

Analysis of Fatigue of Living: Ethical, Philosophical, and Psychosocial Issues

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Abstract

“Fatigue of living”, or existential fatigue, is a multidimensional phenomenon that transcends simple physical or mental weariness. It is characterized by a profound loss of meaning, an alteration of engagement in life, and poses major ethical, philosophical, and psychosocial challenges. This article analyzes this concept by exploring its psychological, social, and medical dimensions. It examines the crucial questions raised by fatigue of living, particularly with regard to the right to individual autonomy in the face of suffering, the limits of medical intervention, and the definition of a dignified life. Particular attention is paid to debates on medical assistance in dying, where fatigue of living is sometimes invoked as a reason, creating tension between respect for autonomy and the protection of vulnerable individuals. The analysis incorporates philosophical perspectives, such as existentialism and Buddhism, as well as innovative clinical approaches such as positive existential psychology and “philosophical health”. Finally, the article highlights the importance of a holistic and culturally sensitive approach, particularly in African contexts where notions of relational autonomy and community (Ubuntu) redefine the ethical frameworks for end-of-life decision-making.

Keywords

Fatigue of Living, Ethics, Autonomy, End of Life, Medical Assistance in Dying

1. Introduction

“Fatigue of living”, or existential fatigue, is a complex and multidimensional phenomenon that encompasses physiological, psychological, and social dimensions (Loriol, 2017). This concept, distinct from simple physical or mental fatigue, is

characterized by a profound weariness with existence, often accompanied by a loss of meaning and an altered ability to engage in life (Bofarull et al., 2024).

This existential condition poses significant ethical and philosophical challenges, particularly with regard to the right to individual autonomy in the face of human suffering and vulnerability (Borges et al., 2024). More specifically, it raises crucial questions about the limits of medical intervention, the role of society in supporting individuals in existential distress, and the very definition of a life worth living (Bofarull et al., 2024). This includes an in-depth analysis of the perceptions and experiences of patients at the end of life, who often distinguish fatigue from simple weariness or exhaustion (Kirshbaum et al., 2012). This distinction is essential to understanding the multidimensional nature of pathological and non-pathological fatigue, and how it can be linked to states of profound existential distress (Jason et al., 2010).

This analysis will also examine the ethical implications and controversies surrounding medical assistance in dying, particularly when “weariness of life” is cited as a reason, raising the complex issue of decision-making autonomy in the face of death (van der Geest & Satalkar, 2019). The course will thus examine the different facets of this phenomenon, drawing on various philosophical and ethical perspectives to understand the complexity of this existential suffering. The convergence between Buddhism and existentialism will also be explored in order to understand how these philosophies address the uncertainty of existence and the search for meaning, aspects intrinsically linked to existential fatigue (Amathabhani & Dissanayake, 2024).

In addition, it will be crucial to examine how current public policies and clinical practices respond to this suffering, and whether alternative approaches, such as those inspired by positive existential psychology, could offer new ways to support individuals facing this existential weariness (Wong & Yu, 2021). This holistic approach will enable the development of a nuanced understanding of fatigue of living, integrating medical, psychological, social, and spiritual dimensions to inform contemporary debates on end-of-life care and support for people in deep distress (Binder, 2022).

With this in mind, the integration of the concept of “philosophical health”, through approaches such as SMILE_PH interviews, is essential to reveal individuals’ frameworks of thought and fundamental values, thus enabling personalized care that goes beyond simple medical diagnosis to encompass the existential dimension of suffering (de Miranda & Loughlin, 2023). “Philosophical health” can be defined as an individual’s ability to maintain inner coherence by articulating their values, beliefs, and relationship to the meaning of existence. It differs from psychological or physical health in that it primarily concerns the reflective and axiological dimension of human life, enabling individuals to navigate trials and tribulations with an ethical and existential orientation. Health is usually considered in its physical and psychological dimensions; the “philosophical” dimension must be integrated into it.

For Africa, we will take a different approach, given the anthropological and cultural aspects specific to our societies. Consequently, a comparative study of the manifestations of existential fatigue and its management in various cultural contexts, particularly African ones, is essential for developing ecologically relevant and culturally sensitive interventions (Graffigna et al., 2011). This broader perspective is essential for addressing the complexity of existential fatigue not only as an individual phenomenon but also as a reflection of societal dynamics and value systems that inform perceptions of life and death (de Miranda & Loughlin, 2023).

2. Analysis of the Concept of “Weariness of Life”

The concept of “weariness of life” transcends simple psychological distress to encompass a profound existential dimension, linked to a loss of meaning and a weariness with existence, a field of study in which existentialism, through its exploration of questions of meaning and morality, offers a particularly relevant framework for analysis (Marimuthu, 2024). This approach highlights the need to integrate existential principles into contemporary mental health practices in order to improve psychological well-being by promoting self-awareness and personal growth (Amani, 2024). Furthermore, it emphasizes the importance of a holistic and personalized approach to mental health care, addressing symptoms alongside underlying existential concerns (Amani, 2024). This perspective aligns with the understanding that existential suffering, particularly at the end of life, is a fundamental dimension of healing and well-being, requiring a holistic palliative approach that integrates the patient’s spiritual resources and the support of their loved ones (Wong & Yu, 2021). Positive existential psychology, in particular, offers tools for addressing existential anxieties such as death, isolation, freedom, and insignificance, thereby helping individuals find renewed meaning and courage (Nel & Govender, 2022). This perspective is crucial for understanding how confronting the impermanence and loneliness inherent in existence can, paradoxically, lead to personal growth and increased resilience in the face of adversity (Cucchi & Qoronfleh, 2025). It also aims to transform existential suffering into an opportunity for personal development, emphasizing the importance of accepting the inevitable aspects of life in order to achieve lasting well-being (Wong & Yu, 2021).

2.1. Definition and Conceptualization

This perspective is based on the fact that suffering, which is inevitably present in human experience, can be transformed into a source of meaning and personal growth, as suggested by Viktor Frankl’s work on logotherapy (Alshehri et al., 2024). Indeed, the ability to find meaning even in the most difficult situations is a pillar of existential resilience, allowing us to transcend perceptions of “weariness of life” by reinterpreting them as catalysts for development. It is essential to recognize that existential positive psychology offers a framework for approaching these forms of suffering as opportunities for psychological maturation, emphasize-

ing the cultivation of meaning, virtue, and resilience (Eisenbeck et al., 2021). This approach recognizes suffering not as a pathology to be eradicated, but as an inherent component of human existence that can lead to personal growth and increased authenticity (Kaftański & Hanson, 2022). Similarly, the integration of philosophical perspectives, notably that of Kierkegaard, allows us to conceptualize well-being not as the absence of suffering, but as the ability to find meaning in it, thus recognizing that “negative” emotions are essential to a rich and full life (Kaftański & Hanson, 2022). This understanding reinforces the idea that authenticity and the search for meaning in suffering can transform the perception of weariness of life into an opportunity for profound transformation (Kaftański & Hanson, 2022).

2.2. Ethical Implications

Therefore, an in-depth analysis of the ethical implications of “weariness of life” is necessary, particularly with regard to the right to individual autonomy in the face of existential suffering and societal responsibilities in terms of support. This analysis should also consider the possibility that intense existential suffering may paradoxically catalyze greater authenticity, as Heidegger proposes with the concept of Dasein, thus transforming distress into a path to deeper well-being (Russo-Netzer, 2025). This perspective raises complex questions about the balance between respect for individual autonomy and the ethical imperative to provide adequate support to alleviate suffering. It invites us to reflect on the tension between the desire for autonomy and human vulnerability, challenging conventional approaches to managing existential suffering (Hall et al., 2010). Furthermore, exploring the philosophical and ethical frameworks of free choice and decision-making at the end of life, or in situations of “weariness of life”, is fundamental to understanding the complexity of contemporary debates on assisted dying (Mari-muthu, 2024). This reflection encompasses a critical analysis of the foundations of clinical practices and public policies, highlighting the need for a nuanced approach that reconciles patient dignity and societal values (Binder, 2022). This approach must examine how moral obligations towards the suffering of others differ from those towards their well-being, recognizing the asymmetry of ethical imperatives in these contexts (Hofmann, 2024). Furthermore, recognizing the positive aspects of suffering and the search for meaning can transform the perception of this fatigue, allowing individuals to redefine their relationship with existence and consider new perspectives (Arredondo & Caparrós, 2023). This approach implies a deep understanding of human dignity, which, far from being simply linked to rational autonomy, is also rooted in the vulnerability and interdependence of individuals (Muñoz Terrón, 2021).

2.3. Philosophical Arguments for and against the Right Not to Live

These arguments often crystallize around the notion of autonomy, exploring whether an individual facing profound existential suffering or “weariness of life”

has an inalienable right to choose their own end (Petersen & Dige, 2022). The debate then revolves around the question of whether respect for autonomy, often invoked to justify assisted dying, is compatible with the preservation of life, particularly when “weariness of life” is not directly related to a terminal medical condition (Sjöstrand et al., 2011). This discussion also raises the importance of considering relational autonomy, which recognizes that individual decisions are often made in a social and family context, influencing and being influenced by interpersonal relationships (Gómez-Vírseda et al., 2020). Autonomy, in this context, is not only an individual capacity for rational choice, but also a relational competence that manifests itself in interaction with others and in the recognition of the intrinsic vulnerability of human beings (Houska & Loučka, 2019). Therefore, the analysis of the arguments for and against the right not to live must also incorporate the dimension of vulnerability, not as a simple deficiency, but as a fundamental characteristic of human existence that requires special ethical attention (Delgado Rodriguez, 2017). Thus, contemporary bioethics strives to reconcile the notion of autonomy with the imperatives of protecting vulnerable persons, recognizing that these two concepts are not mutually exclusive but require a nuanced understanding (Rogers et al., 2012). A Kantian framework of autonomy, for example, can offer a relevant perspective on the duty of self-knowledge and the formulation of universalizable principles, thereby enriching the dialogue on end-of-life ethical dilemmas (Elsner & Rampton, 2022). This perspective, by recognizing the complexity of autonomy and the intrinsic vulnerability of human beings, moves away from a purely individualistic conception to embrace relational autonomy, where choices are shaped by social interactions and mutual support (Walter & Ross, 2014; Morberg Jämterud, 2022).

2.4. Arguments in Favor of the Right Not to Live

Proponents of this right rely primarily on the principle of autonomy, arguing that every competent individual has the right to make decisions about their own life and death, particularly in the face of suffering deemed unbearable or a loss of dignity (Karnik & Kanekar, 2016; Chen & Ren, 2024). This perspective highlights a conception of autonomy that values the independence of individual will (Entwistle et al., 2010), even in the face of radical existential choices. This approach implies a recognition of the right to self-determination, where the individual is seen as the primary arbiter of their own well-being, even if this leads to decisions that may seem paradoxical or contrary to prevailing societal norms (Entwistle et al., 2010). It is based on an understanding of autonomy as negative freedom, where the state and society have no right to interfere with personal choices, even if those choices are perceived as self-destructive (Takala, 2007). Furthermore, the argument in favor of this right can be extended to the notion of dignity, positing that prolonging life in conditions perceived as undignified by the individual may constitute a violation of that dignity (Gandhi, 2020).

