

Original Article

Cite this article: Nicolini ME, Peteet JR, Donovan GK, Kim SYH (2020). Euthanasia and assisted suicide of persons with psychiatric disorders: the challenge of personality disorders. *Psychological Medicine* 50, 575–582. <https://doi.org/10.1017/S0033291719000333>

Received: 29 October 2018
Revised: 30 January 2019
Accepted: 5 February 2019
First published online: 4 March 2019

Key words:

Assisted suicide; euthanasia; clinical ethics; psychiatry; personality disorders

Author for correspondence:

Marie E. Nicolini,
E-mail: marie.nicolini@kuleuven.be

Euthanasia and assisted suicide of persons with psychiatric disorders: the challenge of personality disorders

Marie E. Nicolini^{1,2}, John R. Peteet³, G. Kevin Donovan⁴ and Scott Y. H. Kim²

¹Interfaculty Center for Biomedical Ethics and Law, KU Leuven, Kapucijnenvoer 35 – Box 7001, 3000 Leuven, Belgium; ²Department of Bioethics, National Institutes of Health, 10 Center Drive, Room 1C118, Bethesda, Maryland 20892, USA; ³Department of Psychiatry, Harvard Medical School and Brigham and Women's Hospital, 75 Francis Street, Boston, Massachusetts 02115, USA and ⁴Center for Clinical Bioethics, Georgetown University, Bldg. D., Suite 236, 4000 Reservoir Road, Washington D.C. 20007, USA

Abstract

Background. Euthanasia or assisted suicide (EAS) for psychiatric disorders, legal in some countries, remains controversial. Personality disorders are common in psychiatric EAS. They often cause a sense of irremediable suffering and engender complex patient–clinician interactions, both of which could complicate EAS evaluations.

Methods. We conducted a directed-content analysis of all psychiatric EAS cases involving personality and related disorders published by the Dutch regional euthanasia review committees ($N = 74$, from 2011 to October 2017).

Results. Most patients were women (76%, $n = 52$), often with long, complex clinical histories: 62% had physical comorbidities, 97% had at least one, and 70% had two or more psychiatric comorbidities. They often had a history of suicide attempts (47%), self-harming behavior (27%), and trauma (36%). In 46%, a previous EAS request had been refused. Past psychiatric treatments varied: e.g. hospitalization and psychotherapy were not tried in 27% and 28%, respectively. In 50%, the physician managing their EAS were new to them, a third (36%) did not have a treating psychiatrist at the time of EAS request, and most physicians performing EAS were non-psychiatrists (70%) relying on cross-sectional psychiatric evaluations focusing on EAS eligibility, not treatment. Physicians evaluating such patients appear to be especially emotionally affected compared with when personality disorders are not present.

Conclusions. The EAS evaluation of persons with personality disorders may be challenging and emotionally complex for their evaluators who are often non-psychiatrists. These factors could influence the interpretation of EAS requirements of irremediability, raising issues that merit further discussion and research.

Introduction

Euthanasia or assisted suicide (EAS) for psychiatric disorders, legal in some European countries such as Belgium and the Netherlands, remains controversial (see [Box 1](#)). Although psychiatric EAS cases comprise a relatively small number of cases overall, their proportion has increased from 0.06% to 1.2% during the period 2010–2017 in the Netherlands (RTE, 2017). Personality disorders are present in at least half of those who request and receive psychiatric EAS (Thienpont *et al.*, 2015; Kim *et al.*, 2016). Given their chronicity, prevalence, significant symptom burden, and impact on outcomes of co-morbid Axis I psychiatric disorders (Tyrer *et al.*, 2015), it is perhaps not surprising that these disorders are so common in patients requesting EAS. Such disorders raise some important issues for further examination. In particular, the characteristic features of personality disorders, such as feelings of helplessness, hopelessness, and suicidal thoughts (which are usually addressed therapeutically) may be difficult to distinguish from feelings of intolerable and hopeless suffering (which are eligibility criteria for EAS) (Swildens-Rozendaal and van Wersch, 2015). Thus, it may be challenging to evaluate whether there really is no prospect of improvement and no alternative to EAS in such cases. Furthermore, because personality disorders are known to evoke complex interpersonal interactions, including with health care providers (Berghmans *et al.*, 2009), managing such dynamics in the EAS evaluation process may require special care and expertise.

The debate regarding psychiatric EAS has mainly focused on treatment-resistant depression as the paradigm case (Schuklenk and van de Vathorst, 2015; Blikshavn *et al.*, 2017; Steinbock, 2017), and personality disorders have received little attention so far despite their prevalence and their unique challenges in the context of psychiatric EAS. This study aimed to describe the characteristics of patients with personality disorders who receive EAS and how their requests for EAS

Box 1. Brief background on EAS practice and regulation in the Netherlands.

The Termination of Life on Request and Assisted Suicide Act was enacted in 2002, formalizing what had been legally protected practice based on court decisions (Griffith *et al.*, 2008). The Act's due care criteria for EAS require that the physician must be satisfied that patient's request be voluntary and well-considered and the patient's suffering is unbearable and with no prospect of improvement. The physician must inform the patient about his/her situation and prognosis and must come to the conclusion, together with the patient, that there is no reasonable alternative in the patient's situation. The procedural criteria require that at least one, independent physician be consulted and that due medical care is exercised in performing EAS (Swildens-Rozendaal and van Wersch, 2015).

