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Analysis

Psychiatric euthanasia, suicide and the role of gender

Marie E. Nicolini, Chris Gastmans and Scott Y.H. Kim

The preponderance of women among persons who request and receive euthanasia and assisted suicide based on a psychiatric condition, as shown by data from The Netherlands and Belgium, is virtually unexplored. We provide a critical discussion of this gender gap, and propose that it can inform a key debate point in the controversy over the practice, namely its conflict with suicide prevention.

Keywords
Euthanasia; assisted suicide; suicide; ethics; psychiatry and law.

Euthanasia and/or medically assisted suicide when primarily based on a psychiatric disorder (often referred to as psychiatric EAS) is permitted in some European countries, such as Belgium and The Netherlands, but remains controversial.[1,2] In those countries, EAS is permitted for persons who suffer unbearably and irremediably because of a medical (including psychiatric) condition. Women account for the majority (69–77%) of persons who request and receive euthanasia based on a psychiatric condition.[3–6] Although this is one of the most consistent findings emerging from the research on the topic, the gender gap and its meaning have received virtually no discussion.

In this paper, we discuss how understanding this gender gap can inform a key dispute in the debate about psychiatric EAS, namely its conflict with suicide prevention. One way to address this conflict is to argue that psychiatric EAS and suicide are different phenomena, characterising suicide as an impulsive act of violent self-destruction, and EAS as a planned and well-considered act.[7] However, it is unclear whether this distinction is empirically founded. We will examine whether and how the gender gap can inform this question in an evidence-based manner.

In the following sections, we first briefly provide some background on psychiatric EAS in the Netherlands and Belgium, then critically examine current accounts of the difference between psychiatric EAS and suicide. Next, we turn to ideation-to-action theories of suicide, arguing that, when combined with the gender gap in psychiatric EAS, such theories support the hypothesis that differences between psychiatric EAS and suicide are not based on impulsivity, but rather on the notion of suicide 'capability'. Finally, we outline the implications of this finding for the practice of psychiatric EAS. We argue that the pool of potential psychiatric EAS requestors and the associated risk for error might be higher than previously assumed, and explain how current guidance might contribute to this risk. We conclude by drawing some implications for public policy.

Psychiatric EAS in The Netherlands and Belgium

Legal requirements for EAS

According to the Dutch Termination of Life on Request and Assisted Suicide Act (2002), the substantive requirements are that the attending physician must be satisfied that the patient's request is voluntary and well-considered, and that the patient's suffering is unbearable and without prospect of improvement, and must have come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation.[8,9] The Belgian Act Concerning Euthanasia (2002) has similar, albeit differently formulated, key substantive requirements: the physician must come to the conviction, together with the patient, that the request be voluntary, that the disorder be serious and incurable, and must ascertain that the physical or mental suffering of the patient cannot be alleviated.[2] The procedural requirements and oversight systems in the two jurisdictions are discussed in the following.

Process and oversight systems for EAS

The Belgian Act requires that the physician consult a second physician – a psychiatrist, in cases of psychiatric EAS – and requires a waiting time of at least 1 month for all non-terminally ill cases, including requests based on a psychiatric disorder. Although the Dutch Act requires that the physician consults at least one other independent physician, it does not specify that this be a psychiatrist for psychiatric EAS cases. However, in these cases, a psychiatric consultation is required by the Dutch Euthanasia Review Committees. Both countries have established services providing such consultants: Support and Consultation for Euthanasia in the Netherlands and Life End Information Forum in Belgium. All EAS cases need to be reported to the Regional Euthanasia Review Committees and the Federal Control and Evaluation Commission on Euthanasia, respectively, in The Netherlands and Belgium. These committees review the EAS reports to assess whether the physician who performed EAS conformed to the legal due care criteria.[2,9]

