# Psychiatric Euthanasia in the Netherlands: A Critical Scientific and Clinical Examination

What the evidence, outcomes, and documented practice reveal

## 1. Foreword & Objectives

Over a year ago, I read an article about the planned euthanasia of a 28-year-old Dutch woman called Zoraya because of depression, some autism and personality disorder [1]. She seemed an intelligent person, completely autonomous with no physical limitations or cognitive impairments, who went shopping twice a week and watched television like the rest of us, who lived in her own home with a loving partner and two cats [2]. I was dumbstruck that a doctor, a rational science-driven professional, would someday approach her and intentionally kill her [3]. Having no religious beliefs except my belief in science, logic, and common sense, euthanasia seems, in my humble opinion, a humane thing to do in agonizing, irreversible and intolerable situations with no possibility of improvement. That is exactly what is stated in Dutch law, that euthanasia is only allowed in cases of untreatable, irreversible medical conditions with no prospect of improvement that cause intolerable suffering [4]. In the meantime, I learned this young woman's euthanasia was not an isolated case, but that psychiatric euthanasia is quite common and is carried out on more than 200 patients a year in the Netherlands [5]. One of the patients awaiting euthanasia is a 40-year-old mother of two young children who has suffered from severe depression since giving birth; before she goes through with it, though, she is scheduled to have a meeting where her psychiatrist and a grief counselor will explain to her children why their mother must be killed [6]. I came across a report of the euthanized psychiatric patients at the Expertise Center Euthanasia in the Netherlands, and read all 140 pages of it [7]. The primary diagnoses of those euthanized were related to mood disorders, trauma or stress (victims of sexual abuse, bullying, violence, or other traumatic events), schizophrenia, bipolar disorder, personality disorders, anxiety, obsessive-compulsive disorder, autism, attention deficit hyperactivity disorder, addictive disorders, or a combination of these. Astonishingly, eating disorders, somatic symptom disorder (a condition where a patient feels significant physical symptoms that cause distress and affect daily life, but which cannot be fully explained by a medical condition) or post-partum depression have also led to euthanasia. Even persistent genital arousal disorder and the inability to orgasm have led to euthanasia discussions with doctors [8]. How could physicians like me condone, support, and even actively participate in this? My feelings of anger and incomprehension were so deep and conflicting towards this practice, so irreconcilable with my idea of science-driven Medicine, that I felt compelled to approach the issue the only way I could, i.e. scientifically. Thus, the aim of this paper is to critically evaluate and synthesize all the available data on the subject of psychiatric euthanasia, i.e. euthanasia for mental reasons in non-senile patients without any physical illness.

## 2. Materials & Methods

I decided to restrict myself to facts, numbers and evidence, in order to reach any kind of conclusion and get some insight into this. The following evidence is the result of a 18-months-long investigation. Inclusion criteria comprised peer-reviewed articles published in any language (but mostly English and Dutch), encompassing the relevant medical literature to date (November 2025) about euthanasia for psychiatric reasons, patient interviews, including assessments of renowned key opinion leaders in psychiatry and Nobel Laureates. Given the large volume of data, the most relevant findings and issues are summarized by topic in the results.

## Results

### 3. Some of the most recent known cases of psychiatric euthanasia: the tip of the iceberg

Zoraya ter Beek, 29 years old, was euthanized due to chronic depression, anxiety and trauma due to bullying and personality disorder and was a supporter of euthanasia for psychiatric reasons and gave talks about it; she lived her entire adult life (last 10 years) with a loving supportive partner in her own home; she did not receive any other treatments in the 4 years prior to her euthanasia, yet she was judged to be suffering intolerably and considered incurable. One of the top experts publicly supported her euthanasia [1,2,9,10].

Milou Verhoof, 17 years old, was euthanized due to suicidal depression triggered by social media use; her mother felt that she was suffering from post-traumatic stress disorder rather than depression, as she had also been sexually assaulted during those vulnerable years; certain therapies couldn't be done immediately due to years-long waiting lists; One of the top experts, who was never the patient's attending physician, accelerated the euthanasia authorization and performed the euthanasia himself [6,11].

Romy, 21 years old, suffered a traumatic experience, then ADHD and some eating disorders; access to therapy facilities was complicated by the requirement to resolve personality issues first, waiting lists are too long, and in the end she was euthanized. The family contacted the same top expert that euthanized Milou Verhoof. He readily offered his services to accelerate the euthanasia process [12,13].

Contrary to what one might think, these three young girls were autonomous, independent, not cognitively impaired, and had friends and social media accounts. The published judgements by the Regional Euthanasia Review Committees for some of the euthanized psychiatric cases include a significant number of minors with psychiatric disease, many sexual abuse victims who couldn't overcome their trauma, lonely and socially isolated patients, etc [14]. These patients were not only affected by their psychiatric conditions, but were also impacted by histories of abuse (the Netherlands has one of the highest sexual abuse rate of minors in the EU [15]), sometimes under psychiatric care [16], and a fragmented healthcare system.

**4. Euthanasia for psychiatric reasons does not prevent suicides but increases the number of dead patients**

One of the main arguments for psychiatric euthanasia is that assisted dying would reduce the number of violent and traumatic suicides [17,18]. But Dutch statistics tell a different story. According to the Centraal Bureau voor de Statistiek (Dutch statistics bureau), the suicide rate in the Netherlands is not decreasing. In fact, it has risen steadily for people up to the age of 40, reaching its highest level in the last two decades [19]. While the percentage of euthanasias in the total number of deaths has increased from 1.6% in 2007 to 4.8% in 2021, the number of suicides has also increased, from 8.3 per 100,000 inhabitants in 2007 to 10.6 in 2021, a 27% increase [17]. Thus, there is no evidence that psychiatric euthanasia reduces suicides, as falsely stated or indirectly promoted by the Expertise Center Euthanasia or the new KEA Foundation dedicated exclusively to the euthanasia of psychiatric patients [20]. Several international studies and Dutch experts have also shown that the availability of euthanasia or assisted suicide does not reduce the number of non-assisted suicides or self-harm, but, on the contrary, increases the number of non-assisted suicides in comparison to similar neighboring countries that do not have psychiatric euthanasia, in particular for women [17,21–23]. Estimations point that assisted suicide laws increase self-chosen deaths by 18%, and in cases of women by 40% [24]. Consequently, the availability of euthanasia for psychiatric reasons attracts and encourages people to be euthanized who would otherwise not die by suicide. That's why former eminent supporters of psychiatric euthanasia retracted themselves about it: "By taking this bold step (of allowing psychiatric euthanasia), I thought we would be able to regulate suicide, limiting the all too frequent cases where a person takes his or her own life. I was mistaken." [17]. Looking at the World Bank data, we can also see that the Netherlands, along with Belgium, has one of the highest suicide rates among the female population in the European Union, and it is rising [25]. Additionally, in the last 10 years, the prevalence of psychiatric disease has increased from 17.4% to 26.1%, which is not explainable by the COVID pandemic [26]. Moreover, when the "psychiatric euthanasia experts" are faced with acute suicidal patients, besides offering euthanasia, they don't provide any useful suicide prevention, having several suicides under their belt [27]. This indirectly suggests that the country lacks the expertise to properly care for psychiatric patients compared to other EU countries. In addition to higher and increasing numbers of suicides, the total number of deaths increases further when euthanized psychiatric patients are added. Dutch researchers already presented evidence that the increase in non-assisted suicides and in psychiatric euthanasia represents an almost 50% increase in self-chosen deaths in the Netherlands over the past 10 years [28].

Meanwhile, the psychiatric euthanasia experts want to reduce suicide attempts by making euthanasia readily available. However, for every suicide death, there are approximately 20-30 suicide attempts [29–31]. Even after eliminating repeated attempts by the same person, if you multiply this new number by the 1862 suicide deaths in 2023 in the Netherlands [19], you will get a number in the tens of thousands of potentially euthanizable patients. That means tens of thousands of additional deaths per year by making euthanasia easily available. That's what these experts are going to achieve, and they're not afraid to put it in writing [20].

**5. Up to 25 psychiatric patients who apply for euthanasia must be euthanized to prevent a single suicide**

Available Dutch institutional data already allows this conclusion. The report from the Expertise Center Euthanasia shows that among 1553 psychiatric patients who applied for euthanasia, including 891 rejected cases, only 59 (3.8%) died by suicide, while over 300 withdrew their requests and remained alive [6,7]. This demonstrates that suicide is relatively rare even in this high-risk group. The number needed to harm may be as severe as 5, based only on patients who withdrew their requests after waiting for too long. But bearing in mind the full cohort and ongoing trends toward broader eligibility and accelerated procedures, the number needed to harm may be closer to 25, considering the suicide prevalence in all 1553 patients. In other words, for every suicide potentially avoided, at least 25 lives will have been prematurely ended, most of whom might otherwise have survived or recovered. This raises an ethical question: Is it acceptable to euthanize so many people just because a fraction of them (less than 4%) commit suicide? Moreover, how many of the 149 euthanized patients might have changed their minds without committing suicide if given more time or access to evidence-based treatments?

**6. Lack of suicide prevention and support for families: enter psychiatric euthanasia**

Recent information shows that there are barriers and challenges to effective implementation of suicide prevention practices in the Netherlands. Budget cuts, staff and time limitations, increased workload of mental health services, provision of substandard services, their operational isolation and lack of communication with other health care providers or institutions, failure of mental health professionals to follow an agreed treatment plan or sometimes simply abandoning the patient, hinders recovery or creates feelings of rejection in the patient [26,27,32]. The collapse of support structures, whether unforeseen closures or for reallocation of resources, has left many patients without stabilizing routines or therapeutic continuity. In several cases, such disruptions directly preceded psychiatric decline and led to psychiatric euthanasia requests [16,33]. This lack of psychiatric care is further underscored by the mass lawsuit filed in May 2024 by patients and mental health professionals against the state and health insurers over "unacceptably long" waiting lists for people in need of psychiatric care [34]. Enter the Expertise Center Euthanasia and the KEA Foundation. Both claim to focus on the well-being of patients, yet there is not a single word, recommendation or advice on their institutional websites regarding suicide prevention [35,36]. There is even a button in their website “You are looking for help”, but instead of providing or directing the reader to any suicide prevention or mental health support websites, it rather informs how hopeless and unbearable suffering can be and euthanasia might be justified, as well as advising on how to obtain it [37]. The KEA Foundation has even stated that its goal is to enable and provide more euthanasia for psychiatric patients and also to reduce suicides and suicide attempts by making euthanasia more readily available [36]. On the one hand, these doctors and institutions claim that euthanasia prevents suicides by providing a safe way for resolute suicidal patients to die and avoiding the traumatic experience for them and their families of a potentially violent and unexpected death. On the other hand, if the patients are too afraid to commit suicide by themselves, euthanasia offers the same safe and comfortable way to die in an environment where there is no fear of dying or feeling pain. So, whether suicidal patients have the courage to kill themselves or not, Medicine is now making sure that these patients end up dead.

Surprisingly, while the Expertise Center Euthanasia or the KEA Foundation do not refer patients to suicide prevention services, the opposite is true. The national organization for suicide prevention in the Netherlands, the 113 Suicide Prevention Foundation, has an entire webpage dedicated to the Expertise Center Euthanasia, with several topics about it, such as what the Expertise Center Euthanasia is, how it works, and how long the euthanasia process takes [38]. The 113 Suicide Prevention Foundation openly states that it does not oppose euthanasia or assisted suicide, and advises patients whom to contact to learn more [39]. This foundation is also a well-known supporter of the Zero Suicide Initiative, where several countries have come together to provide better suicide prevention in mental health care [40,41]. Considering that the Foundation’s stated mission is “a country in which no one dies lonely and desperate by suicide” [39], their provision of detailed information about euthanasia and direct referral to euthanasia providers [38], raises the question of whether their interpretation of the Zero Suicide Initiative might encompass a vision in which suicide is not prevented, but instead medically facilitated.