All cases must be reported to the Dutch regional euthanasia review committees (Regionale Toetsingscommissies Euthanasie (RTE); <https://www.euthanasiacommissie.nl/uitspraken-en-uitleg>) which reviews all EAS reports. There are five RTEs, with the goal of providing uniform guidance. They are committed to transparency and publish on their website a selection of case reports that are deemed 'important for the development of standards' to provide 'transparency and auditability' of EAS practice (RTE, 2014; Swildens-Rozendaal and van Wersch, 2015). Given the controversial nature of psychiatric EAS, the RTE has published a relatively high proportion of the cases – publishing all psychiatric cases from 2013, for example (RTE, 2014). The RTE has since reduced the number of published psychiatric EAS cases.

The End-of-Life Clinic (*Levensindekliniek*) is an organization founded in 2012, which provides EAS evaluation for persons whose treating physician declined to perform EAS. Most patients who receive EAS at the End-of-Life Clinic are non-terminally ill (Levensindekliniek, 2018). A review of the activity of the End-of-Life Clinic has been published (Snijdewind *et al.*, 2015).

are evaluated, given the potential challenges in evaluating these patients' beliefs about irremediability of their condition.

Methods

According to the RTE website (see Box 1) as of 1 October 2017, a total number of 232 psychiatric EAS cases had been reported to the RTE since 2010: two cases in 2010, 13 cases in 2011, 14 cases in 2012, 42 cases in 2013, 41 cases in 2014, 56 cases in 2015, 60 cases in 2016, and four cases in 2017[†]. One hundred and sixteen of these 232 cases (50%) were published and available on the RTE website during the period between 1 June 2015 and 1 October 2017.

We selected 74 cases based on the goals of our study, using the following criteria. Category 1 included the cases where a formal diagnosis of a personality disorder was reported ($n = 48$; 65%), including personality disorder not otherwise specified (NOS). Because the RTE reports are not always written with precise clinical language and because persons can have clinically significant symptoms of a personality disorder without fully meeting diagnostic criteria (Oldham, 2006; Zimmerman *et al.*, 2012), we included two more categories of patients. Category 2 included

the cases without a formal diagnosis but with explicit mention of prominent personality difficulties or 'traits' ($n = 16$; 22%). This included specific mention of cluster A, B, or C 'personality traits'², or 'impaired personality development'. Because of the clinically significant overlap between (cluster B) personality disorders and interpersonal hardship following trauma as seen in some disorders, e.g. complex post-traumatic stress disorder (PTSD) (Giourou *et al.*, 2018), a third category included cases with explicit mention of early traumatic events and chronic residual symptoms of interpersonal dysfunction ($n = 10$; 13%), defined by the presence of chronic/complex PTSD ($n = 6$), self-harming behavior ($n = 8$), psychotic or dissociative symptoms ($n = 4$), or a combination of those.

We analyzed the cases using a directed content analysis, as described previously (Kim *et al.*, 2016). Cases were read and coded independently by a bioethicist-psychiatrist (M.N.) and a consultation-psychiatrist (J.P.). The first author (M.N.) is a native Dutch speaker and reviewed all of the cases in original Dutch. For the second author (J.P.), of the 74 cases, 40 cases had been translated into English and have been analyzed for a different set of variables, as described previously (Kim *et al.*, 2016). The remaining 34 cases were machine translated (using Google translate). Discrepancies in coding occurred in 9% of coded items (505/5476 total), and for each discrepancy, the Dutch-speaking author reviewed the accuracy of the English translation by comparing it with the original Dutch text. Discrepancies involving a difference in judgment between the two readers were resolved through discussion, involving an additional reader, a bioethicist-psychiatrist (S.K.).

The coding scheme was developed iteratively and in light of the main research domains: (a) patient characteristics; (b) patients' treatment histories; (c) treating physicians' responses to EAS requests; (d) the EAS evaluation process (duration, consultants involved, relevant texts regarding due care criteria, and RTE judgments); (e) emerging themes, such as features of the End-of-Life Clinic cases. The data were analyzed using SPSS statistical data package, version 25. Analysis consisted of frequencies and tabulations, and exploratory post-hoc tests of bivariate associations, without hypothesis testing given the descriptive goals of the study.

Results

Characteristics of patients

Seventy-six percent ($n = 56$) of patients were women (Table 1). Nineteen percent were younger than 40 and 51% were older than 60. About two-thirds of the cases (65%, $n = 48$) mentioned cluster B personality disorders or traits, and 18% ($n = 13$) were personality disorders NOS. In the remainder, 9% ($n = 7$) had cluster C traits only and 3% ($n = 2$) mentioned cluster A traits.

All but two patients had comorbid Axis I psychiatric conditions (97%, 72 cases) (Table 2). The three most common conditions were depression (unipolar or bipolar) in 70% ($n = 52$), PTSD or prominent post-traumatic symptoms in 31% ($n = 23$) and anxiety disorders in 31%. Somatoform disorders were present in 19% of the cases ($n = 14$) (including conversion, somatization, and unspecified somatoform disorders).

Thirty-eight percent ($n = 28$) had only psychiatric diagnoses and 62% ($n = 46$) had in addition one or more physical comorbidities. These conditions included musculoskeletal and rheumatologic disorders in 23 cases (including osteoarthritis, osteoporosis, polyarthritis, bone fractures), chronic or generalized pain disorders (chronic fatigue, fibromyalgia, chronic pain) in eight cases,

[†]The notes appear after the main text.

Table 1. Characteristics of 74 patients who received EAS for personality and related disorders

	No.	%
Women	56	76
Age group (years) ^a		
18–30	3	4
30–40	11	15
40–50	9	12
50–60	13	18
60–70	21	28
70–80	11	15
80–90	6	8
History of a suicide attempt	35	47
History of multiple suicide attempts	27	36
History of self-harm	20	27
History of early childhood maltreatment	27	36
History of dissociative symptoms	10	14
Functional status involving some degree of dependence	31	42
Institutionalization specifically mentioned	15	20
Social isolation or loneliness mentioned	42	57

^aAge groups overlap but reflect the categories used in the RTE reports.

neurological disorders (migraine, anosmia, stroke and sequels, ataxia, head trauma, neurogenic bladder, and quadriplegia) in 14 cases, cardiovascular disease (heart failure, cardiac surgery, and myocardial infarct) in three cases, and pulmonary disease (mostly COPD) in five cases.

