proportion seriously considered taking such actions themselves (Emanuel, Fairclough, & Emanuel, 2000). This is consistent with other research that found that only approximately 10% of the patients in palliative care report suicidal thoughts (Mosich & Müller-Busch, 2014).

For some, there is a moral distinction between killing or ending-a-life (e.g., withdrawing life-supporting or life-sustaining treatment) and allowing-to-die (e.g., withholding life-supporting or life-sustaining treatment). Some individuals posit that PAS or physician withdrawal of life-sustaining treatment cannot be morally equated to voluntary active euthanasia (Huddle, 2013). This concept of "doing" versus "allowing" remains one of the critical aspects of the debate around active euthanasia and PAS (Bishop, 2006a, 2006b; Huddle, 2013; McLachlan, 2010; Shaw, 2007). In a study comparing the general public to mental health professionals (physicians and nurses), results found that, in general, life-ending actions are more acceptable to lay people than to the health professionals; however, for both groups acceptability is highest when the patient is experiencing enduring physical suffering, is higher when patients end their own lives rather than when physicians complete the act, and, when physicians are completing the act, is higher when patients have clearly expressed a desire to die rather than when they have not (voluntary vs. involuntary euthanasia; Guedj et al., 2005).

It is important to consider whether the condition or illness that the client is managing is acute versus a potential chronically debilitating condition. Some argue that a distinction should be made between those individuals suffering from severe psychiatric disorders and lacking mental capacity and competent patients suffering from enduring pain and incurable physical illness seeking to end their suffering (Macleod, 2012). It has been argued that a person with a serious mental disorder (SMI) is nonautonomous, and therefore, suicide prevention is likely to be deemed legally and morally justified. Further, because some consider psychogenic pain as less real than physical pain, the presence of a mental illness invariably means that a desire to die is irrational and inauthentic (Hewitt, 2013). However, research has shown that some people managing mental illnesses can be rational and that psychological pain is of equal significance to physical suffering (Hewitt, 2013). In accordance, there is a call for greater incorporation of mental health professionals into end-of-life decisions and considerations made by medical professionals (Deschepper, Distelmans, & Bilsen, 2014; Groenewoud et al., 2004; Kelly & McLoughlin, 2002; Macleod, 2012; Sjöberg & Lindholm, 2003). Thus, should individuals managing a

serious mental illness, who are rational and in significant pain, not have the option of *rational suicide*?

Not relegated to public opinion, the debate over euthanasia and PAS has been waged for many decades across a number of fields including, but not limited to, medicine, health care, mental health, individual rights, human rights, religion, professional codes of ethics, and the law. Each practitioner holds very specific personal ethical beliefs regarding euthanasia and PAS. As such, health care and mental health practitioners may face a number of ethical dilemmas stemming from clients considering euthanasia and PAS and should be aware of these issues and their own personal ethics and values. It is necessary to realize that what you believe will directly and indirectly impact your practice. For example, in a survey on the attitudes of nurses, 75% personally felt that PAS may be justified in select cases, but only 46% would be willing to participate if PAS were legalized (Kowalski, 1997). A similar survey with U.S. oncologists found that a willingness to perform PAS was lower than the support for the procedure (Emanuel, Fairclough, Clarridge, et al., 2000; Hilden et al., 2001). Others found that 80% of geriatricians, but only 52% of intensive care physicians, considered active voluntary euthanasia as never justified ethically (Dickinson, Lancaster, Clark, Ahmedzai, & Noble, 2002).

Individual Exercise 1.3

1. Do you agree with the law regarding PAS? Why or why not?
2. If you do support PAS, what are the boundaries or limits of your support? For example, do you feel all clients have a right to choose suicide? Is it limited to those who are terminal and in pain? Does the client's physical versus mental nature of his or her illness influence your determination?
3. Would you participate in PAS? Why or why not?
4. How would you work with a client requesting PAS in a state where it is legal?

Euthanasia, PAS, and Guidelines for Ethical Practice

Many mental health professional organizations, such as the American Psychiatric Association, American Psychological Association, National Association of Social Workers (NASW), and American Counseling Association, are beginning to develop guidelines for members working with clients considering PAS (Werth, 1999). However, each organization has a different perspective on addressing these ethical issues. It is important to understand the professional stance of your governing body.

For example, the National Association of Social Workers (NASW) *Code of Ethics* (2000), Standard 1.02, states that social workers have a responsibility to help clients assert their rights of self-determination (NASW, 2000). According to Mackelprang and Mackelprang (2005), this "suggests that, for terminally ill people who are capable of making decisions, the ethical responsibility to promote self-determination outweighs the social workers' responsibilities to avoid harm" (Mackelprang & Mackelprang, 2005; p. 321). While self-determination is a primary principle, Csikai (1999) iterates that social workers "must be well informed of and comply with the laws of their states concerning end-of-life decisions, including living wills, durable powers of attorney for health care, and laws concerning physician assisted suicide" (pp. 55–56). NASW also dictates that social workers should discuss all options with clients and families in end-of-life situations (Csikai, 1999).

However, the NASW does not articulate clear procedures or provide guidance for when social workers should become involved with terminally ill clients (Allen et al., 2006). Consequently, in working with terminally ill patients considering PAS, social workers

may need, at minimum, to (a) understand the implications of their own personal ethics; (b) determine informed consent; (c) assess the client's self-determination and his or her individual and family's wishes; (d) review all options with client and family; (e) work with the larger health care team; (f) consult with their supervisor, professional organization, and workplace policy and procedures; (g) understand the laws governing their state; and, if necessary, (h) consult with legal counsel.

PROFESSIONAL ETHICS AND SUICIDE

Clearly, the law overwhelmingly obliges practitioners to intervene to prevent suicidal acts. Professional values, those we accept when we choose to enter a profession, serve as yet another guideline for proper behavior that practitioners are expected to follow. Professional codes of ethics define a practitioner's ethical obligations as helping professionals. Ethical codes consist of multiple principles that serve to protect a client (Rosenbluth, Kleinman, & Lowy, 1995; Wagle, Ede, Craig, & Bottum, 2004) and to guide a practitioner through times of conflict involving morals, values, and beliefs (Sasson, 2000). While differences exist, the fundamental principles proposed by the main codes of ethics of the helping professions (social work, psychology, psychiatry, and medicine) share several fundamental features. The ethical principles most relevant when considering a suicidal patient include *autonomy* or *self-determination*, *informed consent*, *duty to protect*, *beneficence*, *nonmaleficence*, and *confidentiality*.

Autonomy

Autonomy is one of the foremost principles that affect a practitioner's course of action regarding a suicidal client. The principle of self-determination involves the client's right to take action rooted in his or her own goals, desires, and wishes (Reamer, 1983). Suicide often occurs in those with mental illness. Thus, granting autonomy to individuals to act on suicidal thoughts and/or feelings is considered, by some, allowing a noncompetent individual to make life-threatening decisions. Respecting one's individual rights might be better served by recognizing their vulnerability and strengthening their resources. In fact, the NASW *Code of Ethics* (2000) permits social workers to limit clients' self-determination when their action or potential actions pose a serious, foreseeable, and imminent risk to themselves or to others.