There are also other institutions such as ThaNet [42], whose mission statement is to ensure that "everyone with psychological complaints has the right to a good conversation about death if they want it, through mental health care" [43]. However, Thanet's goal is also to promote "a fundamental cultural change" where participating in death becomes normal and more accessible for people with psychiatric illness and persistent death wishes. It also wants to "solve practical and organizational problems", such as "committing to have more psychiatrists carry out second opinions in the context of a euthanasia process" and speed up the process [43]. The current president of ThaNet goes so far as to offer an unusual form of hope: "I offer hope for a 'good' dying process" [44]. Some of the management members of ThaNet even appeal to stop psychiatric treatments and go for euthanasia: "…don't keep pushing and trying; stop proposing any further treatments…(euthanasia) is absolutely preferable" [18]. This institution, besides partnering with the Dutch Psychiatry Association, the Dutch GGZ (Dutch Association of Mental Health Care) is also associated with the Expertise Center Euthanasia, The Kea Foundation and even the 113 Suicide Prevention Foundation. In addition to promote the death of treatable patients and appealing them to stop psychiatric treatments, ThaNet also receives financial support from the Dutch Ministry of Health, Welfare and Sport [43,45].

**7. Loneliness and socioeconomic hardship in psychiatric euthanasia**

Many patients mentioned so far have some kind of family support or loved ones. However, there is a silent majority who is suffering from loneliness and requests euthanasia: 70.1% of all applicants to the Expertise Center Euthanasia were single and only 11.4% were married, in comparison to 39% of the Dutch population [7]. Social data is sometimes missing in the studies, but at least 56% of patients euthanized for psychiatric reason mentioned loneliness and social isolation with comments in their files stating that: "the patient was an utterly lonely man whose life had been a failure…" or "the patient indicated that she had had a life without love and therefore had no right to exist" [46]. These lonely people ended up being euthanized. Some are desperately longing for human contact and love, as one of the explicit cases in the Euthanasia Center's report makes clear: "[I want] to know what it is to be in love". He too was considered to be suffering hopelessly and was approved for psychiatric euthanasia [7].

Economic reasons and income have also been demonstrated to be a reason for people to request euthanasia. 88% of the applicants for psychiatric euthanasia received benefits in some form and didn't have an income or salary [7]. Other Dutch authors have also pointed out that the additional burden of financial and socio-economic difficulties and inequalities has increased patients' desire for psychiatric euthanasia [47].

**8. An 18:1 gender disparity – young women are euthanized 6 times *more* than men, but commit 3 times *less* suicide**

The suicide rate of young women (20-40 years old) in the Netherlands is 2.5-3 times *lower* than that of men in the same age group [19,25,30]. However, young women in this group, i.e. Zoraya's group, were euthanized 5-6 times *more* often than young men [7]. This results in a gender disproportion of up to 18:1 between young women who are euthanized for psychiatric reasons and young men who commit suicide. The stark difference between psychiatric euthanasia and suicide rates among young women and men points to potential systemic issues and biases that need urgent attention. A higher tendency for women to request more often euthanasia than men is already known, with studies linking assisted suicide laws to a 40% increase in self-chosen deaths among women and a disproportionate risk of premature mortality [22,24]. Bad as this evidence might be for women, it is even worse in the case of psychiatric euthanasia. Two thirds of the patients euthanized in the Expertise Center Euthanasia report were women. Higher euthanasia rates in women may reflect the disempowerment of those who are more vulnerable to social pressure to die by suicide – for example, through feeling a burden to relatives or society [21,24]. And it is a fact that women are overrepresented in almost all age group groups. Apart from the 41-50 years age group where men were slightly over 20% more euthanized than women, in all the older age groups over 50, women were sometimes 2 to 3 times more often euthanized for psychiatric reasons than men. However in the younger age groups that difference is even more pronounced, where 21- to 40-year-old women are 5 to 6 times more often euthanized than men [7]. Many of these young women would still be alive today if it weren't for the euthanasia services provided by certain doctors (including psychiatrists) or the staff of the Expertise Center Euthanasia or the KEA Foundation.

**9. Disagreements, inconvenience and eagerness to reduce waiting lists for psychiatric euthanasia kills even more patients**

When Dutch experts disagree about the decisional competence of patients or the utility of new treatments, in most cases euthanasia is performed anyway, leaving the disagreements unresolved [46]. And in those rare cases where these Dutch experts are able to recognize that another therapy could be performed, they frequently proceed with euthanasia nevertheless, because there are no vacancies in a treatment facility at the moment, or, if a vacancy does exist, they argue that admission might destabilize the patient (even in the case of euthanized minors), or they consider the patient not sufficiently motivated for therapy, or even overruling other colleagues that suggest other treatments [5,7,48–50].

Measures are being taken to shorten the waiting period between the formal request for euthanasia and its execution. The experts argue that the long waiting period is not humane for those who are suffering and because of the risk of suicide [18,27,51,52]. However, data from the Expertise Center Euthanasia directly contradicts this justification. Of the 1553 patients who registered for psychiatric euthanasia, only 59 died by suicide while waiting, whereas more than 300 later changed their minds and chose to live [7]. Independent studies confirm that longer waiting times are associated with a substantial number of patients abandoning their euthanasia request [6,53]. During this time, many experienced a reduction in suicidal intent, reconsidered death or began treatment, demonstrating that what is declared irreversible suffering is often neither irreversible nor stable. In the name of suicide prevention and relief from suffering, euthanasia is nonetheless increasingly approved for patients, resulting in hundreds of additional deaths among those who might have chosen to live, even after being denied evidence-based treatment. It's a mathematical certainty.

**10. Lack of psychiatric support, false assumption of untreatability, and false dichotomy create Kafkaesque institution for children**

There is a foundation called "Letting go in love" (In liefde laten gaan), to support any parent of a child who is about to be euthanized or has already been euthanized due to mental illness [54]. The stated goals are to support parents through mutual contact, to provide information to parents and professionals, and to promote public understanding of euthanasia for mental illness in children [55]. The very existence of such a foundation only reinforces the incorrect assumption of untreatability, reinforces the false dichotomy of either suffering endlessly or dying, and wrongly reinforces the hopelessness of parents. Their activities cause parents to focus their minds and ultimately their children's lives solely on death, distracting them and indirectly preventing these parents from using their remaining energies and resources to find the right help for their children, to demand better mental health care, better suicide prevention and support, and to fight for their children's lives. The stories and experiences shared on their website are heartbreaking, yet the titles try to convene a feeling of beauty, serenity and peace: "She came in love and left in love", "Tomas (23) was happy that he could stop", "Esther's last wish" [56]. Some of its members even claim that euthanasia can be a beautiful path [57]. The symbol of the institution? A couple of butterflies, an image that recurs repeatedly in accounts of many euthanized young patients and their families during their interviews [11,13,57–59]. There are even animations with the names of euthanized children and young adults flying with butterflies to the background sound of piano music [60]. Could this be a sign of institutional contagion, shaping the perceptions of death in young individuals or their families who are already vulnerable? Interestingly, the only two psychiatrists on the foundation's advisory board are considered to be the two top Dutch experts on psychiatric euthanasia [27,61,62].

**11. Children's and young adults' brains aren't fully developed yet but are already condemned as irrecoverable**

The brain, the organ that harbours psychiatric disease, continues to develop and mature throughout adolescence and early adulthood, with the areas responsible for decision-making, planning, and impulse control, being one of the last to change and mature, completing its development in the mid-20s [63]. Personality traits continue to develop through young adulthood and often stabilize around the age of 30 with increases in social dominance, conscientiousness, and emotional stability, especially in young adulthood (up to the age of 40). Personality traits tend to stabilize with age, but they can still change in response to significant life events or efforts towards self-improvement [64,65]. Diffusion MRI studies demonstrate that human brain maturation, including networks governing judgment, impulse

control, and emotional regulation, continues into the mid-30s, indicating that neurobiological development is not complete before that age [66,67]. Thus, the brain development and personality traits aren't even complete in young adults, let alone in children and teenagers. The two top Dutch experts in psychiatric euthanasia are both child and adolescent psychiatrists, yet they consider these children and young adults untreatable and beyond any help.

**12. Supporters of psychiatric euthanasia suffer from false dichotomy**

There is a reasoning ailment that affects most of these patients, their families and the doctors supporting and enabling psychiatric euthanasia. This ailment is called false dichotomy or false dilemma. False dichotomy occurs when only two choices are presented when more exist. These people believe that either the patients will continue to suffer intolerably their whole life or they must die (through suicide or euthanasia) to avoid it. "I have no other option but to end my life", "dying is the solution", "the thought (of euthanasia) brings me peace...that I don't have to suffer anymore" [2,6]. However, there is clearly a third option or even more, including: first, the option of doing disease-specific, adapted, controlled and supervised evidence-based treatment regimens, which these patients didn't do, as widely demonstrated [68,69]; second, the option of spontaneous recovery seen, for example, in long-term major depression without disease-specific treatments, also demonstrated to happen over several years, sometimes in up to 50% of patients [70,71]; third, the option of not wanting to die anymore, as has happened to several hundreds of patients that were considered eligible and accepted for euthanasia, but withdrew their psychiatric euthanasia requests by their own decision after a prolonged waiting period [7]. Renowned doctors supporting psychiatric euthanasia declared that "the chance of a recovery after years of unsuccessful treatment is depressingly slim, thus patients either suffer unbearably, or they commit suicide", "euthanasia for psychological suffering is a choice between two evils", "it was clear to me after just one conversation that Michel had no other option than to take his own life (or suffer unbearably)", "Mental illness kills you only by suicide and if you don't want that, you are left with euthanasia", "...euthanizing someone so young is very sad, but compared to suicide, I know what I prefer. I'm relieved", "…there is no better alternative (to euthanasia)", "she has no choice at all", "…we have nothing left to offer except death." [6,49,62,72,73]. This clearly demonstrates the dichotomy fallacy afflicting these professionals too. However, when psychiatric euthanasia is available, patients with death wishes or with treatment fatigue leading to death wishes [6,11] often become fixated on the possibility of euthanasia, further reinforcing this false dichotomy, thus denying these patients to see all the other positive life-affirming options.

**13. Psychiatric euthanasia is presented as normal, beautiful, glamorous or even an act of love**

Similar to suicide, there are attempts by some patients, family members, doctors and even institutions to embellish the practice, to destigmatize, glamorize or romanticize the idea of psychiatric euthanasia in young people as something normal or even beautiful, a special privilege: "I feel honored that I am allowed to go", "(euthanasia) can be a beautiful path", "The euthanasia was beautiful", "Euthanasia is a very beautiful road, a special and intimate one" [11,16,18,36,54,57,74]. There are others who view it as something admirable, even courageous, conflating despair with autonomy, and say things like: "I have so much admiration for how you're doing this. It's so incredibly brave and strong […] I wish you strength and courage" [59]. Some psychiatrists go so far as to consider the euthanasia of these patients to be a virtuous act [72,75]. There is, for instance, a PhD thesis about euthanasia for psychiatric patients whose title is "the art of letting go" [48]. One of the known experts even claims "The word death is beautiful" [76]. Many supporters of psychiatric euthanasia consider the killing of these patients an act of love. This attitude can be seen in several journal articles published where titles and statements such as these appear: "She came in love and left in love", "he has to let me go out of love", "She was born out of love, and we let her go in love", "How incredibly strong their love must be to be able to let go of their daughter" [13,58,59,77]. The phrase "sometimes when you love someone, you have to let them go" is even misinterpreted by patients requesting psychiatric euthanasia, where the concept of letting go becomes an acceptance of death rather than continued life apart [1,13].

