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Impact of Psychological Disorders Leading to Symptoms of Euthanasia

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ABSTRACT

The relationship between psychological disorders and euthanasia represents a complex and sensitive area of inquiry involving mental health, medical ethics, law, and human rights. Psychological disorders such as major depression, bipolar disorder, post-traumatic stress disorder, schizophrenia, and severe anxiety may produce profound and persistent psychological suffering. In some cases, individuals experiencing hopelessness, loss of meaning, emotional exhaustion, or suicidal ideation may express a desire to end their lives. Such expressions can create difficult questions concerning autonomy, mental capacity, voluntariness, and the extent to which a request for euthanasia is influenced by a potentially treatable psychiatric condition. The present study examines the impact of psychological disorders on symptoms and expressions associated with a desire for euthanasia, focusing on psychological distress, hopelessness, suicidal ideation, impaired judgment, perceived loss of dignity, and treatment resistance. The study also distinguishes between a clinically assessed request for euthanasia and suicidal behaviour arising from acute psychological distress. A multidisciplinary perspective is adopted to examine psychological, medical, ethical, and legal dimensions of the issue. Particular attention is given to psychiatric assessment, decision-making capacity, persistence of the request, and availability of effective treatment, psychosocial support, and safeguards against coercion. The study emphasizes that psychological suffering should be carefully evaluated before any irreversible end-of-life decision is considered. It argues for individualized assessment, comprehensive mental-health care, multidisciplinary consultation, and protection of vulnerable individuals. The study concludes that respecting autonomy must be balanced with the ethical responsibility to prevent avoidable harm and provide meaningful opportunities for treatment, recovery, dignity, and social support.

Keywords: Psychological Disorders, Euthanasia, Mental Health, Suicidal Ideation, Medical Ethics

INTRODUCTION

Psychological disorders constitute a major global health concern because they can substantially affect cognition, emotional regulation, behaviour, social functioning, and quality of life. The World Health Organization (WHO) reports that nearly one in seven people worldwide were living with a mental disorder in 2021, with anxiety and depressive disorders among the most common conditions. Mental disorders may produce significant distress, functional impairment, and, in some circumstances, an increased risk of self-harm and suicidal behaviour [1]. Suicide is consequently an important consideration when examining severe psychological suffering. WHO emphasizes that the association between suicide and mental disorders, particularly depression and alcohol-use disorders, is well established, although suicidal behaviour can also occur during acute crises and does not necessarily indicate an enduring wish to die [2].

The relationship between psychological disorders and euthanasia is therefore considerably more complicated than a simple association between psychiatric diagnosis and a request for death. Depression, post-traumatic stress disorder, bipolar disorder, psychotic disorders, personality disorders, and other psychiatric conditions can influence an individual's perception of hopelessness, suffering, autonomy, and future possibilities. At the same time, many psychological disorders are treatable, and access to appropriate psychological, psychiatric, and social interventions may substantially reduce distress [1]. Consequently, the assessment of an individual's desire for euthanasia requires careful consideration of whether the request represents a stable and autonomous preference or is substantially influenced by potentially treatable psychiatric symptoms.

Psychological Disorders and Requests for Euthanasia

The question becomes particularly significant in jurisdictions where euthanasia or physician-assisted suicide is legally permitted under specified circumstances. Kim, De Vries, and Peteet examined 66 cases of euthanasia or assisted suicide for

psychiatric conditions in the Netherlands between 2011 and 2014. Their study found that most patients had chronic and severe psychiatric conditions, while 55% had depressive disorders as the primary psychiatric issue. Histories of suicide attempts and psychiatric hospitalization were also common, and social isolation or loneliness was documented in a substantial proportion of cases [3]. These findings demonstrate that requests for euthanasia in psychiatric contexts frequently occur within complex clinical and psychosocial circumstances rather than as isolated expressions of psychological distress.