Furthermore, some argue that denying an individual the opportunity to choose

their own end in cases of unbearable suffering is a form of coercion, thereby denying their fundamental freedom (Gedge et al., 2007). This position is reinforced by the idea that patient autonomy must be respected, even in end-of-life situations, and that caregivers have a responsibility to support the patient's wishes (Akdeniz et al., 2021). This approach emphasizes that respect for patient autonomy is a fundamental ethical principle in medicine, particularly at the end of life, where decisions must above all reflect individual values and preferences (Lorenzl, 2013). Therefore, a nuanced understanding of autonomy, including relational autonomy, is essential to support patients in their end-of-life decision-making, recognizing that these decisions are often influenced by social context and interpersonal relationships (Entwistle et al., 2010; Tahmasebi, 2023). This broader conception of autonomy encourages recognition that the ability to make informed decisions is often modulated by support and interaction with the patient's social and family circle, particularly when it comes to choices as crucial as those at the end of life (Houska & Loučka, 2019). However, the question arises as to whether this autonomy should always take precedence over other considerations, such as the preservation of life or the protection of vulnerable individuals, particularly when it comes to such irreversible decisions (Brock et al., 2014; Peterková, 2013).

2.5. Arguments against the Right Not to Live

Those who oppose this right often invoke the intrinsic value of human life, believing that it is sacred and should not be voluntarily ended, even in cases of suffering (Shahiefisally, 2025; Rababah, 2012). This position is often rooted in ethical, religious, or philosophical considerations that view life as a gift or a fundamental good that must be protected, regardless of individual desires. Furthermore, arguments against the right not to live highlight the risks of potential abuses, such as pressure on vulnerable individuals to choose death, or the erosion of respect for life in society (Sambrizzi, 2022). Some critics also fear that legalizing the right not to live could weaken efforts in palliative care and psychological support, diverting attention from solutions aimed at improving the quality of life of those who are suffering. Moreover, the distinction between autonomy and excessive individualism is crucial, as an overly strict view of autonomy may overlook the influence of relational and societal factors on end-of-life decisions (Spicer et al., 2021). This nuance is particularly relevant when considering the implications of relational autonomy, which recognizes that individual choices are intrinsically linked to interpersonal relationships and social supports, particularly within the family and circle of friends (Ho, 2008; Parks & Howard, 2021). This understanding of autonomy calls for increased vigilance regarding implicit or explicit pressures that could influence such a momentous decision. Furthermore, recognition of the vulnerability inherent in human existence underscores the need for robust safeguards to ensure that such decisions are made of one's own free will and not under duress. This approach highlights the need for rigorous assessment of decision-making capacity and the absence of coercion, particularly for individuals in vulnerable situations

(Lewis, 2021; Sanchini et al., 2022).

2.6. Comparative Analysis of Arguments

A cross-examination of these arguments reveals fundamental tensions between individual autonomy, the sanctity of life, and society's role in protecting vulnerable individuals. This tension is palpable in debates on medical assistance in dying, where respect for patient autonomy must be balanced with the prevention of abuse and the protection of individuals who may be unduly influenced (Vogelstein, 2017). The legalization of medical assistance in dying is a complex ethical issue that provokes intense debate, as it challenges the foundations of social morality and traditional medical ethics (Miller & Fletcher, 1993). The debate is often polarized between those who advocate an approach based on patient autonomy, valuing the individual freedom to choose how to end one's life, and those who advocate an approach based on the "best option" or the best interests of the patient, involving a broader medical and ethical assessment (Rosenwohl-Mack et al., 2021). A critical examination of the opposing positions reveals that a partial resolution to these dilemmas may lie in relational understandings of autonomy, which justify interventions by healthcare professionals and family members to support patients in their decision-making process (Menon et al., 2020). This perspective highlights the need to develop policy frameworks that minimize the risks of abuse while respecting patient autonomy (Miller & Fletcher, 1993). Furthermore, assessing decision-making capacity for medical assistance in dying remains a major concern, requiring precise criteria to ensure that patients are fully capable of consenting (Appel, 2024). Thus, it is imperative to adopt a multidimensional approach to assessing this capacity, integrating medical, psychological, and ethical dimensions (Jöbges et al., 2022). This holistic approach must consider the influence of contextual factors, such as social support and access to palliative care, on the desire to end one's life. This assessment must also take into account the concept of relational autonomy, recognizing that individual decisions are often embedded in a complex network of interpersonal relationships, and that the involvement of family and caregivers can be a key factor in ensuring that choices are truly autonomous and not the result of external pressures (Menon et al., 2020).

In African traditions, particularly through the concept of Ubuntu—"I am because we are"—autonomy is not conceived as radical independence, but as a constitutive interdependence. This perspective enriches the analysis of fatigue of living by emphasizing that vulnerability and the meaning of existence are constructed within the fabric of relationships. Thus, clinical care cannot be limited to the isolated individual, but must include community dynamics, family solidarity, and collective rituals that contribute to resilience. This is particularly evident in African cultures, where Ubuntu means that medical decisions, including those concerning the end of life, are often collective and involve the extended family or community (Sharif & Bugo, 2015). "I am because we are" implies an approach where individual preferences are often subordinated to collective well-being and

social cohesion (Behrens, 2017).

In modern Western logic, autonomy is often understood as the ability to decide alone and to assert one's personal preferences. In Ubuntu, autonomy is not denied, but it is reconfigured: it exists *in and through* relationships. Thus, an individual decision is evaluated in terms of its impact on the community, because collective well-being is considered the very condition of personal fulfillment. Personal choices (for example, in the areas of health, justice, or family life) are often negotiated with relatives, elders, or the community. This is not an arbitrary constraint, but a search for balance: preserving social cohesion, avoiding exclusion, and maintaining solidarity. Individuals accept that some of their preferences may be adjusted or deferred, as they know that their well-being depends on that of others (Ramose, 1999; Metz, 2011).

This cultural complexity highlights the need to develop ethical frameworks that are sensitive to different conceptions of autonomy and decision-making, avoiding a universalist approach that does not take into account societal specificities (Gilbar & Miola, 2014). Therefore, it is essential to recognize the diversity of understandings of autonomy and decision-making, particularly by considering non-Western frameworks of relational autonomy that can enrich the ethical dialogue on assisted dying (Dove et al., 2017; Entwistle et al., 2010).

3. Psychological, Social, and Medical Dimensions of Existential Suffering

The study of existential suffering requires an interdisciplinary approach that integrates psychological, sociological, and medical perspectives to understand the complexity of this human distress. This approach is essential for identifying precipitating and protective factors, as well as for developing holistic interventions aimed at alleviating the burden of those affected. Existential suffering often manifests as a feeling of emptiness, absurdity, or loss of meaning, regardless of diagnosed psychiatric disorders, although it may coexist with them. It can also manifest as profound anxiety about death, existential guilt, or a feeling of radical isolation, even in the presence of interpersonal relationships, and requires care that goes beyond simple symptomatic treatment (Chigangaidze et al., 2021). Indeed, it requires an exploration of the individual's fundamental values and a reassessment of their relationship with the world. This non-pathological dimension of existential suffering challenges conventional biomedical approaches and calls for interventions that integrate philosophy, spirituality, and the social dimensions of human beings. Therapeutic interventions should therefore aim to restore meaning and purpose to existence by helping individuals (re)discover their values and establish meaningful connections with their environment and others (Wilson & Appel, 2013). Existential suffering is a complex phenomenon that requires a holistic approach, recognizing that existential and spiritual needs are intrinsically linked to mental health and overall well-being (Koslander et al., 2009). The integration of psychological, social, and medical perspectives is crucial for a thorough under-

standing of this suffering, transcending the limitations of the traditional medical model to address the quest for meaning inherent in human existence (Wong & Laird, 2023). Furthermore, it is often associated with “noogenic neurosis”, an existential void characterized by a loss of meaning and a sense of absurdity (Leshchenko et al., 2023). This dimension of suffering can be exacerbated by major biographical disruptions, such as the onset of a severe psychiatric disorder, which alters identity and the ability to make sense of experience (Berna et al., 2015). The search for meaning, which transcends mere individual existence and gives significance to life and human suffering, is a universal and timeless quest (Cucchi & Qoronfleh, 2025). This quest for meaning is all the more relevant in the current context of the mental health crisis, where a reductive and biomedical approach tends to medicalize and stigmatize complex human experiences, ignoring profound existential and social factors (Bergström, 2023). The treatment of existential suffering must therefore go beyond the strict framework of psychopharmacology to include psychotherapeutic approaches that aim to restore meaning to life and promote self-transcendence in the face of adversity (Cueto de Souza & Scott, 2022).

3.1. Psychological Aspects

Psychological factors play a central role in existential suffering, encompassing dimensions such as psychological vulnerability, coping mechanisms, and the impact of trauma on the construction of meaning. This vulnerability may be heightened in young adults who experience psychotic episodes, causing them to question their identity and purpose in life (de Vries et al., 2025). These experiences can induce profound ontological anxiety, where the fragility of perceived reality and the threat of identity disintegration confront the individual with the fundamental absurdity of existence (Liu et al., 2023). In addition, stressful life events can disrupt an individual’s worldview and life goals, leading to existential questions and a loss of identity (Kring et al., 2024). Qualitative research has shown that the existential concerns of Mexican university students are mainly focused on career goals, interpersonal relationships, and personal growth (Arredondo & Caparrós, 2023). In this context, existential suffering can even become a catalyst for post-traumatic growth, promoting a reorganisation of values and the acquisition of new skills, as evidenced by some qualitative studies on trauma survivors (Arredondo & Caparrós, 2023).

However, it is crucial to distinguish existential suffering from clinical psychological distress, even though they may influence each other, in order to tailor interventions appropriately (Arredondo & Caparrós, 2023). For example, existential anxiety can be exacerbated by global crises, such as the COVID-19 pandemic, which confronts individuals with uncertainty and mortality (Nel & Govender, 2022). This period has also highlighted the importance of psychosocial factors in mental health, in contrast to a purely biological approach, emphasizing the need for a more nuanced understanding of psychological distress (Oakes, 2023). The ability to endure suffering, whether existential or psychological, can be modulated

by coping mechanisms and personality traits, as highlighted in the empirical literature (Ge & Yang, 2023). Furthermore, recent studies suggest that worldview and ontological security, as well as self-concept, may play a protective role against the risks of mental health problems in young women, particularly depression and anxiety (Lloyd et al., 2017). This psychological resilience is also shaped by the ability to navigate periods of prolonged uncertainty, a common feature of major life transitions such as entering college, where adjustment challenges and relationship issues can exacerbate existential crises (Roy et al., 2023).

3.2. Social Aspects

The social dimension of existential suffering highlights the influence of contextual and relational factors on the search for meaning and individual well-being (El Khoury-Malhame et al., 2024). Interpersonal dynamics, cultural norms, and societal structures can either amplify or mitigate feelings of existential emptiness and loss of bearings. It is surprising to learn, for example, that in Burkina Faso, nearly 45% of the population suffers from a mental or neurological disorder, which represents a considerable burden on the healthcare system and society. This high prevalence highlights the interconnection between socioeconomic challenges, community support structures, and the mental health of populations, illustrating how social deficiencies can exacerbate existential suffering on a collective scale. Societal crises, such as pandemics or armed conflicts, can also exacerbate existential suffering by creating conditions of uncertainty and disruption of social ties (Schäfer et al., 2024; Schäfer et al., 2022; Magomedova & Fatima, 2025). Social isolation and disconnection from support networks can therefore hinder individuals' ability to find meaning in their lives, increasing their vulnerability to psychological distress (Chen et al., 2023). This loss of collective and individual reference points can lead to profound disorientation, exacerbating existing feelings of meaninglessness and futility (Schweizer et al., 2023; Lundvall et al., 2022).

