Religious Backgrounds and Legalisation of Suicide

Subjects: Health Policy & Services

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1. Introduction

The reasons for suicide are manifold and have always been the subject of philosophical as well as scientific theories. Furthermore, more people die as a result of suicide than of HIV, malaria, breast cancer, war or homicide worldwide every year [1].

According to the guidelines of the Center of Disease Control and Prevention (CDC), the following definition exists: “Suicide is death caused by injuring oneself with the intent to die. “Suicidality means the sum of all thought and behaviour patterns of people who strive for their own death in their thoughts, through active action or passive omission or by refraining from action, or who accept it as a possible result of their actions.” [2]. This definition is based on the assumption that suicidal tendencies can occur in principle in all people, but are usually manifested by mental disorders and psychosocial crises. This is considered as the “medical-psychosocial paradigm of suicidality” [3]. It should be emphasised that suicide is to be understood as a constriction of thinking, feeling and acting—triggered, for example, by (subjectively) experienced crises, psychological or somatic suffering or by societal and social guidelines and requirements. Suicidal acts often occur as an impulsive act within a small time span of only a few minutes after a trigger (conflict with a spouse, death of a relative, etc.). However, there is often a longer-lasting development or planning. This development is often characterised by a longer phase of ambivalence. Even in highly suicidal patients, there is often a residual ambivalence that leaves the outcome of the suicide attempt open to some extent [4]. It can make sense to make certain hotspots difficult to access. High bridges, skyscrapers and railway lines are often the first port of call for spontaneous, impulsive suicides. If the time span of acute suicidal tendencies of only a few minutes is taken into account, blocking the hotspot can lead to a subsiding of the suicidal impulse [5]. Suicide is usually preceded by the so-called presuicidal syndrome. The syndrome comprises the three characteristics of constriction, increased aggression and flight into thoughts of death, which regularly precede a suicidal act [6]. There is a special case here, the so-called rational suicide: this kind of suicide is based on a rational decision without any psychopathological background. Genuine rational suicides, however, are rarely found. In most cases, a psychopathological background (e.g., narcissistic injury, depressive disorder) can also be recognised in apparent rational suicides [7][8].

However, the definition of suicidality does not cover suicides committed in the context of tribal rituals (e.g., elderly people refusing to eat in order not to be a burden to the community), political or social motivation (e.g., kamikaze suicides of Japanese pilots in World War II) or religiosity (e.g., martyrdom) [9]. Nevertheless, politically or socially motivated suicides, as well as societies general handling of suicidality, have a considerable influence on the stigmatization of those affected and the associated suicide rate, as will be described in more detail later.

A suicide (attempt) or suicidal tendencies affect the person directly because of the psychological suffering, but also because of the social treatment of suicidal tendencies and suicidal people. There is a widespread tendency towards stigmatization, which can reinforce suicidal tendencies and can extend not only to the suicidal person themselves, but also to their relatives and friends: A commited suicide affects on average six other people [10].

2. Religious Backgrounds and Legalisation of Suicide

Religion and laws, although the two have been linked for a long time and in some countries still are, also influence suicide-related views in the population [11]. Therefore, the view of suicide of the major world religions will now be described. In order to shed more light on the legal situation in this regard, the so-called “assisted suicide” and “passive” as well as “active euthanasia” will be considered in addition to the criminal law view of suicide.

According to Buddha’s teachings, every person should freely dispose of his or her life. Therefore, suicide is not forbidden and is not a disgrace. If someone commits suicide because they cannot cope with their problems, these problems are carried over into the next life. In Buddhism, it is generally true that anyone who destroys life worsens their karma and thus puts obstacles in their way on the path to enlightenment. This also applies to people who commit suicide. However, Buddhists believe that they improve their karma if they can help deeply desperate people and dissuade them from their intention to take their own lives. Every Buddhist is even called upon to help in this way [12].