Informed Consent

The principle of autonomy grows directly out of the doctrine of informed consent, having competent understanding of risks, benefits, and alternatives from which a client can make a decision regarding an appropriate course of action (Beauchamp, 1999). The process of informed consent recognizes the importance of autonomy, of individuals making their own decisions (Bell & Clark, 1998). Prevention of suicide is ethically justified by suggesting that the suicidal person is not competent to give informed consent and to make decisions regarding his or her care (Chadwick & Tadd, 1992), as suicidal behavior is considered to be the byproduct of mental illness (Barraclough et al., 1974; Brent et al., 1993; Chadwick & Tadd, 1992; Hendin, 1982; Isometsa et al., 1995; Kaplan & Harrow, 1996; Robins, 1981; Strakowski, McElroy, Keck, & West, 1996).

Duty to Protect

In entering a therapeutic relationship with a client, practitioners accept certain responsibilities, including the duty to protect the client from harming himself or herself

(Packman & Harris, 1998; Welfel, 2002; Werth & Rogers, 2005). However, how each practitioner applies this duty to protect with a client who is suicidal varies considerably. It has been argued that practitioners should always intervene to protect when a client raises the possibility of self-harm or suicide (Elitzur, 1995). Conversely, psychiatrist Thomas Szasz forwarded the position that clients have a right to decide for themselves whether they wish to die without the protection and intervention of a practitioner (Maris et al., 2000).

Clearly, how one ethically or professionally understands this duty to protect is open to interpretation. Werth and Rogers (2005) have provided some guidelines for the determination of this duty. Specifically, they propose that (a) this duty should apply when a client is engaging in serious self-harm or death within a short period of time, and (b) the best method to protect is to assess for impaired judgment and apply appropriate treatment interventions (Werth & Rogers, 2005).

Confidentiality

Confidentiality is a major area for practitioners as far as suicide is concerned. Most codes of ethics require practitioners to breach confidentiality if their clients represent a danger to themselves or others. Therapists are ethically, and in all states legally, obligated to disclose if the client is homicidal. The responsibility of protecting individuals from harm that may be inflicted by another individual does not frequently pose as an ethical dilemma. However, breaching confidentiality when one poses a threat to self, as is the case with suicide, often results in an ethical conflict (Rosenbluth, Kleinman, & Lowy, 1995; Wagle, Ede, Craig, & Bottum, 2004). In these instances, the principles of beneficence and nonmaleficence can guide the practitioner.

Beneficence

This principle represents the concept of doing the greatest good possible. Practitioners have an ethical responsibility to strive for the well-being of clients. Beneficence should take precedence over autonomy, as the death of an individual would not generally be considered a "good" action (Rosenbluth, Kleinman, & Lowy, 1995; Wagle, Ede, Craig, & Bottum, 2004).

Nonmaleficence

Practitioners have a legal and ethical obligation to protect clients from harm. The principle of nonmaleficence, minimizing or preventing harm, requires a practitioner to take whatever action necessary to prevent a client from taking his or her own life. The practitioner is obligated to work toward the improvement of a client's quality of life and well-being, although this responsibility often conflicts with a client's ability to be independent and make decisions about his or her own life. In the case of a suicidal client, practitioners often find themselves in a paternalistic position (Abramson, 1985; Kelly, 1994). Reamer (1983) provides a framework for making ethical decisions in times of conflict particularly regarding the conflict between supporting and limiting one's autonomy. He suggests that while social workers should carefully avoid excessive intrusion into the lives of clients, paternalism may be justified in certain circumstances. These circumstances include when (a) harmful consequences may result from supporting a client's autonomy that may be irreversible, (b) placing temporary restrictions may potentially generate a wider degree of freedom for the client, and (c) the immediate need to rescue a client from harm exists. Suicidal behavior certainly would fall among these categories. Understanding fully one's responsibilities as dictated by law and one's professional code of ethics can guide a practitioner to take action to prevent a client from acting on suicidal impulses and to feel justified in doing so.

Individual Exercise 1.4

1. According to your personal perspective, rank in order the ethical principles (autonomy or self-determination, informed consent, duty to protect, beneficence, nonmaleficence, and confidentiality) from most important to least important.
2. Justify your ordering of the ethical principles.
3. Consider the implications of your answers for your work with suicidal clients, who may have very different personal perspectives.

Case Vignette 1.2

Samantha, who prefers to go by Sam, is a 46-year-old White female widow with no prior psychiatric history. She was admitted to the adult inpatient psychiatry unit of an urban hospital following an attempted suicide. As the social worker on the unit, your role is to conduct meetings with the client and her family about the factors that led up to her inpatient admission. Prior to scheduling a meeting with significant others in Sam's life, you meet with Sam to conduct an assessment to further understand Sam's presenting situation and to determine who would be the most appropriate member to invite to a family session. Sam has been on the unit for less than a day when you meet with her in the small interview room on the unit. She is disheveled, makes poor eye contact, and is hesitant to meet with you. After describing your role, Sam's first words to you are "you've got the wrong gal. I have no one to ask to come to meet with you." Upon further exploration you learn the following:

Sam is the only child. Her parents, now deceased, were her closest friends growing up. Her mother, Anne, a stay-at-home mom, and her father, Benjamin, a tailor, were loving, warm, supportive, hardworking individuals. Sam was encouraged to be hardworking, to value the importance of education. Neither Sam's mother nor father had attended college, and Sam was groomed to be the first in the family who would do so. Sam, in fact, was very dedicated to her studies and despite the fact that she held a job, managed to graduate from college in 3 years. College was a very happy time in Sam's life. She recalls having a full social network. College is also where she met Richard, her future husband. Richard was Sam's first serious boyfriend. He was an artist and her complete opposite. She adored Richard and felt he was the "love of her life."

After college, Sam got a job in an investment banking firm. While she did not receive an MBA, she managed to work her way up through the company to the position of Managing Director and earned nearly a million dollars a year. Richard continued with his art. It came as a great surprise to Sam when Richard informed her that he had a "once in a lifetime job opportunity" to run a small art gallery in the Southwest. They knew no one there and Sam would have to leave her job. It would be the first time in 32 years she would be unemployed. While the idea was scary, she would do anything to support Richard. The move was the "greatest thing that could have happened." Sam, for the first time in her life, felt truly at ease. She decided not to find a job and instead developed her own hobby, literature. Sam became an avid reader and even dabbled at writing.

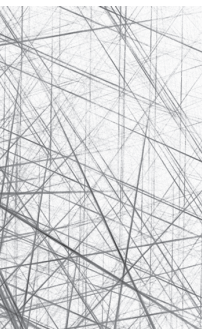
Sam and Richard lived a very quiet life. They never had any children and never felt like they were missing out on anything, "We were all we needed." They never made any close friends in the town to which they moved but that was also not something they missed. Sam felt they had the "perfect life. But perfect never lasts."

