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# PSYCHIATRIC EUTHANASIA, MENTAL CAPACITY, AND A SENSE OF THE POSSIBLE

MATTHEW RATCLIFFE

**ABSTRACT:** Euthanasia for psychiatric conditions is currently legal in Belgium and the Netherlands. It is also highly controversial, as illustrated by some recent, high-profile cases. In this paper, I show how a better understanding of the associated phenomenology can inform debate in this area. I focus on how phenomenological changes that occur in psychiatric illness can erode the ability to experience and entertain certain types of possibility, making some scenarios seem inevitable and others impossible. Although strong convictions that originate in competent decisions differ from verbal and non-verbal behaviours stemming from losses of possibility, detecting the difference is by no means straightforward. I add that a sense of the possible can be sustained, enhanced, or diminished by ways of experiencing and relating to other people. Consequently, the extent to which decision-making capacity is impaired in a given case may vary with interpersonal context. I consider the implications of these points for evaluating euthanasia as a response to mental suffering.

**KEYWORDS:** assisted dying; decision-making; depression; euthanasia; mental capacity; phenomenology

## INTRODUCTION

At the time of writing, euthanasia for psychiatric conditions is legal in Belgium and the Netherlands, in cases that are judged to involve unbearable and untreatable suffering. There is a difference between ‘euthanasia’ (where the physician administers life-ending treatment) and ‘assisted suicide’ or ‘assisted dying’ (where the patient is given the means to end her own life). Although I will refer for the most part to ‘psychiatric euthanasia’, my points apply equally to assisted dying. Even where these practices are legal, they are highly controversial. One case, in particular, received considerable media attention. In the Netherlands, on 26<sup>th</sup> January 2018, a 29-year-old woman called Aurelia Brouwers ended her life by drinking prescribed medication. Press reports are consistent in stating that her diagnoses included depression from the age of 12, at which time she was also informed that she had borderline personality disorder. Other diagnoses followed, including chronic depression, attachment disorder, and psychosis. A documentary, recording during the last few weeks of her life, was

broadcast by a Dutch television company. The story was also reported by various international newspapers, many of which include an evocative photograph taken shortly before Brouwers' death, where she is seen clutching a pink cuddly toy dinosaur.<sup>1</sup>

Rates of psychiatric euthanasia in Belgium and the Netherlands remain low. According to the Annual Report of the Dutch Regional Euthanasia Review Committees, the number of cases there rose from 56 in 2015 to 60 in 2016 and 83 in 2017, but dropped to 67 in 2018 (See: <https://english.euthanasiecommissie.nl/the-committees/annual-reports>; last accessed 17.01.2020). A recent study of 66 cases in the Netherlands reports that depressive disorder was singled out as the main source of distress in 55% of these cases. Other common diagnoses included personality disorders, posttraumatic stress disorder, psychosis, anxiety, somatoform disorders, eating disorders, and autism. 70% of those concerned were women; there was considerable variation in age; and all had tried various other treatments that had proved unsuccessful (Kim, De Vries, & Peteet, 2016). A study conducted in Belgium, focusing on those who requested euthanasia (where 48% of these requests were ultimately approved), reports similar findings (Thienpont et al., 2015).

Public opinion on the matter is divided. It could be maintained that severe mental disorder sometimes consists in a chronic, untreatable illness that inflicts unbearable suffering and makes life no longer worth living (e.g. Schuklenk & van de Vathorst, 2015). In contrast, one psychiatrist raises concerns about 'mission creep' and remarks on how detached the practice is from established medical values. To quote, it involves 'killing (on request) the very kinds of patients to whose hopelessness and helplessness psychiatrists are devoted to address' (Komrad, 2018).

In what follows, I do not take a stance on whether euthanasia and assisted dying are ever appropriate responses to human suffering or, more specifically, to the suffering associated with psychiatric conditions. Instead, I focus on a problem concerning the use of *decision-making capacity* as a criterion. Advocates of psychiatric euthanasia generally agree that it should only be approved where those concerned have the mental capacity required to make the decision. Adopting a phenomenological approach, I will describe a specific way in which decision-making competence is often compromised in severe psychiatric illness (while allowing that it can be compromised in other ways as well), involving an inability to experience and contemplate certain kinds of *possibility*. In so doing, I will emphasize the following points: (i) what might look like an outcome of deliberation is sometimes symptomatic of an inability to contemplate relevant options and thus a lack of capacity; (ii) the difference can be very difficult to discern; (iii) deficits of this kind are likely to have more

impact on major life-decisions than on other types of decision. Taken together, these points pose an epistemic challenge, one that is seldom explicitly acknowledged or addressed.

I go on to argue that loss of possibilities from one's world is inextricable from how one experiences and relates to other people. Hence, 'capacity' is not simply something possessed by an isolated individual. Furthermore, the extent to which it is lacking in a given case may depend, to some degree, on interpersonal context. Reconceptualizing capacity in this way further complicates the task of assessment. For instance, its presence or absence may depend, to some extent, on the relationship and quality of interaction between clinician and patient. Psychiatric euthanasia is carefully monitored and regulated (Thienpont et al., 2015; Kim, De Vries, & Peteet, 2016). However, it is not at all clear that (a) the distinction between loss of possibility and preference for one outcome over another or (b) the role of interpersonal relations in nurturing a sense of the possible have been adequately acknowledged or integrated into practice.