**14. The contagion of psychiatric euthanasia, its promotion by doctors and institutions**

Contagion in mental illness refers to the phenomenon whereby symptoms or behaviors associated with a mental disorder spread from one person to another, often through close contact or social interactions, or even through the media. Zoraya's best friend committed suicide at the age of 16, hence there was that suicidal contagion [1,9]. But there also seemed to be a psychiatric euthanasia contagion. Zoraya had close contact with several other people who were euthanized before her, people she called friends ("My friends who preceded me in euthanasia...") [78]. Some researchers consider the euthanasia law for mental diseases itself to have introduced a novel form of death-seeking behavior, potentially aligning with the traditional contagion effect observed in suicidality [33]. This contagion is increased by the public promotion of psychiatric euthanasia by certain doctors and institutions in the Netherlands. The websites of the Expertise Center Euthanasia or the KEA Foundation, are filled with messages promoting and reassuring psychiatric euthanasia as something perfectly normal, claiming that it is an integral part of clinical practice, that euthanasia doesn't mean failure, and that current medicine is not there yet [35,36]. They are filled with patient histories, especially of young patients who have been euthanized, podcasts, interviews, or even angry statements from psychiatric patients with persistent death wishes when confronted with people who want them to undergo further treatments. The subtext is there's no future for the patient, that the suffering is unbearable and that euthanasia is the right path: "…at some point you have already had all the reasonable treatments that can still be applied and are exhausted. That in principle you do not want to die, but that death is your only way out of your great suffering" [79]. These institutions even offer "buddies" providing attention, understanding, even offering to contact family members about the patient's death wish, to make them understand why the patient wants to die. These "buddies" choice of words make them seem a mentor or a personal trainer encouraging their "athlete" to go on and pursue euthanasia. Obituaries like "Romy (21) chooses euthanasia: 'Life was not made for me.' She left life in the presence of her family holding hands with her mother" seem to embellish the practice and elicit sympathy [12]. The website presents information that consistently promotes the practice of psychiatric euthanasia. Unlike the advertisement of other services or goods, such as a new medical treatment, a trip to the Bahamas, or a new car, these professionals and institutions promote psychiatric euthanasia, attracting and convincing vulnerable, mentally unstable, and highly persuadable people to seek their services, and ultimately killing them. The KEA Foundation even puts patients in touch with other patients who want psychiatric euthanasia, as stated in their goals: "…to contact with fellow sufferers is setting up a forum where psychiatric patients with a wish for euthanasia can find each other…[…] It also offers groups of relatives the opportunity to exchange their experiences surrounding the (upcoming) death of their loved ones" [20]. Facilitating contact between patients who share a desire for psychiatric euthanasia may reinforce existing death-ideation through peer influence, a concern already raised among professionals in psychiatry [33,71]. In such settings, ambivalent patients uncertain about euthanasia are more prone to confirmation bias and social reinforcement, increasing the likelihood they proceed with euthanasia. What initially appears as isolated symbolism reappears repeatedly and with striking consistency across patients, institutions, and public narratives surrounding psychiatric euthanasia. For example, many of these young patients and family members talk about butterflies, saying they feel like trapped butterflies, want to reincarnate as butterflies, want butterflies in their funerals, had butterflies tattooed on them and on family members, and so on [11,13,57–59]. What is the likelihood that these cases are unrelated? The pattern may reflect a form of self-fueled contagion, potentially indicative of a Werther effect contributing to clusters of psychiatric euthanasia, similar to suicide clusters.

In sharp contrast to the promotion of euthanasia for mental reasons, the promotion of suicide is a crime in the Netherlands, according to article 294 of the Dutch Penal Code (Wetboek van Strafrecht) [80]. This law is designed to protect vulnerable people, such as those suffering from mental illness, emotional distress, or suicidal ideation, and to prevent them from taking their own lives, as well as to prevent the risk of suicide contagion or copycat suicides. However, the websites of the Euthanasia Expert Center and the KEA Foundation, as well as many experts and blogs by doctors, promote psychiatric euthanasia, planting thoughts and mental seeds in vulnerable minds or reinforcing already suicidal minds, adding a silver lining to the practice of killing these treatable patients [10,35,36,54].

**15. When support fails: Families and partners accept psychiatric euthanasia amid despair and fear of suicide**

It's puzzling how partners and family members of psychiatric patients, especially parents, would accept euthanasia for their young or adult children [11,13]. Sometimes, they even expressed gratitude for the procedure and the doctors who performed it [2,6,72,81,82]. The explanation is that mental illness affects the patient, but can also create an atmosphere that burdens and wears down those around the patient, family, partners, and even treating physicians. Because of this prolonged and exhausting state, everyone involved and close to the patient can get caught up in the microenvironment and mindset created by the illness. Everybody is feeling helpless and lacking the proper support for their loved one as well as for themselves. In interviews with these patients and their parents, recurring institutional obstacles for a healthy recovery are laid bare. There are yearlong waiting lists for the few available treatment places that provided no effective treatments: "We were constantly running into extremely long waiting lists", "The waiting lists were so long for psychiatric treatments", "She waited 1.5 years for intensive trauma treatment…[At that point] the treatment did not bring what she hoped", "One time I was sent to locked youth care simply because the waiting list for the psychiatric ward that could take me was too long" [11,13,34,83]. There is also a systemic failure across institutions to adopt an integrated treatment approach for patients with comorbid psychiatric disorders, addressing multiple conditions concurrently in a coordinated manner [33]. Often, these patients and their families waited a year or more for a treatment slot for problem A, then, when it became available, were denied admission because of unresolved problem B; after several more months of waiting, when a treatment slot became available to treat problem B, they were again denied admission because of unresolved problem A; "I was considered too complex and no treatment facility offered a solution where my problems could be treated simultaneously" [13]. Another frequent complaint is the denial of admission to treatment programs due to the patient's elevated risk of suicide, ironically excluding those in most urgent need of care [11,13].

The risk of suicide in itself creates one of the greatest worries for parents, the fear of one day finding their child dead from suicide. This haunting fear of impending suicide hangs over parents like the sword of Damocles, causing unbearable anxiety: "We were afraid every day that she would succeed in taking her own life", "I (the father) had been afraid it would happen for years", "R. (21-years-old) tries several times to suicide", "We are happy that M. (17-years-old) endured until she was allowed to go through euthanasia, and did not choose [suicide]...that would have been extra traumatizing for us" [6,11,13,84]. When you add this prolonged emotional burden to the years of watching their loved one struggle and suffer, family members reach a point where they simply can't take it anymore: "it is not a matter of not wanting to [help your child with mental illness] anymore but of really not being able to do it anymore", "I could not have her live longer in this tragedy she was in", "She felt she was too much, too difficult for us" [6,11]. Some family members of already euthanized psychiatric patients become such fierce supporters of euthanasia, that they even incite other parents to stop seeking new treatments: "…don't keep pushing and trying; stop proposing any further treatments (for your child)" [18]. The absence of adequate support or suicide preventive efforts leads to gradual erosion of insight and objectivity among family members. The patient's persistent desire to die, can reinforce this dynamic, leading families to perceive euthanasia as an inevitable or even rational option. In extreme states of despair and systemic neglect, some parents may actively seek physicians, sometimes identified through media, willing to perform euthanasia, which is presented to them as a form of relief: "[Euthanasia] will bring [me, the partner] peace when the time comes", "[I'll] be relieved when the whole thing is over so I [the aunt] can grieve", "it happened in M's (28-year-old) small, narrow room there…her mother and her partner and her sister were there…everyone was very happy that it finally happened" [2,72]. Some family members, despite internal opposition to euthanasia, outwardly support the patient's decision to avoid causing more distress and to preserve the patient's peace of mind. Others remain hopeful that the patient will change their mind at the last minute, leading to emotional charged situations immediately before the euthanasia procedure: "My mother cannot imagine life without me and still hopes that I will make a different choice", "He (the husband) has a hard time with her impending farewell (of his 31 year-old wife suffering from post-partum depression), but understands her.", "Contrary to my feelings, I said it is ok to my daughter, […] because who wants to lose their daughter?" [13,73,85].

**16. Psychiatry lacks the knowledge about the mechanisms of mental diseases**

Doctors defending psychiatric euthanasia, claim there is nothing else to be done for these patients, yet the current knowledge about the inner workings of the human mind or its diseases is minimal. Contrary to other fields in Medicine, the symptom-based classification systems currently used in psychiatry may give the illusion of understanding mental disorders. However, over 90% of the mechanisms involved in shifting the brain's mode of functioning remains undiscovered [86,87]. World-renowned psychiatry experts unequivocally assert that psychiatry lacks a fundamental understanding of the causes of mental illness, that it remains largely ignorant of the underlying biological mechanisms that drive psychiatric disorders. Despite advances in neuroscience and genetics, psychiatric diagnosis still relies exclusively and alarmingly on fallible subjective judgments, with no established biological markers, imaging signatures, or genetic patterns that align consistently with diagnostic categories. These researchers, including a Nobel laureate psychiatrist, conclude that most of psychiatry's knowledge about the development of mental illness remains unknown, speculative at best [88–94]. Even so, the defenders of psychiatric euthanasia claim with absolute certainty that there is nothing else to be done for these psychiatric patients.

**17. There is no objective or factual evidence to support psychiatric euthanasia**

While there is substantial research on euthanasia for terminally ill patients, there is a notable scarcity of high-quality, peer-reviewed clinical studies specifically supporting psychiatric euthanasia. All existing studies focus only on the ethical, psychological, procedural and legal aspects [46,47,95–97]. There are absolutely no clinical studies that provide objective data or any kind of irrefutable evidence demonstrating the benefits or advantages of psychiatric euthanasia. The only study that tried to show any objective results regarding psychiatric euthanasia relates to bereaved partners' grief experiences following suicide vs psychiatric euthanasia [98]: in that study it was established that the planned death provided by psychiatric euthanasia allowed some partners to better prepare for the death of their loved one as opposed to their unexpected death by suicide. But many surviving partners of psychiatric euthanasia patients still remained with doubts and questions regarding themselves and their deceased partners on why they went ahead with psychiatric euthanasia, also evident by statements made outside of that study: "He (the husband) has a hard time with her impending farewell (of his 31-year-old wife and the mother of their six-year old child)" [73]. Neither this study nor any others provide objective data comparing psychiatric euthanasia with alternative approaches that keep the patients alive or tries to improve their conditions. There is simply no hard evidence. The justifications to do psychiatric euthanasia are based solely on personal subjective impressions such as the sense of relieving suffering or the sense of relief and gratitude shown by family-members. History offers multiple examples where similar reliance on subjective impressions led to harmful medical interventions, such as bloodletting, hysterectomies for presumed hysteria, or lobotomies for psychiatric diseases. But even those harmful procedures never intended to kill the patient, which makes psychiatric euthanasia something unique in human history.

**18. There is unbearable suffering and there's *endurable* suffering**

Currently, for psychiatric euthanasia purposes, suffering is "unbearable" when a patient says it is [4,75]. I've seen many terminally ill patients in my career who were suffering bitterly, experiencing pain to a degree that they would urinate or soil themselves, unable to move without crying in pain, some unable to move at all and entirely dependent on others, but with no cognitive impairment, conscious and able to make decisions. Such patients would probably have benefited from euthanasia, if given the choice. These patients and their families sought my help and that of my colleagues to relieve their pain and suffering, sometimes on a daily basis, because the medication they had wasn't enough to make the pain more tolerable. A comparison between physical and psychological pain is not intended here, nor would it be appropriate without the relevant clinical expertise. However, Zoraya's case that prompted this research, was a young autonomous woman that requested euthanasia in 2020 at the age of 24, due to unbearable suffering; however, since that first request and for the last 4 years until her euthanasia at the age of 29, she didn't received any treatment other than focusing on getting her euthanasia approved [1,2,74]. Why is it that during those 4 full years, the unbearable suffering she felt did not compel her to seek or try other treatments? Unlike many of the psychiatric patients who request euthanasia, patients with physical illness who are suffering

intolerably don't refuse any kind of treatment, they are desperate, they grab whatever they can, whatever treatment option they are offered, whatever promises to alleviate their pain. Sometimes, the suffering is so intense that they overcome any fears and take matters into their own hands, resorting to suicide [99]. Regardless of such desperate actions, these terminally ill patients invariably die within a short time, highlighting, once again, a stark contrast with the majority of psychiatric patients, who endure their suffering for years without resorting to suicide and continue to live [7]. This elicits two crucial questions: First, why did none of the doctors involved during the last 4 years of Zoraya's life question the perceived unbearable suffering claimed by a patient who did not do or seek new treatments during that period? Second, how can we justify the euthanasia of a patient on the grounds of unbearable suffering if that patient does not seek any kind of treatment in the 4 years prior to euthanasia? Not providing psychiatric treatment for years before euthanasia is apparently accepted by physicians who enable, authorize, or perform euthanasia for psychiatric reasons [27]. Additionally, in many patients disease symptoms decrease with age and what is felt unbearable today, may be more bearable in the future. This is confirmed by the higher rate of euthanasia request withdrawals among individuals in their 30s and 40s, compared to those in their 20s, who more often stick to their decision to die and go all the way, regardless of psychiatric condition [7]. Notably, many patients in their 30s and 40s, as well as their psychiatrists, report that had euthanasia been available to them in their 20s, they would likely have pursued it, thereby forfeiting the opportunity to recover and eventually lead meaningful, even joyful, lives [71].