Understanding the gender gap in psychiatric EAS

Current explanations for the difference between psychiatric EAS and suicide

Current explanations for the difference between psychiatric EAS and suicide describe different phenomena, with emphasis on the alleged different role of impulsive action in both cases.[7,10,11] The American Association for Suicidology states that suicide and EAS, including psychiatric EAS, are in general quite distinct, involving different patient characteristics. They characterise suicide as associated with violent self-destruction, isolation, loss of meaning, ambivalence and psychological pain. On the other hand, they describe persons requesting EAS as engaging in a planned act of self-preservation, experiencing intensified emotional bonds with loved ones.[7] Others have also characterised suicide as a quasi-impulsive, violent and lonely act, to be distinguished from EAS, which is seen as a carefully executed, non-violent plan in dialogue with others.[10] Some guidelines on psychiatric EAS state that suicidal behaviour 'usually involves impulsive behaviour', as opposed to the death wish in psychiatric EAS.[12] Currently, the same distinction is proposed to explain the different gender distributions in suicide

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and psychiatric EAS: suicides are violent and impulsive (hence the greater proportion of men), whereas psychiatric EAS is planned and controlled (hence the greater proportion of women).[5]

Such contrasting portrayals of persons who die by suicide and those who die by EAS as fundamentally different rely on unfounded assumptions.[11] Their key reliance on impulsivity can be challenged, as the role of impulsive action in suicide has been overstated, and only very little suicidal behaviour (lethal or non-lethal) occurs without planning.[13–15] In fact, impulsive attempts are associated with lower psychopathology,[13] whereas individuals who are at particularly high risk for suicide (i.e. those with depression, substance use and/or a history of childhood sexual abuse) are less likely to engage in impulsive attempts. Impulsive action is neither necessary nor sufficient for suicide, and cannot explain the difference between suicide and psychiatric EAS, nor its different gender distributions.

We should therefore re-examine this empirically unsupported assumption. For this purpose, we will consider the usefulness of ideation-to-action theories, which focus on the suicidal process from suicidal ideation to behaviour.[14–16] This framework has received considerable clinical and research attention.[15,17] Rather than emphasising the role of suicide risk factors, it focuses on the concept of suicide 'capability', which determines the transition from suicidal ideation to (lethal and non-lethal) suicidal behaviour. Within this framework, 'capability' includes practical factors (knowledge of and access to highly lethal means) and psychological factors (fearlessness of death, pain tolerance), both of which can be acquired over time.[14–19] In the following sections, we analyse the gender distributions in suicide and psychiatric EAS, and examine the potential role for capability as an alternative, empirically grounded explanation for the relationship between suicide and psychiatric EAS.

Capability, gender and suicide

The difference between the gender distribution in suicide and in suicide attempts is well known, and is referred to as the suicide 'gender paradox'.[18,20] The most consistently cited explanation for this paradox is the gender difference in methods chosen: women choose less violent and lethal methods than men.[18,21] For example, men tend to use methods such as hanging or fire-arms, whereas women often choose self-poisoning. Research suggests that differences in capability among those who attempt suicide is why more men die by suicide than women.[15]

The choice for low lethality methods may indicate lower suicide capability, especially as it relates to the psychological aspects, since these methods may be perceived as involving less physical pain and be relatively less frightening.[15,22] Furthermore, the robust finding that women show a higher number of non-lethal attempts before a lethal attempt is consistent with the claim that through repeated attempts, women gradually increase their capability and the lethality of their attempts.[13,16,18,23]

We note, however, that other authors emphasise sociocultural beliefs and attitudes toward suicidal behaviour in explaining gender differences in suicide.[17,24] For example, in Western countries, non-lethal suicidal behaviour is considered more socially acceptable for women than for men, but this may be different in non-Western countries.[24] High female suicide rates in countries like China[25] show that women's so-called low capability for suicide in Western countries may vary depending on the sociocultural context.

Capability, gender and psychiatric EAS

The above capability framework suggests a natural explanation of the gender gap in psychiatric EAS, and better conforms to the known literature on suicide than an explanation based on impulsivity. EAS is a painless and highly lethal method of death, which is professionally and socially approved in countries where it is legal. The important psychological components of capability involve the ability to face death and to enact something painful to one's own body.[16,19] The latter barrier, for instance, is removed when someone receives EAS, as it does not involve pain or violence.

This finding is analogous to the well-known case in suicidology of high female suicide rates in rural China. This is attributed to men's and women's equal access to readily available, non-violent but highly lethal pesticides, as opposed to the less toxic analgesics and psychotropic medications commonly ingested in high-income countries.[17,18,25,26] The case of rural China shows that mortality significantly increases when persons with a strong death wish have access to non-violent, lethal methods.