### **CONTRACTIONS OF THE POSSIBLE**

Discussions of decision-making competence in clinical contexts often take, as a starting point, four aspects of capacity emphasized by the MacArthur Competence Assessment Tool for Treatment or 'MacCAT-T': 'understanding information relevant to their condition and the recommended treatment, reasoning about the potential risks and benefits of their choices, appreciating the nature of their situation and the consequences of their choices, and expressing a choice' (Grisso, Appelbaum, & Hill-Fotouhi, 1997, p.1415).<sup>2</sup> In the scenario to be described here, all four capacities are compromised to some degree. What might look like a decision between options  $p$  and  $q$ , made by evaluating the relevant evidence, in fact originates in an inability to even contemplate  $q$  and thus to be swayed by any evidence that supports  $q$ . This impacts on one's ability to appreciate the relevance of information, weigh up risks and benefits, and comprehend the consequences of choices. Phenomenological changes of this nature are also difficult to express and convey to others. My points will apply most clearly to severe forms of depression but are compatible with a range of diagnoses and comorbidities.

To clarify the relevant phenomenology and its relationship to decision-making, I will first sketch an account of how possibilities are more usually experienced, one that is inspired by the phenomenological tradition of philosophy (Ratcliffe, 2008; 2015). Consider the mundane experience of a drinking glass on a nearby table. One does not simply perceive a neutral, external object, wholly detached from one's various capacities and concerns. Rather,

it is encountered *as* something that one could reach out and touch, view from another angle, or pick up and drink from. While some such possibilities might concern perceptual or practical activities to which one is currently indifferent (such as turning a glass around to see what is pictured on the other side), others -those that tend to be most phenomenologically salient- consist of ways in which an actual or anticipated entity, event, or situation *matters* to us. When we are thirsty, how the glass appears significant reflects our current needs and concerns.

There are many ways in which entities, events, and situations are experienced as ‘significant’ or ‘mattering’ (I use these terms interchangeably). Something might present itself as able to satisfy a current desire or need, as potentially obstructing a project, as immediately threatening or harbouring a potential threat, and so forth. As in the case of ‘threat’, many of the significant possibilities that we experience take the form of *anticipation*. They involve a variably determinate sense of what is coming next, what might be coming, and what could be actualized or avoided through one’s own actions or those of others. Hence our sense of the significant possibilities on offer also comprises an orientation towards the future.

Broad types of mattering can be categorized without reference to concrete properties of the environment or specific bodily capacities. Something may threaten us physically in virtue of any number of concrete properties that it and we possess. But, for current purposes, what is of interest is the more general *way* in which it matters: its being *threatening*. This can be classified in broad or more fine-grained ways, as can other types of significant possibility that we experience. Threats can be subdivided into those that are major or minor, immediate or longer-term, localized or non-localized, likely or unlikely, avoidable or unavoidable, personal or impersonal in origin, and determinate or indeterminate in nature. It is debatable which distinctions a comprehensive taxonomy should include – which differences the structure of human experience is sensitive to and how various kinds of mattering relate to one another. Nevertheless, I assume at least that we *do* experience things as mattering in various ways. Philosophers’ views concerning the nature of perceptual content vary considerably. But, regardless of whether these ways of mattering are admitted as constituents of specifically ‘perceptual’ experience, it remains the case that we experience our surroundings as imbued with significance, rather than relying exclusively on inferences *from* our experiences of things. Nevertheless, the significant possibilities we experience are not *restricted* to those that adhere to our current surroundings. The contents of our thoughts, memories, and imaginings are equally infused with a sense of how things matter.

How a specific entity appears significant in a given situation depends on factors of four broad types. First, it often reflects our bodily capacities or abilities: what we can and cannot do, at that time and more generally. Second, it reflects a range of needs, cares, concerns, values, commitments, and projects, all of which are variably idiosyncratic. Third, it depends on other people, who contribute both to our capacities ('I can't do it without you') and to the sustenance or erosion of projects that rely on their participation and cooperation. Fourth, it presupposes established norms and roles of various kinds, which are ordinarily taken for granted as shared, as integral to *our* world.

It follows that happenings of various kinds, involving one or more of these factors, can alter the significance that things have for us and are experienced as having. Effects are seldom limited to how we experience and engage with a single entity, event, or momentary situation. For the most part, how something matters is related to and depends upon ways in which a whole host of other things matter. Webs of significance hang together to varying degrees and, to the extent that they do, they also fall together. For example, suppose a life-event were to end my career as an academic philosopher. The train that takes me to work, the office that I work in, the computer, the stack of papers on the desk, the books on my shelves, my email account - all these things would appear different, in lacking a significance they once had. They would no longer show up as an integrated, meaningful whole, held together by a taken-for-granted life-project.

When such upheavals occur, the transition from one to another way of experiencing and engaging with our surroundings is not instantaneous or smooth, but more usually prolonged and conflicted. Certain things may remain imbued with the possibilities they once offered. Yet, at the same time, those possibilities are experienced *as* no longer applying, *as* lost. Tensions between competing and changing systems of possibility are thus integral to how we experience and relate to the world.

For current purposes, the point to emphasize is that, even when a wide-ranging system of significant possibilities is profoundly disturbed, we remain open to finding things significant in the relevant *ways*. That *p*, *q*, *r*, and many other things now lack a significance they once possessed does not imply an inability to encounter anything as significant in that way again; we can still remember, imagine, and anticipate doing so. Hence, while a concrete *system of significant possibilities* is lost, phenomenological access to the relevant *types of possibility* endures and our deliberations remain receptive to them. However, certain forms of experience associated with diagnoses of severe psychiatric illness are different. It is not merely that numerous entities, events, and situations cease to be significant in a given way.

Rather, one no longer experiences or anticipates experiencing things in that way; a *type* of possibility is gone from one's world.

Alterations of the phenomenological possibility-space can take various forms. For instance, someone might still be able to imagine and anticipate certain kinds of possibility but fail to discover them in her experienced surroundings. Consequently, her experience is riddled with unfulfilled expectation. Alternatively, she might remain capable of experiencing certain kinds of possibility but fail to anticipate or imagine them. So, although she cannot conceive of ever successfully pursuing these possibilities and therefore makes no attempt to do so, she remains able to experience their actualization.