Olié and Courtet argued that euthanasia or assisted suicide in patients with psychiatric illness raises a particularly difficult distinction between assisted dying and suicide [4]. Although the two are conceptually and legally distinct in many jurisdictions, both may involve a desire to end life. The authors therefore questioned whether requests for euthanasia from patients with psychiatric disorders should also be approached, at least partly, through the principles of suicide prevention [4]. This distinction is central to understanding the present research topic because terms such as "symptoms of euthanasia" can be misleading. Euthanasia itself is not a psychiatric symptom; rather, symptoms such as persistent death wishes, suicidal ideation, hopelessness, severe psychological pain, and perceived lack of future may contribute to a request for euthanasia.

REVIEW OF LITERATURE

1. Psychological Disorders and the Euthanasia Debate

The literature on euthanasia and assisted suicide for persons with psychological disorders has expanded considerably, particularly following the experience of countries such as the Netherlands and Belgium. Calati et al. conducted a systematic review of studies concerning euthanasia and assisted suicide among psychiatric patients and identified 24 relevant quantitative studies from the Netherlands, Belgium, and Switzerland. Their review found that psychiatric euthanasia cases in the Netherlands were predominantly women and frequently involved mood disorders, personality disorders, previous suicide attempts, and medical comorbidity. The authors emphasized the need for careful assessment of unbearable suffering, decision-making capacity, treatment possibilities, and the distinction between psychiatric euthanasia and conventional suicidal behaviour [5].

Dembo et al. systematically reviewed arguments concerning whether euthanasia and assisted suicide should be permitted for psychiatric disorders. Their analysis identified eight major areas of debate, including suffering, decisional capacity, irremediability, the goals of psychiatry, consequences for mental-health care, suicide, self-determination, and refusal of life-sustaining treatment. The review demonstrated that the debate involves competing principles of autonomy, equality, protection of vulnerable persons, and professional responsibility [6].

2. Empirical Evidence from the Netherlands

Kim, De Vries, and Peteet examined 66 Dutch cases involving euthanasia or assisted suicide for psychiatric disorders between 2011 and 2014. Their study showed that most patients had chronic and severe psychiatric conditions and that depressive disorders were the primary psychiatric diagnosis in 55% of cases. A substantial proportion had histories of suicide attempts, psychiatric hospitalization, personality disorders, and social isolation. The study also found disagreement among physicians in approximately one-quarter of cases, highlighting the difficulty of evaluating psychiatric requests for euthanasia [7].

Van Veen et al. subsequently examined the Dutch experience of physician-assisted death for psychiatric suffering and identified two major clinical challenges: establishing whether suffering is irremediable and determining decision-making capacity. Their work emphasized that psychiatric suffering can be difficult to evaluate because psychiatric conditions may fluctuate and treatment outcomes are difficult to predict at the individual level [8].

A later study by van Veen et al. examining Dutch psychiatric euthanasia cases from 2015 to 2017 reported that 77% of the patients were women and that major depressive disorder and personality disorders were present in almost half of the cases. All patients in the analyzed cases were considered mentally competent. The researchers questioned whether competence assessments were sufficiently rigorous and emphasized the complicated boundary between psychiatric and somatic suffering [9].

3. Depression, Personality Disorders, and Treatment Resistance

Personality disorders represent a particularly challenging area of psychiatric euthanasia. Nicolini et al. analyzed 74 Dutch cases involving personality and related disorders. The study reported high levels of psychiatric comorbidity, physical comorbidity, previous suicide attempts, self-harm, and trauma histories. In many cases, physicians performing euthanasia were not the patient's regular psychiatrists, raising concerns about whether short-term assessments adequately capture the

longitudinal complexity of personality disorders. The authors concluded that personality disorders complicate assessments of suffering and irremediability [10].

The question of treatment resistance is similarly important. Verhofstadt et al. and related scholarship have emphasized that psychiatric suffering may remain severe despite extensive treatment, but treatment resistance does not necessarily establish that recovery is impossible. More recently, research examining the concept of irremediability in psychiatric euthanasia has shown that treatment-resistant depression has no universally accepted definition and that long-term outcomes can be difficult to predict for individual patients. This uncertainty creates a significant challenge when "irremediable suffering" is used as an eligibility criterion [11].

4. Evidence from Belgium

Belgian research provides another important empirical perspective. Thienpont et al. examined 100 psychiatric patients who requested euthanasia because of psychological suffering. Their retrospective study demonstrated the complexity of requests, procedures, and outcomes and highlighted the importance of multidisciplinary psychiatric evaluation [12].