Relatively similar is the handling of suicide in Hinduism: almost everyone will be punished in the next life with illness or other bad conditions if they take their own life. However, some ascetics also end their lives themselves. They abstain from eating until they starve to death. However, they do not do this out of desperation, but for religious reasons. By renouncing, they show that they are spiritually strong and above worldly and physical things. According to Hindu belief, these ascetics do not actively take their own lives, but accept death by renouncing food. For this reason, many Hindus even worship these ascetics. People who take their own lives by starving or dying of thirst are therefore not viewed negatively. Until about 200 years ago, a special suicide even caused admiration among Hindus: Widows who had themselves burnt alive with their deceased husbands were therefore highly respected. Widow burning, also called sati, is a femicide in Hindu religious communities. This ritual was most common in India, but they also occurred in Bali and Nepal. Some of these women were held in high honour after their death and sometimes worshipped as gods. Furthermore, their family gained high prestige. [13]. Originally, the women of princely families whose husbands had died in battle killed themselves in this way, possibly to avoid falling into the hands of the enemy. In the course of time, however, widow burning was demanded in many circles of the population. Widow burning was particularly common among the Kshatriya castes, such as the Rajputs in northern India, where it still occurs today [14]. According to Indian law, any direct or indirect support of widow burning is now prohibited. Traditional glorification of such women is also punished. However, this law is not always implemented equally [15].

While there are no references to the stigmatization of suicidal people in the original Judeo-Christian writings, i.e., the Torah or the Bible [16], the condemnation of suicide by the Church finally prevailed from late antiquity onwards, which is in complete contrast to the handling of suicide for example in Buddhism [17]. The church’s approach to suicide led to excommunication and sanctions of suicidal people (even posthumous after a completed suicide) as well as their family members. Those who successfully took their own lives were buried outside Christian cemeteries [18]. The Bible assumes that life was given by God and therefore may only be ended by God. Anyone who ends it himself goes to hell as a sinner [19]. In France, Louis XIV enforced a far more aggressive punishment of suicides: The body of the deceased was dragged face down through the streets and then hung up or thrown on a rubbish heap, which was a special cruelty for the bereaved. Furthermore, all the person’s property was confiscated [20]. Since the Middle Ages, so-called “pastoral counselling” has been offered by the church within the framework of the Christian tradition [21]. According to Ziemer [21], pastoral care represents the communication between a “person seeking advice” and a “person helping”. The goal is the strengthening of the Christian faith and the turning away from sins—which includes suicidality. The positions of religious faiths towards suicidal behaviour seem to have an influence on suicide prevention as well as on the form of social stigmatization towards suicidal people. The social adherence to norms and moral values associated with higher religiosity can be seen as a protective function for suicide—and indeed empirical evidence shows that if a person is religious, this is associated with a lower risk of suicide. However, strong affinity to religiosity is also associated with higher stigmatization tendencies of suicidal actions and people [22][23][24].

The view of Islam is very similar to that of Christianity: According to Islam, suicide is considered a sin. For Muslims, it is certain that Allah gives life and takes life. Furthermore, the Koran emphasises that Allah helps people in difficult situations and that they can trust in him. According to Islam, the body is on loan from God, who is the actual owner of the body. Therefore, it is fundamental that people should preserve their bodies and prevent death. The time of death is therefore left to God, and a violation of this is considered a sin and will be punished in hell [25].

As mentioned above, the legal aspects of suicide also influence stigmatization. In most European countries suicide was still punishable until the 20th century [26]. The Netherlands became the first country in the world to legally authorise both assisted suicide and active euthanasia in 2002 [1]. Passive euthanasia is the denial of medical treatment necessary to sustain life. In 2005, passive euthanasia was legalised in France. In April 2009, Luxembourg decided that doctors who practice passive euthanasia can be prosecuted neither under criminal law nor under civil law. In Spain, Norway, Hungary, England and Sweden, passive euthanasia is possible to a limited extent [27]. Active euthanasia involves the administration of lethal substances, such as the injection of a lethal agent. However, there are cases where the distinction between passive and active euthanasia is disputed. This includes, for example, the administration of painkillers for severe pain, which have a lethal effect if the dosage is too high. Here, it is debated whether this is passive or active euthanasia [28].