This account of how we experience the possible is consistent with a substantial and diverse body of testimony offered by people with psychiatric illness diagnoses. Indeed, appealing to the phenomenology of possibility and its vulnerability to disruption is, I maintain, the *only* plausible way of interpreting these testimonies. Furthermore, it provides a remarkable degree of consilience, as a unifying framework that illuminates a range of different and otherwise puzzling forms of experience (Ratcliffe, 2008; 2015; 2017). Consider the following first-person description, obtained via a questionnaire study that I conducted with colleagues as part of a larger project on depression (as were other testimonies quoted in this paper, unless otherwise stated):<sup>3</sup>

Life seems completely pointless when depressed. Depression is the worst feeling in the world and when you're absorbed in its depths you just don't even want to be there, anything to stop the numbness and pain. You can't see far into the future, so you can't see aspirations or dreams. Everything I ever wanted to do with my life before seemed impossible now. I also would think that I would never get out, that I'd be depressed forever. It brings quite irrational thinking because it's not a rational illness. It makes you think all sorts of things about life and yourself that aren't true. I thought I'd never escape from the depths of depression and never achieve anything with my life.

To over-simplify somewhat, what seems to be lacking here (and in many other cases) is the sense that anything could ever change in a good way, that the future incorporates the potential for positive change. One's experienced surroundings, deliberations, and imaginings are devoid of that possibility. Even the past may be remembered as lacking positive development: it *feels* as though one has never been happy, that nothing good has ever happened, that nothing has ever improved. This amounts to the unwavering conviction that

things were always like this, always will be like this, and could not be otherwise; nothing seems more certain. Deliberation therefore occurs against the backdrop of an all-enveloping way of *finding oneself in the world*, one that includes no sense of its own contingency (Ratcliffe, 2008; 2015). This inevitably compromises the ability to evaluate treatment options (Meynen, 2011). As Hindmarch, Hotopf, & Owen (2013, p.3) put it, what is lacking is a kind of ‘appreciative ability’. In the most extreme case we might envisage, *all* sense of positive change is lacking. Therefore, treatment options cannot be understood or evaluated in terms of the relative likelihood of their facilitating improvement.

The difference between a predicament of this nature and a decision that involves evaluating one’s options in the light of potential outcomes need not be evident to an interpreter. Inability to contemplate the possibility of *p* is easily misconstrued as a matter of weighing up the costs and benefits of *p* and *q*, and then opting for *q*. There are many ways in which the impossibility of *p* might be expressed, all of which could be assimilated into alternative interpretations that presuppose intact decision-making. Indeed, inability to contemplate *p* is compatible with being able to voice good reasons for *q*. But, in a case where *q* is already rendered inevitable by an inability to entertain *p*, these reasons have no role to play in the decision. And, even where *q* is more specific in nature, such that reasons do play a role in nudging one towards it, they cannot be countered by reasons in support of a contrasting option, *p*.

This phenomenological approach is to be distinguished from cognitive theories of depression, of the kind that emphasize cognitive biases, styles, schemata, and the like, which contribute to the formation of beliefs. A loss of certain types of possibility from the experiential world is not itself a propositional belief or system of beliefs. Furthermore, the person is not merely *disposed* to adopt certain propositional beliefs rather than others, such as ‘I will never recover’ or ‘recovery is impossible’. What might look like a specific, propositional belief is in fact the expression of a much wider-ranging change in the structure of experience, which renders certain predicaments unintelligible and others seemingly inevitable (Ratcliffe, 2015).

In light of these considerations, it is informative to revisit the case of Aurelia Brouwers. One press report quoted a ‘supporter’ as saying ‘she never had a moment of doubt that she wanted it to end’ ([www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands](http://www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands); last accessed 17.01.2019). This level of conviction could be construed in terms of considering the alternatives and finding them all inferior. However, it could just as well involve an inability to entertain relevant alternatives, let alone to gauge



their relative likelihoods. Brouwers herself is quoted as saying ‘I have never been happy – I don’t know the concept of happiness’ (e.g., [www.bbc.co.uk/news/stories-45117163](http://www.bbc.co.uk/news/stories-45117163); last accessed 17.01.2019). Perhaps it is true that she had never been happy, but her remark is equally consistent with an inability to imagine, remember, or anticipate happiness.<sup>4</sup> The difference is an important one: a person does not have the capacity to make a decision motivated by  $q$  where (a) the decision requires being able to weigh up the relative likelihoods of  $p$  and  $q$  and (b) one lacks the ability to contemplate the possibility of  $p$ . Thus, if it is accepted that psychiatric euthanasia should only be approved only in cases where that capacity remains intact, we face the epistemic challenge of distinguishing two superficially similar but importantly different predicaments. This challenge is seldom acknowledged, let alone addressed.

That deficits of this kind do indeed occur is indicated by numerous first-person accounts of severe psychiatric illness, all of which emphasize an inability to grasp that things could be any different. For example:

When I’m depressed life never seems worth living. I can never think about how my life is different from when I’m not depressed. I think that my life will never change and that I will always been depressed. Thinking about the future makes my depression even worse because I can’t bear to think of being depressed my whole life. I forget what my life is like when I’m not depressed and feel that my life and future is pointless.