Young adults, in particular, are more exposed to stress and at an increased risk of mental health deterioration in the face of the current polycrisis, which is characterized by interconnected global crises (Kałwak et al., 2024). In addition, financial insecurity and lack of family support exacerbate psychological distress among university students, rendering coping strategies ineffective in the face of these multiple pressures (Segú-Odrizola, 2025). The university environment, despite its role in human development, is often associated with negative outcomes due to the academic, financial, and psychosocial constraints that students encounter (Ramsden & Talbot, 2024). Indeed, the search for meaning in life is a significant protective factor against loneliness and psychological distress among urban youth (Chhajer et al., 2024), while the lack of social support is a major risk factor for mental disorders (Magomedova & Fatima, 2025). These observations corroborate the hypothesis that socioeconomic and relational factors, such as poverty and social isolation, are crucial determinants of mental health and well-being, particularly among vulnerable populations (Pigeon-Gagné et al., 2017). Psychological

distress can be significantly amplified by financial insecurity, particularly among young adults, where economic burdens can have lasting consequences on financial security, physical health, and overall well-being (Nasir et al., 2025). This dynamic can create a vicious cycle in which economic hardship exacerbates mental health problems, thereby reducing individuals' ability to overcome financial challenges (Nasir et al., 2025).

3.3. Medical Aspects

The medical dimensions of existential suffering address the interface between subjective experiences of meaning and meaninglessness and the somatic or psychiatric manifestations that may result. This includes consideration of chronic conditions, terminal illnesses, or even mental disorders that may deprive an individual of the ability to find meaning in their existence, thereby altering their quality of life. This complex interaction between the physical and the psychological requires an integrative approach that takes existential suffering into account in the diagnosis and management of medical conditions. In addition, access to appropriate mental health care and psychosocial interventions can play a crucial role in alleviating this suffering by providing a supportive framework for the restructuring of meaning and hope. The comorbidity between existential suffering and medical conditions such as depression or anxiety, often exacerbated by factors such as stress or loneliness, highlights the need for holistic care that includes strategies for reducing stress and promoting well-being (Slimmen et al., 2022). Therefore, the integration of palliative care and patient-centered approaches is essential to address existential suffering in the medical context, recognizing the importance of patient dignity and autonomy in the face of serious or chronic illness. This interdisciplinary approach provides a better understanding of how financial challenges intertwine with mental health issues, significantly affecting individuals' overall well-being (Altaf & Dodamani, 2024; Jung et al., 2024). Studies have shown that unresolved financial distress can manifest itself in physical pain, acting as a metaphor for existential suffering or even reinforcing existing pain (Strang et al., 2004). Thus, chronic pain, for example, can become a profound existential experience, altering an individual's self-image and understanding of the world, and impacting their life goals and integrity (Kieselbach et al., 2022). This interdependence between physical pain and the quest for existential meaning requires a therapeutic approach that transcends the traditional biomedical model (Lima et al., 2014; Le Breton, 2021). Therefore, a thorough understanding of the mechanisms underlying psychiatric disorders concomitant with medical conditions is essential for effective clinical interventions, especially in cases where existential suffering is exacerbated by these comorbidities (Tenea-Cojan et al., 2025).

4. Public Policies and Clinical Practices Related to Assisted Dying

The design of public policies and clinical practices governing assisted dying must

navigate the ethical complexity inherent in end-of-life care, balancing individual autonomy with society's collective responsibilities toward its vulnerable members. This involves a careful analysis of the bioethical implications of the desire to hasten death, considering the principles of autonomy, dignity, and vulnerability (Borges et al., 2024). Therefore, the development of rigorous legislative frameworks is imperative to ensure that decisions to assist in dying are made in an informed and voluntary manner, without external coercion, while protecting the most vulnerable individuals from undue pressure. Furthermore, policies must recognize the correlation between lack of autonomy in palliative care and the existential burden this places on patients at the end of life (Allen, 2002). This recognition is fundamental to refocusing discussions toward approaches that promote quality of life and relief from suffering, rather than focusing solely on prolonging existence. In this context, it is crucial to integrate considerations of life fatigue into clinical assessment, especially in patients with chronic diseases, to distinguish this existential weariness from symptoms of clinical depression (Costanza et al., 2021). Such a distinction is all the more relevant given that chronic pain can profoundly alter one's perception of the meaning of life and exacerbate suicidal ideation, even in the absence of psychiatric comorbidities (Costanza et al., 2021). Understanding this distinction is essential to avoid misinterpreting requests for assistance in dying as a simple depressive symptom, when they may reflect a profound existential fatigue linked to irreducible suffering (Berens & Kim, 2022). Clinical protocols must therefore be refined to include multidimensional assessments that differentiate existential fatigue from treatable psychiatric disorders, thereby enabling appropriate intervention that respects patient autonomy. This requires a nuanced approach that examines the underlying motivations for requests for assistance in dying, taking into account psychological, social, and existential factors.

4.1. Analysis of Public Policies

Analysis of public policies reveals a diversity of regulatory approaches, ranging from strict prohibition to legalization under very specific conditions, as is the case in the Netherlands, where patient autonomy is a central criterion for euthanasia, including for "weariness of life" (van der Geest & Satalkar, 2019). This divergence highlights the tension between protecting life and respecting individual autonomy in the face of suffering deemed unbearable (Bofarull et al., 2024). The complexity of this tension is amplified by the clinical observation that chronic pain often requires a revision of life goals and expectations, thus impacting the individual's existential dimension and perception of the meaning of life (Costanza et al., 2021). Furthermore, data from jurisdictions that have legalized assisted dying, such as Oregon, provide crucial insights into the clinical criteria and safety practices necessary for its implementation, highlighting the importance of rigorous assessment of the patient's decision-making capacity (Orentlicher et al., 2015).

Case studies from these contexts reveal that a patient's ability to lead a meaningful life, even with chronic pain, is highly dependent on their leading role in

their own care, which requires balanced, patient-centered support from healthcare professionals (Dysvik & Furnes, 2018). This situation highlights the need for a holistic approach to the regulation of end-of-life care, which goes beyond simple regulatory instrumentalization to embrace broader ethical considerations (White et al., 2022). It must also address issues of equitable access to palliative care and assisted dying, ensuring that socioeconomic disparities do not influence access to these options (Beek et al., 2013). Therefore, particular attention must be paid to the integration of psychological and social support services, ensuring that patients experiencing fatigue of living receive comprehensive support before making any final decisions. This comprehensive approach aims to prevent requests for assistance in dying resulting from a lack of support or treatable suffering (Bofarull et al., 2024). Furthermore, the implementation of these policies requires in-depth training for healthcare professionals so that they can navigate the ethical and clinical nuances associated with the end of life (McDougall et al., 2023). Finally, legal and ethical frameworks must incorporate a thorough consideration of “weariness of life” as a complex component of existential suffering, distinguishing this profound weariness from traditional psychiatric diagnoses (Petersen & Dige, 2022).

In comparison, in the Netherlands, the notion of “weariness of life” (or *voltooid leven*, “completed life”) is discussed as a possible reason for assisted dying, even in the absence of a terminal illness. Although the 2001 law strictly regulates euthanasia and assisted suicide, this debate questions the boundaries between medical suffering, personal autonomy, and the dignity of life.

4.2. Clinical Practices

Clinical practices at the end of life require a multidisciplinary, patient-centered approach that integrates not only the relief of physical pain, but also consideration of the psychological, social, and spiritual dimensions of existential suffering (Barazzetti et al., 2010). This approach must include a rigorous assessment of the patient’s relational autonomy, recognizing that end-of-life decisions are often influenced by the social and family support network (Gómez-Virseda et al., 2020; Sayid Ahmad & Peled-Raz, 2025). This broader perspective of autonomy, going beyond a simple capacity for individual choice, is essential to ensure that the preferences of patients at the end of life are fully respected and integrated into their care plan (Houska & Loučka, 2019). It also requires transparent and empathetic communication between healthcare professionals, patients, and their loved ones in order to navigate the complex ethical dilemmas that frequently arise in end-of-life care (Akdeniz et al., 2021). In this context, training healthcare teams in the ethical and legal specifics of assisted dying becomes essential to ensure that care is provided in a manner that respects the patient’s wishes (Akdeniz et al., 2021).

For clinicians, it is important not to confuse “weariness of life” with “clinical depression” when requests for “terminal sedation” come from certain patients. “Weariness of life” expresses an existential weariness: the subject says they are “tired of living”, which reflects real suffering. It is a subjective indicator of distress: it re-

veals that the person is experiencing saturation, a loss of meaning, or difficulty in planning for the future. It may be linked to contextual factors that need to be deciphered and managed (stress, isolation, spiritual crisis, social difficulties); this cry of distress should therefore be heard as a call for help.

Clinical depression, on the other hand, is defined by specific diagnostic criteria (DSM-5, ICD-10): persistent depressive mood, anhedonia, sleep disturbances, guilt, psychomotor retardation, suicidal thoughts, etc. The diagnosis of depression requires a structured and multidimensional assessment: duration of symptoms, intensity, impact on daily functioning, and the presence of biological or cognitive signs. Fatigue of living is too general and non-specific: it can appear in many situations (burnout, grief, spiritual crisis, physical fatigue), as shown in **Table 1** below. Two pitfalls must be avoided: pathologizing an existential feeling, which requires listening and empathy; or trivializing real depression, which requires an evaluative approach, objective criteria, and appropriate therapeutic care (Hell, 2015).

Table 1. Comparison between fatigue of living and clinical depression.

Fatigue of living	Clinical depression
Diffuse existential feeling: weariness, loss of interest in life, feeling of being “overwhelmed” or saturated.	Psychiatric disorders are defined by diagnostic criteria (DSM-5, ICD-10): persistent depressive mood, loss of interest, and impaired functioning.
May be transient, linked to social or spiritual contexts, or to accumulated stress.	Long-lasting condition (≥ 2 weeks), not limited to a particular context, with an overall impact.
Often expressed in philosophical or metaphorical terms (“I’m tired of living”).	Specific symptoms include sadness, anhedonia, sleep disturbances, loss of energy, excessive guilt, and suicidal thoughts.
Not necessarily associated with biological or cognitive impairment.	Frequent neurobiological and cognitive changes: psychomotor slowing, concentration problems, and impaired memory.
May be relieved by rest, a change of scenery, or social or spiritual support.	Requires medical treatment: psychotherapy, pharmacotherapy, and psychiatric follow-up.
Does not in itself constitute a medical diagnosis.	Recognized medical diagnoses, with standardized criteria and therapeutic implications.
Risk: trivialization or invisibility of real suffering.	Risk: progression to chronicity, somatic complications, and suicidal tendencies.

In New Zealand, for example, studies have highlighted the need for better training of healthcare professionals in discussing end-of-life options and managing family dynamics (Arshad et al., 2025). Furthermore, it is also crucial to take into account the emotional and ethical burden on caregivers, particularly in contexts where assisted dying is legalized, as evidenced by the challenges faced by nurses confronted with these difficult decisions (Alanazi et al., 2024). This complexity highlights the importance of robust psychological and institutional support for healthcare teams in order to prevent burnout and maintain a high quality of care in such a sensitive area (Alanazi et al., 2024). In addition, the integration of early palliative care is recognized as a best practice, aimed at improving the quality of

life of patients and their families by addressing physical, psychological, social, and spiritual symptoms as soon as a serious illness is diagnosed (Alanazi et al., 2024). This approach optimizes symptom control, improves existential well-being, and facilitates peaceful preparation for the end of life, in accordance with best practices in palliative care (Barazzetti et al., 2010).