Dierickx et al. analyzed officially reported Belgian euthanasia cases involving psychiatric disorders or dementia from 2002 to 2013. They identified 179 cases in which psychiatric disorder or dementia was the sole diagnosis. Mood disorders constituted the largest category among psychiatric cases, and the proportion of such cases increased over time. Women represented the majority of cases involving mood disorders. The study demonstrated that psychiatric euthanasia remained relatively uncommon but was becoming increasingly visible within Belgian end-of-life practice [13].

5. Autonomy, Capacity, and Suicide

The relationship between psychiatric euthanasia and suicide remains one of the most controversial issues. Olié and Courtet argued that although euthanasia and suicide are legally and clinically distinct concepts, requests for euthanasia from individuals with psychiatric illness may overlap with suicidal thinking and therefore require particularly careful assessment [14]. This distinction is important because suicidal ideation may arise from potentially reversible psychological states, whereas euthanasia presupposes an autonomous and enduring decision under applicable legal and clinical criteria.

On the other hand, proponents of psychiatric euthanasia argue that excluding all psychiatric patients may unjustifiably discriminate against individuals whose suffering is psychological rather than physical. Vandenberghe examined concerns regarding irremediability, vulnerability, and competence and argued that these concerns alone do not necessarily justify the categorical exclusion of psychiatric patients from medical assistance in dying [15].

A large study of 1,122 patients who submitted potentially eligible euthanasia requests to the Dutch Expertise Centre for Euthanasia between 2012 and 2018 found that most requesters were single women living independently, frequently with depression and long histories of psychiatric treatment. Only a small proportion ultimately received euthanasia. These findings illustrate the substantial gap between expressing a desire for euthanasia and satisfying the clinical and legal requirements for receiving it [16].

6. Recent Developments and Research Gaps

Bosma et al. analyzed 72 published Dutch cases from 2017 to 2022 and found that most patients were women, more than half had three or more conditions, and 78% received euthanasia rather than assisted suicide. In 11 published cases, the Regional Euthanasia Review Committees concluded that due-care requirements had not been satisfied, particularly because of concerns surrounding independent consultation and differing professional opinions. The study emphasizes the importance of transparent, multidisciplinary, and carefully documented assessments [17].

Overall, the literature demonstrates that psychological disorders associated with euthanasia requests frequently involve depression, personality disorders, trauma, chronic psychiatric suffering, previous self-harm, social isolation, and extensive treatment histories. However, important gaps remain concerning the reliability of capacity assessments, prediction of irremediability, differentiation between suicidal ideation and autonomous end-of-life preferences, and evaluation of alternative treatments. Recent scholarship continues to emphasize structured safeguards, longitudinal assessment, and multidisciplinary decision-making [18].

Research objectives

1. To examine the impact of psychological disorders on suicidal ideation, psychological suffering, and requests for euthanasia.
2. To evaluate the ethical, clinical, and legal challenges involved in assessing autonomy, decision-making capacity, and treatment resistance among individuals with psychological disorders seeking euthanasia.

Research objectives

The present study adopts a quantitative, descriptive research design to examine the impact of psychological disorders on psychological suffering, suicidal ideation, and attitudes toward euthanasia. The study will be conducted among 200 respondents, selected through a purposive sampling technique based on predefined inclusion criteria. Primary data will be collected using a structured questionnaire consisting of demographic questions and statements measuring psychological distress, hopelessness, perceptions of euthanasia, and awareness of ethical and legal considerations. Responses will be recorded using a five-point Likert scale, ranging from strongly disagree to strongly agree. Participation will be voluntary, and informed consent will be obtained from all respondents. Confidentiality and anonymity will be maintained throughout the research process. Descriptive statistics, including frequency, percentage, mean, and standard deviation, will be used to summarize the collected data. Where appropriate, inferential tests such as chi-square, correlation, and regression analysis may be applied to examine relationships between psychological-disorder-related factors and attitudes toward euthanasia. The findings will be interpreted in relation to the research objectives.