**19. Treatment refusal or patients' perception of incurability also labels them as untreatable**

Again, for purposes of psychiatric euthanasia, a treatment alternative is not a reasonable alternative if the patient refuses it [4,75]. However, refusal of an effective treatment does not make an illness untreatable in the real word. If a patient with end-stage liver disease is on the waiting list for a liver transplant but refuses to stop drinking, that patient will never be selected to receive a new liver, despite his urgent wish to receive one. Human livers are a very limited resource, so physicians reserve those livers for patients who follow our recommendations and have the best predictable long-term outcome and life expectancy. Yet many patients who request psychiatric euthanasia are non-compliant, refuse suggested treatments, are more easily labeled as treatment-resistant and untreatable, and still get what they wish, i.e., euthanasia. Not only are these patients missing out on successful treatment options because of their refusal, but also due to lack of knowledge on the part of the treating physicians [68], and thus are inaccurately labeled as untreatable or treatment-resistant. A review of euthanized psychiatric patients found that mental illness played a significant role in treatment refusal in more than half of the cases [46]. Some physicians enable this attitude and even see it as an evolution to accept the patient's subjective perception of being incurable as a medical definition of being untreatable: "If [the 17-year-old patient] can explain why it is no longer possible [or curable] and she has parents who support her in this [death] wish, who am I as a doctor to doubt that?" [11,100]. In some cases, the refusal could also be a sign that the desire to get better is probably not on the patient's mind or even their goal, as perceived in the multiple interviews and their speech, and this lack of motivation is recognized and even accepted by psychiatrists [48].

**20. Most justifications for psychiatric euthanasia have been provided by non-clinicians, using pseudo-scientific and pseudo-rational arguments**

The vast majority of the arguments in favor of psychiatric euthanasia are based on subjective, intangible criteria, and abstract concepts such as the individual's own perception of suffering, intolerability, dignity, discrimination, and the protection of self-determination. Most scientific articles supporting psychiatric euthanasia are written by non-medical authors (75%) [101], focus on subjective arguments, and appeal to ignorance, e.g.: they conflate physical and mental illness and suffering, disregarding the poorly understood etiology of mental illness [102,103]; they argue that the capacity of psychiatric patients to make decisions about their own euthanasia should be as simple and easy to evaluate as their decision capacity for any other medical procedure, and the threshold for assessing capacity for euthanasia should be even lowered in order to promote and facilitate self-determination [104]; they claim judgments about irremediability should rely not only on statistical chances of recovery, but depend heavily on the person's own judgment [105]; they argue that waiting for possible new treatments, such as ketamine for treatment-resistant depression, which is successfully used in other countries, does not

justify delaying euthanasia for too long [106,107]; they claim that refusing psychiatric euthanasia drives patients to attempt or commit suicide [108]; that if patients can refuse life-sustaining treatment, they should also have the right to psychiatric euthanasia even if there are effective treatments or even in the absence of suffering [109]; that because there is little empirical evidence that psychiatric euthanasia has negative consequences, the extension of psychiatric euthanasia to existential suffering is something inevitable, and these non-medical authors say that's not necessarily bad in itself [110]; they argue that depressed people may be so blocked that they can't take the step to kill themselves, or may accidentally kill others while attempting suicide, or that unsuccessful suicide attempts may reduce ability to work and earn less, or since treatment is very expensive, refusal of euthanasia is even more discriminatory [108]; they also argue that, since medical errors already exist in medicine, the risk of false positives (ending the lives of people who do not actually meet the criteria for euthanasia) is a perfectly acceptable consequence [111]. Curiously, in a society which currently rejects established figures of authority and knowledge in favor of self-determination and autonomy, 95% of applicants for active life termination in the Netherlands, don't have the courage to kill themselves and ask the authoritarian figure of a doctor to do it for to them [112]. Various doctors and psychiatrists, supposed to be scientifically sound, are now parroting these pseudo-scientific and pseudo-rational arguments to support their actions of euthanizing psychiatric patients and even adding appeals to ignorance themselves. They say: "You don't need to understand"; "If the (minor) patient explains why it is no longer possible to live and has parents who supports her wish, who am I to doubt that?"; "I don't know what I am doing in a spiritual sense… I hope I end suffering for people… I can only trust my own conscience"; "you can never be sure if a death wish is not a symptom" [6,10,11,113].

**21. Physician disengagement, permissiveness, and the devaluation of life**

Psychiatric illness creates a heavy atmosphere around the patient, affecting families and health care professionals. Even the world's best experts admit that dealing with these patients is difficult [68,114]. Appropriate teams of professionals need to be trained to deal with this particular subset of patients because it is easy for some professionals to feel helpless, horrified, guilty, angry, betrayed, and sad for the patient [68]. This is one of the reasons why so many doctors give up on them. They tell a patient that there is nothing more that can be done for his or her condition, as so many patients have been told [58,74,81], which is not only scientifically incorrect given the current state of the art [115–118], but it also tells the patient that the doctors have given up, causing the patient to lose all hope of recovery [82]. One of the top Dutch psychiatric euthanasia experts said: "The worst thing I can say to you now is that I have some options to make you better. I don't have any options" [58]. This reinforces and encourages the death wish that many of these people already have. If euthanasia is then made available to them, they will use it as a way to end their perceived suffering, as evidenced by the yearly increase in euthanasia cases for psychiatric illness in the Netherlands, with doctors giving in to psychiatric patients' suicidal wishes [75].

Despite technological advances and successful treatment options, ethical standards for life seem to be regressing. Compared to psychiatrists, Dutch general practitioners were almost three times more likely to approve euthanasia for psychiatric illness, and even in cases where the patient just feels tired of living without any severe disease [68,119]. This is a clear case of the Dunning-Kruger effect, in which individuals, such as general practitioners, with little skill, knowledge, or experience in a particular area overestimate their own ability or understanding, and thus are often mistakenly more confident in their opinions and more likely to support or endorse practices about which they know little, such as psychiatric euthanasia [50,120]. Regardless of their honesty or good intentions, how is scientific conviction and evidence-based medicine compatible with trusting a doctor about the usefulness of a life-ending procedure who says, "if the patient and the family wants it, who am I to doubt…I don't know what I'm doing...I hope I'm ending suffering...I can only trust my own conscience…I can never be sure"?

The apparent ease with which some patients are deemed untreatable and approved for euthanasia raises serious questions about clinical judgment and standards of care. One of the cases mentioned in the report of the Expertise Center Euthanasia [7] is that of a lonely man in his 50s: he was often bullied in his adult life, never had an intimate relationship or even sex, craved for the desire to feel and fall in love at least once in his live; he was considered by several specialists, including those of the Expertise Center, on different occasions over a period of 16 months to fulfill all the criteria of being incurable and suffering unbearably, and was therefore eligible for euthanasia. These

patients desperately need friendship, human contact, they need doctors who will listen, really listen, even if it is only to listen to their wish to die. Listening doesn't mean enabling euthanasia, it means understanding, understanding their fears and anxieties. They need doctors who support them, who give them hope, not doctors who take it all away from them by emphasizing their hopelessness and supporting their death wish [82]. Prof. Lars Mehlum, one of the foremost psychiatric experts in the field, told me personally that many experts seriously disregard the profound interpersonal and psychological aspects of people's desire to die in the face of suffering; that we are social beings and that our psychological existence depends heavily on others, their support, their acceptance and their love. So, it is deeply disturbing that psychiatrists can turn a blind eye to this, but apparently passing the medical board exam (in psychiatry) is no guarantee that a doctor will be truly compassionate and follow Edward Trudeau's maxim that a doctor may be able to "to cure sometimes, to relieve often, but to comfort always". These patients are not getting the right treatments and have lost hope [68,69], have had doctors who explicitly have given up on them, reinforcing the idea of untreatability, actively undermining future recovery efforts, and blocking other more competent professionals from helping these patients by deliberately killing them beforehand.

**22. Outdated knowledge, inadequate procedures and *no* evidence-based treatment for the majority of euthanized patients**

The prolonged suffering of patients with years of inadequate treatments leading to treatment fatigue and despair is clearly illustrated:"She could no longer live her life. As much as she wanted to, it was no longer possible. She was exhausted, treatment-tired, treatment-resistant"; "It's not that I want to die, it's that I don't want to live this life anymore […] I've tried everything there is" [6,11]. It is the duty of the Regional Euthanasia Review Committees to verify whether the criteria of due care have been met after an euthanasia procedure [121]. However, a recent scientific review by Prof. Lars Mehlum, past president of the European Society for the Study of Personality Disorders concluded that most euthanized psychiatric patients in the Netherlands were far from having exhausted all therapeutic options: these patients were labeled untreatable and without prospects for improvement based on outdated knowledge and ignorance about the state-of-the-art in the treatment of psychiatric diseases [68]. In fact, a larger Dutch study including 116 euthanized psychiatric patients, based on data provided by the Regional Euthanasia Review Committees, concluded that only one patient with personality disorder received some partial evidence-based treatment specific to personality disorders; 99% of euthanized psychiatric patients received no evidence-based treatment prior to euthanasia [69]. Yet they were considered untreatable by the Dutch experts and the Regional Euthanasia Review Committees sanctioned that the proper due care criteria had been met.

**23. Clinical, scientific and academic limitations of the psychiatric euthanasia experts**

The two top experts in psychiatric euthanasia in the Netherlands are both child and adolescent psychiatrists [27,62]. Yet, the majority of cases of euthanasia they deal with are in adults. They judge the untreatability of adults, and enable and sometimes perform the psychiatric euthanasia on adults themselves. Could this be a further example of the Dunning-Kruger effect since their field of expertise is not adult psychiatry? But despite these doubts, given their responsiveness to evaluate, to give second opinions about the untreatability of certain psychiatric patients and to euthanize so many of them, one must assume that their expertise and knowledge of mood disorders, depression, and other psychiatric illnesses would be considerable. As a fellow physician and scientist, I searched several databases for published peer-reviewed articles by these top experts on these subjects, including euthanasia. However, there are none. Besides some blog posts and one opinion article [10,49], none of them has published any peer-review articles about these topics [122]. This means that these top experts have no scientific background, nor have they published any field work to validate their actions. These and other experts rely only on their beliefs, convictions, their subjective perceptions and personal sense of satisfaction to justify psychiatric euthanasia: "…(Dr. O.) found it so intense how long I had been suffering that he wanted to help relieve me of that pain.", "he described her suffering as unlievable", "I heard from Dr. V. that she was going to provide euthanasia to the mother of a six-year-old boy…I spoke to her too…that convinced me immediately…that woman suffered so terribly", "His story was so convincing that all my theoretical objections disappeared", "I have sleepless nights,… but what helps me is the gratitude of people, their parents, families and partners.", "(If you don't euthanize these patients) you let them down", "I fulfilled an ultimate wish. So how wonderful it is to have that wish come true...", "I am relieved

(about the euthanasia), I know what I prefer", "Euthanasia seems very healthy to me" [6,11,13,49,51,62,72]. Such professional attitudes may explain why the Netherlands has one of the highest rates of mental health disease and suicide rates in the European Union [15,25,26].

**24. In other EU countries, similar patients survive and thrive**

In the Netherlands, the psychiatric euthanasia establishment provided death to over 600 treatable patients in the last 5 years alone. However, similar patients in other EU countries are able to survive and thrive, without killing themselves, their families get the support they need to get through the more difficult phases of the disease, they have significantly lower suicide rates than the Netherlands (2 to 4 times lower female suicide rates in Italy, Spain or Greece) [25], and they don't have psychiatric euthanasia available. Other European experts have repeatedly demonstrated the curability of psychiatric disorders through successful treatment regimens delivered by trained teams of professionals and expert therapists. Experts like Prof. Lars Mehlum have hundreds of peer-reviewed publications, studies and real-world clinical data to establish, guide and explain their success in the same area [123].

**25. Once euthanasia is approved, the constant, untreatable, years-long symptoms of the disease disappear**

Curiously, the majority of patients who wish to die and request psychiatric euthanasia experience an astonishing improvement and sometimes even complete remission of their symptoms after receiving permission to be euthanized. From interviews with family members after euthanasia, or from interviews with patients just before euthanasia, they report that the psychological burden they had felt for years, the anxiety and anguish, the feelings of despair and hopelessness, the suicidal thoughts, almost every negative aspect of their illness suddenly disappeared. Even severe anorexic patients start to eat better. They begin to appreciate life, some start living again with their families without the recurring conflicts, do things with their families and partners that they rarely did during the years of their illness, engage in activities that they enjoy or have been putting off, travel, and generally seem to enjoy life, claiming the weeks before euthanasia as the happiest days of their lives: "We had a wonderful last time […] Everything was right in the weeks before euthanasia and on the day of the farewell"; "we had some very nice fun, moments", "the last few weeks had been their happiest weeks in years!"; "Those last six weeks were happy ones, the family took walks, drank mugs of coffee and watched feel-good movies at night, the anger and hostility that had splintered the family evaporated"; "(After the approval) the weeks before E. died were the happiest of her adult life"; "For the first time in a long time we lived together as a family again and had the opportunity to make beautiful memories.", "I went to Disneyland with a friend so I could give Stitch a hug one more time", "Once the date was set, we had such a great week, even including trips to the zoo" [11,13,57,58,77,78,85,124]. The descriptions in these interviews are of people grabbing life with both hands, living and enjoying everyday life peacefully and happily, without stress or significant burden caused by the disease. There are some scientific articles and even a PhD thesis documenting this phenomenon: upon knowing that their euthanasia is approved these patients feel an immediate state of intense happiness, euphoria, a sense of being blessed and intense relief that persists; they also feel less burdened with self-destructive ideation and behaviors and suppress suicidal thoughts [47,95,125]. Some patients, after knowing that they had the option to proceed with the euthanasia, that alone gave them sufficient peace of mind to continue with their lives or even consider further treatments: "So when I finally got the permission to die, that was a huge relief…since then I'm experiencing better moments and I'm also in doubt now…we discuss other available options" [47,95].