The experienced impossibility of positive change is a common theme in published autobiographical accounts of depression. What often does turn out to be temporary and what one might even *know* (in a hollow, ineffectual, propositional way) to be temporary still *feels* eternal in a manner that holds sway over the person:

I was advised to ‘hang in there, Dave, the pain will pass.’ This was true enough – it’s just that I found it unbelievable at the time. (Webb, 2010, p.4)

I have absolutely no faith, in fact, in anything. In a muddy way, I see that depression manifests itself as a crisis of faith. Not religious faith, but the almost born instinct that things are fluid, that they unfold and change, that new kinds of moment are eventually possible, that the future will arrive. I am in a time-locked place, where the moment I am

in will stretch on, agonizingly, for ever. There is no possibility of redemption or hope. It is a final giving up on everything. It is death. (Lott, 1996, pp.246-7)

In the middle of a depressive episode, it is impossible to believe it will pass. It is, oddly, a problem of believing that one is seeing the world ‘as it really is’ and unable or unwilling to put a gloss on that perception. (Burnard, 2006, p.244)

Experiences of this kind do, to some extent at least, resemble strong feelings of conviction that are compatible with competent decision-making. A given decision or belief often *feels right* to the extent that all the alternatives cease to have any affective pull. There is thus a comparable sense of certainty surrounding that decision or belief: I am sure I should marry this person, take this job, buy that house, help these people. However, feelings of conviction more usually concern concrete propositions or states of affairs, to which various kinds of significance may attach. They are therefore importantly different from feeling certain about something because one cannot contemplate *types* of significant possibility. In both cases, the feeling of conviction involves a lack of *affective pull* in any other direction. But, in the mundane case, it is situation-specific. Where capacity is lacking, it is a structural constraint on all experience and thought, something that is insensitive to differences between the potential outcomes one considers.

## **CAPACITY AND CONTEXT**

Where there is a non-localized loss of possibilities, not all decisions need be impaired in the same way or to the same degree. The relevant phenomenology encompasses considerable variety, both in the *extent* to which possibilities are eroded and in the *kinds* of possibility that are eroded. Whatever form it takes, it is likely to affect different types of decision in different ways, as not all decisions involve reckoning with the same kinds of possibility. Where all sense of positive development in one’s own life is lacking, one might remain able to make various other evaluative judgments: distinguish a good film from a bad one, determine what is the right or wrong thing to do in a situation where established, shared norms apply, perhaps appreciate what others should do in certain circumstances, and so forth.

Lack of capacity can also be context-sensitive: that something seems inevitable or impossible may reflect a privation of imagination, memory, and / or and anticipation that is not present to the same degree in practically engaged perceptual experience. While someone might judge ‘I can’t do *p*’ and decide accordingly, her sense of the possible could change

once she is immersed in the relevant situation. So, what I am concerned with here is not simply a matter of lacking all sense that the future could differ in consequential ways from the present. As Owen et al. (2015) observe, even very severely depressed patients retain certain ‘temporal abilities’ when making decisions.<sup>5</sup> For instance, they experience themselves as situated at a distinctive point in time, appreciate time constraints, and make decisions that involve preferring some situations to others (such as wanting to discontinue an interview and return to one’s room). Given this, it might appear that decision-making capacity remains intact. However, Owen et al. go on to show how discerning interviews can reveal profound deficits. While someone might continue to utter platitudes such as ‘I hope so’ in response to questions about what the future holds, impaired ability to contemplate positive change is more apparent when one attempts to elicit specific expressions of hope with concrete contents. In severe cases, at least, there is a change in the structure of temporal experience: a diminished sense of there being an open, meaningful future into which one might progress. Consequently, there is a lack of capacity to make decisions that involve evaluating one potential autobiographical future as preferable to another. Lack of capacity therefore involves degrees of ‘decision-specificity’ (Owen et al., 2015, p.177).

For current purposes, I restrict my considerations to extreme cases, where one is unable to contemplate the prospect of positive change in one’s own life. Some decisions are more important than others, and the stakes are especially high when the decision is whether to live or die. As one psychiatrist observes, ‘it seems reasonable to insist on a progressively more stringent test of competence as the stakes become higher in terms of the magnitude and probability of possible harm to the patient’ (Young, Corby, & Johnson, 1993, p.509). This is even more so when it is acknowledged that losses of possibility can be expressed in ways that resemble (superficially, at least) rationally evaluating the available evidence and making a decision. Furthermore, the kinds of decisions most likely to be compromised are those that involve anticipating how we might *feel* in certain circumstances and acting *in order to* realize or avoid the relevant feelings. Not all decisions take that form. For instance, I might do something because I judge it to be the morally right thing to do or because I am professionally obliged to do it. Even if one insists that no such actions would be performed in the absence of the positive feelings that they elicit (something I am doubtful of), the explicit aim of the action is not to change how one feels but to bring about something else, which might in turn have the effect of altering one’s feelings.

Charland (e.g. 1999) has suggested that instruments such as the MacCAT-T fail to accommodate the important contributions that emotions make to decision-making. In short,

decision-making requires evaluation, which depends on emotion. My position here is consistent with his criticism, but more specifically focused. I am concerned with how disturbance of a certain *type* of affective feeling gives rise to a distinctive kind of evaluative impairment: a diminished ability to appreciate the contingency of one's current predicament. 'Feeling', in this context, should not be construed solely as a matter of localized affective experiences. It also encompasses 'existential feeling': a changeable sense of reality and belonging, which can be understood in terms of phenomenological access to various types of possibility (Ratcliffe, 2008). The point is that, if one's current existential feeling or *way of finding oneself in the world* renders one impervious to its own contingency and potential for change, this will inevitably impact on the capacity to make decisions that are explicitly concerned with manipulating the feeling in question. Thus, as Banner (2013) argues, an exclusively procedural conception of capacity is unworkable in practice and the contents of the person's beliefs, values, and decisions also need to be taken into consideration. In the type of case I am concerned with, this is because the ability to factor possible outcomes into decision-making is retained for some outcomes and not others. Whether or not one is able to deliberate therefore depends on the contents of one's deliberations.