If the different gender distributions in suicide and psychiatric EAS are primarily accounted for by differences in capability, we should expect similar gender ratios between those who attempt suicide (as opposed to those who complete suicide) and persons receiving psychiatric EAS. And this is what we find. Men are two to three times more likely to die by suicide than women in most countries, including The Netherlands, whereas women are about twice as likely (2.1:1) to attempt suicide.[3,17,26,27] The women:men ratio in psychiatric EAS (2.3:1) is virtually identical to that of those who attempt suicide, not those who complete it.

This suggests that the relationship between suicide and psychiatric EAS is not based the problematic concept of impulsivity. Rather, capability is more likely to explain why some patients resort to EAS rather than suicide. This suggests that patient profiles of people requesting and receiving psychiatric EAS could be more similar in terms of suicidal behaviour than previously assumed.[11] Persons with a strong death wish but low capability, who might not die if they attempt suicide, can achieve death if they use EAS instead.

Discussion

Whether psychiatric EAS conflicts with the duty to prevent suicide remains a topic of debate. One way to address this conflict is to distinguish between suicide and (psychiatric) EAS, by characterising suicide as an impulsive, typically violent action, and EAS as planned and well considered.[7] However, this distinction is not well-grounded empirically and does little to refute the claim that psychiatric EAS is in conflict with suicide prevention. Ideation-to-action explanations of suicide, focusing on the suicidal *process*, suggest that the distinction is not as straightforward as some have argued. The notion of capability that they invoke suggests that the gender paradox in suicide is closely related to the gender gap in psychiatric EAS: women resort to psychiatric EAS as a form of suicide of which they are 'capable'. And, as we have shown, the numbers are consistent with this analysis. Persons requesting and receiving psychiatric EAS tend to be similar to those attempting suicide, a finding corroborated by emerging data from the practice of psychiatric EAS.[3,11,28,29] In suicide terms, the use of EAS turns those who attempt suicide with low capability into those who complete suicide. This raises several, so far underexplored, implications for the practice of psychiatric EAS and public policy.

First, it suggests that the number of persons engaging in suicidal behaviour, both non-lethal and lethal (i.e. those who attempt and those who complete suicide), could provide an approximation of the pool size of potential psychiatric EAS requestors. For example, in a country like Belgium, with 11 million inhabitants and notoriously high suicide rates, the region of Flanders counts three suicides and an estimated average of 28 suicide attempts per day.[30] This amounts to 1095 suicides and over 10 000 suicide attempts per year – nine attempts for every suicide. It is reasonable to assume that a significant

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proportion of these persons might consider psychiatric EAS at some point during their suicidal process, as psychiatric EAS becomes better known as an option. Hence, the pool of potential requestors is likely large, perhaps more so than previously assumed.

For some, providing a more humane alternative to persons who would otherwise die by suicide is the aim of psychiatric EAS.[31,32] For example, psychiatrist Lieve Thienpont, one of the three physicians acquitted in the Belgian Tine Nys court trial, stated that 'We have 3 to 4 suicides per day in Flanders, 90% of whom suffer mentally. What can we do to shift this suicidal thought to a request for euthanasia?'.[31] However, this view does not take into account that such a shift would not be limited to those who complete suicide.

Second, a large pool of potential requestors that mostly consists of those who attempt suicide raises the issue of an increased opportunity for error, i.e. the risk for avoidable deaths. The risk for error is a known area of dispute in the debate about psychiatric EAS.[32] Scholars disagree on whether it should count as an argument against psychiatric EAS or merely as grounds for caution. Regardless of where one stands, the dispute has so far mainly referred to potential errors in assessing the irremediability of the person's psychiatric condition, their unbearable suffering or their decision-making capacity. The findings of our analysis point to a different type of risk, namely the one associated with not detecting suicidal behaviour that could respond to treatment. The question is particularly salient for subgroups with low suicide capability and a more protracted suicide process, like women or younger adults,[17,18] as the choice of psychiatric EAS over traditional means of suicide could result in a substantial increase in mortality. That is, the difference between expected mortality rates through suicide versus through EAS could be highest in these subgroups and the risk for error may, on average, come at a higher cost for each individual.