These recoveries didn't happen because of medication, physical intervention on the patient's body, alterations in their living environment, the people around them, or shifts in their social context. They occurred solely following an administrative event, informing them that they were finally approved for euthanasia and going to be euthanized in the next 4 to 6 weeks or so. No new treatments were introduced, nothing was changed in the patient's biology, yet a simple external trigger, such as a notification, caused this sustained improvement until the patient was euthanized. This raises again critical clinical questions: What happened to the daily and continuous unbearable suffering? What happened to the immutable euthanasia premise and criterion "without prospect of improvement" [4]? This pattern is strikingly different from any other physically terminally-ill patients who want euthanasia, who, despite receiving similar communications, continue to suffer without improvement, reporting pain until death. There is no suggestion that psychiatric patients were malingering or fabricating

their symptoms prior to approval. They likely experienced genuine distress, hopelessness, and suffering. However, if a mere administrative notification, a letter or a phone call can induce such a profound, unprecedented, week-long lasting improvement, and positive impact on these patients and their families, the claim of untreatability becomes clinically questionable. What medical basis remains for asserting that the condition is truly irreversible, intolerable, and beyond therapeutic reach? There are also several cases of patients who, after spending years on the psychiatric euthanasia waiting list and finally receiving approval, suddenly fall in love just one month before their scheduled death. Remarkably, all symptoms vanish as if by magic, and they renounce both euthanasia and their long-held wish to die [71,126].

**26. Lack of inquiry culture, diagnostic failures, and psychiatric impunity**

People should always question others and themselves about what they are doing and why they are doing it, especially when it comes to life and death decisions. The importance of this questioning is heightened by the fact that misdiagnosis in psychiatry is not incidental, but systemic. Several studies have shown that misdiagnosis is transversal to all the major psychiatric areas. Misdiagnosis rates reach impressive levels over 60% for major depressive disorder, over 90% for bipolar disorder, or over 80-90% for anxiety disorders [127]. Some patients consulted on average 4 different physicians before getting the correct diagnosis, and over a third waited 10 years before receiving an accurate diagnosis [128]. If patients exhibit autistic traces and are women, then the chance of misdiagnoses triples in comparison to men [129]. Even in specialized psychiatric settings and academic centers with inpatients, the misdiagnosis rate for severe psychiatric disorders reaches levels up to 40% [130,131]. Suffice to say that 6% of euthanized psychiatric patients in the report of the Expertise Center Euthanasia didn't actually have a specific psychiatric diagnosis at all, it was simply unknown [7]. There are in fact reported cases of misdiagnosis in patients requesting psychiatric euthanasia, or even last-minute recovery before euthanasia after 10 years of wrong diagnosis with complete and full remission of the disease [48,132]. And yet, there have been multiple cases where psychiatric patients, after years of firmly convincing doctors, relatives, and review committees that euthanasia was their only escape, reversed their decision at the very last moment, in some cases as the needle approached [133,134]. If such profound turnarounds at the point of no return can happen after years of unwavering conviction, how can we possibly assume that others wouldn't have changed their minds later, if only given more time? Such last-minute reversals fundamentally challenge the reliability of psychiatric assessments that deem mental suffering irremediable and death the only option. However, euthanizing the patient is the perfect self-concealing way of hiding medical errors, because no one will ever be able to prove that the diagnosis was wrong or the disease treatable, since the only proof or witness, i.e. the patient, is dead. So, besides psychiatry being a specialty with the highest misdiagnosis rate in medicine, and consequently higher chances of error and uncertainty, it is also the only specialty which, based on these uncertainties, proposes and performs the most definitive, ultimate and irreversible act of all medicine, i.e. the deliberate killing of physically fit patients. Despite all of these failures, psychiatry has the lowest malpractice lawsuit rate of any medical specialty [135,136].

**27. Euthanasia is the new cure for mental illness**

30 years ago, Professor Herbert Hendin said that normalizing suicide as a medical option lays the groundwork for a society that makes euthanasia a "cure" for suicidal depression [137]. Currently, psychiatric euthanasia happens so often, that even professionals within the euthanasia establishment, such as Prof. Theo Boer, who was on the Regional Euthanasia Review Committees in the Netherlands for 10 years, saw how death by euthanasia as a last resort became death by euthanasia as the default option for psychiatric cases. Some of these professionals, including Prof. Boer, were so disgusted by the practice that they resigned from their positions [1,17,74,138]. Numbers show that euthanasia is becoming the standard of care for psychiatric illness: In 2023, 138 patients were euthanized due to mental disorders; by 2024, that number had risen to 219, an increase of 59% in just one year; while euthanasia for unbearable suffering of cancer patients in the Netherlands has increased by 37.5% in the last 10 years, euthanasia for psychiatric reasons has increased by 421% in the same period, with 219 people killed in 2024 [5,139,140]. These numbers don't include elderly or demented patients, but only people with purely psychiatric illnesses, the majority of which would be alive, properly and successfully treated in other countries. The euthanasia process

for psychiatric illness is promoted and presented as a treatment with a selection process with apparent medical criteria that then justify and support the decision to euthanize the psychiatric patient [4,7]. Since some doctors have become public supporters of psychiatric euthanasia and are known for facilitating euthanasia authorizations, desperate people see them on TV and come to them requesting for a second opinion [6]. There should be no bias or tendency towards psychiatric euthanasia, but the facts and data provided by the direct institutional facilitators say otherwise: 2024 had the highest number of psychiatric euthanasia deaths ever [5,140]. However, euthanasia is not a treatment but a final act that eliminates any possibility of recovery or future treatment for psychiatric patients.

**28. The euthanasia slippery slope**

There have been many warnings from doctors that allowing euthanasia for psychiatric illness could become a slippery slope. Isn't the killing of treatable patients, some of whom are not even suffering unbearably, who want to die, or whose family members are terrified that they might commit suicide, a sign of that slippery slope? The cases of the lonely people who never fell in love or had sex, the mother of two who can't stand her life, the 35-year old hockey world-champion who couldn't get over the death of her mother, the belgian 23-year old girl who couldn't overcome the terrorist attack she witnessed or the 34-year-old woman euthanized a couple of months after the breakup with her boyfriend are perfect examples [6,7,46,141–144]. Will euthanasia become the new way to deal with frustration and dissatisfaction about life, the loss of a job, with grief or romantic disappointments [142]? If unbearable suffering alone becomes sufficient grounds for euthanasia, then financial ruin, imprisonment, or other irreversible life circumstances could likewise be framed as "incurable", turning euthanasia into a means of escaping adversity, responsibility, or social consequences.

**29. Euthanasia offers no second chances**

There is a wide range of scientifically proven successful treatments for all the cases mentioned or any other psychiatric patient, with the potential to help them by making life more bearable and worth living. Unfortunately, in the Netherlands, for one reason or another, many patients do not have access to them and live miserable lives, commit suicide, or are euthanized. Regardless of euthanasia, the physically terminally ill patient has death always running toward him, and treatment options allow very few second chances at life. But that was not Zoraya's or any of the other cases. Would they still be alive today without euthanasia? Many definitely would, because they were afraid and didn't have the will or courage to do it themselves and take their own lives, having to rely on others to do it for them and sweeten the pill. Would all this presented evidence make them reconsider? We will never know, because euthanasia offers no second chances. Dead patients can't change their minds.

## 30. Conclusions & Afterword

Pseudo-scientific and pseudo-rational arguments, hegemony of irrationality to accommodate patients' wishes, outdated knowledge about the treatment of psychiatric disorders, ignorance about personalized successful treatment regimens, lack of scientific evidence or background or academic knowledge of the top experts in the field or of the major parties to support their actions, overempathic biased doctors endorsing and performing psychiatric euthanasia, years-long waiting lists for inefficient treatment facilities, withholding evidence-based treatments, patients inaccurately labeled as untreatable, abandoned patients, exhausted and wearied partners and parents, ignored families fearing the suicide of their loved ones, families pressed to support psychiatric euthanasia due to absence of efficient psychiatric assistance, lack of practical suicide prevention for patients and no support for their families, one of the highest suicide rates in Europe, unbearable suffering in patients who manage to survive for years without any treatment of which over 96% do not suicide, 18:1 gender disproportion of euthanasia vs. suicide slaying young women, euthanasia guaranteed for suicidal patients or who attempt suicide, euthanasia as a default option for depression, outlawed promotion of suicide vs. institutional promotion of psychiatric euthanasia, institutional encouragement of contagion and psychiatric euthanasia clusters, doctors setting up foundations to accelerate the killing, unbearable and untreatable disease symptoms that suddenly disappear, last-second retractions that discredit years of prior psychiatric

conclusions, accelerated killing of hundreds of spontaneously recovering patients, Kafkaesque institutions indirectly endorsing the euthanasia of treatable children, killing of treatable patients who would survive and thrive in other countries. The list goes on.

How can a great country like the Netherlands explain this magnitude and accumulation of errors, negligence and incompetence, with the complicity of political leaders? Europe has seen many health ministers fall for just a fraction of this disaster. Given the significantly lower suicide rates and the absence of psychiatric euthanasia in many EU countries, comparable patients have experienced different outcomes, being treated or maybe even cured, enjoying life and contributing to the lives of those around them. Though safeguards are formally in place, the evidence exposes that the psychiatric euthanasia system functions with alarming inconsistency, poor adherence to clinical standards, and systemic failures that would be unthinkable elsewhere in medical practice. Does the situation where an older man encourages and directly kills several younger women and teenagers and openly says he wants to hasten the demise of many others not set off alarm bells in the Netherlands? Why is the innovative Dutch euthanasia law, which stood for a fundamentally humane aspect of alleviating suffering, being distorted and manipulated by certain doctors (and patients) and becoming so inhumane? Any medical professional has the responsibility to provide state-of-the-art care and to be aware of the successful treatments available today. While ignorance in other medical fields can unintentionally kill patients, in psychiatry it can result in patients being deliberately killed, with full legal endorsement from Dutch lawmakers. It doesn't require a medical degree to recognize that this practice stands in clear contradiction to common sense, rationality, and evidence-based clinical standards. How many more treatable young patients must be deliberately killed, how many orphaned children, widowed partners or bereaved parents will it take before Dutch doctors, their medical associations, politicians or the general public react? What cannot withstand scrutiny does not deserve quiet acceptance. In matters of life and death, silence is not neutrality, it is complicity. And that complicity extends to all who read these words, recognize the truth, and choose to look away. To remain passive in the face of preventable death is to stand on the wrong side of medicine, of reason, and of humanity.

May these senseless deaths lead to critical reflection on what went wrong, to improve the training of expert psychiatrists, and stop these unnecessary deaths. Most importantly, let's give patients and families facing severe psychiatric suffering precise evidence-based care and sustained support, so that instead of merely surviving and dying, they can start living.

**31. Institutional Non-Response**

Following the documentation and analysis presented in this paper, the Dutch Medical Association (KNMG) and the Dutch Association of Psychiatry (NVvP) were formally contacted and invited to respond to the documented institutional data and peer-reviewed evidence. The Dutch Medical Association, despite representing the medical profession as a whole and having been provided with the same documentation, deferred responsibility entirely to the Dutch Association of Psychiatry and did not address the substance of the concerns raised. In written correspondence, the Dutch Association of Psychiatry stated that it had no capacity to refute the substance of these findings. Despite this absence of engagement, the Dutch Association of Psychiatry, with the backing of the Dutch Medical Association, the Regional Euthanasia Review Committees and political authorities, continues to publicly assure patients and the broader public that psychiatric euthanasia is safe, careful, and beyond serious questioning.