Five years after they moved, Richard became ill and was diagnosed with a terminal illness. The doctors gave him 2 to 3 years to live but the illness progressed rapidly and within 8 months of his diagnosis he died. Sam "died that day, too." She never recovered from his death which, at the time of admission, was 2 years earlier. She moved back to the city they had left 7 years prior but could not manage to get a job and make any friends. She lived a solitary life; the life built around Richard was gone. She struggled for 2 years to make meaning out of his death and to figure out what she "was being punished for." She could no longer find a reason to live.

Three weeks prior to her admission, Sam decided she would end her life. She came up with an elaborate plan. She went to the dentist complaining of terrible sensitivity to pain in one of her teeth, and was informed that she needed a root canal. After having the procedure, she saved up the prescribed pain medication. A week later, she called her physician to explain that she had just had a root canal and that her dentist was out of town for the next week but that she continued to experience severe pain. Her doctor prescribed pain medication on the condition that Sam see her dentist upon his return from vacation. She then spent the next week paying all of her bills, reviewing photos of her husband, and mailing his artwork to the gallery in the Southwest. Sam became at ease with the idea that her life was going to end and felt she would finally be reunited with Richard. The night prior to her admission, she overdosed on pain medications.

Sam's well-planned suicide would have been successful had her superintendent not entered her apartment to check for a suspected leak in Sam's bathroom. Sam does not regret her attempted suicide and is "angry" that the superintendent interrupted her. She understands that some may find suicide to be the "easy way out" but she feels it "is the only thing that makes sense." Sam explains that there is no one on whom she can call to attend a family session because "the only people she ever cared about are dead." She understands that medication and therapy can make some people feel better but feels strongly that she has "nothing to feel better about, so why bother." She is unwilling to comply with the treatment team's decision to begin medication, and a decision has to be made as to whether or not to seek court-ordered treatment to medicate her against her will.

1. *Should a court-order mandating treatment be obtained? Why or why not?*
2. *What professional values and ethics guide your decision?*
3. *How would your personal ethics, values, and beliefs influence your decision?*
4. *How can you support Sam's right to self-determination and informed consent while still upholding your professional responsibilities?*



ROLE-PLAY 1.2

Using Case Vignette 1.2 of Sam, engage in a role-play in which you would present the possibility of court-ordered mandated treatment to Sam. One participant plays the role of Sam, the other plays the role of a mental health practitioner discussing the treatment.

MEDIA AND SUICIDE ETHICS

Can a newspaper article, television news story, or video clip on the Internet cause or encourage an individual to attempt suicide? A recent review identified 28 countries where media guidelines on suicide reporting exist, but fewer than 20 countries' recommendations were listed in the national press codex (Erlangsen, 2013). In and of itself, reading or viewing a story about someone else attempting or committing suicide is generally not sufficient to cause an individual to attempt suicide (World Health Organization [WHO], 2000). However, research informs us that if an individual has a preexisting vulnerability to suicide, such as a mental illness, he or she may be more sensitive to suicide reporting and may be more inclined to attempt suicide, as a result of exposure to a suicide report (Etzersdirfer & Sonneck, 1998; Pirkis & Blood, 2001). Research has also indicated an increase in the rate of suicide as suicide reports in newspapers and television increase (Motto, 1967, 1970; Phillips, 1974, 1982; Wasserman, 1984). In particular, researchers found

a substantial increase in the number of suicides within the 10-day period following the highlighting of a suicide in television news. What, then, is the ethical responsibility of the media in regard to suicide? Can editorial freedom cross the line into an ethical violation?

Clearly, in an era dominated by 24-hour news, the Internet, and webcasts, the media plays a crucial role in the transfer of knowledge. Social media, including Facebook, Twitter, Snapchat, Instagram, and others, has brought new challenges as messages are distributed to large numbers of recipients by people unaware of any press-reporting guidelines on suicide (Erlangsen, 2013). How the media reports information and transfers knowledge has become a source of much contention, particularly as it relates to reports of suicide in newspapers, television, and, increasingly, in social media. Concerns center on the detailed accounts of suicide events (attempted suicide and completed suicide) and the fear that such reports will motivate vulnerable individuals to copy those events, often referred to as the "contagion" or "Werther effect" (Alvarez, 1975; Phillips, 1974). There is a fear that, in an attempt to grab readers, sensational headlines, photos of the deceased and glorified accounts of death may lead to more unnecessary deaths by suicide (Blood & Pirkis, 2007; Motto, 1970; Wasserman, 1984). Additionally, in the rush to meet deadlines and put out a story, information may be presented as fact that has not actually been confirmed. Are these ethical violations or just detailed news required in an increasingly competitive market?

The effect of media is not limited to newspapers, radio, and television. In this ever-growing electronic era, the impact of the Internet is undeniable (Alao, Soderberg, Pohl, & Alao, 2006; Baume, Cantor, & Rolfe, 1997). Websites posting specific instructions on how to attempt suicide by various means can be found in multiples. With a simple click of a mouse, an individual can be directed to a web page that accurately describes how to end one's life. Evidence-based research on the influence of the Internet on suicide attempt risk is limited but should be the focus of future research as the Internet continues to grow and its influence expands to new and younger audiences.

A recent discussion paper on media recommendations by Maloney and colleagues (2013) on reporting suicide noted that fewer than 25% of media recommendations include the following factors that may prevent imitation:

- Not mentioning the name and characteristics of the suicidal person
- Not citing or printing photographs of suicide notes
- Not referring to online suicide forums
- Not mentioning suicide pacts
- Not mentioning suicides that are close in time or space (suicide clusters)
- Not mentioning an accumulation of suicidal acts at certain locations (hot spots)
- Not mentioning positive consequences of suicidal behavior
- Referring to self-help groups

According to the WHO, minimizing media reporting of suicide is one of its key strategies for suicide prevention. The media is in a position to decrease the incidence of tragic deaths due to suicide by reporting suicide in an appropriate and accurate manner (WHO, 2000). Furthermore, the media can report on the warning signs for suicide and convey the means for seeking help. This suggests that when reports of suicide do not follow these guidelines, ethical boundaries are in fact being crossed, as the reason for the reporting has shifted from conveying matters of public interest to vying for customers.

Guidelines for Ethical Suicide Reporting in the Media

In light of these findings, several main principles have been proposed as guidelines to follow for ethical reporting of suicide. These include avoiding the following:

1. Sensationalizing headlines
2. Describing the means employed in the suicide event

3. Mentioning names or publishing photos to limit the perception that suicide is a means to draw attention to oneself
4. Oversimplifying the cause of suicide; suicide is complex and often is the result of a combination of factors
5. Sanitizing when mental illness and/or substance abuse are involved
6. Describing the suicide event as a "success" or as a "solution" (Canadian Association for Suicide Prevention, 2003; The Samaritans, 2005; WHO, 2000).