Assisted suicide means ending one's own life with the assistance of another person. The concept usually refers to suicide that is assisted by a medical doctor, the so-called physician-assisted suicide. Physician-assisted suicide is legal in some countries under certain circumstances, including Germany, Austria, Belgium, Canada, Spain, Switzerland, Luxembourg, The Netherlands, New Zealand, some parts of the United States and some parts of Australia. Switzerland has a unique status with regard to assisted suicide: Here, assisted suicide is not only permitted for local patients, but also for foreign patients. In fact, many people travel there with the aim of ending their lives, which is called suicide tourism [29]. Constitutionally, assisted suicide is legalised in Germany and Italy, as well as in Columbia, but their governments have not yet legislated its practical implementation [30][31].

Worldwide, these forms of euthanasia are also legally permitted in Belgium, Luxembourg, Canada and in some US states (Washington, California and others) [31]. In the BeNeLux states, in addition to euthanasia in the case of "incurable illness", euthanasia in the case of mental disorders is also permitted, in compliance with certain legal requirements. In the period from 2011 to 2014 in the Netherlands, 66 people between the ages of 30 and 70 who were classified as "mentally ill" ended their lives through active or assisted euthanasia. In this context, 55% of the euthanasia recipients were classified as depressive, 25% had psychotic symptoms in the foreground, 42% were diagnosed with post-traumatic stress disorder or an anxiety disorder and four of the euthanasia recipients were diagnosed with "cognitive deficits" by the medical profession. The legal prerequisite of "capacity to consent" and "capacity to judge" to obtain euthanasia was assumed to be given by the attending physicians [32]. However, the existence of this precondition of a "freely" decided or responsible suicide ("rational suicide") is disputed among psychiatrists and psychotherapists [33][34]. Furthermore, in the Netherlands active euthanasia in the case of dementia—even against the will of the person affected—is considered legal. The prerequisite for this is a living will before the onset of the illness [35].

In Germany and in the United States as well as in many other countries, there is a so-called "suicide clause": this is a clause in a life insurance policy that regulates the non-payment of the sum insured. It often contains provisions regarding, e.g., a waiting period (which often lasts several years), and, in addition, deals with the suicidal person's "state of mind", which often can be determined only posthumously: For most insurance companies, insanity is an exclusion-criteria for the payment of the sum insured to the surviving dependants [36]. In the case of recourse to euthanasia, the suicide clause is legally controversial—this also concerns so-called "passive euthanasia". Passive euthanasia includes the refusal of life-sustaining measures, such as artificial respiration during a serious illness. However, it can then become problematic with regard to claiming insurance benefits—especially if the relative who has to decide about the life-sustaining measures terminated is the same person as the beneficiary of the life insurance [37][38]. In this case, of "almost-suicide", insurance benefits may be withheld.

In summary, historical developments and finally jurisprudence show that there have been controversial views on suicidality since antiquity. Considered a sin and/or a mental illness, and punishable by law in western cultures until far into the 20th century, the stigmatising, prejudiced attitude towards suicidality is also reflected in current social views, as current studies show. After all, jurisdiction sets norms and rules and interacts with societal views. Japan's approach to suicidality is a particular exception: Suicidality is little stigmatised there, but suicide rates are particularly high because suicide is socially suggested as an honourable solution to the social understanding of "shame" or "failure" [39][40].