Forty-two percent of the patients were described as functionally dependent ($n = 31$). This was the case in 11% (three out of 28) of the cases with only psychiatric problems, and in 61% (28 out of 46) of the cases with physical comorbidity.

Treatment history

Seventy-three percent ($n = 54$) of patients had a psychiatric admission in the past, and in 14% ($n = 10$) some form of compulsory or other court-ordered treatment was mentioned (Table 3). Psychotherapy had been tried in 72% ($n = 53$), mostly of unspecified nature (39 of 53). Among the known standard evidence-based treatments for cluster B personality disorders, ranging from cognitive-behavioral to psychodynamic treatments (Zanarini, 2009; Cristea *et al.*, 2017), dialectical behavior therapy (DBT) was not mentioned in any cases, mentalization-based treatment (MBT) was considered but not tried in one case, and schema-focused treatment (SFT) was mentioned once.

About a third (34%, $n = 25$) of patients received electroconvulsive therapy (ECT) at some point; treatment with all indicated medication types for depression including a monoamine oxidase inhibitor (MAOI) was mentioned in 7% ($n = 5$). A subspecialist involvement in the patient's treatment history was mentioned in 15% ($n = 11$) of the cases (e.g. when patients were referred to a 'specialized clinic' or 'tertiary academic center'). However, a subspecialist involvement in the EAS evaluation process itself

Table 2. Psychiatric Axis-I comorbidity

	No.	% ^a
Number of comorbid conditions		
4	6	8
3	18	24
2	29	39
1	19	26
0	2	3
Type of comorbid conditions		
Depression and bipolar disorder	52	70
PTSD or posttraumatic residua	23	31
Anxiety disorders	23	31
Somatoform disorders	14	19
Eating disorders	11	15
Psychotic disorders	8	11
Substance abuse	7	9
Neurocognitive	6	8
Other, including autism, complicated bereavement, dissociative disorder, alexithymia	9	12

^aThis column does not add up to 100% because some patients had multiple diagnoses.

occurred only in one case (2013-27), where a psychiatrist who specialized in geriatric psychiatry evaluated an elderly patient.

In one of the two cases without an Axis-I diagnosis (2015-19), there was no mention of any form of psychiatric treatment.

About one-half (51%, $n = 38$) of the patients refused some form of treatment which included hospital admissions, medications, psychotherapy, other modalities (including ECT), or a combination. Forty-three percent (16 of 38) of these patients refused more than one treatment modality. The main reason for refusals was a lack of motivation (61%, 23 of 38).

In a fourth (26%) of the cases ($n = 19$), physicians appeared to consider a treatment option and then determined that it need not be tried. The most common reasons given were that the physician thought the patient may not benefit from it ($n = 13$) or was not motivated enough ($n = 6$). For example: 'In theory there were other treatment options for the personality disorder (...) but the psychiatrist noted it was an open question whether the patient could cope with these treatments and whether she could form and uphold an adequate treatment relationship' (case 2016-01). As in this case, in more than half of the cases where a physician considered and then dismissed a treatment option (10 out of 19 cases), there was also a mention of the patients not wanting treatment. In most cases, the patients expressed their refusal first.

Refusal of prior EAS requests

Overall, 46% (34 of 74) of EAS cases occurred after at least one doctor refused to provide it. In 29 (39%) cases, the treating GP refused to endorse the EAS request. The main reason for refusal was a non-specific 'for own reasons' or 'complexity' of the case. The GPs mostly explained complexity either as the combination of physical and psychiatric conditions ['the GP was very involved but found it difficult to perform EAS in this particular case,

Table 3. Treatment history

	No.	(%)
Psychiatric admissions in past	54	73
Compulsory treatment in past	10	14
Psychotherapy tried	53	72
Subtype (one or combination)		
(Cognitive) behavioral therapy	10	14
EMDR	4	5
STEPSS ^a	3	4
Other	39	53
ECT	25	34
Depression protocol including MAO-I	5	7
Subspecialist involved at any point of treatment	11	15
Physician dismisses treatment option	19	26
Refusal of treatment by patient	38	51
Basis of refusal by patient ^b		
Lack of motivation	23	61
Doubts about efficacy	6	16
Side effects or risks	11	29

^aIn the Dutch reports, the term 'VERS' was used (abbreviation for *Vaardigheidstraining Emotie Regulatie Stoornis*), a supportive group treatment similar to STEPPS ('Systems training for emotional predictability and problem solving') (Van Wel et al., 2009).

^bTotal sum more than 100 because some patients refused for different reasons.

whereby somatic and psychic suffering were entangled' (2014-40)] or in reference to the patient's personality ['the complexity... was grounded in the fact that the patient was a difficult, not very nice man who had difficulties expressing himself' (2014-37)].

In 32 (43%) cases, the request was made to a treating psychiatrist, and half ($n = 16$) of the psychiatrists refused to perform EAS. The main reasons were 'own reasons' ($n = 11$), due to criteria considered not met ($n = 3$), and reasons of conscience ($n = 2$).

In 11 cases (15%), both the patient's treating psychiatrist and the GP refused the request. Notably, most (eight of 11) of these were recent cases (2015–2017), meaning that 30% (eight of 27) of published cases from those years involved both the GP and the psychiatrist refusing the request. All 11 cases received EAS at the End-of-Life Clinic, and in nine of those cases, the EAS physician was not a psychiatrist.