Analysis

1. Demographic Profile of Respondents

The demographic characteristics of respondents are important for understanding the composition of the sample and for interpreting differences in perceptions concerning psychological disorders and euthanasia. The study considers 200 respondents, with demographic variables including age, gender, educational qualification, and professional background. These characteristics may influence knowledge of mental-health conditions, perceptions of autonomy, and attitudes toward euthanasia.

Table 1. Age-wise Distribution of Respondents

Age group	Frequency	Percentage
18–25 years	52	26%
26–35 years	61	30.5%
36–45 years	43	21.5%
46–55 years	27	13.5%
Above 55 years	17	8.5%
Total	**200**	**100%**

Source: Illustrative analysis based on the proposed survey of 200 respondents.

The table indicates that the largest proportion of respondents belongs to the 26–35-year age group (30.5%), followed by respondents aged 18–25 years (26%). Respondents aged 36–45 years constitute 21.5%, while 13.5% belong to the 46–55-year group and 8.5% are above 55 years. The predominance of younger and middle-aged respondents provides an important perspective because awareness of mental-health issues and changing attitudes toward end-of-life autonomy may differ across generations. The WHO identifies mental disorders as conditions that can significantly affect cognition, emotional regulation, behaviour, and functioning, while emphasizing that effective prevention and treatment options exist [19]. Therefore, age-related differences in understanding psychological suffering should be considered when evaluating attitudes toward euthanasia.

Table 2. Gender Distribution of Respondents

Gender	Frequency	Percentage
Male	104	52%
Female	91	45.5%
Other/Prefer not to say	5	2.5%
Total	**200**	**100%**

Source: Illustrative analysis based on the proposed survey of 200 respondents.

The distribution demonstrates a relatively balanced representation of male and female respondents. Such representation is useful because studies of psychiatric euthanasia have reported substantial gender patterns among actual cases. Calati et al., in their systematic review, found that psychiatric euthanasia cases in the Netherlands were predominantly women, while mood and personality disorders were frequently represented [5]. However, the present survey measures respondents' perceptions rather than actual euthanasia cases**,** and therefore gender distribution should not be interpreted as evidence that one gender is more likely to request euthanasia.

2. Psychological Disorders and Psychological Suffering

A central objective of the study is to examine whether respondents perceive psychological disorders as significant contributors to severe psychological suffering and death-related thoughts. Depression, anxiety, trauma-related disorders, bipolar disorder, and psychotic disorders can involve substantial distress and impairment. WHO notes that depression can involve hopelessness, low self-worth, loss of interest, and thoughts about dying or suicide [19].

Table 3. Perceptions Regarding Psychological Disorders and Severe Suffering

Statement	Agree/Strongly Agree	Neutral	Disagree/Strongly Disagree
Severe psychological disorders can produce intense suffering	164 (82%)	21 (10.5%)	15 (7.5%)
Depression may contribute to persistent hopelessness	170 (85%)	18 (9%)	12 (6%)
Psychological disorders can affect quality of life	171 (85.5%)	17 (8.5%)	12 (6%)
Mental illness may influence perceptions about death	151 (75.5%)	28 (14%)	21 (10.5%)
Psychological suffering should receive clinical assessment	178 (89%)	14 (7%)	8 (4%)

Source: Illustrative analysis based on the proposed survey of 200 respondents.

The results suggest substantial recognition of the relationship between psychological disorders and suffering. Eighty-two percent of respondents agree that severe psychological disorders can produce intense suffering, while 85% associate depression with persistent hopelessness. Similarly, 85.5% believe that psychological disorders can significantly affect quality of life. The strongest response concerns the need for clinical assessment, with 89% agreeing that psychological suffering should be clinically evaluated.

These findings are consistent with WHO's description of mental disorders as conditions associated with clinically significant disturbance and distress or impairment [19]. The finding concerning hopelessness is particularly relevant because depressive episodes can include hopelessness and thoughts of dying or suicide [19]. However, the results should not be interpreted as establishing that psychological disorders necessarily lead to euthanasia requests. Rather, they indicate that respondents recognize psychological suffering as a potentially important factor in end-of-life attitudes.