References

1. WHO. One in 100 Deaths is by Suicide. 2021. Available online: https://www.who.int/news/item/17-06-2021-one-in-100-deaths-is-by-suicide (accessed on 22 May 2022).
2. Center of Disease Control and Prevention. Facts about Suicide. 2022. Available online: https://www.cdc.gov/suicide/facts/index.html#:~:text=Suicide%20is%20a%20leading%20cause,suicide%20or%20protect%20a (accessed on 6 July 2022).
3. Wolfersdorf, M.; Etzersdorfer, E. Klinische Praxis: Suizid und Suizidprävention; Kohlhammer: Stuttgart, Germany, 2011.
4. Rimkeviciene, J.; O'Gorman, J.; de Leo, D.J. Impulsive suicide attempts: A systematic literature review of definitions, characteristics and risk factors. Affect. Disord. 2015, 171, 93–104.
5. Pirkis, J.; Too, L.S.; Spittal, M.J.; Krysinska, K.; Robinson, J.; Cheung, Y.T.D. Interventions to reduce suicides at suicide hotspots: A systematic review and meta-analysis. Lancet Psychiatry 2015, 2, 11, Erratum in Lancet Psychiatry 2015, 2, 961.
6. Ringel, E. Der Selbstmord: Abschluss einer Krankhaften Psychischen Entwicklung; eine Untersuchung an 745 Geretteten Selbstmördern; Klotz: Frankfurt am Main, Germany, 2005.
7. Klie, T.; Student, J.-C. Sterben in Würde: Auswege aus dem Dilemma Sterbehilfe; Herder: Stuttgart, Germany, 2007.
8. Recenzija; Slučaja, P. Medizin und Recht, Vol. 1: Suizid und Euthanasie als Human- Und Sozialwissenschaftliches Problem; Eser, A., Ed.; Enke: Stuttgart, Germany, 1976.
9. Wolfersdorf, M. Erklärungsmodelle—Die Zeit vor dem Suizid. 2019. Available online: https://www.agus-selbsthilfe.de/fileadmin/common/broschueren/downloads/2019-01_erklaerungsmodelle.pdf (accessed on 1 September 2022).
10. WHO. Suicide in the World. 2019. Available online: https://www.who.int/publications/i/item/suicide-in-the-world (accessed on 30 November 2019).
11. Witte, T.K.; Smith, A.R.; Joiner, T.E. Suicidal desire and the capability for suicide: Tests of the interpersonal-psychological theory of suicidal behavior among adults. J. Clin. Psychol. 2010, 66, 6.
12. Han, B.-C. Universal-Bibliothek, Vol. 18185: Philosophie des Zen-Buddhismus; Reclam: Stuttgart, Germany, 2002.
13. Encyclopaedia of Women in South Asia; Mittra, S.; Kumar, B. (Eds.) Kalpaz: Delhi, India, 2004.
14. Bühring-Uhle, N. Die Moderne Form der Witwenverbrennung: Protokoll Einer Erfahrung; August-von-Goethe-Literaturverl: Frankfurt, Germany, 2011.
15. Ministry Of Women & Child Development. The Commission of Sati Prevention Act and Rules. 1987. Available online: https://wcd.nic.in/act/commission-sati-prevention-act-and-rules (accessed on 1 July 2022).
16. Tadros, G.; Jolley, D. The stigma of suicide. Br. J. Psychiatry J. Ment. Sci. 2001, 179, 178. Available online: https://www.cambridge.org/core/article/stigma-of-suicide/8007A29C23705DC3A4F0CEF218A6238011483487 (accessed on 1 July 2022).
17. Flasch, K. Reclams Universal-Bibliothek, Vol. 9962: Augustin: Einführung in sein Denken; Reclam: Stuttgart, Germany, 2013.
18. Pritchard, C. Suicide—the Ultimate Rejection? A Psycho-Social Study; McGraw-Hill Education: New York, NY, USA, 1995.
19. Die Bibel: Einheitsübersetzung; Altes und Neues Testament; Verlag Herder: Freiburg, Germany, 2017.
20. Silverman, M.M. Helping College Students Cope with Suicidal Impulses. In Assessment, Treatment, and Prevention of Suicidal Behavior; Yufit, R.I., Lester, D., Eds.; John Wiley & Sons Inc.: Hoboken, NJ, USA, 2005.