4.3. Challenges and Controversies

The challenges and controversies associated with end-of-life care and assisted dying are manifold, encompassing profound ethical dilemmas concerning patient autonomy, the value of life, and the role of medicine in death (Alanazi et al., 2024). Navigating these complex issues requires careful consideration of the perceptions of healthcare professionals, particularly palliative care nurses, who face ethical dilemmas on a daily basis and must assess patients' quality of life while adhering to their rights (Ibrahim et al., 2024). A case in point is that of a young girl who asked to go to another country to die because assisted suicide is prohibited in her own country. This case highlights international legislative disparities and the cross-border ethical implications of medical assistance in dying, raising the question of access to this option for individuals residing in restrictive jurisdictions. It also highlights the tension between national sovereignty and the individual's right to control their own body, exacerbated by the globalization of healthcare and patient mobility. Furthermore, the issue of "weariness of life" differs from recognized psychiatric illnesses, which complicates the determination of eligibility for assisted dying and raises debates about the medicalization of existential suffering. This distinction is crucial to avoid the excessive pathologization of existential distress while recognizing the legitimacy of profound suffering that does not fall within a standardized psychiatric diagnosis. This nuance implies a reassessment of the eligibility criteria for assisted dying, incorporating a more sophisticated understanding of suffering beyond traditional diagnostic categories.

Therefore, it is imperative to develop clear ethical guidelines and nuanced clinical protocols to address these complex situations, ensuring both respect for individual autonomy and the protection of vulnerable individuals. This requires effective communication and patient involvement in end-of-life decisions, a complex process in which caregivers must balance autonomy, beneficence, and relationships (Alanazi et al., 2024). In addition, conflicts between family members and healthcare professionals may arise, particularly when end-of-life decision-making involves differences of opinion regarding the withdrawal or continuation of treatment, highlighting the importance of ethical mediation (Nnate, 2021). The emergence of artificial intelligence in the field of healthcare could offer new perspectives to assist in these complex decision-making processes, particularly by classifying and analyzing cases of assisted dying according to established standards, although its application in such sensitive areas inevitably raises new ethical questions (Spitale et al., 2023).

Positive existential psychology and philosophical health, benefiting from innovative clinical approaches, can be translated into concrete interventions. For example, in a palliative care unit, the practitioner may invite the patient to revisit their sources of meaning through open-ended questions (“What remains essential to you today?”). In a community setting, ethical reflection workshops or Ubuntu-inspired talking circles allow patients to share their values and strengthen their resilience. These practices illustrate how a philosophical approach can enrich therapeutic communication and support dignity at the end of life. A specialization in palliative care would allow all these aspects to be integrated, benefiting the overall care of patients at the end of life.

5. Critical Reflection on Autonomy and Vulnerability

This chapter aims to deepen our understanding of these interdependent concepts by exploring how recognizing the intrinsic vulnerability of human existence can enrich, rather than contradict, the principle of autonomy in the context of end-of-life decisions (Muñoz Terrón, 2021; Delgado Rodriguez, 2017). This analysis will seek to move beyond a simplistic view of autonomy as a mere exercise of individual choice, placing it within a relational and contextual framework where the capacity to act is intrinsically linked to social conditions and human interactions. From this perspective, vulnerability is not a failure of autonomy, but a universal condition that requires an ethical approach to care focused on relationships and support, particularly in palliative care (Morberg Jämterud, 2022). It highlights the importance of considering the patient’s capacity to make informed decisions, while recognizing the limits of this autonomy when external or internal factors significantly impact the decision-making process (Karnik & Kanekar, 2016). This relational perspective on autonomy implies a reassessment of existing ethical frameworks in order to better integrate the dimensions of dependence and interdependence into the development of end-of-life care policies (Houska & Loučka, 2019). It highlights the need for an individualized approach that takes into account the specificities of each situation, including cultural and personal considerations that influence patients’ choices (Karnik & Kanekar, 2016). Furthermore, the complexity of patient autonomy in end-of-life decisions is exacerbated by the tension between self-determination and the uncertainty inherent in these choices (Lorenzl, 2013). In this context, the patient’s decision-making capacity must be assessed not only in terms of understanding information and reasoning, but also in terms of recognizing emotional influences and relational dynamics (Walter & Ross, 2014; Entwistle et al., 2010).

5.1. Issues of Autonomy

Therefore, a thorough understanding of autonomy requires consideration of how caregiver-patient relationships can support or hinder an individual’s ability to exercise meaningful autonomy (Entwistle et al., 2010). This approach highlights the crucial role of caregivers in maintaining and strengthening patient autonomy, go-

ing beyond simply facilitating decisions to encompass support for identity and self-determination capacities (Entwistle et al., 2010). Thus, patient autonomy is not a static entity, but a dynamic and evolving process, intrinsically linked to the context of palliative care and the quality of human interactions (Entwistle et al., 2010). This relational conception of autonomy implies a reassessment of clinical practices, promoting continuous and empathetic dialogue where the patient's voice is central and respected, even in the face of increasing vulnerability (Bertaud et al., 2025). This approach recognizes that autonomy at the end of life is intrinsically linked to a person's ability to exercise their choices and preferences in a supportive environment (Stavert, 2020). It also emphasizes the importance for healthcare professionals to consider family and relational dimensions in decision-making, as these are often paramount for patients and their loved ones (Parks & Howard, 2021). Another point to clarify is the patient's dependence in relation to their claim to autonomy. A nuanced understanding of this dynamic is essential to ensure that decision-making fully respects the patient's values and wishes, without their physical or emotional dependence compromising the expression of their self-determination (Tahmasebi, 2023). It is therefore crucial to adopt a perspective that integrates vulnerability as an inherent component of autonomy, in order to ensure care that not only respects individual choices, but also protects and supports individuals in their integrity in the face of illness and the end of life (AjLuni, 2023).

5.2. Issues of Vulnerability

In this context, vulnerability is perceived not as a deficiency, but as a universal human condition that requires special attention and tailored support strategies (Pols et al., 2017). This recognition of the intrinsic vulnerability of human existence enriches our understanding of patient autonomy, highlighting the need for an individualized approach and enhanced relational support to ensure informed decisions that respect patient dignity (Elina et al., 2022; Kurkowski et al., 2022). It highlights the importance of a patient-centered approach in palliative care, where dignity and acceptance of death are crucial aspects that influence patients' choices and preferences (Staats et al., 2025; Mapes et al., 2019; Yedidia, 2006; Oliveira & Silva, 2010). This perspective recognizes that vulnerability is often exacerbated by specific circumstances, such as advanced illness or end of life, requiring a pragmatic and contextual approach to protection and support (Sossauer et al., 2019). Thus, vulnerability is not a static attribute but a dynamic condition, influenced by personal, relational, and environmental factors that require in-depth exploration to fully understand its ethical and clinical implications (Mackay, 2017). This complexity requires a rigorous analysis of conceptual frameworks of vulnerability in the context of end-of-life care, particularly with regard to older populations and the ethical challenges posed by informed consent and decision-making (Sanchini et al., 2022). It is therefore imperative to reconcile respect for patient autonomy with the obligations to protect vulnerable individuals (Rogers et al., 2012).

6. Balancing Autonomy and Vulnerability

This reconciliation requires a nuanced understanding of vulnerability as a universal condition of human existence rather than a simple disability or marginal status (Gjengedal et al., 2013). This approach recognizes that vulnerability is inherent in the human experience and manifests itself in various ways, influencing an individual's ability to exercise autonomy (Boldt, 2019; Finlayson, 2013). It calls for support strategies that strengthen individuals' capacities to make informed choices, even in situations of increased dependence or fragility (Boldt, 2019; Alves & Ribeiro, 2023). Thus, protecting vulnerable people should not be done at the expense of their autonomy, but rather by providing them with the resources and support they need to make informed choices that are consistent with their core values (Lewis, 2021). This implies recognizing the intrinsic dignity of each individual, regardless of their health status, and adhering to the ethical principles of beneficence and non-maleficence in all clinical interactions (Rosenwohl-Mack et al., 2021). This approach requires striking a delicate balance between protecting the patient and preserving their ability to make informed decisions, especially when they are faced with complex illnesses or cognitive limitations (Marnfeldt & Wilber, 2025; Alodhialah et al., 2024). The question of what constitutes the "best interests of the patient" then becomes central, especially when the patient's preferences cannot be clearly expressed or conflict with the views of family or healthcare professionals (van Bruchem-Visser et al., 2020). In this context, the concept of informed consent is crucial, although it is often complex to fully implement, particularly in older adults whose decision-making capacity may be impaired (Seedsman, 2019). Indeed, assessing decision-making capacity in vulnerable individuals, particularly older adults, represents a major ethical and clinical challenge that requires a multidimensional approach that goes beyond purely cognitive assessment (Mackenzie & Rogers, 2013). We agree with the foundations of Hippocratic medicine, which give primacy to the principles of non-maleficence and beneficence, requiring healthcare professionals to always act in the best interests of the patient while respecting their autonomy. Love the patient before seeking to treat them and save their life. This maxim highlights the humanistic dimension of care, where the therapeutic relationship takes precedence, thus guiding all medical interventions, including discussions about the end of life (Kapp, 2015). Respect for autonomy, even in contexts of increased vulnerability, remains a fundamental pillar of contemporary medical ethics, requiring healthcare professionals to support patients in expressing their wishes. In addition, cultural and societal considerations play a significant role in the perception and exercise of autonomy, requiring a flexible and culturally sensitive approach to care.

In several African societies, for example, when a person is going through a difficult time (illness, bereavement, discouragement), they are not left alone to bear their burden. The community organizes discussion groups where everyone can share their experiences, listen, and offer advice or encouragement. This system is not only therapeutic on an individual level; it rebuilds relationships and reminds

the person that they are part of a supportive community, as shown in **Table 2** below. Clinically, this acts as a resilience factor, as collective support reduces isolation and restores meaning to life (Koulayan, 2008; Ngomane, 2019).

When illness persists, healing and solidarity rituals are commonly used in African societies. When a member is weakened (by illness or psychological distress), the family and sometimes the village organizes collective rituals: songs, blessings, and symbolic gestures of purification or protection. These rituals are aimed not only at biological healing but also at the social and spiritual reintegration of the person. They serve as a reminder that vulnerability is shared and that the community bears the burden of suffering together. In a clinical approach, recognizing and integrating these practices helps to build trust, value local resources, and support resilience (Baylet, 2012; Kedzierska Manzon, 2022).

Table 2. Comparison between western autonomy and relational autonomy (Ubuntu).

Aspect	Western autonomy	Relational autonomy (Ubuntu)
Definition	The ability of an individual to make decisions alone, independently of others.	The ability of individuals to act and make decisions within and through relationships.
Core value	Individual freedom, personal choice, and independence.	Social cohesion, solidarity, and shared responsibility.
Relationship to the community	The community is an external, sometimes secondary framework.	The community is fundamental to identity and the meaning of existence.
Practical consequences	Medical, legal, or ethical decisions are centered on the individual.	Decisions are negotiated with family, elders, or the community.
View of vulnerability	Vulnerability as an individual weakness to be overcome.	Vulnerability is a shared experience, a source of connection and resilience.
Concrete example	Medical consent: the patient decides alone.	Medical consent: The decision was discussed with the family and community to preserve harmony.

7. Conclusion

This complexity requires an in-depth analysis of existing ethical frameworks and continuous adaptation of clinical practices to meet the specific needs of patients. It highlights the importance of ongoing reflection on the interface between individual autonomy and collective responsibility (Menon et al., 2020), particularly in the face of medical advances and societal challenges. Thus, the development of public policies and clinical guidelines must integrate this dynamic to ensure that patients' rights are protected while optimizing their well-being (Carrese, 2006; Budd & Mlinac, 2025).