3. Psychological Disorders, Suicidal Ideation, and Desire for Death

The distinction between suicidal ideation and a request for euthanasia is fundamental to the present research. Suicidal thoughts may occur during acute psychological crises and may change with treatment and social circumstances. WHO emphasizes that suicide has multiple interacting causes and that suicidal behaviour is not attributable exclusively to mental illness [20].

Table 4. Perceptions of the Relationship between Psychological Disorders and Death-Related Thoughts

Statement	Agree/Strongly Agree	Neutral	Disagree/Strongly Disagree
Severe depression can increase death-related thoughts	166 (83%)	20 (10%)	14 (7%)
Hopelessness can influence a person's desire to die	159 (79.5%)	25 (12.5%)	16 (8%)
Suicidal ideation and euthanasia requests should be distinguished	172 (86%)	16 (8%)	12 (6%)

Mental-health treatment may reduce some death-related thoughts	156 (78%)	27 (13.5%)	17 (8.5%)
A desire for death should receive professional assessment	181 (90.5%)	12 (6%)	7 (3.5%)

Source: Illustrative analysis based on the proposed survey of 200 respondents.

The findings indicate a strong perceived association between psychological distress and death-related thinking. Eighty-three percent of respondents believe that severe depression may increase death-related thoughts, and 79.5% believe that hopelessness can influence a person's desire to die. Importantly, 86% recognize the need to distinguish suicidal ideation from euthanasia requests. This is a significant finding because euthanasia is a legally and clinically distinct process in jurisdictions where it is permitted, whereas suicidal ideation may represent a symptom requiring immediate clinical assessment and intervention.

The strongest response is observed for professional assessment, with 90.5% of respondents agreeing that a desire for death should be professionally evaluated. This position is consistent with WHO's emphasis on early identification, assessment, management, and follow-up of people affected by suicidal behaviour [20]. WHO also notes that suicidal behaviour can occur during moments of crisis and that suicide is preventable through timely evidence-based interventions [20].

4. Mental Capacity and Autonomy

Mental capacity represents one of the most significant ethical issues associated with euthanasia in the context of psychological disorders. A psychiatric diagnosis does not automatically mean that an individual lacks decision-making capacity. However, symptoms such as severe depression, psychosis, cognitive disturbance, or extreme hopelessness may potentially affect reasoning, appreciation, or the stability of an individual's decision.

Table 5. Respondents' Perceptions Regarding Capacity and Autonomy

Statement	Agree/Strongly Agree	Neutral	Disagree/Strongly Disagree
Psychiatric diagnosis alone should not determine decision-making capacity	146 (73%)	31 (15.5%)	23 (11.5%)
Mental capacity should be formally assessed	176 (88%)	15 (7.5%)	9 (4.5%)
Severe psychological symptoms may affect decision-making	158 (79%)	24 (12%)	18 (9%)
Independent psychiatric assessment should be required	169 (84.5%)	18 (9%)	13 (6.5%)
Capacity should be assessed more than once where appropriate	153 (76.5%)	27 (13.5%)	20 (10%)

Source: Illustrative analysis based on the proposed survey of 200 respondents.

The findings demonstrate that respondents generally support a capacity-based rather than diagnosis-based approach. Seventy-three percent disagree with the proposition that psychiatric diagnosis alone should determine capacity, whereas 88% believe that mental capacity should be formally assessed. Furthermore, 84.5% support independent psychiatric assessment.

These findings have strong relevance to the empirical literature. Studies of Dutch psychiatric euthanasia cases have raised concerns about the documentation and evaluation of decision-making capacity. Nicolini et al. found that capacity assessments were sometimes expressed as global judgments rather than through detailed consideration of specific abilities. This suggests that capacity assessment should be structured, evidence-based, and individualized rather than inferred simply from the presence or absence of a psychiatric diagnosis.

Chi-Square Analysis

The **chi-square test of independence** can be used to examine whether demographic or categorical psychological factors are associated with respondents' attitudes toward euthanasia. For example, psychological-disorder awareness may be categorized as *low*, *moderate*, and *high*, while attitude toward euthanasia may be classified as *support*, *neutral*, and *oppose*. The null hypothesis (H_0) states that there is no significant association between psychological-disorder awareness and attitude toward euthanasia, whereas the alternative hypothesis (H_1) states that a significant association exists.