One could respond that there are sometimes compelling medical grounds for taking the patient's self-appraisal to be correct, that some cases really are hopeless. For instance, Berghmans, Widdershoven, & Widdershoven-Heerding (2013) and Schuklenk & van de Vathorst (2015) argue that some cases of chronic and severe psychiatric illness are both unbearable and untreatable, and that euthanasia may well be an appropriate course of action here. It is questionable whether any cases really are wholly untreatable or even what is meant by 'untreatable' in this context (Bilkshavn, Husum, & Magelssen, 2017; Broome & de Cates, 2015). However, even if we accept that this clinical judgment is accurate in some cases, the issue of capacity remains. Suppose that (a) a patient concludes that she has no realistic chance of recovery from unbearable suffering and therefore requests euthanasia, and (b) the physician also concludes that this patient has no realistic chance of recovery from unbearable suffering. If decision-making capacity is a necessary condition for the request's approval, then the patient's appraisal of her situation must, like that of the physician, originate in a competent decision-making process. Being unable to conceive of the contrary does not fit the bill - the patient's strength of conviction, the feeling of *certainty*, stems from privation of the ability to entertain relevant alternatives. Even if recovery were medically guaranteed, she would still insist on its impossibility. To approve a request for euthanasia, while at the same time recognizing its imperviousness to situational factors, would be to rely on the decision-

making capacity of the clinician rather than that of the patient. One might take the line that, where there really is unbearable and untreatable suffering, this is sometimes justifiable. Given that the patient's capacity is lacking but not entirely absent, the input of the clinician could be conceived of as a form of support or 'scaffolding' that compensates for certain deficits in capacity. However, so far as I am aware, none of those who support the practice have sought to develop, defend, or implement such a view.

But are there other cases, where a person endures unbearable suffering due to psychiatric illness and *does* retain the decision-making capacity required to choose euthanasia? Broome & de Cates (2015) suggest that there may be no actual instances where (a) a *psychiatric* condition is severe enough to warrant euthanasia and (b) the person's capacity to make the decision remains intact. To put it in my terms, loss of possibility is integral to suffering and the sense that 'this is inescapable and will go on forever' plays a major role in rendering it unbearable.<sup>6</sup> One might go so far as to suggest that, where the suffering attributable to a chronic psychiatric condition is so severe that a euthanasia request is considered seriously, the patient will inevitably lack the capacity needed to make the decision. 'Unbearable psychiatric suffering' is thus conceived of in such a way as to render it incompatible with intact capacity. More generally, though, unbearable suffering can take many different forms and there are insufficient grounds for maintaining that, in the context of psychiatry, it *invariably* incorporates an inability to even contemplate the possibility of positive change in one's life. Nevertheless, the fact that loss of possibilities can be partly constitutive of 'unbearable suffering' suggests that degree of suffering in psychiatric contexts will often be associated with diminished ability to contemplate alternatives.<sup>7</sup>

## **THE INTERPERSONAL AND THE POSSIBLE**

Up to this point, I have drawn on phenomenology to raise an epistemic issue: inability to contemplate *p* is easily mistaken for that belief that *not p*, formed by weighing up the respective likelihoods of *p* and *not p*. However, one could also take the line that the very notion of 'capacity' fails to capture the nature of impaired decision-making in psychiatric illness and that a phenomenological approach may provide the basis for an alternative (Donnelly (2017)). In this section, I will address one way in which a phenomenological account of experiencing the possible at least complicates how we think of decision-making capacity.

A sense of positive life-development as impossible is inextricable from a change in how one experiences and relates to *other people*. This is not to insist that the relevant

predicament is always or even sometimes interpersonally caused. Rather, I am making a constitutive claim: a world devoid of certain kinds of possibility *implies* a pervasive detachment from other people, and vice versa. First-person accounts of severe psychiatric illness often convey a non-localized feeling of estrangement and detachment from other people. Others in general may seem distant and inaccessible. For some, the interpersonal world is permeated by lack of trust and an air of threat or menace. Many emphasize being a ‘burden’ on others, something that is closely associated with shame, guilt, self-hate and / or negative feelings directed at other people for not caring, for making one feel like a burden. For example:

The world appears to be a frightening place full of people who are bad and threatening.

I always feel as though they’re fed up of me, that they don’t want to be around me, despite how loving they may be acting. I feel like I’m a terrible burden and they would be better off without me around.

When I’m depressed I feel like my relationships are less stable and I trust others a lot less. I try to avoid people, as they seem angry and irritated at me, and like they don’t want me around. I feel like a burden to others and don’t want to cause anyone unnecessary distress.

People don’t like me, I’m a burden, they become patronizing because they know I can’t cope. When they care, it’s because they have to - and their happiness always seems to be in spite of me, never because of me, and I know I get in their way.

The reason why forms of interpersonal experience such as these are inextricable from losses of possibility is that experienced and anticipated interactions with other people more usually involve opening up new possibilities. Expecting a given type of interaction with a particular individual may involve anticipating some quite specific eventualities, from meeting for coffee, to working on a joint project, to having a heated discussion about something or other. However, when anticipating interpersonal interactions of whatever kind, there is also a less determinate sense of other people in general as loci of self-affecting possibilities, as *pointing to the possibility of new possibilities* (Ratcliffe, 2018). The prospect of relating to others in certain ways amounts to a kind of ‘openness’; it *is* to experience one’s current

predicament as contingent, as not exhausted by the concrete possibilities that one is currently able to entertain. In contrast, other kinds of interpersonal encounter involve a diminishment of possibilities. Most of us can recall conversations that left us feeling invigorated, filling the world with new and enticing possibilities, to be contrasted with awkward or outright distressing encounters that left us feeling deflated and diminished, draining our surroundings of vitality (Ratcliffe, 2018).