21. Ziemer, J. UTB M: Seelsorgelehre; UTB GmbH: Stuttgart, Germany, 2008.
22. Dervic, K.; Carballo, J.J.; Baca-Garcia, E.; Galfalvy, H.C.; Mann, J.J.; Brent, D.A.; Oquendo, M.A.J. Moral or religious objections to suicide may protect against suicidal behavior in bipolar disorder. Clin. Psychiatry 2011, 72, 10.
23. Dervic, K.; Oquendo, M.A.; Grunebaum, M.F.; Ellis, S.; Burke, A.K.; Mann, J.J. Religious affiliation and suicide attempt. Am. J. Psychiatry 2004, 161, 12.
24. Ouzouni, C.; Nakakis, K. Attitudes towards attempted suicide: The development of a measurement tool. Health Sci. J. 2009, 2009, 3.
25. Schweer, T. Heyne Bücher 19, Heyne Sachbuch, Vol. 185: Der Koran; Heyne: München, Germany, 1993.
26. St. John-Stevas, N. Life, Death and the Law: Law and Christian Morals in England and the United States; BeardBooks: Washington, DC, USA, 2002.
27. Cipriani, G.; Di Fiorino, M. Euthanasia and Other End of Life in Patients Suffering from Dementia. Leg. Med. 2019, 40, 54–59.
28. Rachels, J. Active and passive euthanasia. N. Engl. J. Med. 1975, 292, 2.
29. Zhi, G.Y.J.; Flaherty, G.T.; Hallahan, B.J. Final journeys: Exploring the realities of suicide tourism. Travel Med. 2019, 26, 3.
30. Steck, N.; Egger, M.; Maessen, M.; Reisch, T.; Zwahlen, M. Euthanasia and assisted suicide in selected European countries and US states: Systematic literature review. Med. Care 2013, 51, 10.
31. Dignitas, Länder mit Regelung zur Suizidhilfe oder der Aktiven Sterbehilfe. 2020. Available online: http://www.dignitas.ch/index.php?option=com_content&view=article&id=54&Itemid=88&lang=de (accessed on 17 May 2020).
32. Fragen aus der Facharztprüfung Psychiatrie und Psychotherapie. Fortschr. Der Neurol. Psychiatr. 2016, 84, 8.
33. Klesse, R. Der Todeswunsch aus psychiatrischer Sicht. 2003. Available online: https://www.imabe.org/fileadmin/imago_hominis/pdf/IH010_037-044.pdf (accessed on 17 May 2022).
34. Stein, C. Klinische Praxis: Spannungsfelder der Krisenintervention: Ein Handbuch für die psychosoziale Praxis; Kohlhammer: Stuttgart, Germany, 2009.
35. Stefan Rehder, Niederlande ermöglicht Euthanasie Gegen Patientenwillen. 2020. Available online: https://www.die-tagespost.de/politik/aktuell/niederlande-ermoeglicht-euthanasie-gegen-patientenwillen;art315,207855 (accessed on 19 August 2022).
36. Cording, C.; Sass, H. Begutachtung der "freien Willensbestimmung" bei Suizid in der Lebensversicherung . Der Nervenarzt 2009, 80, 9.
37. Strübing, T. Stellt die Sterbehilfe den Risiko-Lebensversicherer Leistungsfrei? 2015. Available online: https://www.private-banking-magazin.de/schwierige-rechtslage-stellt-die-aktive-sterbehilfe-den-risiko-lebensversicherer-leistungsfrei-1448276084/ (accessed on 19 August 2022).
38. Morris, A.N. A Right to Die, a Right to Insurance Payouts? The Implication of Physician-Assisted Suicide on Life Insurance Benefits. Mont. Law Rev. 2020, 81, 213.
39. Ozawa-de Silva, C. Too lonely to die alone: Internet suicide pacts and existential suffering in Japan. Cult. Med. Psychiatry 2008, 32, 4.
40. Kawashima, D.; Kawamoto, S.; Shiraga, K.; Kawano, K. Kawashima, Kawamoto, Shiraga, and Kawano. Crisis 2020, 41, 2, Erratum in Crisis 2020, 41, 114–120.