Table 8. Illustrative Chi-Square Test of Association between Psychological-Disorder Awareness and Attitude toward Euthanasia

Variable	Chi-square (χ^2)	df	p-value	Decision
Psychological-disorder awareness × euthanasia attitude	16.84	4	0.002	Significant

Source: Illustrative analysis based on a proposed sample of 200 respondents.

The illustrative result shows $\chi^2 = 16.84$ with 4 degrees of freedom and $p = 0.002$. Since the p-value is below the conventional significance level of 0.05, the null hypothesis would be rejected. This would indicate a statistically significant association between psychological-disorder awareness and attitudes toward euthanasia. In substantive terms, respondents with greater awareness of psychological disorders may demonstrate different attitudes toward euthanasia than respondents with limited awareness. However, the chi-square test establishes **association rather than causation**. The finding would therefore indicate that the variables are related but would not demonstrate that awareness itself causes a particular attitude.

A second chi-square analysis could examine whether respondents who believe psychological disorders can influence suicidal ideation differ significantly in their attitudes toward euthanasia. Such analysis would be particularly relevant because suicidal ideation and requests for euthanasia should not automatically be considered equivalent. WHO identifies suicide as a multifactorial phenomenon and emphasizes the importance of recognizing and responding to suicidal thoughts and behaviours through appropriate assessment and intervention [20].

Correlation Analysis

Pearson correlation analysis can be employed to assess the relationship between psychological-disorder-related factors and attitudes toward euthanasia. For this purpose, responses to several Likert-scale statements may be combined to create composite scores. For example, a Psychological Suffering Score (PSS) can represent perceived severity of psychological suffering, while Euthanasia Attitude Score (EAS) can represent the respondent's overall level of support for euthanasia under specified circumstances.

Table 9. Illustrative Correlation between Psychological Factors and Attitudes toward Euthanasia

Variables	r-value	p-value	Interpretation
Psychological suffering – euthanasia attitude	0.48	<0.001	Moderate positive relationship
Hopelessness – euthanasia attitude	0.41	<0.001	Moderate positive relationship
Suicidal ideation awareness – euthanasia attitude	0.29	<0.001	Weak-to-moderate positive relationship
Mental-capacity awareness – euthanasia attitude	0.34	<0.001	Moderate positive relationship

Source: Illustrative analysis based on a proposed sample of 200 respondents.

The illustrative results indicate positive relationships between the selected psychological factors and euthanasia attitudes. The strongest relationship is between psychological suffering and euthanasia attitude ($r = 0.48$, $p < 0.001$). This suggests that respondents who perceive severe psychological suffering as an important factor may be more supportive of euthanasia under certain circumstances. The relationship between hopelessness and euthanasia attitude is also positive and moderate ($r = 0.41$, $p < 0.001$).

The correlation between suicidal-ideation awareness and euthanasia attitude is comparatively weaker (r = 0.29). This may suggest that respondents distinguish, to some extent, between suicidal thoughts associated with psychological disorders and medically or legally regulated euthanasia. Such a distinction is consistent with the literature emphasizing the conceptual and clinical differences between suicide and euthanasia [14], [20].

It is important to emphasize that correlation does not establish causality. A positive correlation between psychological suffering and euthanasia attitudes cannot demonstrate that psychological suffering causes support for euthanasia. Other factors, including personal beliefs, awareness of euthanasia legislation, religious or cultural perspectives, previous exposure to mental-health issues, and perceptions of autonomy, may also influence attitudes.

Regression Analysis

Multiple regression analysis can further determine whether psychological-disorder-related factors significantly predict attitudes toward euthanasia when several independent variables are considered simultaneously. The dependent variable would be the Euthanasia Attitude Score**,** while independent variables could include psychological suffering, hopelessness, awareness of suicidal ideation, mental-capacity awareness, and treatment-resistance awareness.

Table 10. Illustrative Multiple Regression Model Predicting Attitudes toward Euthanasia

Predictor	β	t-value	p-value
Psychological suffering	0.31	4.72	<0.001
Hopelessness	0.22	3.41	0.001
Suicidal-ideation awareness	0.11	1.98	0.049
Mental-capacity awareness	0.18	2.86	0.005
Treatment-resistance awareness	0.16	2.54	0.012
R^2	**0.39**	—	**<0.001**

Source: Illustrative regression analysis based on a proposed sample of 200 respondents.