ETHICS IN THE AFTERMATH OF A CLIENT SUICIDE

What happens to the practitioner when a client completes suicide? Although professionals are very effective in assessing and treating suicidal patients, there will be clients in treatment who successfully complete suicide. This phenomenon is often neglected or minimized in practice, and literature regarding how professionals manage a client's suicide is limited (Gitlin, 1999). Following a client's suicide, practitioners' reactions may vary from grief, shock, denial, distress, depression, isolation, self-blame, a sense of failure, strain on their personal and professional lives, fear of another suicide, and loss of confidence, to avoidance of triggering stimuli (Alexander et al., 2000; Cooper, 1995; Dewar et al., 2000; Eagles, Klein, Gray, Dewar, & Alexander, 2001; Halligan & Corcoran, 2001; Maltsberger, 1992; Spiegelman & Werth, 2005; Strom-Gottfried & Mowbray, 2006).

Though the literature is relatively limited on ethically managing this issue, a number of professions, including social workers (D. Feldman, 1987; Strom-Gottfried & Mowbray, 2006; Ting, Sanders, Jacobson, & Power, 2006), medical doctors (Alexander et al., 2000; Dewar et al., 2000; Eagles et al., 2001; Halligan & Corcoran, 2001; Talseth & Gilje, 2007), nurses (Cooper, 1995; Gilje, Talseth, & Norberg, 2005), and psychologists (Kleespies, 1993; Spiegelman & Werth, 2005), have begun to investigate the impact of a client suicide on practitioners. Please go to Chapter 21 for a full discussion of this important issue.

SUMMARY

The majority of clinical practitioners will encounter a suicidal client in the course of their careers. It is essential to be aware of personal values, ethics and philosophical beliefs, professional ethical responsibilities, legal obligations, and the manner in which these factors interact to influence the course of action that would be taken when faced with a suicidal client. The personal and professional stance of providers can be a significant ethical challenge as providers weigh the expressions of patient wishes versus their own views of beneficence, nonmaleficence, and professional integrity (Venkat & Drori, 2014). Ethics matter.

KEY POINTS

1. In working with a suicidal client, it is essential to candidly consider and openly understand your own ethics, morals, values, and beliefs relating to suicide and the impact of these thoughts and attitudes on your own practice.
2. Some argue that suicide may be a rational decision under certain circumstances and should be a matter of individual choice.
3. It is critical to be aware of the legal and ethical responsibilities related to the role of a practitioner, particularly concerning malpractice liability.

(*continued*)

KEY POINTS (*continued*)

4. Practitioners are expected to uphold their professional standard of care, despite their personal beliefs.
5. Regardless of personal values or ethics, practitioners are legally expected to actively prevent the suicide of a client.
6. There are four types of euthanasia: passive, active, voluntary, and involuntary.
7. There is neither a constitutional prohibition nor a constitutional right to euthanasia and PAS.
8. The ethical principles most relevant when considering a suicidal patient include autonomy or self-determination, informed consent, duty to protect, beneficence, nonmaleficence, and confidentiality.
9. Minimizing unethical media reporting of suicide is one of the key strategies for suicide prevention.
10. The media has the potential to play an important role in reducing suicide by reporting on warning signs and how/where to seek treatment.

ELECTRONIC RESOURCES

RATIONAL SUICIDE

Suicide prevention, awareness, and support
www.suicide.org
Suicide and crisis support information in 10 languages, suicide support from Befrienders International
www.suicideinfo.org
American Association of Suicidology
www.suicidology.org

SUICIDE AND THE LAW

Developments in New York law
http://tswartz1.typepad.com/new_york_legal_update/2007/07/suicide-and-psy.html
Practice Pointers, the NASW Assurance Services
www.naswassurance.org
Ethics and malpractice
www.kspope.com/ethics/index.php
Psychiatry and law updates
www.reidpsychiatry.com
Search engine for medical literature
www.ncbi.nlm.nih.gov/entrez/query.fcgi
American Association of Suicidology
www.suicidology.org

EUTHANASIA

Death With Dignity National Center
www.deathwithdignity.org
Euthanasia Research & Guidance Organization
www.finalexit.org
Voluntary Euthanasia Society of London, England
www.dignityindying.org.uk
Hemlock Society USA
www.endoflifechoices.org
Compassion and Choices
www.compassionandchoices.org
World Federation of Right to Die Societies
www.worldrtd.net
Exit International
www.exitinternational.net

CODE OF ETHICS

American Psychiatric Association
www.psych.org/psych_pract/ethics/ethics.cfm
American Psychological Association
www.apa.org/ethics/code2002.html
NASW
www.socialworkers.org/pubs/code/code.asp
www.iap.org.au/ethics.htm
Links to additional ethics codes
www.kspope.com/ethcodes/index.php

MEDIA

International World Health Organization's resource
www.who.int/mental_health/resources/suicide/en
American Foundation for Suicide Prevention—Reporting on Suicide
https://afsp.org
www.mindframe-media.info/ (Further information)
Project on Death in America
http://www.soros.org/death
Social Workers in End-of-Life and Palliative Care
www.swlda.org
National Association of Social Workers End-of-Life Care
www.socialworkers.org/research/naswResearch/EndofLifeCare

KNOWLEDGE ACQUISITION TEST (KAT)

True or False

1. According to the Kantian perspective, a client's suicide that reduces pain or suffering to self and others may be morally acceptable.
2. The majority of those who commit suicide have a mental illness at the time of their death.
3. Experiencing a client suicide during professional training is not common.
4. The Death With Dignity Act of 1998 legalized PAS in all states.
5. An individual may be more inclined to attempt suicide as a result of exposure to a suicide report when he or she has a mental illness.
6. Nonmaleficence represents the concept of doing the greatest good possible.
7. Involuntary euthanasia exists only when the client is incompetent.
8. It is acceptable, under certain circumstances, to allow one's personal values to influence one's professional actions.
9. Social media abides by the same suicide-reporting guidelines as television and print media.
10. Only 25% of identified media includes limiting reporting on identifiable core factors that may prevent imitation.

Short Answer

11. What are the four key elements to support a claim of malpractice?
12. Under what circumstances can you as a practitioner breach confidentiality?
13. Is failure to secure previous records a breach of standard care practices?
14. What are three key ways to minimize risk of malpractice? If someone is going to commit suicide, can media reporting encourage or discourage their decision-making process? Why or why not?
16. Which ethical principles support an individual's right to commit suicide?
17. What is the difference between voluntary and involuntary euthanasia?
18. What are the core factors that may prevent imitation and are recommended to be considered when media reports on suicide?
19. How has social media challenged suicide reporting?

Multiple Choice

20. Which if the following is an ethical principle that does not support an individual's right to suicide?
    A. Informed consent
    B. Self-determination
    C. Confidentiality
    D. Duty to protect
    E. None of the above
    F. All of the above
21. Reamer's (1983) framework for ethical decision making proposes that limiting a client's autonomy is justifiable under which of the following circumstances:
    A. The client's family requests the assistance of the practitioner in facilitating the suicidal act.
    B. Harmful consequences that may be irreversible are likely to result should the client's autonomy be supported.
    C. There is potential that at some point in the future the need to rescue a client from harm may exist.

D. When a colleague expresses that limiting the client's autonomy would be appropriate.
E. None of the above.
F. All of the above.