Peter Kronenberg, MD, PhD
Consultant Urological Surgeon
Fellow of the European Board of Urology
Former President of PETRA Urogroup (Progress in Endourology, Technology and Research Association)
ESU (European School of Urology) Faculty/Trainer
Scientific Advisor of the Major Medical Device Companies
Former Commanding Medical Officer

**Disclaimer:** The opinions published by the author, do not necessarily reflect those of the organizations with which the author is affiliated.

**Funding:** This work received no external funding.

**Conflict of Interest:** The author declares no conflicts of interest related to this work.

## References


**1** Harriet Sherwood. Dutch woman, 29, granted euthanasia approval on grounds of mental suffering. *The Guardian.* Updated May 16, 2024. https://www.theguardian.com/society/article/2024/may/16/dutch-woman-euthanasia-approval-grounds-of-mental-suffering. Accessed July 13, 2024.

**2** Bosma O. Interview Zoraya - Onno Bosma. *Onno Bosma.* Updated February 18, 2024. https://onnobosma.nl/interview-zoraya/. Accessed July 14, 2024.

**3** Baard L. Haar diepste wens is vervuld, Zoraya uit Oldenzaal kreeg kort na haar verjaardag euthanasie. *Tubantia.* Updated May 22, 2024. https://www.tubantia.nl/oldenzaal/haar-diepste-wens-is-vervuld-zoraya-uit-oldenzaal-kreeg-kort-na-haar-verjaardag-euthanasie~a3699232/?referrer=https%3A%2F%2Fwww.google.com%2F. Accessed July 20, 2024.

**4** Euthanasia Code 2022. https://english.euthanasiecommissie.nl/the-committees/euthanasia-code-2022. Updated July 14, 2024. Accessed July 14, 2024.

**5** Regional Euthanasia Review Committees. *Annual Report 2024*; 2025. https://www.euthanasiecommissie.nl/documenten/2024/03/24/index.

**6** Buchanan A. Why the Dutch are euthanising physically healthy young adults – and could the UK be next? *The Telegraph.* Updated June 8, 2024. https://www.telegraph.co.uk/news/2024/06/08/dutch-euthanasia-healthy-children/. Accessed July 9, 2024.

**7** Kammeraat M, Kölling P. *Psychiatrische patiënten bij Expertisecentrum Euthanasie: Retrospectieve dossierstudie naar de achtergronden en het verloop van euthanasieverzoeken op grond van psychiatrisch lijden bij Expertisecentrum Euthanasie*. Den Haag; 2020. https://expertisecentrumeuthanasie.nl/app/uploads/Onderzoeksrapportage-Psychiatrische-Patienten-Expertisecentrum-Euthanasie-1.pdf.

**8** Petra's lichaam is altijd in opgewonden staat, maar komt nooit tot een hoogtepunt: 'Het drijft me tot wanhoop' - LINDA.nl. https://www.linda.nl/persoonlijk/pgad-petra-opgewonden-orgasme/. Updated September 18, 2025. Accessed September 18, 2025.

**9** Subramanya R. She Was 29. And Doctors Helped Her Die. *The Free Press.* Updated May 28, 2024. https://www.thefp.com/p/zoraya-ter-beek-dead-assisted-suicide. Accessed July 22, 2024.

**10** Menno Oosterhoff. You don’t need to understand. - Menno Oosterhoff. https://www.menno-oosterhoff.nl/media/blogs/you-dont-need-to-understand/. Updated July 10, 2024. Accessed July 10, 2024.

**11** Jong N de. Mireille's dochter Milou (17) koos na psychisch lijden voor euthanasie: 'Ze regelde haar eigen uitvaart'. *LINDA.* Updated November 17, 2023. https://www.linda.nl/persoonlijk/opvoeden/mireille-dochter-milou-euthanasie/. Accessed July 15, 2024.

**12** Romy (21) kiest voor euthanasie: ‘Het leven is niet voor mij gemaakt.’ | Stichting KEA. https://stichtingkea.nl/romy-21-kiest-december-2023-voor-euthanasie-het-leven-is-niet-voor-mij-gemaakt/.

**13** Boterkooper G. Romy (21) kiest deze maand voor euthanasie: 'Het leven is niet voor mij gemaakt'. *LINDA.* Updated December 7, 2023. https://www.linda.nl/meiden/meiden-reallife/romy-december-euthanasie/. Accessed July 15, 2024.

**14** Regionale Toetsingscommissies Euthanasie. Documenten | Regionale Toetsingscommissies Euthanasie: Patiënten met een psychische stoornis. https://www.euthanasiecommissie.nl/uitspraken?trefwoord=&startdatum=&einddatum=&uitspraak-uitleg=Pati%C3%ABnten+met+een+psychische+stoornis&type=Alle+uitspraken. Updated July 21, 2024. Accessed July 21, 2024.

**15** Angelini Pharma. The incidence of mental disorders in European countries. https://www.angelinipharma.com/our-responsibility/headway-a-new-roadmap-in-mental-health/the-incidence-of-mental-disorders-in-european-countries/.

**16** Expertisecentrum Euthanasie. 'Ik vind het een eer dat ik mag gaan.' - Expertisecentrum Euthanasie. https://expertisecentrumeuthanasie.nl/Interviews/ik-vind-het-een-eer-dat-ik-mag-gaan/. Updated March 28, 2023. Accessed September 11, 2024. During the investigation this report/interview was removed from the webiste of the

Expertisecentrum Euthanasie, but the same text can be found, word by word, at https://vriendenvanee.nl/Interviews/ik-vind-het-een-eer-dat-ik-mag-gaan-3/.

**17** Boer T. Assisted dying: 'What is seen as an opportunity by some has become an urge to give in to despair for others'. *Le Monde.* Updated April 12, 2022. https://www.lemonde.fr/en/opinion/article/2022/12/04/assisted-dying-what-is-seen-as-an-opportunity-by-some-has-become-an-urge-to-give-in-to-despair-for-others_6006522_23.html. Accessed July 22, 2024.

**18** Een waardig afscheid van haar dochter. De ervaring van Heleen. https://thanet.nl/ervaringen/een-waardig-afscheid-van-haar-dochter-de-ervaring-van-heleen/. Accessed July 28, 2024.

**19** Centraal Bureau voor de Statistiek. 1,862 suicide deaths in 2023. *Centraal Bureau voor de Statistiek Newsletter.* Updated May 7, 2024. https://www.cbs.nl/en-gb/news/2024/18/1-862-suicide-deaths-in-2023. Accessed July 13, 2024.

**20** Over KEA | Stichting KEA. https://stichtingkea.nl/over-kea/#watzijnonzedoelen. Updated September 10, 2023. Accessed July 18, 2024.

**21** Doherty AM, Axe CJ, Jones DA. Investigating the relationship between euthanasia and/or assisted suicide and rates of non-assisted suicide: systematic review. *BJPsych Open*. 2022;8(4):e108. doi:10.1192/bjo.2022.71.

**22** Jones DA. Euthanasia, Assisted Suicide, and Suicide Rates in Europe. *Journal of Ethics in Mental Health*. 2022;Open Volume 11:1-35.

**23** Jones DA. Rapid response: Legalising the encouragement and assistance of suicide will not help prevent suicide. *BMJ*. 2022;377. https://www.bmj.com/content/377/bmj.o1014/rr-7.

**24** Paton D, Girma S. Assisted suicide laws increase suicide rates, especially among women. *VoxEU.* Updated April 29, 2022. https://cepr.org/voxeu/columns/assisted-suicide-laws-increase-suicide-rates-especially-among-women. Accessed July 14, 2024.

**25** World Bank Open Data. Suicide mortality rate, female (per 100,000 female population) - European Union. https://data.worldbank.org/indicator/SH.STA.SUIC.FE.P5?locations=EU. Updated July 10, 2024. Accessed July 10, 2024.

**26** Have M ten, Tuithof M, van Dorsselaer S, Schouten F, Luik AI, Graaf R de. Prevalence and trends of common mental disorders from 2007-2009 to 2019-2022: results from the Netherlands Mental Health Survey and Incidence Studies (NEMESIS), including comparison of prevalence rates before vs. during the COVID-19 pandemic. *World Psychiatry*. 2023;22(2):275-285. doi:10.1002/wps.21087.

**27** Effting M, Kraak H. Psychiater Kit Vanmechelen vertrok bij het euthanasie-centrum vanwege de wachtlijst: 'Ik vind het onacceptabel'. *de Volkskrant.* Updated February 17, 2024. https://www.volkskrant.nl/binnenland/psychiater-kit-vanmechelen-vertrok-bij-het-euthanasie-centrum-vanwege-de-wachtlijst-ik-vind-het-onacceptabel~b54f1945/?referrer=https%3A%2F%2Fwww.inliefdelatengaan.nl%2F. Accessed July 18, 2024.

**28** UK Parliament Committees, ed. *What to expect when you permit assisted dying: some comments from the Netherlands: Written evidence submitted Professor Theo Boer (ADY0484)*; 2023.

**29** Rens E, Portzky G, Morrens M, Dom G, van den Broeck K, Gijzen M. An exploration of suicidal ideation and attempts, and care use and unmet need among suicide-ideators in a Belgian population study. *BMC Public Health*. 2023;23(1):1741. doi:10.1186/s12889-023-16630-7.

**30** Hegerl U. Prevention of suicidal behavior. *Dialogues Clin Neurosci*. 2016;18(2):183-190. doi:10.31887/DCNS.2016.18.2/uhegerl.

**31** American Foundation for Suicide Prevention. Suicide statistics. https://afsp.org/suicide-statistics/;. Updated May 30, 2024. Accessed July 13, 2024.

**32** Elzinga E, Kruif AJTCM de, Beurs DP de, Beekman ATF, Franx G, Gilissen R. Engaging primary care professionals in suicide prevention: A qualitative study. *PLoS One*. 2020;15(11):e0242540. doi:10.1111/hsc.12198.

**33** Verhofstadt M, Marijnissen R, Creemers D, et al. Exploring the interplay of clinical, ethical and societal dynamics: two decades of Medical Assistance in Dying (MAID) on psychiatric grounds in the Netherlands and Belgium. *Front Psychiatry*. 2024;15. doi:10.3389/fpsyt.2024.1463813.

**34** Sanou H. Mental health professionals file mass claim over waiting lists - DutchNews.nl. https://www.dutchnews.nl/2024/05/mental-health-professionals-file-mass-claim-over-waiting-lists/. Updated May 30, 2024. Accessed July 1, 2024.

**35** Zorgvuldig en zorgzaam - Expertisecentrum Euthanasie. https://expertisecentrumeuthanasie.nl/. Updated July 18, 2024. Accessed July 22, 2024.

**36** Stichting KEA - Euthanasie bij psychische aandoeningen. https://stichtingkea.nl/. Updated September 10, 2023. Accessed July 14, 2024.

**37** Expertisecentrum Euthanasie. U zoekt hulp - Expertisecentrum Euthanasie. https://expertisecentrumeuthanasie.nl/u-zoekt-hulp/. Updated March 5, 2024. Accessed July 22, 2024.

**38** Levenseindekliniek | 113 Zelfmoordpreventie. https://www.113.nl/i/levenseindekliniek. Updated July 24, 2024. Accessed July 25, 2024.

**39** Over ons | 113 Zelfmoordpreventie. https://www.113.nl/over-113/over-ons. Updated July 26, 2024. Accessed July 27, 2024.

**40** Rotterdam Zero Suicide Declaration | 113 Zelfmoordpreventie. https://www.113.nl/actueel/rotterdam-zero-suicide-declaration. Updated July 26, 2024. Accessed July 27, 2024.

**41** Zero Suicide. Rotterdam 2018 | Zero Suicide. https://www.zerosuicide.org/rotterdam-2018. Updated July 27, 2024. Accessed July 27, 2024.

**42** ThaNet - Een breder gesprek over de dood en de psychiatrie. https://thanet.nl/.

**43** ThaNet mission statement. https://thanet.nl/over/missie/.

**44** Vaarwerk L. Radboud Marijnissen over zijn ervaring met second opinions bij euthanasieverzoeken. https://thanet.nl/ervaringen/radboud-marijnissen-over-zijn-ervaring-met-second-opinions-bij-euthanasieverzoeken/. Accessed July 27, 2025.

**45** Over ThaNet. https://thanet.nl/over/.

**46** Kim SYH, Vries RG de, Peteet JR. Euthanasia and Assisted Suicide of Patients With Psychiatric Disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry*. 2016;73(4):362-368. doi:10.1001/jamapsychiatry.2015.2887.