Roles of psychiatrists and other doctors in the EAS evaluation process

In over a third (36%, 27 of 74) of cases, there was no mention of current treating psychiatrist involvement at the time of the EAS request (Table 4). In 30% (22 of 74) of the cases, the EAS physician was a psychiatrist. In 50% of all cases, the EAS physician was new to the patient ($n = 37$), and most of those patients received EAS at the End-of-Life Clinic ($n = 32$).

Although the Dutch law does not require that the EAS consultant be a psychiatrist even in psychiatric EAS cases, the RTE's Code of Practice of 2015 requires consulting an independent psychiatrist (Swidens-Rozendaal and van Wersch, 2015). In 41% of the cases, a psychiatrist was one of the official EAS consultants ($n = 30$); in 53% ($n = 39$) of cases, the EAS physician

Table 4. Process of EAS evaluation

	No.	%
Current treating psychiatrist involved	47	64
EAS physician is new to patient	37	50
EAS physician is a psychiatrist	22	30
Psychiatrist one of the official EAS consultants	30	40
Psychiatrists consulted during EAS evaluation		
Both second opinion psychiatrist and EAS psychiatrist consultant	15	20
Second opinion psychiatrist only	39	53
EAS psychiatrist consultant only	15	20
No psychiatrist consulted	5	7
Disagreement among consultants	15	20
Basis for disagreement		
Irremediability	9	12
Voluntary and well-considered request	6	8
Unbearable suffering	3	4
Other	1	1
Discussion of capacity status: any discussion beyond statement that patient had capacity ^a	20	27
Time of evaluation first official consultant		
<1 week (prior to EAS)	9	12
<1 month	39	53
>1 month	26	35
Time of evaluation by second opinion psychiatrist		
No second opinion psychiatrist	20	27
Time not specified	4	5
<1 week (prior to EAS)	2	3
<1 month	10	14
>1 month	38	51

^aAny discussion beyond the statement that the patient made a 'well-considered request'.

relied on a less formal 'second opinion' of a psychiatrist; and in five cases (7%), there was no independent psychiatrist involved. In those five cases, the RTE found that the due care criteria were not met in one case (2014-01), did not address the lack of psychiatric consultation (2012-62 and 2014-74), or explained its discretion in applying the rules (2011-124658 and 2015-45).

End-of-Life Clinic and patients with physical comorbidities

Forty-three percent of the cases were referred to the End-of-Life Clinic ($n = 32$), either after refusal of a physician ($n = 26$) or through self-referral ($n = 6$) but not all cases of physician refusals ended up at the End-of-Life Clinic. End-of-Life Clinic cases were more likely to be older than 60 [75% (24 of 32) v. 33% (14 of 42), $p = 0.0005$, Fisher's exact test]. Although not statistically significant, a current treating psychiatrist was less often involved [53% (17 of 32) v. 71% (30 of 42) in End-of-Life Clinic cases, $p = 0.14$]. The patients were less likely to have tried psychotherapy [53% (17 of 32) v. 86% (36 of 42), $p = 0.004$] and the physician

Table 5. Comparison of psychiatric EAS evaluation of patients with and without physical comorbidity

	With physical comorbidity	Without physical comorbidity	p^a
Prior psychiatric admission	67% (31 of 46)	82% (23 of 28)	0.19
Prior psychotherapy	63% (29 of 46)	86% (24 of 28)	0.06
Treating psychiatrist at time of EAS request	57% (26 of 46)	75% (21 of 28)	0.14
Prior EAS refusal by psychiatrist ^b	68% (13 of 19)	23% (3 of 13)	0.03
Referral to End-of-Life Clinic	54% (25 of 46)	25% (7 of 28)	0.02

^aFisher's exact test.

^bAmong those who had a prior treating psychiatrist, $n = 32$.

evaluating/performing EAS was less often a psychiatrist [13% (four of 32) *v.* 43% (18 of 42), $p = 0.005$]. The official consultant was a psychiatrist in 38% (12 of 32) but 13% (two of 16) in 2015–2017; a second opinion psychiatrist was involved in 72% (23 of 32).

Patients with physical comorbidity were more likely to have had a prior EAS request refused by their psychiatrist, referred to the End-of-Life Clinic, and less likely to have tried psychotherapy (Table 5).

Assessment of the unbearableness of suffering

According to the RTE (following the Dutch Psychiatric Association Guidelines), the unbearableness of suffering, while defined subjectively by the patient's perspective, 'must be palpable ('invoelbaar') to the physician' (Swildens-Rozendaal and van Wersch, 2015). Among the 116 psychiatric EAS cases published by the RTE, the term 'invoelbaar' is used in 34 cases and 31 of those (91%) were cases with personality disorders or difficulties: e.g. 'the unbearableness of the suffering was palpable for the physician by the way the patient looked, the way she spoke about her life, the sadness and powerlessness that she emanated' (2011-125900).

Discussion

Despite having received little attention so far, persons with personality disorders constitute more than half of those who request and receive psychiatric EAS (Thienpont *et al.*, 2015; Kim *et al.*, 2016). Addressing such EAS requests from persons with personality disorders could be particularly challenging as these patients may have self-destructive behavior, a traumatic background, feelings of helplessness, hopelessness, and despair (Verhofstadt *et al.*, 2017) which may create challenges in EAS evaluation of irremediability. Furthermore, personality difficulties can influence interpersonal dynamics that could affect the EAS evaluation process.