22. Which of the following is a definition of voluntary euthanasia?
A. An act taken to shorten life
B. The withdrawal or withholding of artificial life-support or medical treatments that may prolong life
C. Individuals requesting assistance from anyone in ending their lives
D. Intentionally causing the death of an individual without informed consent or explicit request
E. None of the above
F. All of the above

23. Failures to uphold the standard of care include:
A. Keeping accurate, up-to-date records
B. Assessing suicide risk during the last clinical contact
C. Securing records from prior psychiatric treatment
D. Developing an adequate treatment plan
E. None of the above
F. All of the above

24. In considering ethical issues related to suicide, a practitioner must:
A. Maintain current knowledge of relevant governing laws.
B. Have self-awareness regarding personal ethics, values, beliefs concerning suicide.
C. Possess mastery of professional obligations as defined in relevant professional code of ethics.
D. Take adequate steps to minimize risk of malpractice liability should a client suicide.
E. None of the above.
F. All of the above.

25. Which of the following media recommendations are intended to prevent suicide imitations?
A. Not referring to online suicide forums
B. Not mentioning suicide pacts
C. Not mentioning suicides that are close in time or space
D. Not mentioning an accumulation of suicidal acts at certain locations
E. All of the above
F. None of the above

REFERENCES

Abramson, M. (1985). The autonomy-paternalism dilemma in social work practice. *Social Casework*, *66*, 387–393.

Alao, A. O., Soderberg, M., Pohl, E. L., & Alao, A. L. (2006). Cybersuicide: Review of the role of the internet on suicide. *Cyberpsychological Behavior*, *9*(4), 489–493.

Alexander, D. A., Klein, S., Gray, N. M., Dewar, I. G., & Eagles, J. M. (2000). Suicide by patients: Questionnaire study of its effect on consultant psychiatrists. *British Medical Journal*, *320*, 1571–1574.

Allen, J., Chavez, S., DeSimone, S., Howard, D., Johnson, K., LaPierre, L., Montero, D., Sanders, J. (2006). Americans' attitudes toward euthanasia and physician-assisted suicide, 1936–2002. *Journal of Sociology & Social Welfare*, *3*(2), 5–23.

Alvarez, A. (1975). Literature in the nineteenth and twentieth centuries. In S. Perlin (Ed.), *A handbook for the study of suicide* (pp. 153–178). New York, NY: Oxford University Press.

Barraclough, B., Bunch, J., Nelson, B., & Salisbury, P. (1974). A hundred cases of suicide: Clinical Aspects. *British Journal of Psychiatry*, *125*, 355–373.

Baume, P., Cantor, C. H., & Rolfe, A. (1997). Cybersuicide: The role of interactive suicide notes on the internet. *Crisis*, *18*(2), 73–79.

Beauchamp, T. L. (1999). The philosophical basis of psychiatric ethics. In S. Bloch, P. Chodoff, & S. A. Green (Eds.), *Psychiatric ethics* (3rd ed., pp. 25–48). Oxford, UK: Oxford University Press.

Bell, C. C., & Clark, D. C. (1998). Adolescent suicide. *Pediatric Clinics of North America*, *45*(2), 365–380.

Bendiane, M. K., Bouhnik, A. D., Galinier, A., Favre, R., Obadia, Y., & Peretti-Watel, P. (2009). French hospital nurses' opinions about euthanasia and physician-assisted suicide: A national phone survey. *Journal of Medical Ethics*, *35*(4), 238–244.

Berman, A. L. (2006). Risk management with suicidal patients. *Journal of Clinical Psychology*, *62*(2), 171–184.

Bishop, J. P. (2006a). Euthanasia, efficiency, and the historical distinction between killing a patient and allowing a patient to die. *Journal of Medical Ethics*, *32*(4), 220–224.

Bishop, J. P. (2006b). Framing euthanasia. *Journal of Medical Ethics*, *32*(4), 225–228.

Blood, R. W., & Pirkis, J. (2007). Media reporting of suicide methods: An Australian perspective. *Crisis*, *28*(Suppl. 1), 64–69.

Bongar, B. (2002). *The suicidal patient: Clinical and legal standards of care* (2nd ed.). Washington, DC: American Psychological Association.

Bongar, B., & Greaney, S. A. (1994). Essential clinical and legal issues when working with the suicidal patient. *Death Studies*, *18*(5), 529–548.

Bongar, B., Maris, R. W., Berman, A. L., & Litman, R. E. (1992). Outpatient standards of care and the suicidal patient. *Suicide and Life-Threatening Behavior*, *22*(4), 453–478.

Bongar, B. M. (1991). Suicide: Legal perspectives. In B. M. Bongar (Ed.), *The suicidal patient: Clinical and legal standards of care* (pp. 33–59). Washington, DC: American Psychological Association.

Brassington, I. (2006). Killing people: What Kant could have said about suicide and euthanasia but did not. *Journal of Medical Ethics*, *32*, 571–574.

Breitbart, W., & Rosenfeld, B. D. (1999). Physician-assisted suicide: The influence of psychosocial issues. *Cancer Control*, *6*(2), 146–161.

Brent, D., Perper, J., Moritz, G., Baugher, M., Schweers, J., & Roth, C. (1993). Firearms and adolescent suicide: A community case-control study. *American Journal of Disorders of Childhood*, *147*, 1066–1071.

Brent, D. A., Perper, J. A., Moritz, G., Liotus, L., Scheweers, J., Balach, L., Roth, C. (1994). Familial risk factors for adolescent suicide: A case-control study. *Acta Psychiatrica Scandinavica*, *89*, 52–58.

Brock, D. W. (1985). Taking human life. *Ethics*, *95*(4), 851–865.

Canadian Association for Suicide Prevention. (2003). Media guidelines. Retrieved from https://www.suicideprevention.ca/understanding/for-media/

Cantor, C. H., & McDermott, P. M. (1994). Suicide litigation: From legal to clinical wisdom. *Australian & New Zealand Journal of Psychiatry*, *28*(3), 431–437.

Carasevici, B. (2016). Dilemmas in the attitude towards suicide. *Revista Medico-Chirurgicală A Societăţii De Medici Şi Naturalişti Din Iaşi*, *120*(1), 152–157.

Chadwick, R., & Tadd, W. (1992). *Ethics and nursing practice*. London, UK: The Macmillan Press.

Chemtob, C. M., Hamada, R. S., Bauer, G., Kinney, B., & Torigoe, R. Y. (1988). Patients' suicides: Frequency and impact on psychiatrists. *American Journal of Psychiatry*, *145*(2), 224–228.

Chemtob, C. M., Hamada, R. S., Bauer, G., Torigoe, R. Y., & Kinney, B. (1988). Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*, *19*(4), 416–420.