The integration of the relational autonomy perspective, which recognizes the influence of interpersonal relationships on decision-making, is essential to refine this approach and ensure that patients' choices truly reflect their values in a social context (Dove et al., 2017). This relational perspective on autonomy, which moves away from a strictly individualistic view, allows for greater consideration of the family and social dynamics that influence end-of-life decisions (Spicer et al., 2021;

Menon et al., 2020). Furthermore, it is crucial to recognize that patient autonomy is not absolute and must be balanced with the principles of beneficence, non-maleficence, and justice, which are the pillars of medical ethics (Mennella et al., 2024) (Nnate, 2021).

This holistic view is particularly relevant for patients from non-Western cultures, where the family often plays a central role in medical decision-making, influencing the notion of individual autonomy and challenging the unilateral patient-centered approach (Gilbar & Miola, 2014). This approach highlights the importance of ongoing ethical dialogue to navigate the tensions between individual and collective values, thereby ensuring respectful and culturally competent care (Alolod et al., 2024; Berestova et al., 2019). What conclusions can we draw for our African cultures?

For African cultures, the emphasis on relational autonomy and respect for individuals, rather than strictly individualistic autonomy, is fundamental and more appropriate (Behrens, 2017). This implies considering medical decisions as being deeply influenced by the well-being of the community and the extended family, rather than by the exclusive desires of the individual (Akpa-Inyang & Chima, 2021). This approach requires an adaptation of Western ethical practices, which often focus on individual autonomy, to encompass the collective dynamics and family hierarchies specific to these contexts (López-Soto & Santos, 2023; Thompson et al., 2022). This perspective requires a nuanced understanding of local cultural values and belief systems to facilitate shared decision-making processes that integrate individual aspirations within the collective framework. As a result, the role of the family in medical decision-making, particularly at the end of life, is often predominant, even decisive, reflecting a collective view of the person in which the individual is intrinsically linked to their community (Ho, 2008).

Man is man's remedy, as an African proverb says. This maxim emphasizes an ethic of interdependence and collective responsibility, where the well-being of the individual is intrinsically linked to that of their community, which often differs from Western conceptions of individual autonomy that prioritize personal rights and choices (Akpa-Inyang & Chima, 2021; Alfahmi, 2022). In this context, the principles of Ubuntu or Botho, which emphasize human interconnectedness and recognition of the person through the community, offer a relevant ethical framework for navigating the complex dilemmas of the end of life (Ikuenobe, 2015). These community-based philosophies, such as Ubuntu/Botho and Ukama, emphasize the predominance of communitarianism over individual rights, which makes the application of individual-based models of informed consent difficult in many African contexts (Akpa-Inyang & Chima, 2021; Appiah et al., 2024).

This cultural divergence requires a reassessment of standard bioethical frameworks to ensure they are sensitive to the nuances of African social structures and value systems that prioritize collective solidarity (Ramabu, 2019; Jecker & Atuire, 2021). Therefore, integrating African philosophies into ethical discussions about the end of life is crucial for developing approaches that respect both individual

rights and community values (Odero et al., 2024; Sharif & Bugo, 2015). More specifically, principles such as those of Ubuntu, which promote collective well-being and human interdependence, can inform the development of appropriate ethical frameworks that foster a holistic approach to medical care (Odero et al., 2024; Metz, 2009).

Conflicts of Interest

The author declares no conflicts of interest regarding the publication of this paper.

References

- Ajluni, V. (2023). Respecting Autonomy: Prioritizing Patient-Centered Care and Decision-Making Capacity for Stronger Doctor-Patient Relationships. *Journal of Family Medicine and Primary Care*, 12, 1752-1753. https://doi.org/10.4103/jfmmpc.jfmmpc_712_23
- Akdeniz, M., Yardımcı, B., & Kavukcu, E. (2021). Ethical Considerations at the End-Of-Life Care. *SAGE Open Medicine*, 9, 1-9. <https://doi.org/10.1177/20503121211000918>
- Akpa-Inyang, F., & Chima, S. C. (2021). South African Traditional Values and Beliefs Regarding Informed Consent and Limitations of the Principle of Respect for Autonomy in African Communities: A Cross-Cultural Qualitative Study. *BMC Medical Ethics*, 22, Article No. 111. <https://doi.org/10.1186/s12910-021-00678-4>
- Alanazi, M. A., Shaban, M. M., Ramadan, O. M. E., Zaky, M. E., Mohammed, H. H., Amer, F. G. M. et al. (2024). Navigating End-Of-Life Decision-Making in Nursing: A Systematic Review of Ethical Challenges and Palliative Care Practices. *BMC Nursing*, 23, Article No. 467. <https://doi.org/10.1186/s12912-024-02087-5>
- Alfahmi, M. Z. (2022). Patients' Preference Approach to Overcome the Moral Implications of Family-Centred Decisions in Saudi Medical Settings. *BMC Medical Ethics*, 23, Article No. 128. <https://doi.org/10.1186/s12910-022-00868-8>
- Allen, F. (2002). Where Are the Women in End-Of-Life Research? *Behaviour Change*, 19, 39-51. <https://doi.org/10.1375/bech.19.1.39>
- Alodhialah, A. M., Almutairi, A. A., & Almutairi, M. (2024). Ethical and Legal Challenges in Caring for Older Adults with Multimorbidities: Best Practices for Nurses. *Healthcare*, 12, Article 1585. <https://doi.org/10.3390/healthcare12161585>
- Alolod, G. P., Litsas, D. C., & Siminoff, L. A. (2024). Reconsidering Autonomy: Asian Americans' Use of Relational Autonomy in Organ Donation Decisions. <https://doi.org/10.21203/rs.3.rs-5110495/v1>
- Alshehri, H., Alturkestani, R., Hijan, B., Almalki, S., Alobaidi, R., Almufti, S. et al. (2024). The Prevalence of Existential Anxiety and Its Association with Depression, General Anxiety, and Stress in Saudi University Students. *Middle East Current Psychiatry*, 31, Article No. 47. <https://doi.org/10.1186/s43045-024-00435-4>
- Altaf, R., & Dodamani, S. (2024). The Multifaceted Impact of Financial Stress on Physiological, Psychological Well-Being, and Success: A Comprehensive Review and Strategic Interventions. <https://doi.org/10.20944/preprints202411.1862.v1>
- Alves, R. M. d. S., & Ribeiro, R. C. (2023). Intensive Care and the Different Meanings of Vulnerability. *Critical Care Science*, 35, 102-106. <https://doi.org/10.5935/2965-2774.20230317-en>
- Amani, C. (2024). The Impact of Existentialism on Contemporary Mental Health Practices. *International Journal of Philosophy*, 3, 14-27. <https://doi.org/10.47941/ijp.2088>

- Amathabhani, B., & Dissanayake, N. (2024). Existential Buddhism: Embracing Life's Uncertainties and Finding Meaning Within. *South Florida Journal of Development*, 5, e4540. <https://doi.org/10.46932/sfjdv5n10-042>
- Appel, J. M. (2024). Legal and Ethics Considerations in Capacity Evaluation for Medical Aid in Dying. *Journal of the American Academy of Psychiatry and the Law*, 52, 311-326.
- Appiah, R., Raviola, G., & Weobong, B. (2024). Balancing Ethics and Culture: A Scoping Review of Ethico-Cultural and Implementation Challenges of the Individual-Based Consent Model in African Research. *Journal of Empirical Research on Human Research Ethics*, 19, 143-172. <https://doi.org/10.1177/15562646241237669>
- Arredondo, A. Y., & Caparrós, B. (2023). Positive Facets of Suffering, Meaningful Moments, and Meaning Fulfilment: A Qualitative Approach to Positive Existential Issues in Trauma-Exposed University Students. *Psychological Studies*, 68, 13-23. <https://doi.org/10.1007/s12646-022-00698-z>
- Arshad, W., Dekhoda, A., Carey, M., Menkes, D. B., Hoeh, N., Sundram, F., Frey, R., & Cheung, G. (2025). The First Year of Assisted Dying in New Zealand through the Lens of Healthcare Professionals Not Directly Involved in the Process. *BMC Palliative Care*, 24, Article No. 194. <https://doi.org/10.1186/s12904-025-01838-8>
- Barazzetti, G., Borreani, C., Miccinesi, G., & Toscani, F. (2010). What "Best Practice" Could Be in Palliative Care: An Analysis of Statements on Practice and Ethics Expressed by the Main Health Organizations. *BMC Palliative Care*, 9, Article No. 1. <https://doi.org/10.1186/1472-684x-9-1>
- Baylet, R. (2012). *Anthropology and healing practices in West Africa*. Montpellier Academy of Sciences and Letters.
- Beek, K. V., Woitha, K., Ahmed, N., Menten, J., Jaspers, B., Engels, Y. et al. (2013). Comparison of Legislation, Regulations and National Health Strategies for Palliative Care in Seven European Countries (Results from the Europall Research Group): A Descriptive Study. *BMC Health Services Research*, 13, Article No. 275. <https://doi.org/10.1186/1472-6963-13-275>
- Behrens, K. G. (2017). A Critique of the Principle of 'Respect for Autonomy', Grounded in African Thought. *Developing World Bioethics*, 18, 126-134. <https://doi.org/10.1111/dewb.12145>
- Berens, N., & Kim, S. Y. (2022). Rapid-Response Treatments for Depression and Requests for Physician-Assisted Death: An Ethical Analysis. *The American Journal of Geriatric Psychiatry*, 30, 1255-1262. <https://doi.org/10.1016/j.jagp.2022.07.003>
- Berestova, A. V., Gorenkov, R. V., Orlov, S., & Starostin, V. P. (2019). Ethics in Medical Decision Making: An Intercultural Outlook. *Utopía y Praxis Latinoamericana: Revista Internacional de Filosofía Iberoamericana y Teoría Social*, 24, 144-151. <https://dialnet.unirioja.es/descarga/articulo/7531733.pdf>
- Bergström, T. (2023). From Treatment of Mental Disorders to the Treatment of Difficult Life Situations: A Hypothesis and Rationale. *Medical Hypotheses*, 176, Article ID: 111099. <https://doi.org/10.1016/j.mehy.2023.111099>
- Berna, F., Mandhouj, O., & Huguélet, P. (2015). Les éléments psychologiques du rétablissement dans les troubles mentaux sévères: Identité, spiritualité et sens. *European Psychiatry*, 30, S26-S26. <https://doi.org/10.1016/j.eurpsy.2015.09.079>
- Bertaud, S., Wilkinson, D., & Kelley, M. (2025). The Heart of Palliative Care Is Relational: A Scoping Review of the Ethics of Care in Palliative Medicine. *BMC Palliative Care*, 24, Article No. 150. <https://doi.org/10.1186/s12904-025-01784-5>
- Binder, P. (2022). Suffering a Healthy Life—On the Existential Dimension of Health. *Frontiers in Psychology*, 13, Article 803792. <https://doi.org/10.3389/fpsyg.2022.803792>