But why accept any of this? After all, a few brief assertions about the nature of interpersonal experience are hardly conclusive. We can further support these phenomenological claims by turning to the topic of emotion-regulation. It is through our various emotions, along with a wider range of affective experiences, that we encounter things as salient and significant, that we experience various types of possibility as inherent in them. For instance, to find an entity threatening (rather than merely judge it to be a threat) is to feel fear, something that involves experiencing a distinctive kind of significant possibility or mattering. Our various emotions are not just *experienced* by us but also *regulated* in a range of often intricate ways, as made clear by the substantial and fast-growing interdisciplinary literature on emotion-regulation (e.g., Gross, 2014). In humans, it is arguable that many emotion-regulation processes, perhaps the vast majority, are not wholly internal to the individual but interpersonally and socially *distributed*. Even if one declines to endorse this strong claim, it remains the case that these processes are in many ways *dependent* on interpersonal, social, and / or cultural arrangements. To regulate our emotions, we rely on relationships with specific individuals, on wider sets of expectations concerning other people, on many different types of interpersonal interaction, and on engagement with a shared, social environment. With or without explicit insight into what we are doing, we relate to our surroundings (especially our social surroundings) in ways that shape, maintain, and re-shape our emotional responses (Campos, Walle, Dahl, & Main, 2011; Colombetti & Krueger, 2015; Szanto, 2017; Ratcliffe, 2017). This is perhaps most evident when we consider relations between infants and carers, where patterned interactions play essential roles in eliciting and regulating infants' emotional responses. However, patterns of co-regulation are also evident in adulthood, as illustrated by the effects of spousal bereavement (Ratcliffe, 2019). In fact, it has been argued that depression is similar in structure to infant separation, both of which centrally involve the 'felt unavailability of others as potential external co-regulators' (Varga & Krueger, 2013, p.273). Consistent with the roles that other people play in emotion-regulation, I propose that what we anticipate from them includes at least some appreciation of their potential influence on how things matter to us.

This suggests that how we relate to others has the potential to enhance or diminish ‘capacity’ by affecting our sense of the possible. If that is right, then assessing capacity is not just a matter of measuring something internal to an individual. Something else to be taken into account is that individual’s ability to anticipate, experience, and relate to others in self-affecting ways. To be more specific, central to many of the ways in which we engage with others is a non-localized form of what we might call ‘trust’: a pre-reflective, non-conceptual, default mode of anticipating their behaviour, which takes for granted that exchanges will be benign. In contrast to this, consider a world where others appear only in the guise of actual or anticipated threat. There is no prospect of positive development; the only sense of contingency associated with specifically interpersonal possibilities is the prospect of things getting even worse. In a world without trust, one is cut off from various kinds of regulatory process and also from the numerous ways in which other people more usually aid us in making decisions. As Martin & Hickerson (2013) observe, although ‘decisional competence’ is routinely construed in individualistic terms, most of the important decisions we make -even for ourselves- are made with others, against the backdrop of wider communities. Trusting relations are a prerequisite for this. To take others’ advice on board, to regard them as honest, committed, and well-meaning, to experience their words, gestures, and actions in terms of promising, supporting, consoling, sympathizing, and reassuring – all of this requires being open to the prospect of certain kinds of interpersonal relations. Without this openness, well-meaning or friendly gestures will be misinterpreted or even *experienced* as meaning something different: ‘The world looks entirely different whilst I am depressed. If a person is to smile at me whilst I am depressed, I am filled with anxiety, wondering why they are laughing at me, and usually decide in my mind that it is because I am hopeless’.

Wide-ranging loss of trust is commonplace among those with diagnoses of severe psychiatric illness, and is often associated with autobiographical reports of mistreatment at the hands of others, including neglect or abuse during childhood (Fonagy & Allison, 2014; Ratcliffe, 2017). It is inextricable from loss of hope, given that one can no longer call upon others to repair, sustain, or re-instill the sense of contingency and possibility that is lacking.

All of this has significant implications for evaluations of capacity. If decision-making is ordinarily interpersonally supported, and if a sense of being irrevocably cut off from this kind of interpersonal support is integral to one’s suffering, then capacity is likely to be impaired. Where lack of trust encompasses relationships with healthcare professionals, one will not regard them as reliable sources of relevant information, interfering with the ability to access and evaluate information directly relevant to one’s condition (Donnelly, 2017).



Nevertheless, loss of trust need not involve refusal to believe *everything* that is said, and it need not apply to all the people one encounters in exactly the same way. Indeed, pervasive distrust may remain compatible with ‘trusting’ the testimony of someone who acknowledges and supports one’s conviction that recovery is impossible.

Consider an analogy. Suppose that, for several months, you have had a growing sense of failing in your job. After a time, all you anticipate from colleagues as you enter a shared office is ridicule and condemnation. The prospect of their being welcoming or supportive never enters the picture. Eventually, you receive a letter of dismissal from the head of the company, along with a request to attend a meeting during which the terms of your departure will be negotiated. As you enter the meeting, losing your job is taken as given; it is inevitable. The prospect of staying on, of succeeding, of feeling comfortable and fulfilled in your working environment never even crosses your mind. You are going; no other possibilities present themselves. Hence, the only remaining issues concern the terms of your departure and, as you plead, that is all you plead for. When you are offered one of the less painful departure options, you express gratitude and relief, perhaps even a limited ‘trust’ in this individual, but only within the context of a wider absence of possibilities, including those possibilities your colleagues might otherwise have offered.