One way to address this conundrum is by establishing clear guidance for clinicians, to identify those whose requests for psychiatric EAS stem from suicidal ideation and behaviour that could respond to treatment. Currently, guidelines are silent on whether suicidal ideation and behaviour should play a role in how 'irremediability' is defined, potentially exacerbating the risk for error. In fact, they define the criterion exclusively in terms of treatment options for the underlying psychiatric condition.[12,33] This may be because of the assumption that treating a psychiatric condition will also improve associated suicidal behaviour. However, this assumption is mistaken. Treatments targeting a psychiatric condition do not necessarily reduce suicidal thoughts or behaviour.[15] Furthermore, although established evidence-based treatments for suicidal behaviour exist, including pharmacological and psychological treatment, only about 60% of people with suicidal ideation and behaviour receive treatment.[15] This raises important questions about the extent of unmet needs among persons at risk for suicide who request psychiatric EAS.

For example, psychological treatments such as dialectical behaviour therapy for borderline personality disorder or cognitive therapy for those who have recently attempted suicide have proven effective.[15,17] However, in a recent analysis, we found that these interventions are rare among persons receiving psychiatric EAS: cognitive therapies were reported in 14% and dialectical behaviour therapy in 0% of the 74 included personality-related disorder cases, whereas 47% had attempted suicide once and 36% had attempted suicide multiple times before their request.[29] To reduce the risk that a psychiatric EAS request actually stems from suicidal behaviour, further discussion is needed about the role for established suicidal behaviour treatments in current guidance defining irremediability. This also points to the need for sufficient and independent expertise in these evaluations going forward, as both The Netherlands and Belgium continue to face difficulties recruiting psychiatrists who are willing to be actively involved in these evaluations.[31,34,35]

Finally, the similarities between persons at risk for suicide and those requesting psychiatric EAS calls for further attention to population-wide suicide risk factors that may apply to psychiatric EAS. For example, the effect of media reporting on imitation behaviour is a risk factor targeted in key population-level suicide prevention strategies.[17] Although the regulation of media reporting does not apply to (psychiatric) EAS, similar patterns of imitation could be expected in persons who consider requesting psychiatric EAS. To assume that the same patterns do not apply is only tenable if the clinical profiles are distinct, but not if they appear similar. Yet patients' perceptions and attitudes toward others' deaths by psychiatric EAS remains an open empirical question.

The overlap between suicide and psychiatric EAS calls for further research to better characterise persons who request psychiatric EAS. Given that the majority of people who attempt suicide are women, particular attention should be paid to women's reasons for requesting psychiatric EAS. This includes possible reasons for why women are more likely to express a death wish in the first place, why some persons with a death wish request psychiatric EAS and others do not, and why some proceed with their request once it is granted and others withdraw. But, if some of the reasons also include known actionable societal or gendered risk factors for mental disorders and suicidal behaviour, this raises additional issues warranting attention in the context of psychiatric EAS and public policy.

For example, gender-based violence, affecting 35% of women worldwide, is a clear example of a gendered environmental risk factor for mental disorders and suicidal behaviour that is common among persons requesting psychiatric EAS,[28,29] and an important public health issue for which prevention and management remains suboptimal.[36,37] Other gender-specific risk factors for common mental disorders include gender-based discrimination and unfavourable social and economic circumstances, such as low employment, income inequality, low social rank and status, and the unequal division of domestic labour and care.[37] Hence, the findings of this analysis raise implications for policy and research that go far beyond the boundaries of psychiatry.

Conclusions

Despite being empirically well established, the gender gap in psychiatric EAS has been underexplored so far. An analysis of its meaning using the ideation-to-action suicide theories shows that the gender gap provides key evidence that persons requesting and receiving psychiatric EAS could be more similar to persons engaging in suicidal behaviour than previously assumed. This raises important implications for the practice of psychiatric EAS and public policy.

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None.