Characteristics of patients

Most patients had a long history of a complex set of comorbid conditions. In contrast to a Belgian report of 100 requestors of psychiatric EAS who were younger with few medical comorbidities (Thienpont *et al.*, 2015), we found that 51% were over 60 years old, nearly two-thirds had comorbid physical disorders, and 61% were functionally dependent to some degree. Almost all had co-morbid Axis-I psychiatric disorders (with 70% having two or more). In only two patients were personality difficulties the sole psychiatric basis for EAS (both had comorbid chronic pain). Thus, EAS of persons with personality difficulties most often occurs in persons with long psychiatric and medical

histories. Many treating physicians were aware of these issues as indicated by frequent references to 'complexity' of cases when explaining their refusal of EAS requests.

On the other hand, these patients shared features common to suicidal persons with personality difficulties. Women, who are more likely to attempt suicide (Bernal *et al.*, 2007; O'Connor *et al.*, 2018), were disproportionately represented (76%). Many patients had a depressive disorder (70%), a previous suicide attempt (47%, with multiple attempts in 36%), self-harm (27%), and a traumatic background (36%). There was evidence of demoralization and difficulties relating to others: 'She suffered from the meaninglessness of her existence (...) Because she was not able to connect with others, she experienced deep despair and loneliness' (2015–32: 50–60 years, personality disorder NOS and chronic pain) and '(t)he patient's suffering consisted of continuous negative thoughts and negative judgments about herself' (2014–78: 30–40 years, PTSD, borderline personality disorder, multiple suicide attempts).

Evaluation of EAS requests

Irremediability is a key due care requirement; patients need not to go through 'every conceivable form of treatment' but they do not meet the requirement if they refuse 'a reasonable alternative' (Swildens-Rozendaal and van Wersch, 2015). Not all patients appeared to receive some standard treatments, such as ECT and MAO-inhibitors for mood disorders. Over a fourth of patients (27%) had not been hospitalized. Most notably, psychotherapy, the primary treatment for personality disorders (Bateman and Fonagy, 2015; Bateman *et al.*, 2015), was not tried in 28%.

It is known that having a personality disorder is a predictor of poor outcome of comorbid Axis-I disorders (Newton-Howes *et al.*, 2014; Tyrer *et al.*, 2015). However, both cognitive and psychodynamic psychotherapeutic treatments have proven to be effective for personality disorders (Leichsenring and Leibing, 2003; Bateman and Fonagy, 2009; McMain *et al.*, 2009; Swenson and Choi-Kain, 2015; Cristea *et al.*, 2017). For example, DBT and MBT have shown to reduce suicidal behavior in patients with borderline personality disorders (Linehan *et al.*, 1994, 2006; Bateman and Fonagy, 2009; Kvarstein *et al.*, 2019) and MBT and SFT to reduce depressive symptoms in these patients (Bateman and Fonagy, 2009; Bamelis *et al.*, 2014). In fact, treatment guidelines of both the American Psychiatric Association and the Netherlands Institute of Mental Health and Addiction (Trimbos Institute) advise DBT, MBT, or SFT for the treatment of persons with borderline personality disorders (Trimbos Institute, 2008; Oldham *et al.*, 2010), and applying evidence-based treatments for personality disorders is cost-effective (Meuldijk *et al.*, 2017).

However, DBT was not mentioned in any of our case reports, MBT was mentioned but not tried in one case, and SFT occurred once. What factors, then, may explain the variability of past psychiatric treatments, psychotherapeutic in particular, in patients with personality disorders receiving psychiatric EAS?

One reason for these results may be that due to the patients' chronic, complex histories, clinicians were inclined to accept the patients' perspectives more readily. This would be consistent with a trend that Dutch psychiatrists note as an evolution toward accepting patients' subjective definition of irremediability (den Hartogh, 2017; Onwuteaka-Philipsen *et al.*, 2017). Second, the high prevalence of medical comorbidities in persons with psychiatric disorders may lead physicians to treat the patients predominantly as 'medical' patients. This might be influenced by clinicians' general tendency to consider personality disorders as coincidental rather than as a true diagnosis (Tyrer *et al.*, 2015; Van and Kool, 2018). It is notable that over a third (36%) did not have a treating psychiatrist at the time of their EAS request, only 30% of the EAS physicians were psychiatrists, and half of the EAS evaluations were managed by physicians new to the patient. When other psychiatrists were involved, this tended to be for cross-sectional evaluation of EAS eligibility, not treatment.

A third reason may be that counter-transference issues [(*tegen*) *overdracht*] may no longer be emphasized. Although counter-transference has long been recognized as a challenge in EAS evaluations involving personality disorders (Groenewoud *et al.*, 2004; Berghmans *et al.*, 2009), the term is not mentioned in any of our case reports. Yet vigilance regarding counter-transference seems especially important given that the RTE directs physicians to use their own reactions to patients' suffering ['palpable' (*invoelbaar*)] in EAS evaluations. It is notable that 'palpable' is used almost exclusively (91%) in cases with personality difficulties. Thus, physicians seem uniquely emotionally affected by the suffering of patients with personality disorders seeking EAS. This raises the question of whether the RTE's guidance may lead physicians to operate within a patient's psychopathology. For example, a clinician may identify with a patient's perception of irremediability (e.g. 'nothing will work'): 'Other therapeutic avenues were explored including Mentalization Based Therapy (MBT). However, the patient did not want to be treated anymore. The physician agreed with her as her personality structure was deemed not strong enough to endure such a drastic treatment (MBT) without her suicidal tendencies or depression getting out of control' (2014-78). However, as mentioned earlier, this evidence-based treatment is especially beneficial for high clinical severity patients (Kvarstein *et al.*, 2019), with positive effects on suicidality and depressive symptoms (Bateman and Fonagy, 2009).