Chochilnov, H. M., & Breitbart, W. (2000). *Handbook of Psychiatry in Palliative Medicine*. New York, NY: Oxford University Press.
Cooper, C. (1995). Patient suicide and assault: Their impact on psychiatric hospital staff. *Journal of Psychosocial Nursing and Mental Health Services*, *33*(6), 26–29.
Coverdale, J. H., Roberts, L. W., & Louie, A. K. (2007). Encountering patient suicide: Emotional responses, ethics, and implications for training programs. *Academic Psychiatry*, *31*(5), 329–332.
Csikai, E. L. (1999). Euthanasia and assisted suicide: Issues for social work practice. *Journal of Gerontological Social Work*, *31*(3–4), 49–63.
Daigle, M. S. (2005). Suicide prevention through means restriction: Assessing the risk of substitution: A critical review and synthesis. *Accident Analysis Prevent*, *37*(4), 625–632.
Deschepper, R., Distelmans, W., & Bilsen, J. (2014). Requests for euthanasia/physician-assisted suicide on the basis of mental suffering: Vulnerable patients or vulnerable physicians. *Journal of the American Medical Association Psychiatry*, *71*(6), 617–618.
Dewar, I. G., Eagles, J. M., Klein, S., Gray, N., & Alexander, D. A. (2000). Psychiatric trainees' experiences of, and reactions to, patient suicide. *Psychiatric Bulletin*, *24*(1), 20–23.
Dickinson, G. E., Lancaster, C. J., Clark, D., Ahmedzai, S. H., & Noble, W. (2002). U.K. physicians' attitudes toward active voluntary euthanasia and physician-assisted suicide. *Death Studies*, *26*(6): 479–490.
Donagan, A. (1977). *The theory of morality*. Chicago, IL: University of Chicago Press.
Drickamer, M. A., Lee, M. A., & Ganzini, L. (1997). Practical issues in physician-assisted suicide. *Annals of Internal Medicine*, *126*(2), 146–151.
Eagles, J. M., Klein, S., Gray, N. M., Dewar, I. G., & Alexander, D. A. (2001). Role of psychiatrists in the prediction and prevention of suicide: A perspective from north-east Scotland. *British Journal of Psychiatry*, *178*, 494–496.
Elitzur, A. C. (1995). In defense of life: On the mental-health professions' failure to confront the suicide epidemic *OMEGA: The Journal of Death and Dying*, *31*(4), 305–310.
Emanuel, E. J. (2002). Euthanasia and physician-assisted suicide: A review of the empirical data from the United States. *Archives of Internal Medicine*, *162*, 142–152.
Emanuel, E. J. (2016). Attitudes and practices of euthanasia and physician-assisted suicide in the United States, Canada, and Europe. *Journal of the American Medical Association*, *316*(1), 79–90.
Emanuel, E. J., Fairclough, D., Clarridge, B. C., Blum, D., Bruera, E., Penley, W. C., . . . Mayer, R. J. (2000). Attitudes and practices of U.S. oncologists regarding euthanasia and physician-assisted suicide. *Annals of Internal Medicine*, *133*(7), 527–532.
Emanuel, E. J., Fairclough, D. L., & Emanuel, L. L. (2000). Attitudes and desires related to euthanasia and physician-assisted suicide among terminally ill patients and their caregivers. *Journal of the American Medical Association*, *284*, 2460–2468.
Erazo, N., Baumert, J. J., & Ladwig, K. H. (2005). Factors associated with failed and completed railway suicides. *Journal of Affect Disorders*, *88*(2), 137–143.
Erlangsen, A. (2013). Media reporting on suicide: Challenges and opportunities. *Acta Psychiatrica Scandinavica*, *128*, 316–317.
Etzersdirfer, E., & Sonneck, G. (1998). Preventing suicide by influencing mass-media reporting: The Viennese Experience 1980–1996. *Archives of Suicide Research*, *4*(1), 67–74.
Feldman, D. (1987). A social work student's reaction to client suicide. *Social Casework*, *68*, 184–187.
Feldman, S. R., Moritz, S. H., & Benjamin, G. (2005). Suicide and the law: A practical overview for mental health professionals. *Women & Therapy*, *28*(1), 95–103.
Fintzy, R. T. (1993). The dangers of legalizing physician assisted suicide. *American Journal of Psychiatry*, *150*(12), 1901–1904.
Frankena, W. K. (1980). *Thinking about morality*. Ann Arbor: University of Michigan Press.
Gielen, J. (2008). Attitudes of European physicians toward euthanasia and physician-assisted suicide: A review of the recent literature. *Journal of Palliative Care*, *24*(3), 173–184.
Giese, C. (2009). German nurses, euthanasia and terminal care: A personal perspective. *Nursing Ethics*, *16*(2), 231–237.
Gilje, F., Talseth, A. G., & Norberg, A. (2005). Psychiatric nurses' response to suicidal psychiatric inpatients: Struggling with self and sufferer. *Journal of Psychiatric and Mental Health Nursing*, *12*(5), 519–526.
Gitlin, M. J. (1999). A psychiatrist's reaction to a patient's suicide. *American Journal of Psychiatry*, *156*(10), 1630–1634.
Gould, M., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicide. *Archives of General Psychiatry*, *53*, 1155–1162.

Groenewoud, J. H., Van Der Heide, A., Tholen, A. J., Schudel, W. J., Hengeveld, M. W., Onwuteaka-Philipsen, B. D., . . . Van Der Wal, G. (2004). Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide. *General Hospital Psychiatry, 26*(4), 323–330.

Guedj, M., Gibert, M., Maudet, A., Munoz, S., Mullet, E., & Sorum, P. (2005). The acceptability of ending a patient's life. *Journal of Medical Ethics, 31*, 311–317.

Gutheil, T. G. (1992). *Suicide and clinical practice*. Washington, DC: American Psychiatric Press.

Halligan, P., & Corcoran, P. (2001). The impact of patient suicide on rural general practitioners. *British Journal of General Practice*, *51*(465), 295–296.

Hendin, H. (1982). *Suicide in America*. New York, NY: Norton.

Hewitt, J. (2013). Why are people with mental illness excluded from the rational suicide debate? *International Journal of Law and Psychiatry, 363*, 58–65.

Heyd, D., & Bloch, S. (1999). The ethics of suicide. In S. Bloch, P. Chodoff, & S. Green (Eds.), *Psychiatric ethics* (pp. 441–460). Oxford, UK: Oxford University Press.

Hilden, J. M., Emanuel, E. J., Fairclough, D. L., Link, M. P., Foley, K. M., Clarridge, B. C., . . . Mayer, R. J. (2001). Attitudes and practices among pediatric oncologists regarding end-of-life care: Results of the 1998 American Society of Clinical Oncology survey. *Journal of Clinical Oncology, 19*(1), 205–212.

Hill, T. E. (1983). Self-regarding suicide: A modified Kantian view. *Suicide and Life-Threatening Behavior, 13*(4), 254–275.

Ho, A. O. (2014). Suicide: Rationality and responsibility for life. *Canadian Journal of Psychiatry, 59*, 141–147.

Huddle, T. S. (2013). Moral fiction or moral fact? The distinction between doing and allowing in medical ethics. *Bioethics*, *27*(5), 257–262.

Isometsa, E., Henrikksson, M., Marttunen, M., Heikkinen, M., Aro, H., Kuoppasalmi, K., & Lonnqvist, J. (1995). Mental disorders in young and middle aged men who commit suicide. *British Medical Journal*, *310*, 1366–1367.

Jobes, D. A., & Berman, A. L. (1993). Suicide and malpractice liability: Assessing and revising policies, procedures, and practice in outpatient settings. *Professional Psychology, Research and Practice*, *24*(1), 91–99.