References

1 Griffith J, Weyers H, Adams M. *Euthanasia and Law in Europe*. Hart Publishing, 2008.

2 Jones DA, Gastmans C, MacKellar C. *Euthanasia and Assisted Suicide: Lessons from Belgium*. Cambridge University Press, 2017.

3 Kim SY, De Vries RG, Peteet JR. Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry* 2016; **73**(4): 362–8.

4 Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K, De Deyn PP. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open* 2015; **5**: e007454.

5 van Veen SMP, Weerheim FW, Mostert M, van Delden JJM. Euthanasia of Dutch psychiatric patients in 2015–2017. *Tijdschr Psychiatr* 2019; **61**(4): 241–7.

6 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**: 203.

7 American Association of Suicidology. *Statement of the American Association of Suicidology: 'Suicide' Is Not the Same as 'Physician Aid in Dying'*. American Association of Suicidology, 2017 (https://suicidology.org/wp-content/uploads/2019/07/AAS-PAD-Statement-Approved-10.30.17-ed-10-30-17.pdf).

8 Onwuteaka-Philipsen BD, Legemaate J, van Der Heide A, van Delden H, Evenblij K, El Hammoud I, et al. *Derde Evaluatie Wet Toesting Levensbeeindiging op Verzoek en Hulp bij Zelfdoding. [Third Evaluation of the Dutch Termination of Life on Request and Assisted Suicide Act.]* The Netherlands Organisation for Health Research and Development (ZonMW), 2017 (https://publicaties.zonmw.nl/fileadmin/zonmw/documenten/Kwaliteit_van_zorg/Evaluatie_Regelgeving/Derde_evaluatie_Wtl.pdf).

9 Regional Euthanasia Review Committees. *Euthanasia Code 2018: Review Procedures in Practice*. Regional Euthanasia Review Committees, 2018 (https://english.euthanasiecommissie.nl/the-committees/code-of-practice).

10 den Hartogh G. Two kinds of suicide. *Bioethics* 2016; **30**(9): 672–80.

11 Kim SYH, Conwell Y, Caine ED. Suicide and physician-assisted death for persons with psychiatric disorders: how much overlap? *JAMA Psychiatry* 2018; **75** (11): 1099–100.

12 Nederlanse Vereniging voor Psychiatrie. *Levensbeëindiging op Verzoek bij Patiënten met een Psychische Stoornis. [Termination of Life on Request in Patients with a Mental Disorder.]* Federation of Medical Specialists, 2018 (https://richtlijnendatabase.nl/richtlijn/levensbeeindiging_op_ verzoek_psychiatrie/startpagina_-_levensbe_indiging_op_verzoek.html).

13 Anestis MD, Soberay KA, Gutierrez PM, Hernández TD, Joiner TE. Reconsidering the link between impulsivity and suicidal behavior. *Pers Soc Psychol* 2014; **18**(4): 366–86.

14 Klonsky ED, May AM, Saffer BY. Suicide, suicide attempts, and suicidal ideation. *Annu Rev Clin Psychol* 2016; **12**(1): 307–30.

15 O'Connor RC, Nock MK. The psychology of suicidal behaviour. *Lancet Psychiatry* 2014; **1**(1): 73–85.

16 Van Orden KA, Witte TK, Cukrowicz KC, Braithwaite SR, Selby EA, Joiner TE Jr. The interpersonal theory of suicide. *Psychol Rev* 2010; **117**(2): 575–600.

17 Turecki G, Brent DA, Gunnell D, O'Connor RC, Oquendo MA, Pirkis J, et al. Suicide and suicide risk. *Nat Rev Dis Primers* 2019; **5**(1): 74.

18 Schrijvers DL, Bollen J, Sabbe BG. The gender paradox in suicidal behavior and its impact on the suicidal process. *J Affect Disord* 2012; **138**(1–2): 19–26.

19 Franklin JC, Hessel ET, Prinstein MJ. Clarifying the role of pain tolerance in suicidal capability. *Psychiatry Res* 2011; **189**(3): 362–7.

20 Canetto SS, Sakinofsky I. The gender paradox in suicide. *SuicideLife Threat Behav* 1998; **28**(1): 1–23.

21 Hawton K. Sex and suicide. Gender differences in suicidal behaviour. *Br J Psychiatry* 2000; **177**: 484–5.

22 Nock MK, Hwang I, Sampson NA, Kessler RC. Mental disorders, comorbidity and suicidal behavior: results from the National Comorbidity Survey Replication. *Mol Psychiatry* 2010; **15**(8): 868–76.