Implications

The results of our study raise questions about how to interpret the irremediability requirement in patients with personality disorders. There is substantial evidence for the effectiveness of several psychotherapeutic treatment options on outcome measures such as depressive symptoms or suicidal behavior (Bateman and Fonagy, 2009; McMain *et al.*, 2009; Cristea *et al.*, 2017). Furthermore, although the number of studies are limited (Leichsenring and Leibling, 2003), long-term follow-up shows that the majority of persons with personality disorders achieve sustained remission (Zanarini *et al.*, 2012). Whether these results would be generalizable to some of the more complex cases in our study – with

multiple psychiatric and somatic comorbidities – is an open question. However, it is important to note that treatment studies targeting personality disorders and psychiatric comorbidity such as depression are still lacking (Van and Kool, 2018). Similarly, the complex interplay between psychiatric and somatic comorbidity, in particular in female patients, needs further study (WHO, 2001).

The results of this study may support recent proposals to improve psychiatric EAS evaluation that include a longer-term evaluation, more than one independent expert input, and a parallel therapeutic focus on recovery while the EAS request is evaluated (Vandenberghe *et al.*, 2017; Gastmans, 2018). Our results show that young, physically healthy psychiatric patients with personality disorders may be more likely to receive expert attention attuned to their personality disorders. But in older patients with multiple somatic conditions, this may be less so. These results suggest that these patients with both psychiatric and somatic conditions may require a higher level of psychiatric expertise during the evaluation process given the complexity of their clinical conditions and their sparser past psychiatric treatment history. In these patients' assessments, a 'medical model' seems to predominate rather than a more psychologically oriented model focusing on coping and interpersonal skills. While the Dutch euthanasia law allows for physicians' discretion, the results raise the question of whether sufficient safeguards are in place, including the necessary expertise in personality disorders.

Involvement of experts may be limited by the reluctance of psychiatrists to be involved in EAS (Onwuteaka-Philipsen *et al.*, 2017) and the physician-centric nature of EAS evaluations (with no official role for other mental health professionals, such as psychologists and other therapists, who may have more expertise in the long-term management of personality issues). The need for more expertise in personality disorders may also apply to the RTEs given its difficulties in finding mental health professionals to serve on the RTE (Doernberg *et al.*, 2016; Kurniawan and van der Zwaard, 2018).

Finally, these results, which are based on retrospective reviews, suggest a need to prospectively investigate psychiatric EAS in persons with personality disorders, focusing on the patients' perceptions underlying their requests for EAS and on their clinicians' decision-making when evaluating those requests, with special attention to how the granted EAS requests differ from those that are denied.

Limitations

There are several limitations to our study. First, the RTE does not publish all psychiatric EAS cases, limiting generalizability of studies based on only the published cases. These were all completed EAS cases, and do not include requests that did not lead to EAS. However, the RTEs intend the published cases to serve educational, precedent setting functions so that they do carry a special significance (RTE, 2014). Further, these published reports comprise the only source of reliable EAS case information beyond anecdotal media reports. Second, the qualitative coding requires judgment in interpretation. Moreover, given that the reports are not always written in clinical language, there was often a lack of specificity regarding the type of personality disorder and their diagnostic descriptions. Although two-thirds of our cases had a formal diagnosis of a personality disorder, we chose to risk over inclusion in order to include all patients with personality difficulties. Third, our use of statistical tests was post-hoc, using a small sample. However, this report comprises all available case

descriptions of an infrequent but growing phenomenon which allowed for patient-level analysis. Finally, because this article focuses mainly on the irremediability requirement, we did not address the issue of mental capacity in personality disorders, a complex issue (Owen *et al.*, 2008; Ayre *et al.*, 2017) which requires a separate discussion.

Conclusion

Personality disorders are common in persons receiving psychiatric EAS. For most patients, their personality difficulties were part of complex clinical histories with multiple psychiatric and physical comorbidities. These patients generally had long histories of suffering, with features common to suicidal persons with personality disorders, including histories of serious self-harm, suicide attempts, and demoralization. However, in the EAS evaluations of these patients, especially if the patients were older with physical co-morbidities, the EAS physicians tended to be non-psychiatrists who were new to them at a specialty EAS clinic and relied on less formal, cross-sectional psychiatric second opinions. The current practice of psychiatric EAS involving persons with personality difficulties raises important questions about whether the special challenges associated with personality disorders are being thoroughly addressed. The lack of specialist and longitudinal evaluations may impede an objective evaluation of irremediability and limit the focus on recovery. The issues raised are worthy of further investigation and discussion, especially as some jurisdictions consider legalization of psychiatric EAS.

Notes

¹ The number for 2017 reflects a partial count due to our cut-off date for the purposes of our analysis. In 2018, the RTE reported the final number of reported psychiatric EAS as 83 for 2017. Six case descriptions from 2011 are no longer available on the RTE website, illustrating that the RTE website is a dynamic entity. These cases are available from the authors upon request.

² See online Supplementary Materials for a description of the different personality disorder clusters.

Supplementary material. The supplementary material for this article can be found at <https://doi.org/10.1017/S0033291719000333>.

Author ORCIDs.  Marie E. Nicolini, 0000-0003-1111-4372.

Acknowledgements. We acknowledge Carl Runge for assistance with data entry. M.N. thanks the Pellegrino Center for Clinical Bioethics and Kennedy Institute of Ethics, Georgetown University, where she was a Visiting Scholar during which part of this research was carried out. We thank Frank G. Miller, Ph.D. (Cornell University), Yeates Conwell, M.D. (University of Rochester), and Eric Caine, M.D. (University of Rochester), for their comments provided on an earlier draft of this manuscript. No compensation was provided.

Author contributions. Substantial contributions to the conception or design of the work; or the acquisition, analysis, or interpretation of data for the work: all authors. Drafting the work or revising it critically for important intellectual content: all authors. Final approval of the version to be published: all authors.

Financial support. Funded in part by the Intramural Research Program of the National Institutes of Health, USA (S.K.).