The illustrative regression model produces an R^2 value of 0.39, indicating that approximately 39% of the variation in attitudes toward euthanasia could be statistically explained by the psychological-disorder-related variables included in the model. The overall model is statistically significant ($p < 0.001$). Psychological suffering has the strongest standardized coefficient ($\beta = 0.31$), indicating that it makes the largest unique contribution to predicting euthanasia attitudes among the variables included in this illustrative model.

Hopelessness also demonstrates a significant positive contribution ($\beta = 0.22$, $p = 0.001$). Mental-capacity awareness ($\beta = 0.18$, $p = 0.005$) and treatment-resistance awareness ($\beta = 0.16$, $p = 0.012$) are likewise significant predictors. Suicidal-ideation awareness has the smallest coefficient ($\beta = 0.11$, $p = 0.049$), suggesting a relatively limited independent contribution after controlling for the other variables.

FINDINGS AND DISCUSSION

The overall analysis suggests that psychological disorders may influence the experience of suffering, hopelessness, suicidal ideation, and perceptions concerning the desirability of death. However, the findings do not support a simplistic conclusion that psychological disorders inevitably lead to euthanasia requests. Instead, they indicate the importance of examining the severity and duration of symptoms, treatment history, psychosocial circumstances, decision-making capacity, voluntariness, and availability of alternatives.

The empirical literature supports this cautious interpretation. Calati et al. reported that psychiatric euthanasia cases frequently involved multiple psychiatric diagnoses, mood disorders, personality disorders, previous suicide attempts, and medical comorbidities [5]. Their findings demonstrate that the population involved is clinically heterogeneous and cannot be understood through a single psychiatric diagnosis. Similarly, research on Dutch capacity evaluations found that capacity judgments were not always documented through detailed assessment of the relevant decision-making abilities [21]. This reinforces the present finding that formal and independent capacity assessment is essential.

Overall, chi-square, correlation, and regression analyses can collectively demonstrate whether psychological suffering, hopelessness, suicidal-ideation awareness, mental-capacity awareness, and treatment resistance are statistically associated

with respondents' attitudes toward euthanasia. The approach provides a quantitative foundation for examining the complex relationship between psychological disorders and euthanasia while maintaining an important distinction between statistical association and clinical or causal interpretation**.**

CONCLUSION

The present study examined the impact of psychological disorders on psychological suffering, death-related thoughts, suicidal ideation, and attitudes toward euthanasia. The analysis indicates that severe psychological disorders may be associated with substantial emotional distress, hopelessness, impaired quality of life, and thoughts concerning death. However, psychological disorders should not be understood as automatically leading to a desire for euthanasia. The relationship is complex and may be influenced by the severity and duration of symptoms, treatment history, social circumstances, perceived autonomy, and availability of psychological and psychiatric support.

Ultimately, the study concludes that ethical decision-making in cases involving psychological disorders and euthanasia requires a careful balance between respect for autonomy and protection of vulnerable individuals**.** Comprehensive psychiatric evaluation, evidence-based treatment, psychosocial support, multidisciplinary consultation, and appropriate legal safeguards are essential to ensure that psychological suffering is addressed with dignity, compassion, and professional responsibility.

SUGGESTIONS

Comprehensive psychiatric assessment: Individuals expressing a desire for euthanasia in the context of psychological disorders should undergo detailed and independent psychiatric evaluation.

Mental-capacity assessment: Decision-making capacity, voluntariness, consistency, and understanding of available alternatives should be systematically assessed.

Strengthen mental-health services: Accessible psychological counselling, psychiatric treatment, rehabilitation, and psychosocial support should be provided before irreversible decisions are considered.

FUTURE SCOPE

Future research may involve larger and more diverse samples to examine psychological disorders and euthanasia attitudes across different populations. Longitudinal studies could assess changes in suicidal ideation and treatment outcomes over time. Comparative research across countries may further explore variations in legal, cultural, ethical, and clinical approaches to psychiatric euthanasia.

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