It could well be that some requests for psychiatric euthanasia are similar in structure to this. A psychiatrist’s refusal to take seriously the patient’s request for euthanasia might itself be a source of distress, while the consideration and even approval of that request might be a source of comfort (Verhofstadt, Thienpont, & Peters, 2017). In the latter case, it may also seem that the patient trusts the doctor, that she has come to a reasoned decision, and that the doctor-patient relationship is a good one. Nevertheless, the potential role played by a backdrop of absent possibilities also needs to be acknowledged. In a world that is no longer populated by certain kinds of imagined and anticipated interaction with others, it could be that the only options left on the table involve either having one’s despair vindicated or having it exacerbated by yet another dismissal.<sup>8</sup> However, there remains question as to whether or not one retains the capacity to be affected by others in ways that have the potential to re-instill some sense of hope. The loss of possibilities may be context-sensitive to varying degrees. In some instances, at least, it is not something that can be assessed in isolation from styles of interaction with other people, including those charged with assessing capacity. Any attempt on the part of the clinician to assess capacity will thus require skillful interaction with the patient. Where a patient cannot imagine or anticipate experiencing certain kinds of interpersonal relation, perhaps she really is incapable. Then again, it could be that what she is

able to imagine and anticipate does not reflect what she is able to experience. Here, clinician-patient interactions may harbor the potential to rekindle types of possibility that are currently absent from experience and thought, upon which decision-making capacity depends.

Conversely, confirming a patient's suffering to be untreatable risks consolidating the loss of possibilities: there really is no prospect of improvement.

### **THE INTERPERSONAL CONTEXT OF PSYCHIATRIC EUTHANASIA**

The issues raised here are not merely hypothetical; publicly available information suggests that many actual cases are consistent with the phenomenological account I have offered.

Social isolation and loneliness are prominent and consistent themes in the self-narratives of those requesting psychiatric euthanasia. Kim, De Vries, & Peteet (2016) report that, in the 66 records they examined, most of those concerned 'had personality disorders and were described as socially isolated or lonely' (p.362). Case reports included observations such as 'the patient indicated that she had had a life without love and therefore had no right to exist' and 'the patient was an utterly lonely man whose life had been a failure' (p.365). Although brief, these remarks point to a sense of alienation from the social world, of the kind that I have suggested is inextricable from inability to entertain certain kinds of significant possibility. Berghmans, Widdershoven, & Widdershoven-Heerding (2013, pp. 439-40) consider one case in detail, noting that the patient concerned 'did not participate in any social activities', 'was unable to appreciate anything', and 'repeatedly indicated that she did not wish to continue living this way'. They add that, according to one of the psychiatrists involved, the person 'no longer had hopes of success in alleviating her state of mind' and that her life 'lacked all quality as she was unable to adjust to any situation'. In this case, the patient's request was approved and assistance-in-dying was provided. I have suggested that the proper interpretation and appraisal of such testimonies hinges on the distinction between accurately recognizing one's life to be without hope and taking it to be without hope because one is currently unable to contemplate relevant alternatives.

Furthermore, the unbearable suffering, to which euthanasia is sometimes deemed an appropriate response, seems to consist largely in an overwhelming sense of estrangement, isolation, and hopelessness. Verhofstadt, Thienpont, & Peters (2017) examine the unsolicited written or spoken accounts of 26 patients who requested euthanasia, with a view to clarifying the nature of their suffering. Five prominent dimensions of suffering are distinguished: 'medical, intrapersonal, interpersonal, societal, and existential'. Hopelessness is also observed to be an 'important contributor' (2017, p.238). On closer inspection, all these

themes appear to be bound up with interpersonal or social relations. Even the ‘intrapersonal’ includes the likes of ‘traumatic background history’, involving past events that are mostly interpersonal in nature. As for explicitly ‘interpersonal’ factors, it is noted that testimonials refer to ‘serious conflicts or disruptions with important others (parents, partners and/or children) both in the past and the present’ (2017, p.241). Bereavements are also mentioned, as is lack of understanding and support from others and being a ‘burden’ on them. The category of ‘societal’ suffering includes ‘suffering related to one’s place and interaction in society’, including financial problems, work-related issues, and adjusting to society more generally. Again, this cannot be disentangled from how one anticipates, experiences, and relates to other people. Then there is existential suffering, which includes feeling overwhelmed, fearing life, and losing control. In considering what such feelings consist of, we should keep in mind the regulatory roles that interpersonal relations more usually play in preventing, controlling, and responding to such experiences. We feel overwhelmed when we are under pressure and unsupported; we fear life when we experience others as uniformly hostile; and we lose control when we cannot rely on others and the world becomes unpredictable, unmanageable.

Turning to medical suffering, where this is largely attributable to a condition such as ‘depression’, it cannot be extricated from the interpersonal dimensions of the illness: the suffering is unbearable because it seems endless; it seems endless because one cannot entertain alternative possibilities; and an inability to entertain alternative possibilities is, at the same time, a pervasive estrangement from others. Verhofstadt, Thienpont, & Peters (2017, p.243) emphasize the need to distinguish hopelessness as a symptom of depression from hopelessness as a rational appraisal of one’s situation. However, where the situation to be evaluated involves one’s being chronically, severely depressed and unlikely to recover, the distinction cannot be sustained. A rational appraisal would involve feeling hopeless about one’s state of hopelessness, where the latter prohibits one from feeling anything else in a way that is non-rational.

The phenomenological account developed here is also supported by studies of what it is to feel suicidal. Psychiatric euthanasia (including ‘assisted dying’) differs in important respects from most of those suicides attributable to psychiatric illness: it involves the expression of a consistent, long-term ‘preference’, which is discussed at length with relevant professionals and -most likely- others too, culminating in legal approval and practical support. Even so, those requesting psychiatric euthanasia often have a history of suicide attempts, while others go on to commit suicide before or after the request is granted, or after it is refused. It is therefore highly likely that the underlying phenomenology and motivating

factors are similar in many cases. Benson et al. (2016) examine the first-person accounts of people who have attempted suicide, their friends and family, and others who have been bereaved by suicide. They draw out three common themes: 'lack of trust'; 'lack of inherent worth'; and what they call 'suicidal exhaustion'. By 'trust' and 'worth', they do not mean specifically directed attitudes but pervasive and deep-rooted aspects of self- and other-experience that are more usually taken as given. It is exhausting to live without trusting relationships or an underlying sense of self-worth. Suicidal exhaustion thus arises from the overarching structure of one's life, from something that seems unavoidable and inescapable. Hence, the movement towards suicide differs from a motivated decision, made against the backdrop of an intact possibility-space. According to Benson, Gibson, & Brand (2013, pp.56-60) there is a 'disruption in the experience of the self as an agent'; 'a fundamental change in the person's experiential background such that no thought, perception, or emotional response is left completely unchanged'; 'a reorientation of the whole of one's existence rather than simply a wish to die by one's own hand'.