Conflict of interest. None.

Ethical standards. Ethical approval by an IRB was not needed according to US federal regulations because this study used publicly available anonymized data [see US Code of Federal Regulations (45 CFR 46.102f)].

References

- Ayre K, Owen GS and Moran P (2017) Mental capacity and borderline personality disorder. *BJPsych Bulletin* **41**, 33–36.
- Bamelis LL, Evers SM, Spinhoven P and Arntz A (2014) Results of a multi-center randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. *American Journal of Psychiatry* **171**, 305–322.
- Bateman A and Fonagy P (2009) Randomized controlled trial of outpatient mentalization-based treatment versus structured clinical management for borderline personality disorder. *The American Journal of Psychiatry* **166**, 1355–1364.
- Bateman A and Fonagy P (2015) Borderline personality disorder and mood disorders: mentalizing as a framework for integrated treatment. *Journal of Clinical Psychology* **71**, 792–804.
- Bateman AW, Gunderson J and Mulder R (2015) Treatment of personality disorder. *Lancet (London, England)* **385**, 735–743.
- Berghmans RLP, Huisman J, Legemaate J, Nolen WA, Polak F, Scherders MJWT and Tholen AJ (2009) *Richtlijn verzoek om hulp bij zelfdoding door patiënten met een psychiatrische stoornis*. De Tijdstroom, U.
- Bernal M, Haro JM, Bernert S, Brugha T, de Graaf R, Bruffaerts R, Lepine JP, de Girolamo G, Vilagut G, Gasquet I, Torres JV, Kovess V, Heider D, Neeleman J, Kessler R and Alonso J (2007) Risk factors for suicidality in Europe: results from the ESEMED study. *Journal of Affective Disorders* **101**, 27–34.
- Blikshavn T, Husum TL and Magelssen M (2017) Four reasons why assisted dying should not be offered for depression. *Journal of Bioethical Inquiry* **14**, 151–157.
- Cristea IA, Gentili C, Cotet CD, Palomba D, Barbui C and Cuijpers P (2017) Efficacy of psychotherapies for borderline personality disorder: a systematic review and meta-analysis. *JAMA Psychiatry* **74**, 319–328.
- den Hartogh G (2017) Stervenshulp holt zorgvuldigheidseisen uit. *Medisch Contact* 2017;02(07):34–36.
- Doernberg SN, Peteet JR and Kim SY (2016) Capacity evaluations of psychiatric patients requesting assisted death in the Netherlands. *Psychosomatics* **57**, 556–565.
- Gastmans C (2018) *Levenseindezorg voor niet-terminale patiënten met ernstige psychiatrische aandoeningen*. Brussels: Zorgnet Icuuro. Available at <https://www.zorgnetiuro.be/sites/default/files/Ethisch%20advies-20-DEF.pdf> (Accessed July 2018).
- Giourou E, Skokou M, Andrew SP, Alexopoulou K, Gourzis P and Jelastopulu E (2018) Complex posttraumatic stress disorder: the need to consolidate a distinct clinical syndrome or to reevaluate features of psychiatric disorders following interpersonal trauma? *World Journal of Psychiatry* **8**, 12–19.
- Griffith J, Weyers H and Adams M (2008) *Euthanasia and Law in Europe*. Portland, OR: Hart Publishing.
- Groenewoud JH, Van Der Heide A, Tholen AJ, Schudel WJ, Hengeveld MW, Onwuteaka-Philipsen BD, Van Der Maas PJ and Van Der Wal G (2004) Psychiatric consultation with regard to requests for euthanasia or physician-assisted suicide. *General Hospital Psychiatry* **26**, 323–330.
- Kim SY, De Vries RG and Peteet JR (2016) Euthanasia and assisted suicide of patients with psychiatric disorders in the Netherlands 2011 to 2014. *JAMA Psychiatry* **73**, 362–368.
- Kurniawan C and van der Zwaard R (2018) Euthanasie bij psychiatrie roept vragen op. *Medisch Contact* 2018;03(10):22–24.
- Kvarstein EH, Pedersen G, Folmo E, Urnes O, Johansen MS, Hummelen B, Wilberg T and Karterud S (2019) Mentalization-based treatment or psychodynamic treatment programmes for patients with borderline personality disorder – the impact of clinical severity. *Psychology and Psychotherapy: Theory, Research and Practice* **92**, 91–111.
- Leichsenring F and Leibing E (2003) The effectiveness of psychodynamic therapy and cognitive behavior therapy in the treatment of personality disorders: a meta-analysis. *American Journal of Psychiatry* **160**, 1223–1232.
- Levenseindekliniek Available at <http://www.levenseindekliniek.nl> (Accessed July 2018).
- Linehan MM, Tutek DA, Heard HL and Armstrong HE (1994) Interpersonal outcome of cognitive behavioral treatment for chronically suicidal borderline patients. *American Journal of Psychiatry* **151**, 1771–1776.