- Bofarull, M., Esquerda, M., Lorenzo, D., Torralba, F., Cusi, V., Suffo, J. A. et al. (2024). Life Fatigue: A Critical Analysis. *The American Journal of Geriatric Psychiatry*, 33, 200-208. <https://doi.org/10.1016/j.jagp.2024.08.002>
- Boldt, J. (2019). The Concept of Vulnerability in Medical Ethics and Philosophy. *Philosophy, Ethics, and Humanities in Medicine*, 14, Article No. 6. <https://doi.org/10.1186/s13010-019-0075-6>
- Borges, P. J., Hernández-Marrero, P., & Martins Pereira, S. (2024). A Bioethical Perspective on the Meanings behind a Wish to Hasten Death: A Meta-Ethnographic Review. *BMC Medical Ethics*, 25, Article No. 23. <https://doi.org/10.1186/s12910-024-01018-y>
- Brock, D. W., Park, J. K., & Wendler, D. (2014). Making Treatment Decisions for Oneself: Weighing the Value. *Hastings Center Report*, 44, 22-25. <https://doi.org/10.1002/hast.284>
- Budd, M. A., & Mlinac, M. E. (2025). Overview of Practical Applications of Healthcare Ethics for Older Adults. *OBM Geriatrics*, 9, 1-26. <https://doi.org/10.21926/obm.geriatr.2502314>
- Carrese, J. A. (2006). Refusal of Care: Patients' Well-Being and Physicians' Ethical Obligations. *JAMA*, 296, 691-695. <https://doi.org/10.1001/jama.296.6.691>
- Chen, L. H., Law, W., Chang, D. H. F., & Sun, D. (2023). Editorial: The Bio-Psycho-Social Approach to Understanding Mental Disorders. *Frontiers in Psychology*, 14, Article 1225433. <https://doi.org/10.3389/fpsyg.2023.1225433>
- Chen, L., & Ren, M. (2024). Is It Really Better to "Die" than "Live"? Reflections on the Practice of "Death with Dignity" in China. *Frontiers in Public Health*, 12, Article 1426257. <https://doi.org/10.3389/fpubh.2024.1426257>
- Chhajer, R., Chaudhry, S., & Mishra, A. (2024). Combating the Mental Health Challenge of Loneliness among Urban Youth: Could Finding Meaning in Life and Experiencing Thriving Enhance Their Well-Being? *BMC Public Health*, 24, Article No. 3586. <https://doi.org/10.1186/s12889-024-21185-2>
- Chigangaidze, R. K., Matanga, A. A., & Katsuro, T. R. (2021). Ubuntu Philosophy as a Humanistic-Existential Framework for the Fight against the COVID-19 Pandemic. *Journal of Humanistic Psychology*, 62, 319-333. <https://doi.org/10.1177/00221678211044554>
- Costanza, A., Chytas, V., Piguët, V., Luthy, C., Mazzola, V., Bondolfi, G. et al. (2021). Meaning in Life among Patients with Chronic Pain and Suicidal Ideation: Mixed Methods Study. *JMIR Formative Research*, 5, e29365. <https://doi.org/10.2196/29365>
- Cucchi, A., & Qoronfleh, M. W. (2025). Cultural Perspective on Religion, Spirituality and Mental Health. *Frontiers in Psychology*, 16, Article 1568861. <https://doi.org/10.3389/fpsyg.2025.1568861>
- Cueto de Souza, R., & Scott, C. (2022). From Mental Health Crisis to Existential Human Suffering: The Role of Self-Transcendence in Contemporary Mindfulness. *Religions*, 13, Article 681. <https://doi.org/10.3390/rel13080681>
- de Miranda, L., & Loughlin, M. (2023). Philosophical Health: Unveiling the Patient's Personal Philosophy with a Person-Centred Method of Dialogue. *Journal of Evaluation in Clinical Practice*, 29, 1161-1170. <https://doi.org/10.1111/jep.13871>
- de Vries, M. L. D., Janse, P., Anbeek, C. W., & Braam, A. W. (2025). Existential Concerns among Young Adults with Psychotic Vulnerability in Mental Health Care: A Qualitative Study in the Netherlands. *BMC Psychiatry*, 25, Article No. 103. <https://doi.org/10.1186/s12888-025-06551-7>
- Delgado Rodriguez, J. (2017). The Relevance of the Ethics of Vulnerability in Bioethics. *Les ateliers de l'éthique*, 12, 154-179. <https://doi.org/10.7202/1051280ar>

- Dove, E. S., Kelly, S. E., Lucivero, F., Machirori, M., Dheensa, S., & Prainsack, B. (2017). Beyond Individualism: Is There a Place for Relational Autonomy in Clinical Practice and Research? *Clinical Ethics*, 12, 150-165. <https://doi.org/10.1177/147750917704156>
- Dysvik, E., & Furnes, B. (2018). Living a Meaningful Life with Chronic Pain—Further Follow-up. *Clinical Case Reports*, 6, 896-900. <https://doi.org/10.1002/ccr3.1487>
- Eisenbeck, N., Carreno, D. F., & Pérez-Escobar, J. A. (2021). Meaning-Centered Coping in the Era of COVID-19: Direct and Moderating Effects on Depression, Anxiety, and Stress. *Frontiers in Psychology*, 12, Article 648383. <https://doi.org/10.3389/fpsyg.2021.648383>
- El Khoury-Malhame, M., Bou Malhab, S., Chaaya, R., Sfeir, M., & El Khoury, S. (2024). Coping during Socio-Political Uncertainty. *Frontiers in Psychiatry*, 14, Article 1267603. <https://doi.org/10.3389/fpsy.2023.1267603>
- Elina, H., Sofia, E., Tricia, C. S., Jaana-Maija, K., Katariina, K., & Anu, S. (2022). Patients Receiving Palliative Care and Their Experiences of Encounters with Healthcare Professionals. *OMEGA—Journal of Death and Dying*, 89, 497-513. <https://doi.org/10.1177/00302228221077486>
- Elsner, A. M., & Rampton, V. (2022). “Accompanied Only by My Thoughts”: A Kantian Perspective on Autonomy at the End of Life. *The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, 47, 688-700. <https://doi.org/10.1093/jmp/jhac026>
- Entwistle, V. A., Carter, S. M., Cribb, A., & McCaffery, K. (2010). Supporting Patient Autonomy: The Importance of Clinician-Patient Relationships. *Journal of General Internal Medicine*, 25, 741-745. <https://doi.org/10.1007/s11606-010-1292-2>
- Finlayson, C. (2013). Review: Reflections on Access: Too Vulnerable to Research? *Journal of Research in Nursing*, 20, 38-38. <https://doi.org/10.1177/1744987113499519>
- Gandhi, A. (2020). *Euthanasia: A Study into the Ethical and Legal Dimensions*. Zenodo (CERN European Organization for Nuclear Research).
- Ge, B. H., & Yang, F. (2023). Transcending the Self to Transcend Suffering. *Frontiers in Psychology*, 14, Article 1113965. <https://doi.org/10.3389/fpsyg.2023.1113965>
- Gedge, E., Giacomini, M., & Cook, D. (2007). Withholding and Withdrawing Life Support in Critical Care Settings: Ethical Issues Concerning Consent. *Journal of Medical Ethics*, 33, 215-218. <https://doi.org/10.1136/jme.2006.017038>
- Gilbar, R., & Miola, J. (2014). One Size Fits All? On Patient Autonomy, Medical Decision-Making, and the Impact of Culture. *Medical Law Review*, 23, 375-399. <https://doi.org/10.1093/medlaw/fwu032>
- Gjengedal, E., Ekra, E. M., Hol, H., Kjelsvik, M., Lykkeslet, E., Michaelsen, R. et al. (2013). Vulnerability in Health Care—Reflections on Encounters in Every Day Practice. *Nursing Philosophy*, 14, 127-138. <https://doi.org/10.1111/j.1466-769x.2012.00558.x>
- Gómez-Virseda, C., de Maeseneer, Y., & Gastmans, C. (2020). Relational Autonomy in End-Of-Life Care Ethics: A Contextualized Approach to Real-Life Complexities. *BMC Medical Ethics*, 21, Article No. 50. <https://doi.org/10.1186/s12910-020-00495-1>
- Graffigna, G., Vegni, E., Barello, S., Olson, K., & Bosio, C. A. (2011). Studying the Social Construction of Cancer-Related Fatigue Experience: The Heuristic Value of Ethnoscience. *Patient Education and Counseling*, 82, 402-409. <https://doi.org/10.1016/j.pec.2010.12.017>
- Hall, M. E. L., Langer, R., & McMartin, J. (2010). The Role of Suffering in Human Flourishing: Contributions from Positive Psychology, Theology, and Philosophy. *Journal of Psychology and Theology*, 38, 111-121. <https://doi.org/10.1177/009164711003800204>

- Hell, D. (2015). Fatigue et dépression. *Revue Médicale Suisse*, *11*, 918-921. <https://doi.org/10.53738/REVMED.2015.11.471.0918>
- Ho, A. (2008). Relational Autonomy or Undue Pressure? Family's Role in Medical Decision-Making. *Scandinavian Journal of Caring Sciences*, *22*, 128-135. <https://doi.org/10.1111/j.1471-6712.2007.00561.x>
- Hofmann, B. (2024). Moral Obligations Towards Human Persons' Wellbeing versus Their Suffering: An Analysis of Perspectives of Moral Philosophy. *Health Policy*, *142*, Article ID: 105031. <https://doi.org/10.1016/j.healthpol.2024.105031>
- Houska, A., & Loučka, M. (2019). Patients' Autonomy at the End of Life: A Critical Review. *Journal of Pain and Symptom Management*, *57*, 835-845. <https://doi.org/10.1016/j.jpainsymman.2018.12.339>
- Ibrahim, A. M., Zaghamir, D. E. F., Ramadan Abdel-Aziz, H., Elalem, O. M., Al-yafeai, T. M., Sultan, H. M. S. et al. (2024). Ethical Issues in Palliative Care: Nursing and Quality of Life. *BMC Nursing*, *23*, Article No. 854. <https://doi.org/10.1186/s12912-024-02530-7>
- Ikuenobe, P. (2015). Relational Autonomy, Personhood, and African Traditions. *Philosophy East and West*, *65*, 1005-1029. <https://doi.org/10.1353/pew.2015.0101>
- Jason, L. A., Evans, M., Brown, M., & Porter, N. (2010). What Is Fatigue? Pathological and Nonpathological Fatigue. *PM&R*, *2*, 327-331. <https://doi.org/10.1016/j.pmrj.2010.03.028>
- Jecker, N. S., & Atuire, C. (2021). Bioethics in Africa: A Contextually Enlightened Analysis of Three Cases. *Developing World Bioethics*, *22*, 112-122. <https://doi.org/10.1111/dewb.12324>
- Jöbges, S., Kumpf, O., Hartog, C. S., Spies, C., Haase, U., Balzer, F. et al. (2022). Presentation of Ethical Criteria during Medical Decision-Making for Critically Ill Patients: A Mixed Methods Study. *BJA Open*, *2*, Article ID: 100015. <https://doi.org/10.1016/j.bjao.2022.100015>
- Jung, J., Mukherjee, K., Brown, M., & Sadigh, G. (2024). Association between Financial Hardship and Psychological Burden and the Role of Social and Mental Health Support: An Observational Study. *Medicine*, *103*, e38871. <https://doi.org/10.1097/md.000000000038871>
- Kaftański, W., & Hanson, J. (2022). Suffering, Authenticity, and Meaning in Life: Toward an Integrated Conceptualization of Well-Being. *Frontiers in Psychology*, *13*, Article 1079032. <https://doi.org/10.3389/fpsyg.2022.1079032>
- Kałwak, W., Weziak-Białowolska, D., Wendołowska, A., Bonarska, K., Sitnik-Warchulska, K., Bańbura, A. et al. (2024). Young Adults from Disadvantaged Groups Experience More Stress and Deterioration in Mental Health Associated with Polycrisis. *Scientific Reports*, *14*, Article No. 8757. <https://doi.org/10.1038/s41598-024-59325-8>
- Kapp, M. (2015). Evaluating Decision Making Capacity in Older Individuals: Does the Law Give a Clue? *Laws*, *4*, 164-172. <https://doi.org/10.3390/laws4020164>
- Karnik, S., & Kanekar, A. (2016). Ethical Issues Surrounding End-Of-Life Care: A Narrative Review. *Healthcare*, *4*, Article 24. <https://doi.org/10.3390/healthcare4020024>
- Kedzierska Manzoni, A. (2022). Retour Aux Sources? Nouvelles formes de ritualisation et d'expertise rituelle en Afrique et ailleurs. *École pratique des hautes études. Section des sciences religieuses*, *129*, 1-6. <https://doi.org/10.4000/asr.3973>
- Kieselbach, K., Koesling, D., Wabel, T., Frede, U., & Bozzaro, C. (2022). Chronischer Schmerz als existenzielle Herausforderung. *Der Schmerz*, *37*, 116-122. <https://doi.org/10.1007/s00482-022-00632-2>
- Kirshbaum, M. N., Olson, K., Pongthavornkamol, K., & Graffigna, G. (2012). Understanding the Meaning of Fatigue at the End of Life: An Ethnoscience Approach. *European Journal of Oncology Nursing*, *17*, 146-153.