Kaplan, K. J., & Harrow, M. (1996). Positive and negative symptoms as risk factors for later suicidal activity in schizophrenics versus depressives. *Suicide and Life-Threatening Behavior, 26*(2), 105–120.

Kelly, B., & McLoughlin, D. M. (2002). Euthanasia, assisted suicide and psychiatry: A Pandora's box. *The British Journal of Psychiatry*, *181*, 278–279.

Kelly, T. B. (1994). Paternalism and the marginally competent: An ethical dilemma, no easy answers. *Journal of Gerontological Social Work*, *23*(1/2), 67–84.

Kleespies, P. M. (1993). The stress of patient suicidal behavior: Implications for interns and training programs in psychology. *Professional Psychology: Research and Practice*, *24*(4), 477–482.

Kovacs, M., Obrosky, S., Gatsonis, C., & Richards, C. (1997). First-episode major depressive and dysthymic disorder in childhood: Clinical and sociodemographic factors in recovery. *Journal of the American Academy of Child & Adolescent Psychiatry*, *36*(6), 777–784.

Kowalski, S. D. (1997). Nevada nurses' attitudes regarding physician-assisted suicide. *Clinical Nurse Specialist*, *11*(3), 109–115.

Leeman, C. P. (2004). Commentary on Elger and Harding: Can suicide be rational in persons who are not terminally ill? *General Hospital Psychiatry, 26*(2), 145–146.

Lester, D., & Leenaars, A. A. (1996). The ethics of suicide and suicide prevention. *Death Studies*, *20*, 163–184.

Levene, I. (2011). Prevalence of depression in granted and refused requests for euthanasia and assisted suicide: A systematic review. *Journal of Medical Ethics: Journal of the Institute of Medical Ethics*, *37*(4), 205–211.

Linke, S., Wojciak, J., & Day, S. (2002). The impact of suicide on community mental health teams findings and recommendations. *Psychiatric Bulletin*, *26*, 50–52.

Litman, R. E. (1982). Hospital suicides: Lawsuits and standards. *Suicide and Life-Threatening Behavior*, *12*, 212–220.

Litman, R. E. (1996). Suicidology: A look backward and ahead. *Suicide and Life-Threatening Behavior*, *26*(1), 1–7.

Lizardi, D., Currier, D., Galfalvy, H., Sher, L., Burke, A., Mann, J. J., & Oquendo, M. (2007). Perceived reasons for living at index hospitalization and future suicide attempt. *Journal of Nervous and Mental Disease*, *195*(5), 451–455.

Lynch, T. R., Cheavens, J. S., Morse, J. Q., & Rosenthal, M. Z. (2004). A model predicting suicidal ideation and hopelessness in depressed older adults: The impact of emotion inhibition and affect intensity. *Aging and Mental Health*, *8*(6), 486–497.

Mackelprang, R. W., & Mackelprang, R. D. (2005). Historical and contemporary issues in end-of-life decisions: Implications for social work. *Social Work*, *50*(4), 315–324.
Macleod, S. (2012). Assisted dying in liberalized jurisdictions and the role of psychiatry: A clinician's view. *Australian and New Zealand Journal of Psychiatry*, *46*(10), 936–945.
Maloney, J., Pfuhlmann, B., Arensman, E., Coffey, C., Gusmão, R., Poštuvan, V., . . . Schmidtke, A. (2013). Media recommendations on reporting suicidal behaviour and suggestions for optimisation. *Acta Psychiatrica Scandinavica*, *128*, 314–315.
Maltsberger, J. T. (1992). The implications of patient suicide for the surviving psychotherapist. In D. Jacobs (Ed.), *Suicide and clinical practice* (Vol. Clinical Practice Number 21, pp. 169–182). Washington, DC: American Psychiatric Press.
Maris, R. W. (1982). Rational suicide: An impoverished self-transformation. *Suicide and Life-Threatening Behavior*, *12*, 3–16.
Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive textbook of suicidology*. New York, NY: Guilford Press.
Mayo, D. J. (1984). Confidentiality in crisis counseling: A philosophical perspective. *Suicide and Life-Threatening Behavior*, *14*(2), 96–112.
McLachlan, H. V. (2010). Assisted suicide and the killing of people? Maybe. Physician-assisted suicide and the killing of patients? No: The rejection of Shaw's new prospective on euthanasia. *Journal of Medical Ethics: Journal of the Institute of Medical Ethics*, *36*(5), 306–309.
Mishara, B. L., & Weisstub, D. N. (2013). Premises and evidence in the rhetoric of assisted suicide and euthanasia. *International Journal of Law and Psychiatry*, *36*(5–6), 427–435.
Mishna, F., Antle, B. J., & Regehr, C. (2002). Social work with clients contemplating suicide: Complexity and ambiguity in the clinical, ethical, and legal considerations. *Clinical Social Work Journal*, *30*(3), 265–280.
Mosich, V., & Müller-Busch, H. C. (2014). Suicidal drug overdose while receiving palliative home care: A case report. *Wiener Medizinische Wochenschrift*, *164*(9–10), 184–188.
Motto, J. (1967). Suicide and suggestibility. *American Journal of Psychiatry*, *124*, 252–256.
Motto, J. (1970). Newspaper influence on suicide: A controlled study. *Archives of General Psychiatry*, *23*, 143–148.
Motto, J. A. (1999). A psychiatric perspective on rational suicide: 24 points of view. In J. L. Werth (Ed.), *Contemporary perspectives on rational suicide*, (pp. 121–125). Philadelphia, PA: Brunner/Mazel.
National Association of Social Workers. (2000). *Code of ethics*. Washington, DC: NASW Press. Retrieved from http://www.socialworkers.org/pubs/code/code.asp
Overholser, J. C. (2006). Treatment of suicidal patients: A risk-benefit analysis. *Behavioral Sciences & the Law*, *13*(1), 81–92.
Packman, W. L., & Harris, E. A. (1998). Legal issues and risk management in suicidal patients. In B. Bonger, A. L. Berman, R. W. Maris, M. M. Silverman, E. A. Harris, & W. L. Packman (Eds.), *Risk management with suicidal patients*, (pp. 150–186). New York, NY: Guilford Press.
Paris, J. (2002). Chronic suicidality among patients with borderline personality disorder. *Psychiatric Services*, *53*, 738–742.
Phillips, D. P. (1974). The influence of suggestion on suicide: Substantive and theoretical implications of the Werther effect. *American Sociological Review*, *39*(3), 340–354.
Phillips, D. P. (1982). The impact of fictional television stories on US adult fatalities: New evidence on the effect of the mass media on violence. *American Journal of Sociology*, *87*, 1340–1359.
Pinch, W. J., & Dougherty, C. J. (1993). Competency after a suicide attempt: An ethical reflection. *Dimensions of Critical Care Nursing*, *12*(4), 206–211.
Pirkis, J., & Blood, R. W. (2001). Suicide and the media part 1: Reportage in nonfictional media. *Crisis*, *22*(4), 146–154.
Quill, T. E., Meier, D. E., Block, S. D., & Billings, J. A. (1998). The debate over physician-assisted suicide: Empirical data and convergent views. *Annals of Internal Medicine*, *128*(7), 552–558.
Reamer, F. G. (1983). The concept of paternalism in social work. *Social Service Review*, *57*, 254–271.
Regan, D. H. (1983). Suicide and the failure of modern moral theory. *Suicide and Life-Threatening Behavior*, *13*(4), 276–292.
Robins, E. (1981). *The final months: A study of the lives of 134 persons who committed suicide*. New York, NY: Oxford University Press.
Rosenbluth, M., Kleinman, I., & Lowy, F. (1995). Suicide: The interaction of clinical and ethical issues. *Psychiatric Services*, *46*(9), 919–921.
Rosenfeld, B. (2004). *Assisted suicide and the right to die: The interface of social science, public policy, and medical ethics*. Washington, DC: American Psychological Association.