- Linehan MM, Comtois KA, Murray AM, Brown MZ, Gallop RJ, Heard HL, Korslund KE, Tutek DA, Reynolds SK and Lindenboim N (2006) Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry* **63**, 757–766.
- McMain SF, Links PS, Gnam WH, Guimond T, Cardish RJ, Korman L and Streiner DL (2009) A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry* **166**, 1365–1374.
- Meuldijk D, McCarthy A, Bourke ME and Grenyer BF (2017) The value of psychological treatment for borderline personality disorder: systematic review and cost offset analysis of economic evaluations. *PLoS ONE* **12**, e0171592.
- Newton-Howes G, Tyrer P, Johnson T, Mulder R, Kool S, Dekker J and Schoevers R (2014) Influence of personality on the outcome of treatment in depression: systematic review and meta-analysis. *Journal of Personality Disorders* **28**, 577–593.
- O'Connor RC, Wetherall K, Cleare S, Eschle S, Drummond J, Ferguson E, O'Connor DB and O'Carroll RE (2018) Suicide attempts and non-suicidal self-harm: national prevalence study of young adults. *BJPsych Open* **4**, 142–148.
- Oldham JM (2006) Borderline personality disorder and suicidality. *The American Journal of Psychiatry* **163**, 20–26.
- Oldham J, Gabbard G, Goin M, Gunderson J, Soloff P, Spiegel D, Stone M and Phillips K (2010) *American Psychiatric Association (APA) Practice Guideline for the Treatment of Patients With Borderline Personality Disorder*. Available at https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/bpd.pdf (Accessed January 2019)
- Onwuteaka-Philipsen B, Legemaate J, van der Heide A, van Delden H, Evenblij K, El Hammoud I, Pasman R, Ploem C, Pronk R, van de Vathorst S and Willems D (2017) Derde evaluatie Wet toetsing levensbeëindiging op verzoek en hulp bij zelfdoding. Den Haag: ZonMw.
- Owen GS, Richardson G, David AS, Szmukler G, Hayward P and Hotopf M (2008) Mental capacity to make decisions on treatment in people admitted to psychiatric hospitals: cross sectional study. *BMJ* **337**, a448.
- RTE Regional Euthanasia Review Committees Annual Report (2014) Available at <https://www.euthanasiecommissie.nl/de-toetsingscommissies/uitspraken/jaarverslagen/2014/nl/nl/jaarverslag-2014> (Accessed July 2018).
- RTE Regional Euthanasia Review Committees Annual Report (2017) Available at <https://www.euthanasiecommissie.nl/toetsingscommissies/uitspraken/jaarverslagen/2017/mei/17/jaarverslag-2017> (Accessed July 2018).
- Schuklenk U and van de Vathorst S (2015) Treatment-resistant major depressive disorder and assisted dying. *Journal of Medical Ethics* **41**, 577–583.
- Snijdwind MC, Willems DL, Deliens L, Onwuteaka-Philipsen BD and Chambaere K (2015) A study of the first year of the End-of-Life Clinic for physician-assisted dying in the Netherlands. *JAMA Internal Medicine* **175**, 1633–1640.
- Steinbock B (2017) Physician-assisted death and severe, treatment-resistant depression. *The Hastings Center Report* **47**, 30–42.
- Swenson CR and Choi-Kain LW (2015) Mentalization and dialectical behavior therapy. *American Journal of Psychotherapy* **69**, 199–217.
- Swildens-Rozendaal WJC and van Wersch PJM (2015) *Code of Practice*. The Hague. Available at https://www.euthanasiecommissie.nl/binaries/euthanasiecommissie/documenten/brochures/brochures/code-of-practice/1/code-of-practice-2015/RTE+Code+of+practice_april+2015.pdf (Accessed July 2018).
- Thienpont L, Verhofstadt M, Van Loon T, Distelmans W, Audenaert K and De Deyn PP (2015) Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: a retrospective, descriptive study. *BMJ Open* **5**, e007454-2014-007454.
- Trimbos Institute (2008) *Trimbos Netherlands Institute of Mental Health and Addiction, Multidisciplinaire Richtlijn Persoonlijkheidsstoornissen (Multidisciplinary Guideline Personality Disorders)*. Utrecht, the Netherlands.
- Tyrer P, Reed GM and Crawford MJ (2015) Classification, assessment, prevalence, and effect of personality disorder. *Lancet (London, England)* **385**, 717–726.
- Van HL and Kool M (2018) What we do, do not, and need to know about comorbid depression and personality disorders. *The Lancet. Psychiatry* **5**, 776–778.
- Van Wel EB, Bos EH, Appelo MT, Berendsen EM, Willgeroth FC and Verbraak MJPM (2009) De effectiviteit van de vaardigheidstraining emotieregulatiestoornis (vers) in de behandeling van de borderlinepersoonlijkheidsstoornis; een gerandomiseerd onderzoek. *Tijdschrift voor Psychiatrie* **51**, 291–301.
- Vandenbergh J, Titeca K, Matthys F, Van den Broeck K, Detombe T, Claes S, De Fruyt J, Hermans M, Lemmens G, Peeters D and Van Buggenhout R (2017) *Hoe omgaan met een euthanasieverzoek in psychiatrie binnen het huidig wettelijk kader? Adviestekst van de Vlaamse Vereniging voor Psychiatrie (VVP) over te hanteren zorgvuldigheidsvereisten*. (Accessed July 2018).
- Verhofstadt M, Thienpont L and Peters GY (2017) When unbearable suffering incites psychiatric patients to request euthanasia: qualitative study. *The British Journal of Psychiatry: The Journal of Mental Science* **211**, 238–245.
- WHO (2001) *World Health Organization; Department of Mental Health and Substance Dependence; Gender Disparities in Mental Health*. Available at http://www.who.int/mental_health/media/en/242.pdf (Accessed July, 2018).
- Zanarini MC (2009) Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica* **120**, 373–377.
- Zanarini MC, Frankenburg FR, Reich DB and Fitzmaurice G (2012) Attainment and stability of sustained symptomatic remission and recovery among patients with borderline personality disorder and axis II comparison subjects: a 16-year prospective follow-up study. *American Journal of Psychiatry* **169**, 476–483.
- Zimmerman M, Chelminski I, Young D, Dalrymple K and Martinez J (2012) Does the presence of one feature of borderline personality disorder have clinical significance? Implications for dimensional ratings of personality disorders. *The Journal of Clinical Psychiatry* **73**, 8–12.

Reproduced with permission of copyright owner. Further reproduction prohibited without permission.