**47** Verhofstadt M, Thienpont L, Peters G-JY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry*. 2017;211(4):238-245. doi:10.1192/bjp.bp.117.199331.

**48** van Veen SMP. *The art of letting go: A study on irremediable psychiatric suffering in the context of physician assisted death*. [PhD-Thesis - Research and graduation internal]: Vrije Universiteit Amsterdam; 2022.

**49** Vanmechelen K. Kit Vanmechelen over euthanasie op psychische gronden. *NTVG.* Updated December 27, 2023. https://www.ntvg.nl/artikelen/kit-vanmechelen-over-euthanasie-op-psychische-gronden?check_logged_in=1. Accessed July 18, 2024.

**50** Bosma F, Mink KR, van Delden JJM, van der Heide A, van de Vathorst S, van Thiel GJMW. The Dutch practice of euthanasia and assisted suicide in patients suffering from psychiatric disorders: a qualitative case review study. *Front Psychiatry*. 2024;15:1452835. doi:10.3389/fpsyt.2024.1452835.

**51** Oosterhoff M. Psychiaters, zie de rauwe werkelijkheid onder ogen. *NRC.* Updated March 21, 2024. https://www.nrc.nl/nieuws/2024/03/21/psychiaters-zie-de-rauwe-werkelijkheid-onder-ogen-a4193778. Accessed July 18, 2024.

**52** Goffau M de. Vlak voor zijn zelfgekozen dood spreekt David nog één keer over zijn psychisch lijden, bij Khalid & Sophie. *Metro.* Updated May 10, 2023. https://www.metronieuws.nl/televisie/2023/10/euthanasie-david-mulder-khalid-sophie-menno-oosterhoff/. Accessed July 18, 2024.

**53** Kammeraat M, van Rooijen G, Kuijper L, Kiverstein JD, Denys DAJP. Patients requesting and receiving euthanasia for psychiatric disorders in the Netherlands. *BMJ Ment Health*. 2023;26(1). doi:10.1136/bmjment-2023-300729.

**54** In liefde laten gaan – Stichting voor ouders van een kind dat binnenkort euthanasie krijgt of al heeft gekregen op basis van een psychische aandoening. https://www.inliefdelatengaan.nl/. Updated July 14, 2024. Accessed July 14, 2024.

**55** Doelstellingen – In liefde laten gaan. https://www.inliefdelatengaan.nl/doelstellingen/. Updated July 17, 2024. Accessed July 17, 2024.

**56** Onze verhalen – In liefde laten gaan. https://www.inliefdelatengaan.nl/onze-verhalen/. Updated July 17, 2024. Accessed July 17, 2024.

**57** Hensbergen E. Ellens dochter Esther koos na psychisch lijden voor euthanasie: 'Niet iedereen wordt beter'. *LINDA.* Updated September 24, 2023. https://www.linda.nl/persoonlijk/opvoeden/ellen-dochter-esther-euthanasie-psychisch-lijden/. Accessed July 15, 2024.

**58** Buchanan A. 'My 33-year-old anorexic daughter died by euthanasia – my husband and I stood by her'. *The Telegraph.* Updated April 7, 2024. https://www.telegraph.co.uk/family/life/euthanasia-anorexia-husband-didnt-agree-netherlands/. Accessed July 10, 2024.

**59** Hoorn I. 'Maartje (23) is zwak, maar scherp als het over haar uitvaart gaat: de dag van haar overlijden noemt ze haar bevrijdingsdag'. *LINDA.* Updated May 14, 2024. https://www.linda.nl/persoonlijk/iede-hoorn-uitvaartverhalen-maartje/. Accessed July 26, 2025.

**60** In Memoriam – In liefde laten gaan. https://www.inliefdelatengaan.nl/in-memoriam/. Updated July 17, 2024. Accessed July 17, 2024.

**61** Wie zijn wij? – In liefde laten gaan. https://www.inliefdelatengaan.nl/wie-zijn-wij/. Updated July 18, 2024. Accessed July 18, 2024.
**62** Bos K. 'We relativeren allebei de maakbaarheid van het bestaan'. *NRC.* Updated June 9, 2023. https://www.nrc.nl/nieuws/2023/09/06/we-relativeren-allebei-de-maakbaarheid-van-het-bestaan-a4173713. Accessed July 18, 2024.
**63** Blakemore S-J, Choudhury S. Development of the adolescent brain: implications for executive function and social cognition. *J Child Psychol Psychiatry*. 2006;47(3-4):296-312. doi:10.1111/j.1469-7610.2006.01611.x.
**64** Roberts BW, Walton KE, Viechtbauer W. Patterns of mean-level change in personality traits across the life course: a meta-analysis of longitudinal studies. *Psychol Bull*. 2006;132(1):1-25. doi:10.1037/0033-2909.132.1.1.
**65** Caspi A, Roberts BW, Shiner RL. Personality development: stability and change. *Annu Rev Psychol*. 2005;56:453-484. doi:10.1146/annurev.psych.55.090902.141913.
**66** Lewsey F. Scientists identify five ages of the human brain over a lifetime. https://www.cam.ac.uk/stories/five-ages-human-brain. Accessed January 31, 2026.
**67** Mousley A, Bethlehem RAI, Yeh F-C, Astle DE. Topological turning points across the human lifespan. *Nat Commun*. 2025;16(1):10055. doi:10.1038/s41467-025-65974-8.
**68** Mehlum L, Schmahl C, Berens A, et al. Euthanasia and assisted suicide in patients with personality disorders: a review of current practice and challenges. *Borderline Personal Disord Emot Dysregul*. 2020;7:15. doi:10.1186/s40479-020-00131-9.
**69** Nicolini ME, Peteet JR, Donovan GK, Kim SYH. Euthanasia and assisted suicide of persons with psychiatric disorders: the challenge of personality disorders. *Psychol Med*. 2020;50(4):575-582. doi:10.1017/S0033291719000333.
**70** Kessler RC, Berglund P, Demler O, et al. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*. 2003;289(23):3095-3105. doi:10.1001/jama.289.23.3095.
**71** Verhofstadt M, van Assche K, Pardon K, Gleydura M, Titeca K, Chambaere K. Perspectives on the eligibility criteria for euthanasia for mental suffering caused by psychiatric disorder under the Belgian Euthanasia Law: A qualitative interview study among mental healthcare workers. *Int J Law Psychiatry*. 2024;93:101961. doi:10.1016/j.ijlp.2024.101961.
**72** Bosma O. Interview huisarts Dirk Jan van Wijk - Onno Bosma. *Onno Bosma.* Updated April 14, 2024. https://onnobosma.nl/interview-huisarts-dirk-jan-van-wijk/. Accessed July 10, 2024.
**73** Oosterhoff M. Geen spoor van twijfel. *Medisch Contact blogs&columns.* Updated February 28, 2020. https://www.medischcontact.nl/opinie/blogs-columns/blog/geen-spoor-van-twijfel-.
**74** Subramanya R. 'I'm 28. And I'm Scheduled to Die in May.'. *The Free Press.* Updated January 4, 2024. https://www.thefp.com/p/im-28-and-im-scheduled-to-die. Accessed July 14, 2024.
**75** Boudewijn Chabot. Verontrustende cultuuromslag rond de zelfgekozen dood. *NRC.* Updated June 16, 2017. https://www.nrc.nl/nieuws/2017/06/16/de-euthanasiegeest-is-uit-de-fles-11123806-a1563406. Accessed July 6, 2024.
**76** Oosterhoff M. Esther is over lijden. *Medisch Contact blogs&columns.* Updated December 27, 2021. https://www.medischcontact.nl/opinie/blogs-columns/blog/esther-is-over-lijden. Accessed July 17, 2024.
**77** Expertisecentrum Euthanasie. 'Ze is in liefde gekomen en in liefde gegaan.' - Expertisecentrum Euthanasie. https://expertisecentrumeuthanasie.nl/Interviews/ze-is-in-liefde-gekomen-en-in-liefde-gegaan/. Updated December 9, 2022. Accessed July 15, 2024. During the investigation this report/interview was removed from the webiste of the Expertisecentrum Euthanasie, but the same text can be found, word by word, at https://www.inliefdelatengaan.nl/onze-verhalen/ze-is-in-liefde-gekomen-en-in-liefde-gegaan/.
**78** Bosma O. Zoraya en de SCEN-arts - Onno Bosma. *Onno Bosma.* Updated April 15, 2024. https://onnobosma.nl/zoraya-en-de-scen-arts/. Accessed July 22, 2024.
**79** Ik wil graag een buddy | Stichting KEA. https://stichtingkea.nl/ik-wil-graag-een-buddy/. Updated February 14, 2024. Accessed July 22, 2024.
**80** Artikel 294 Wetboek van Strafrecht. https://maxius.nl/wetboek-van-strafrecht/artikel294/.
**81** Bosma O. Interview Mandy - Onno Bosma. *Onno Bosma.* Updated November 30, 2023. https://onnobosma.nl/interview-mandy/. Accessed July 14, 2024.
**82** Israël L, Lévy É. *Les dangers de l'euthanasie: Entretiens avec Élisabeth Lévy*. Paris: Éd. des Syrtes; 2002.
**83** Pothoven N. Blog van Noa Pothoven, 17 jaar. https://www.hsleiden.nl/binaries/content/assets/hsl/lectoraten/residentiele-jeugdzorg/nieuws/blog-noa-020419.pdf. Accessed July 22, 2025.

**84** Faber K. *Letting You Go - Ik laat je gaan*. Netherlands: IDFA 2014; 2014. https://www.idfa.nl/en/film/00f013eb-0bd3-45c4-af46-1ef9fbb29d1a/letting-you-go/.
**85** 'Ik leef op de gedachte dat dit haar grootste wens was.'. https://expertisecentrumeuthanasie.nl/Interviews/er-is-kracht-nodig-om-voor-euthanasie-te-kiezen/. Updated March 15, 2021. During the investigation this report/interview was removed from the webiste of the Expertisecentrum Euthanasie, but the same text can be found, word by word, at https://vriendenvanee.nl/Interviews/er-is-kracht-nodig-om-voor-euthanasie-te-kiezen/.
**86** Thomasy H. Eight ways scientists are unwrapping the mysteries of the human brain. *MIT Technology Review.* Updated August 25, 2021. https://www.technologyreview.com/2021/08/25/1031458/scientific-mysteries-human-brain/. Accessed June 29, 2024.
**87** Doelling KB, Assaneo MF. Neural oscillations are a start toward understanding brain activity rather than the end. *PLOS Biology*. 2021;19(5):e3001234. doi:10.1371/journal.pbio.3001234.
**88** Insel TR. Disruptive insights in psychiatry: transforming a clinical discipline. *J Clin Invest*. 2009;119(4):700-705. doi:10.1172/JCI38832.
**89** Kandel ER. A new intellectual framework for psychiatry. *Am J Psychiatry*. 1998;155(4):457-469. doi:10.1176/ajp.155.4.457.
**90** Zachar P, Kendler KS. Psychiatric disorders: a conceptual taxonomy. *Am J Psychiatry*. 2007;164(4):557-565. doi:10.1176/ajp.2007.164.4.557.
**91** Hyman SE. The diagnosis of mental disorders: the problem of reification. *Annu Rev Clin Psychol*. 2010;6:155-179. doi:10.1146/annurev.clinpsy.3.022806.091532.
**92** Whooley O. *On the heels of ignorance: Psychiatry and the politics of not knowing*. Chicago: The University of Chicago Press; 2019.
**93** Read J. Doctoring the Mind: Why psychiatric treatments fail. *Journal of Mental Health*. 2010;19(2):223-224. doi:10.3109/09638230903469285.
**94** Phillips J, Frances A, Cerullo MA, et al. The six most essential questions in psychiatric diagnosis: a pluralogue. Part 4: general conclusion. *Philos Ethics Humanit Med*. 2012;7:14. doi:10.1186/1747-5341-7-14.
**95** Thienpont L, Verhofstadt M, van Loon T, Distelmans W, Audenaert K, Deyn PP de. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open*. 2015;5(7):e007454. doi:10.1136/bmjopen-2014-007454.
**96** Dierickx S, Deliens L, Cohen J, Chambaere K. Euthanasia for people with psychiatric disorders or dementia in Belgium: analysis of officially reported cases. *BMC Psychiatry*. 2017;17(1):203. doi:10.1186/s12888-017-1369-0.
**97** Verhofstadt M, van Assche K, Sterckx S, Audenaert K, Chambaere K. Psychiatric patients requesting euthanasia: Guidelines for sound clinical and ethical decision making. *Int J Law Psychiatry*. 2019;64:150-161. doi:10.1016/j.ijlp.2019.04.004.
**98** Snijdewind MC, Keijser J de, Casteelen G, Boelen PA, Smid GE. "I lost so much more than my partner" - Bereaved partners' grief experiences following suicide or physician-assisted dying in case of a mental disorder. *BMC Psychiatry*. 2022;22(1):454. doi:10.1186/s12888-022-04098-5.
**99** Marks S, Rosielle D. FF #210 Suicide Attempts in The Terminally Ill: Palliative Care Network of Wisconsin. https://www.mypcnow.org/fast-fact/suicide-attempts-in-the-terminally-ill/. Updated November 11, 2024. Accessed June 16, 2025.
**100** Hartogh G. Stervenshulp holt zolgvuldigheidseisen uit. *Medisch Contact*. 2017;02(07):34-36. https://www.medischcontact.nl/actueel/laatste-nieuws/artikel/stervenshulp-holt-zorgvuldigheidseisen-uit.
**101** Nicolini ME, Kim SYH, Churchill ME, Gastmans C. Should euthanasia and assisted suicide for psychiatric disorders be permitted? A systematic review of reasons. *Psychol Med*. 2020;50(8):1241-1256. doi:10.1017/S0033291720001543.
**102** Tanner R. An Ethical-Legal Analysis of Medical Assistance in Dying for Those with Mental Illness. *ALR*. 2018:149. doi:10.29173/alr2500.
**103** Parker M. Defending the indefensible? Psychiatry, assisted suicide and human freedom. *Int J Law Psychiatry*. 2013;36(5):485-497. doi:10.1016/j.ijlp.2013.06.007.
**104** Hartogh G den. Why extra caution is needed in the case of depressed patients. *J Med Ethics*. 2015;41(8):588-589. doi:10.1136/medethics-2015-102814.
**105** Schuklenk U, van de Vathorst S. Treatment-resistant major depressive disorder and assisted dying. *J Med Ethics*. 2015;41(8):577-583. doi:10.1136/medethics-2014-102458.