Ruskin, R., Sakinofsky, I., Bagby, R. M., Dickens, S., & Sousa, G. (2004). Impact of patient suicide on psychiatrists and psychiatric trainees. *Academic Psychiatry*, *28*(2), 104–110.

Samaritans. (2005). Media guidelines: Portrayals of suicide. Retrieved from https://www.samaritans.org/media-centre/media-guidelines-reporting-suicide

Sasson, S. (2000). Beneficence versus respect for autonomy: An ethical dilemma in social work practice. *Journal of Gerontological Social Work*, *33*(1), 5–16.

Schoonman, M. K., van Thiel, G. J., & van Delden J. J. (2014). Non-physician-assisted suicide in The Netherlands: A cross-sectional survey among the general public. *Journal of Medical Ethics*, *40*, 842–848.

Schramme, T. (2013). Rational suicide, assisted suicide, and indirect legal paternalism. *International Journal of Law and Psychiatry*, *36*(5–6), 477–484.

Schulsinger, F., Kety, S. S., Rosenthal, D., & Wender, P. H. (1979). A family study of suicide. In M. Schou & E. Stromgren (Eds.), *Origin, prevention and treatment of affective disorders*, (pp. 277–287). Orlando, FL: Academic Press.

Schwyn, E. (1976). Ethical norms of suicide prevention and crisis intervention. *Mental Health and Society*, *393*(40), 142–147.

Shaw, D. (2007). The body as unwarranted life support: A new perspective on euthanasia. *Journal of Medical Ethics*, *33*, 519–521.

Sjöberg, R. L., & Lindholm, T. (2003). Decision-making and euthanasia. *The British Journal of Psychiatry*, *182*, 172.

Smokowski, P. R., & Wodarski, J. S. (1996). Euthanasia and physician assisted suicide: A social work update. *Social Work in Health Care*, *23*(1), 53–65.

Snijdewind, M. (2014). Complexities in euthanasia or physician-assisted suicide as perceived by Dutch physicians and patients' relatives. *Journal of Pain and Symptom Management*, *48*(6), 1125–1134.

Sorta-Bilajac, I. (2008). Croatian physicians' and nurses' experience with ethical issues in clinical practice. *Journal of Medical Ethics: Journal of the Institute of Medical Ethics*, *34*(6), 450–455.

Spiegelman, J. S., & Werth, J. L. (2005). Don't forget about me: The experiences of therapists-in-training after a client has attempted or died by suicide. *Women & Therapy*, *28*(1), 35–57.

Strakowski, S. M., McElroy, S. L., Keck, P. E., & West, S. A. (1996). Suicidality among patients with mixed and manic bipolar disorder. *American Journal of Psychiatry*, *153*, 674–676.

Strom-Gottfried, K., & Mowbray, N. D. (2006). Who heals the helper? Facilitating the social worker's grief. *Families in Society*, *87*(1), 9–15.

Sullivan, A. D., Hedberg, K., & Fleming, D. W. (2000). Legalized physician-assisted suicide in Oregon: The second year. *New England Journal of Medicine*, *342*(8), 598–604.

Szasz, T. S. (1999). *Fatal freedom: The ethics and politics of suicide*. Westport, CT: Praeger/Greenwood Publishing Group.

Talseth, A. G., & Gilje, F. (2007). Unburdening suffering: Responses of psychiatrists to patients' suicide deaths. *Nursing Ethics: An International Journal for Health Care Professionals*, *14*(5), 620–636.

Tamayo-Velazquez, M., Simon-Lorda, P., & Cruz-Piqueras, M. (2012). Euthanasia and physician-assisted suicide: Knowledge, attitudes and experiences of nurses in Andalusia. *Nursing Ethics*, *19*(5), 677–691.

Ting, L., Sanders, S., Jacobson, J. M., & Power, J. R. (2006). Dealing with the aftermath: A qualitative analysis of mental health social workers' reactions after a client suicide. *Social Work*, *51*(1), 329–341.

Trankle, S. A. (2014). Decisions that hasten death: Double effect and the experiences of physicians in Australia. *BioMed Central Medical Ethics*, *15*, 26. doi: 10.1186/1472-6939-15-26

Tsuang, M. T. (1983). Risk of suicide in relatives of schizophrenics, manics, depressives, and controls. *Journal of Clinical Psychiatry*, *44*, 396–400.

Venkat, A., & Drori, J. (2014). When to say when: Responding to a suicide attempt in the acute care setting. *Narrative Inquiry in Bioethics*, *4*, 263–270.

Wagle, R. K., Ede, K., Craig, J., & Bottum, K. (2004). An ethical dilemma: When the family wants the withdrawal of care. *Journal of Psychiatric Practice*, *10*(5), 334–336.

Waltzer, H. (1980). Malpractice liability in a patient's suicide. *American Journal of Psychotherapy*, *34*(1), 89–98.

Wasserman, I. (1984). Imitation and suicide: A reexamination of the Werther effect. *American Sociological Review*, *49*, 427–436.

Weissman, M. M., Fendrich, M., Warner, V., & Wickramaratne, P. (1992). Incidence of psychiatric disorder in offspring at high and low risk for depression. *Journal of the American Academy of Child & Adolescent Psychiatry*, *31*, 640–648.

Welfel, E. R. (2002). *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (2nd ed.). Pacific Grove, CA: Brooks/Cole.

Wender, P. H., Kety, S. S., Rosenthal, D., Schulsinger, F., Ortmann, J., & Lunde, I. (1986). Psychiatric disorders in the biological and adoptive families of adopted individuals with affective disorders. *Archives of General Psychiatry*, *43*, 923–929.

Werth, J. L. (1999). Mental health professionals and assisted death: Perceived ethical obligations and proposed guidelines for practice. *Ethics and Behavior*, *9*(2), 159–183.

Werth, J. L., & Rogers, J. R. (2005). Assessing for impaired judgment as a means of meeting the "duty to protect" when a client is a potential harm-to-self: Implications for clients making end-of-life decisions. *Mortality*, *10*(1), 7–21.

World Health Organization. (2000). Preventing suicide: A resource for media professionals. Retrieved from http://www.who.int/mental_health/media/en/426.pdf