Feeling suicidal in this way is thus bound up with a loss of possibility and consequent sense of one's predicament as otherwise inescapable, as suggested by first-person descriptions such as these:

I almost always feel suicidal for at least some of the time when I am feeling depressed. My life feels hopeless, as if there's no point in continuing because I'm never going to get better or be able to change.

When depressed my thoughts about life are very negative, unhappy, self-critical, unbalanced and distorted compared to when I'm not depressed. I think about how my life seems empty, unsuccessful, lonely, limited, poverty stricken, grief stricken, unfulfilling and pointless: especially when compared with other people's lives around me. The worst part of thinking and therefore feeling this way when depressed is the complete lack of hope I attribute to every part of my life and the whole of life in general. This makes life unbearable and my thoughts turn to suicide.

You feel tempted to end the suffering - however this is not a calculated decision (to end the suffering), it is a feeling as though it's a natural next step to take (just like animals seek solitude to die).

When someone is granted psychiatric euthanasia, is that person really incurable? That may well be the case sometimes. Nevertheless, the suffering in question often consists, to a large extent, in the loss of interpersonal possibilities. So, it is not to be conceived of in terms of an illness *plus* its impact on interpersonal relations. Rather, it is permeated through and through by how the person experiences and relates to (or fails to relate to) others. A pervasive sense of estrangement from other people is also integral to impaired decision-making capacity, given its inextricability from loss of possibilities. Hence, the task of determining whether suffering really is unbearable and untreatable is inextricable from that of somehow determining whether or not certain kinds of self-transformative interpersonal relations are most likely forever beyond a person's reach. Where that is so, I have suggested that capacity will also be lacking. Therefore, whether or not psychiatric euthanasia should be considered in such a scenario then depends, in part, on whether one continues to insist on intact 'capacity' as a requirement.

To summarize, I have argued that, when evaluating psychiatric euthanasia as a response to unbearable suffering, we need to acknowledge the existence of cases where (a) a sense of the suffering as endless is intrinsic to its being unbearable; (b) its endlessness is constituted by loss of access to possibility; (c) loss of access to possibility erodes the capacity to make life-decisions; and (d) loss of possibility (with consequent loss of capacity) is inextricable from an inability to imagine, anticipate, and / or participate in certain types of interpersonal relation. I have not challenged the practice of psychiatric euthanasia *per se*. Rather, I have argued that, *if* capacity on the part of the patient is to be insisted upon as a requirement for approval, then psychiatric euthanasia should not be approved in these cases. It is not at all clear from the relevant literature that the practitioners concerned are sufficiently sensitive to the distinction. Furthermore, certain descriptions of patients who have requested euthanasia strongly suggest that their suffering takes the form I have described. Additional issues arise once it is acknowledged that psychiatric suffering, loss of possibilities, and loss of capacity are bound up with how a person experiences and relates to others. This calls into question an individualistic conception of capacity and also complicates the task of measurement.

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<sup>1</sup> For representative examples of news reports, see *The Guardian* newspaper ([www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands](http://www.theguardian.com/society/2018/mar/17/assisted-dying-euthanasia-netherlands)) and the BBC News website: ([www.bbc.co.uk/news/stories-45117163](http://www.bbc.co.uk/news/stories-45117163)), both accessed 22.01.2019. Excerpts from interviews with Aurelia Brouwers, recorded by the Dutch network RTL News, appear with English translations in this BBC Radio 4 documentary: <https://www.bbc.co.uk/programmes/b0bdb9qk> (last accessed 22.01.2019).

<sup>2</sup> See also Grisso and Appelbaum (1998). For phenomenological studies of mental capacity that draw on this definition, see Owen, Freyenhagen, Hotopf, & Martin (2015, p.177); Hindmarch, Hotopf, & Owen (2013, p.1); Meynen (2011, p.182).

<sup>3</sup> The questionnaire study was conducted as part of the AGRC- and DFG-funded project 'Emotional Experience in Depression' (2009-2012). For details, see Ratcliffe (2015, Chapter 1).

<sup>4</sup> In a discussion of depression, capacity, and treatment-refusal, Sullivan & Youngner (1994, p.971) are sensitive to this crucial distinction, stating that 'depressive hopelessness can make it impossible to imagine that life will ever offer a better balance of pleasure and pain than it does at present'.

<sup>5</sup> See also Martin and Hickerson (2013) for a discussion of 'temporal capacities' and the ability to take account of 'future subjunctive information'.

<sup>6</sup> See Wyllie (2005, p.182) for an interesting discussion of how an altered sense of time in severe depression contributes to one's suffering by making it seem endless. See also Broome (2005).

<sup>7</sup> See Svenaeus (2018) for a detailed, discerning, and wide-ranging discussion of the phenomenology of suffering.

<sup>8</sup> See also Blikshavn, Husum, & Magelssen (2017) for the concern that considering a request for psychiatric euthanasia risks vindicating despair. They observe that hope can be 'therapeutic' and that there is therefore the risk of a 'self-fulfilling prophecy' when clinicians concede that there is no hope of improvement.