- <https://doi.org/10.1016/j.ejon.2012.04.007>
- Koslander, T., da Silva, A. B., & Roxberg, Å. (2009). Existential and Spiritual Needs in Mental Health Care. *Journal of Holistic Nursing*, 27, 34-42. <https://doi.org/10.1177/0898010108323302>
- Koulayan, N. (2008). Mondialisation et dialogue des cultures: L'Ubuntu d'Afrique du Sud. *Hermès*, 51, 183-187. <https://doi.org/10.4267/2042/24195>
- Kring, L., Iversen, E., Ibsen, B., & Fehsenfeld, M. (2024). Exploring the Impact of Stressful Life Events on Quality of Life: Meaning Making and Narrative Reconstruction. *International Journal of Qualitative Studies on Health and Well-Being*, 19, Article ID: 2330117. <https://doi.org/10.1080/17482631.2024.2330117>
- Kurkowski, S., Heckel, M., Pfaller, L., Peters, J., Bazata, J., Schildmann, E. et al. (2022). Possible Age-Related Differences in Healthcare Professionals' Perspectives on Younger and Older Patients' Autonomy and Decision-Making in the Context of Sedation in Specialised Palliative Care: Exploratory Secondary Qualitative Content and Linguistic Conversation Analysis of Interviews with Healthcare Professionals. *BMC Palliative Care*, 21, Article No. 71. <https://doi.org/10.1186/s12904-022-00963-y>
- Le Breton, D. (2021). De la souffrance d'existence à celle du corps. *Douleurs: Évaluation—Diagnostic—Traitement*, 22, 140-147. <https://doi.org/10.1016/j.douler.2021.04.003>
- Leshchenko, A., Laut, O., Shaulska, H., Yarovi, A., & Makarov, Z. (2023). Existential Aspects of Human Existence and the Human-Centered Paradigm in Public Administration. *Revista Amazonia Investiga*, 12, 361-367. <https://doi.org/10.34069/ai/2023.64.04.38>
- Lewis, J. (2021). Safeguarding Vulnerable Autonomy? Situational Vulnerability, the Inherent Jurisdiction, and Insights from Feminist Philosophy. *Medical Law Review*, 29, 306-336. <https://doi.org/10.1093/medlaw/fwab010>
- Lima, D., Alves, V. L., & Turato, E. (2014). The Phenomenological-Existential Comprehension of Chronic Pain: Going Beyond the Standing Healthcare Models. *Philosophy, Ethics, and Humanities in Medicine*, 9, Article No. 2. <https://doi.org/10.1186/1747-5341-9-2>
- Liu, C. T. X., Menzies, R. E., & Menzies, R. G. (2023). A Systematic Review of Existential Concerns in Borderline Personality Disorder. *Journal of Humanistic Psychology*. <https://doi.org/10.1177/00221678231165792>
- Lloyd, C. S., Af Klinteberg, B., & DeMarinis, V. (2017). An Assessment of Existential Worldview Function among Young Women at Risk for Depression and Anxiety—A Multi-Method Study. *Archive for the Psychology of Religion*, 39, 165-203. <https://doi.org/10.1163/15736121-12341337>
- López-Soto, P., & Santos, M. J. (2023). El problema de la autonomía individual y la autoridad familiar en la toma de decisiones en ética clínica. *Medicina y Ética*, 34, 585-648. <https://doi.org/10.36105/mye.2023v34n3.01>
- Lorenzl, S. (2013). End of One's Life—Decision Making between Autonomy and Uncertainty. *Geriatric Mental Health Care*, 1, 63-66. <https://doi.org/10.1016/j.gmh.2013.04.009>
- Loriol, M. (2017). A Sociological Stance on Fatigue and Tiredness: Social Inequalities, Norms and Representations. *Neurophysiologie Clinique/Clinical Neurophysiology*, 47, 87-94. <https://doi.org/10.1016/j.neucli.2016.12.001>
- Lundvall, M., Palmér, L., Hörberg, U., Carlsson, G., & Lindberg, E. (2022). Finding an Existential Place to Rest: Enabling Well-Being in Young Adults. *International Journal of Qualitative Studies on Health and Well-being*, 17, Article ID: 2109812.

- <https://doi.org/10.1080/17482631.2022.2109812>
- Mackay, K. (2017). Choosing to Live with Harm? A Presentation of Two Case Studies to Explore the Perspective of Those Who Experienced Adult Safeguarding Interventions. *Ethics and Social Welfare, 11*, 33-46. <https://doi.org/10.1080/17496535.2017.1280069>
- Mackenzie, C., & Rogers, W. (2013). Autonomy, Vulnerability and Capacity: A Philosophical Appraisal of the Mental Capacity Act. *International Journal of Law in Context, 9*, 37-52. <https://doi.org/10.1017/s174455231200047x>
- Magomedova, A., & Fatima, G. (2025). Mental Health and Well-Being in the Modern Era: A Comprehensive Review of Challenges and Interventions. *Cureus, 17*, e77683. <https://doi.org/10.7759/cureus.77683>
- Mapes, M. V., DePergola, P. A., & McGee, W. T. (2019). Patient-Centered Care and Autonomy: Shared Decision-Making in Practice and a Suggestion for Practical Application in the Critically Ill. *Journal of Intensive Care Medicine, 35*, 1352-1355. <https://doi.org/10.1177/0885066619870458>
- Marimuthu, P. (2024). Exploring Unconventional Approaches to Morality: An Existentialist Framework. *Social Science and Humanities Journal, 8*, 4498-4507. <https://doi.org/10.18535/sshj.v8i07.1028>
- Marnfeldt, K., & Wilber, K. (2025). The Safety-Autonomy Grid: A Flexible Framework for Navigating Protection and Independence for Older Adults. *The Gerontologist, 65*, gnaf111. <https://doi.org/10.1093/geront/gnaf111>
- McDougall, R., Pratt, B., & Sellars, M. (2023). Ethical Diversity and Practical Uncertainty: A Qualitative Interview Study of Clinicians' Experiences in the Implementation Period Prior to Voluntary Assisted Dying Becoming Available in Their Hospital in Victoria, Australia. *Journal of Bioethical Inquiry, 20*, 71-88. <https://doi.org/10.1007/s11673-022-10224-5>
- Mennella, C., Maniscalco, U., De Pietro, G., & Esposito, M. (2024). Ethical and Regulatory Challenges of AI Technologies in Healthcare: A Narrative Review. *Heliyon, 10*, e26297. <https://doi.org/10.1016/j.heliyon.2024.e26297>
- Menon, S., Entwistle, V. A., Campbell, A. V., & van Delden, J. J. M. (2020). Some Unresolved Ethical Challenges in Healthcare Decision-Making: Navigating Family Involvement. *Asian Bioethics Review, 12*, 27-36. <https://doi.org/10.1007/s41649-020-00111-9>
- Metz, T. (2009). African and Western Moral Theories in a Bioethical Context. *Developing World Bioethics, 10*, 49-58. <https://doi.org/10.1111/j.1471-8847.2009.00273.x>
- Metz, T. (2011). Ubuntu as a Moral Theory and Human Rights in South Africa. *African Human Rights Law Journal, 11*, 532-559.
- Miller, F. G., & Fletcher, J. C. (1993). The Case for Legalized Euthanasia. *Perspectives in Biology and Medicine, 36*, 159-176. <https://doi.org/10.1353/pbm.1993.0079>
- Morberg Jämterud, S. (2022). Acknowledging Vulnerability in Ethics of Palliative Care—A Feminist Ethics Approach. *Nursing Ethics, 29*, 952-961. <https://doi.org/10.1177/09697330211072361>
- Muñoz Terrón, J. M. (2021). Vulnerable Dignity, Dignified Vulnerability: Intertwining of Ethical Principles in End-Of-Life Care. *International Journal of Environmental Research and Public Health, 18*, Article 482. <https://doi.org/10.3390/ijerph18020482>
- Nasir, A., Javed, U., Hagan, K., Chang, R., Kundi, H., Amin, Z. et al. (2025). Social Determinants of Financial Stress and Association with Psychological Distress among Young Adults 18-26 Years in the United States. *Frontiers in Public Health, 12*, Article 1485513. <https://doi.org/10.3389/fpubh.2024.1485513>