**106** Dembo J, Schuklenk U, Reggler J. "For Their Own Good": A Response to Popular Arguments Against Permitting Medical Assistance in Dying (MAID) where Mental Illness Is the Sole Underlying Condition. *Can J Psychiatry*. 2018;63(7):451-456. doi:10.1177/0706743718766055.
**107** Teo MTL. Why the irremediability requirement is not sufficient to deny psychiatric euthanasia for patients with treatment-resistant depression. *J Med Ethics*. 2024;50(11):753-757. doi:10.1136/jme-2023-109644.
**108** Sagan A. Equal in the presence of death? *J Med Ethics*. 2015;41(8):584. doi:10.1136/medethics-2015-102810.
**109** Player CT. Death with Dignity and Mental Disorder. *Arizona Law Review*. 2018;60:115-161. https://arizonalawreview.org/death-with-dignity-and-mental-disorder/. Accessed July 14, 2024.
**110** Steinbock B. Physician-Assisted Death and Severe, Treatment-Resistant Depression. *Hastings Cent Rep*. 2017;47(5):30-42. http://www.jstor.org/stable/26628311.
**111** Rooney W, Schuklenk U, van de Vathorst S. Are Concerns About Irremediableness, Vulnerability, or Competence Sufficient to Justify Excluding All Psychiatric Patients from Medical Aid in Dying? *Health Care Anal*. 2018;26(4):326-343. doi:10.1007/s10728-017-0344-8.
**112** Death on demand: has euthanasia gone too far? *The Guardian.* Updated January 18, 2019. https://www.theguardian.com/news/2019/jan/18/death-on-demand-has-euthanasia-gone-too-far-netherlands-assisted-dying. Accessed September 13, 2024.
**113** Pressly L. The troubled 29-year-old helped to die by Dutch doctors. *BBC News.* Updated August 9, 2018. https://www.bbc.com/news/stories-45117163. Accessed July 18, 2024.
**114** Frances A, Fyer M, Clarkin J. Personality and suicide. *Ann N Y Acad Sci*. 1986;487:281-293. doi:10.1111/j.1749-6632.1986.tb27907.x.
**115** Cristea IA, Gentili C, Cotet CD, Palomba D, Barbui C, Cuijpers P. Efficacy of Psychotherapies for Borderline Personality Disorder: A Systematic Review and Meta-analysis. *JAMA Psychiatry*. 2017;74(4):319-328. doi:10.1001/jamapsychiatry.2016.4287.
**116** Stoffers JM, Völlm BA, Rücker G, Timmer A, Huband N, Lieb K. Psychological therapies for people with borderline personality disorder. *Cochrane Database Syst Rev*. 2012;2012(8):CD005652. doi:10.1002/14651858.CD005652.pub2.
**117** Storebø OJ, Stoffers-Winterling JM, Völlm BA, et al. Psychological therapies for people with borderline personality disorder. *Cochrane Database Syst Rev*. 2020;5(5):CD012955. doi:10.1002/14651858.CD012955.pub2.
**118** Simonsen S, Bateman A, Bohus M, et al. European guidelines for personality disorders: past, present and future. *Borderline Personal Disord Emot Dysregul*. 2019;6:9. doi:10.1186/s40479-019-0106-3.
**119** Bolt EE, Snijdewind MC, Willems DL, van der Heide A, Onwuteaka-Philipsen BD. Can physicians conceive of performing euthanasia in case of psychiatric disease, dementia or being tired of living? *J Med Ethics*. 2015;41(8):592-598. doi:10.1136/medethics-2014-102150.
**120** Kruger J, Dunning D. Unskilled and unaware of it: how difficulties in recognizing one's own incompetence lead to inflated self-assessments. *J Pers Soc Psychol*. 1999;77(6):1121-1134. doi:10.1037/0022-3514.77.6.1121.
**121** Regionale Toetsingscommissies Euthanasie. www.euthanasiecommissie.nl. Accessed July 22, 2024.
**122** ResearchGate. Menno OOSTERHOFF | lentis | Research profile. https://www.researchgate.net/profile/Menno-Oosterhoff. Updated June 28, 2018. Accessed July 16, 2024.
**123** ResearchGate. Lars MEHLUM | Professor, Head of Department | MD PhD | University of Oslo, Oslo | National Centre for Suicide Research and Prevention (NSSF) | Research profile. https://www.researchgate.net/profile/Lars-Mehlum. Updated July 10, 2024. Accessed July 16, 2024.
**124** Ellin A. Should anorexia ever be called 'terminal'? *The Washington Post.* Updated November 1, 2023. https://www.washingtonpost.com/style/of-interest/2023/11/01/anorexia-suicide-controversy-jennifer-gaudiani/. Accessed July 14, 2024.
**125** Verhofstadt M. *Euthanasia in the Context of Adult Psychiatry: Walking the Tightrope Between Life and Death*: Vrije Universiteit Brussel; 2022.
**126** Haan B. Damiaan Denys: 'De wens om niet te willen leven mag je niet gelijkstellen aan de wens om dood te zijn'. *NRC.* Updated July 19, 2024. https://www.nrc.nl/nieuws/2024/07/19/de-wens-om-niet-te-willen-leven-mag-je-niet-gelijk-stellen-aan-de-wens-om-dood-te-zijn-a4860058. Accessed July 22, 2024.
**127** Vermani M, Marcus M, Katzman MA. Rates of detection of mood and anxiety disorders in primary care: a descriptive, cross-sectional study. *Prim Care Companion CNS Disord*. 2011;13(2). doi:10.4088/PCC.10m01013.
**128** Hirschfeld RMA, Lewis L, Vornik LA. Perceptions and impact of bipolar disorder: how far have we really come? Results of the national depressive and manic-depressive association 2000 survey of individuals with bipolar disorder. *J Clin Psychiatry*. 2003;64(2):161-174.

**129** Kentrou V, Livingston LA, Grove R, Hoekstra RA, Begeer S. Perceived misdiagnosis of psychiatric conditions in autistic adults. *EClinicalMedicine*. 2024;71:102586. doi:10.1016/j.eclinm.2024.102586.
**130** Rothschild AJ, Winer J, Flint AJ, et al. Missed diagnosis of psychotic depression at 4 academic medical centers. *J Clin Psychiatry*. 2008;69(8):1293-1296. doi:10.4088/jcp.v69n0813.
**131** Ayano G, Demelash S, yohannes Z, et al. Misdiagnosis, detection rate, and associated factors of severe psychiatric disorders in specialized psychiatry centers in Ethiopia. *Annals of General Psychiatry*. 2021;20(1):10. doi:10.1186/s12991-021-00333-7.
**132** Schmahl O, Oude Voshaar R, van de Poel-Mustafayeva A, Marijnissen R. Request for euthanasia by a psychiatric patient with undetected intellectual disability. *BMJ Case Rep*. 2021;14(8). doi:10.1136/bcr-2020-239862.
**133** New York Post. 22-year-old reveals the question that saved her life just moments before assisted suicide. https://nypost.com/2024/11/14/lifestyle/22-year-old-backs-out-of-euthanasia-at-the-last-second/. Updated November 14, 2024. Accessed July 24, 2025.
**134** How a young Dutch woman's life began when she was allowed to die. *The Guardian.* Updated December 17, 2024. https://www.theguardian.com/society/ng-interactive/2024/dec/17/euthanasia-assisted-dying-netherlands-stephanie-bakker. Accessed July 24, 2025.
**135** Klemann, Désirée M T V, Mertens, Helen J M M, van Merode GG. Health care claims per medical specialty in the Netherlands: a 10-year overview. *Ned Tijdschr Geneeskd*. 2019;163.
**136** Taylor M. 22 specialties with the highest malpractice frequency. *Becker's Hospital Review.* Updated October 27, 2023. https://www.beckershospitalreview.com/hospital-physician-relationships/22-specialties-with-the-highest-malpractice-frequency.html. Accessed July 16, 2024.
**137** Hendin H. Assisted suicide, euthanasia, and suicide prevention: the implications of the Dutch experience. *Suicide Life Threat Behav*. 1995;25(1):193-204.
**138** Kreulen E. 'Euthanasie bij wilsonbekwame dementiepatiënten is niet te verdedigen'. *Trouw.* Updated January 13, 2018. https://www.trouw.nl/nieuws/euthanasie-bij-wilsonbekwame-dementiepatienten-is-niet-te-verdedigen~b70bdd45/. Accessed September 13, 2024.
**139** Regionale Toetsingscommissies Euthanasie. Jaarverslagen 2014. https://www.euthanasiecommissie.nl/uitspraken/jaarverslagen/2014/nl/nl/jaarverslag-2014. Updated July 22, 2024. Accessed July 22, 2024.
**140** Sanou H. More people opt for euthanasia because of mental suffering - DutchNews.nl. *Dutch News.* Updated April 4, 2024. https://www.dutchnews.nl/2024/04/more-people-opt-for-euthanasia-because-of-mental-suffering/. Accessed July 22, 2024.
**141** Redactie S. Hockeyclub Rotterdam rouwt om overlijden 'kind van de club' Fleur (35): 'Ontzettend verdrietig'. *OPEN Rotterdam.* Updated February 22, 2024. https://openrotterdam.nl/hockeyclub-rotterdam-rouwt-om-overlijden-kind-van-de-club-fleur-35-ontzettend-verdrietig/. Accessed September 13, 2024.
**142** Euthanasia for depression: the 'Shanti case' cancels hope. https://newdailycompass.com/en/euthanasia-for-depression-the-shanti-case-cancels-hope. Updated September 11, 2024. Accessed September 11, 2024.
**143** Wilde B de. Eindelijk erkenning voor Shanti (23), die euthanasie pleegde nadat ze getuige was van aanslagen Zaventem. *LINDA.* Updated July 26, 2023. https://www.linda.nl/nieuws/buitenland/shanti-23-pleegt-euthanasie-na-aanslagen-op-brussel-airport/. Accessed September 11, 2024.
**144** Hert M de, Loos S, Sterckx S, Thys E, van Assche K. Improving control over euthanasia of persons with psychiatric illness: Lessons from the first Belgian criminal court case concerning euthanasia. *Front Psychiatry*. 2022;13:933748. doi:10.3389/fpsyt.2022.933748.

Website: www.psychiatrischeeuthanasie.nl

Correspondence: contact@psychiatrischeeuthanasie.nl