23 Isometsa ET, Lonnqvist JK. Suicide attempts preceding completed suicide. *Br J Psychiatry* 1998; **173**: 531–5.

24 Dahlen ER, Canetto SS. The role of gender and suicide precipitant in attitudes toward nonfatal suicide behavior. *Death Stud* 2002; **26**(2): 99–116.

25 Turecki G, Brent DA. Suicide and suicidal behaviour. *Lancet* 2016; **387**(10024): 1227–39.

26 World Health Organization Global Health Observatory. *Age-Standardized Suicide Rates*. WHO, 2019 (https://www.who.int/data/gho/data/themes/mental-health).

27 Bernal M, Haro JM, Bernert S, Brugha T, de Graaf R, Bruffaerts R, et al. Risk factors for suicidality in Europe: results from the ESEMED study. *J Affect Disord* 2007; **101**(1–3): 27–34.

28 Verhofstadt M, Thienpont L, Peters GY. When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *Br J Psychiatry* 2017; **211**(4): 238–45.

29 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): 575–82.

30 Vancayseele N, Portzky G, van Heeringen K, Cloots H, Hendrickx E, Kongs A, et al. *Kenmerken Suicidepogingen in Gent en Vlaanderen. [Characteristics of Suicide Attempts in Ghent and Flanders.]* Agency for Care and Health, 2018 (https://www.zorg-en-gezondheid.be/sites/default/files/atoms/files/EZO_su%C3%AFcidepogingen_2017.pdf).

31 Truyts J. *Psychiater Lieve Thienpont strijdvaardig na vrijspraak op euthanasieproces: 'Ik zet mijn werk voort, dat Is zeker'. [Psychiatrist Lieve Thienpont combatant after euthanasia process acquittal: 'I will continue my work, that's for sure'.]* VRT NWS, 2020 (https://www.vrt.be/vrtnws/nl/2020/02/02/euthanasieproces-zevende-dag/).

32 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): 1241–56.

33 Vandenberghe J, Titeca K, Matthys F, Van den Broeck K, Detombe T, Claes S, et al. *Hoe Omgaan met een Euthanasieverzoek in Psychiatrie Binnen het Huidig Wettelijk Kader? Adviestekst van de Vlaamse Vereniging voor Psychiatrie (VVP) over te Hanteren Zorgvuldigheidsvereisten. [How to Deal with a Euthanasia Request in Psychiatry Within the Current Legal Framework? Advisory Report of the Flemish Association for Psychiatry (VVP) on Handling the Due Care Requirements.]* Flemish Association for Psychiatry, 2017 (http://vvponline.be/uploads/docs/bib/euthanasie_finaal_vvp_1_dec.pdf).

34 Huisman C. *Levenseindekliniek kan de vraag niet aan en zoekt tientallen nieuwe artsen. [End-of-Life Clinic Cannot Meet the Demand and is Looking for Dozens of New Doctors]* De Volkskrant, 2017 (https://www.volkskrant.nl/wetenschap/levenseindekliniek-kan-de-vraag-niet-aan-en-zoekt-tientallen-nieuwe-artsen~b3bff775/?referrer=https%3A%2F%2Fwww.google.com%2F)

35 van de Wier M. *Drie jaar vechten om te mogen sterven: wachten op euthanasie in de psychiatrie. [Three Years' Fight to be Allowed to Die: Waiting for Euthanasia in Psychiatry]* Trouw. 2019 (https://www.trouw.nl/nieuws/drie-jaar-vechten-om-te-mogen-sterven-wachten-op-euthanasie-in-de-psychiatrie~b2de0bbd/).

36 Oram S, Khalifeh H, Howard LM. Violence against women and mental health. *Lancet Psychiatry* 2017; **4**(2): 159–70.

37 World Health Organization Department of Mental Health and Substance Dependence. *Gender Disparities in Mental Health*. WHO, 2001 (http://www.who.int/mental_health/media/en/242.pdf).

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