- Nel, K. A., & Govender, S. (2022). Existential Positive Psychology (EPP): A Positive Tool for Healing Existential Anxieties in South Africa During, and After, the COVID-19 Pandemic. *International Journal of Environmental Research and Public Health*, 19, Article 10248. <https://doi.org/10.3390/ijerph191610248>
- Ngomane, M. (2019). *Ubuntu: I Am Because You Are. Lessons in African Wisdom*. Harper Collins.
- Nnate, D. A. (2021). Treatment Withdrawal of the Patient on End of Life: An Analysis of Values, Ethics and Guidelines in Palliative Care. *Nursing Open*, 8, 1023-1029. <https://doi.org/10.1002/nop2.777>
- Oakes, M. B. (2023). Ontological Insecurity in the Post-Covid-19 Fallout: Using Existentialism as a Method to Develop a Psychosocial Understanding to a Mental Health Crisis. *Medicine, Health Care and Philosophy*, 26, 425-432. <https://doi.org/10.1007/s11019-023-10157-9>
- Odero, B., Nderitu, D., & Samuel, G. (2024). The Ubuntu Way: Ensuring Ethical AI Integration in Health Research. *Wellcome Open Research*, 9, Article 625. <https://doi.org/10.12688/wellcomeopenres.23021.1>
- Oliveira, A. C. d., & Silva, M. J. P. d. (2010). Autonomia em cuidados paliativos: Conceitos e percepções de uma equipe de saúde. *Acta Paulista de Enfermagem*, 23, 212-217. <https://doi.org/10.1590/s0103-21002010000200010>
- Orentlicher, D., Pope, T. M., & Rich, B. A. (2015). Clinical Criteria for Physician Aid in Dying. *Journal of Palliative Medicine*, 19, 259-262. <https://doi.org/10.1089/jpm.2015.0092>
- Parks, J. A., & Howard, M. (2021). Dying Well in Nursing Homes during COVID-19 and Beyond: The Need for a Relational and Familial Ethic. *Bioethics*, 35, 589-595. <https://doi.org/10.1111/bioe.12881>
- Peterková, H. (2013). Autonomy—A Leading Principle in the End-Of-Life Decision Making? *Journal of Hospital Administration*, 3, 19-23. <https://doi.org/10.5430/jha.v3n2p19>
- Petersen, T. S., & Dige, M. (2022). Critique of Autonomy-based Arguments against Legalising Assisted Dying. *Bioethics*, 37, 165-170. <https://doi.org/10.1111/bioe.13125>
- Pigeon-Gagné, É., Hassan, G., Yaogo, M., & Ridde, V. (2017). An Exploratory Study Assessing Psychological Distress of Indigents in Burkina Faso: A Step Forward in Understanding Mental Health Needs in West Africa. *International Journal for Equity in Health*, 16, Article No. 143. <https://doi.org/10.1186/s12939-017-0633-8>
- Pols, J., Pasveer, B., & Willems, D. (2017). The Particularity of Dignity: Relational Engagement in Care at the End of Life. *Medicine, Health Care and Philosophy*, 21, 89-100. <https://doi.org/10.1007/s11019-017-9787-9>
- Rababah, D. M. (2012). Physician-Assisted Suicide: Legality and Ethicality. *SSRN Electronic Journal*. <https://doi.org/10.2139/ssrn.2063919>
- Ramabu, N. M. (2019). Whose Autonomy Is It? Botswana Socio-ethical Approach to the Consenting Process. *Developing World Bioethics*, 20, 184-193. <https://doi.org/10.1111/dewb.12253>
- Ramose, M. B. (1999). *African Philosophy through Ubuntu*. Mond Books.
- Ramsden, E., & Talbot, C. V. (2024). The Role of Tiktok in Students' Health and Wellbeing. *International Journal of Mental Health and Addiction*, 23, 2180-2202. <https://doi.org/10.1007/s11469-023-01224-6>
- Rogers, W., Mackenzie, C., & Dodds, S. (2012). Why Bioethics Needs a Concept of Vulnerability. *International Journal of Feminist Approaches to Bioethics*, 5, 11-38.

- <https://doi.org/10.3138/ijfab.5.2.11>
- Rosenwohl-Mack, S., Dohan, D., Matthews, T., Batten, J. N., & Dzung, E. (2021). How Individual Ethical Frameworks Shape Physician Trainees' Experiences Providing End-Of-Life Care: A Qualitative Study. *Journal of Medical Ethics, 47*, e72. <https://doi.org/10.1136/medethics-2020-106690>
- Roy, P., Muhamad, M. M., & Che Amat, M. A. B. (2023). Existential Crisis among University Students in Bangladesh. *International Journal of Academic Research in Progressive Education and Development, 12*, 676-690. <https://doi.org/10.6007/ijarped/v12-i2/16989>
- Russo-Netzer, P. (2025). Positive Anxiety: Existential Authenticity as a Pathway to Well-Being. *The Journal of Positive Psychology, 20*, 823-833. <https://doi.org/10.1080/17439760.2025.2498128>
- Sambrizzi, E. A. (2022). Un Proyecto de ley que admite la eutanasia activa. *Prudentia Iuris, 93*, 271-285. <https://doi.org/10.46553/prudentia.93.2022.pp.271-285>
- Sanchini, V., Sala, R., & Gastmans, C. (2022). The Concept of Vulnerability in Aged Care: A Systematic Review of Argument-Based Ethics Literature. *BMC Medical Ethics, 23*, Article No. 84. <https://doi.org/10.1186/s12910-022-00819-3>
- Sayid Ahmad, M., & Peled Raz, M. (2025). End of Life Care Preferences in the Arab Population in Israel—Bridging the Gap between Unfounded Assumptions and Autonomous Wishes. *BMC Medical Ethics, 26*, Article No. 42. <https://doi.org/10.1186/s12910-025-01201-9>
- Schäfer, S. K., Kunzler, A. M., Kalisch, R., Tüscher, O., & Lieb, K. (2022). Trajectories of Resilience and Mental Distress to Global Major Disruptions. *Trends in Cognitive Sciences, 26*, 1171-1189. <https://doi.org/10.1016/j.tics.2022.09.017>
- Schäfer, S. K., Supke, M., Kausmann, C., Schaubrich, L. M., Lieb, K., & Cohrdes, C. (2024). A Systematic Review of Individual, Social, and Societal Resilience Factors in Response to Societal Challenges and Crises. *Communications Psychology, 2*, Article No. 92. <https://doi.org/10.1038/s44271-024-00138-w>
- Schweizer, S., Lawson, R. P., & Blakemore, S. (2023). Uncertainty as a Driver of the Youth Mental Health Crisis. *Current Opinion in Psychology, 53*, Article ID: 101657. <https://doi.org/10.1016/j.copsyc.2023.101657>
- Seedsman, T. (2019). Aging, Informed Consent and Autonomy: Ethical Issues and Challenges Surrounding Research and Long-Term Care. *OBM Geriatrics, 3*, 1-30. <https://doi.org/10.21926/obm.geriatr.1902055>
- Segú-Odriozola, M. (2025). The Mental Health of University Students: A Social Ecology Perspective. *Societies, 15*, Article 110. <https://doi.org/10.3390/soc15040110>
- Shahiefisally, M. (2025). Euthanasia in Singapore: Laying the Push for Legalisation to Rest. *SSRN Electronic Journal*. <https://doi.org/10.2139/ssrn.5031592>
- Sharif, T., & Bugo, J. (2015). The Anthropological Approach Challenges the Conventional Approach to Bioethical Dilemmas: A Kenyan Maasai Perspective. *African Health Sciences, 15*, 628-633. <https://doi.org/10.4314/ahs.v15i2.41>
- Sjöstrand, M., Helgesson, G., Eriksson, S., & Juth, N. (2011). Autonomy-Based Arguments against Physician-Assisted Suicide and Euthanasia: A Critique. *Medicine, Health Care and Philosophy, 16*, 225-230. <https://doi.org/10.1007/s11019-011-9365-5>
- Slimmen, S., Timmermans, O., Mikolajczak-Degrauwe, K., & Oenema, A. (2022). How Stress-Related Factors Affect Mental Wellbeing of University Students a Cross-Sectional Study to Explore the Associations between Stressors, Perceived Stress, and Mental Well-being. *PLOS ONE, 17*, e0275925. <https://doi.org/10.1371/journal.pone.0275925>

- Sossauer, L., Schindler, M., & Hurst, S. (2019). Vulnerability Identified in Clinical Practice: A Qualitative Analysis. *BMC Medical Ethics*, 20, Article No. 87. <https://doi.org/10.1186/s12910-019-0416-4>
- Spicer, J., Ahluwalia, S., & Shah, R. (2021). On Challenges to Respect for Autonomous Decision Making in Primary Care. *Clinical Ethics*, 17, 458-464. <https://doi.org/10.1177/14777509211069908>
- Spitale, G., Schneider, G., Germani, F., & Biller-Andorno, N. (2023). Exploring the Role of AI in Classifying, Analyzing, and Generating Case Reports on Assisted Suicide Cases: Feasibility and Ethical Implications. *Frontiers in Artificial Intelligence*, 6, Article 1328865. <https://doi.org/10.3389/frai.2023.1328865>
- Staats, K., Svendsen, S. J., & Lockertsen, V. (2025). Navigating toward Acceptance of Death: Home-Dwelling Patients in the Palliative Phase. *BMC Palliative Care*, 24, Article No. 71. <https://doi.org/10.1186/s12904-025-01707-4>
- Stavert, J. (2020). Respecting the Autonomy of the Living and Dying. *Journal of Integrated Care*, 28, 379-385. <https://doi.org/10.1108/jica-06-2020-0038>
- Strang, P., Strang, S., Hultborn, R., & Arnér, S. (2004). Existential Pain—An Entity, a Provocation, or a Challenge? *Journal of Pain and Symptom Management*, 27, 241-250. <https://doi.org/10.1016/j.jpainsymman.2003.07.003>
- Tahmasebi, M. (2023). Ethics and Palliative Care: A Case of Patient's Autonomy. *Journal of Medical Ethics and History of Medicine*, 15, Article 16. <https://doi.org/10.18502/jmehm.v15i16.11574>
- Takala, T. (2007). Concepts of “Person” and “Liberty”, and Their Implications to Our Fading Notions of Autonomy. *Journal of Medical Ethics*, 33, 225-228. <https://doi.org/10.1136/jme.2006.016816>
- Țenea-Cojan, Ș., Dinescu, V., Gheorman, V., Dragne, I., Gheorman, V., Forțofoiu, M. et al. (2025). Exploring Multidisciplinary Approaches to Comorbid Psychiatric and Medical Disorders: A Scoping Review. *Life*, 15, Article 251. <https://doi.org/10.3390/life15020251>
- Thompson, G. A., Segura, J., Cruz, D., Arnita, C., & Whiffen, L. H. (2022). Cultural Differences in Patients' Preferences for Paternalism: Comparing Mexican and American Patients' Preferences for and Experiences with Physician Paternalism and Patient Autonomy. *International Journal of Environmental Research and Public Health*, 19, Article 10663. <https://doi.org/10.3390/ijerph191710663>
- van Bruchem-Visser, R. L., van Dijk, G., de Beaufort, I., & Mattace-Raso, F. (2020). Ethical Frameworks for Complex Medical Decision Making in Older Patients: A Narrative Review. *Archives of Gerontology and Geriatrics*, 90, Article ID: 104160. <https://doi.org/10.1016/j.archger.2020.104160>
- van der Geest, S., & Satalkar, P. (2019). Autonomy and Dying: Notes about Decision-Making and “Completed Life” Euthanasia in the Netherlands. *Death Studies*, 45, 613-622. <https://doi.org/10.1080/07481187.2019.1671543>
- Vogelstein, E. (2017). Evaluating the American Nurses Association's Arguments against Nurse Participation in Assisted Suicide. *Nursing Ethics*, 26, 124-133. <https://doi.org/10.1177/0969733017694619>
- Walter, J. K., & Ross, L. F. (2014). Relational Autonomy: Moving Beyond the Limits of Isolated Individualism. *Pediatrics*, 133, S16-S23. <https://doi.org/10.1542/peds.2013-3608d>
- White, B. P., Willmott, L., & Close, E. (2022). Better Regulation of End-Of-Life Care: A Call for a Holistic Approach. *Journal of Bioethical Inquiry*, 19, 683-693. <https://doi.org/10.1007/s11673-022-10213-8>

- Wilson, P. M., & Appel, S. W. (2013). Existential Counselling and Psychotherapy and Māori Clients. *Asia Pacific Journal of Counselling and Psychotherapy*, 4, 137-146. <https://doi.org/10.1080/21507686.2013.822400>
- Wong, P. T. P., & Laird, D. (2023). Varieties of Suffering in the Clinical Setting: Re-Envisioning Mental Health Beyond the Medical Model. *Frontiers in Psychology*, 14, Article 1155845. <https://doi.org/10.3389/fpsyg.2023.1155845>
- Wong, P. T. P., & Yu, T. T. F. (2021). Existential Suffering in Palliative Care: An Existential Positive Psychology Perspective. *Medicina*, 57, Article 924. <https://doi.org/10.3390/medicina57090924>
- Yedidia, M. J. (2006). Transforming Doctor-Patient Relationships to Promote Patient-Centered Care: Lessons from Palliative Care. *Journal of Pain and Symptom Management*, 33, 40-57. <https://doi.org/10.1016/j.jpainsymman.2006.06.007>