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Psychoanalytic understanding of the request for assisted suicide

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ABSTRACT

The legalisation of assisted dying, including euthanasia and physician assisted suicide, is increasing in countries across the world and constitutes a key contemporary debate, reflecting social changes, in which two views of suicide conflict; that (1) rational reasons justify assisted suicide, providing dignity and control of terminal illness and (2) suicidal wishes are driven by unconscious and disturbing internal conflicts. In this paper we explore the unconscious motives and meanings of requests for assisted suicide. Although there is a paucity of psychoanalytic literature on the subject, and an absence of practice examples, we make two links, firstly, with the literature of palliative and end of life care, and, secondly, with psychoanalytic understanding of suicide, in order to develop the view that unconscious factors are crucial to understanding requests for assisted suicide. We provide an illustrative case example of psychodynamic psychotherapy with a 94-year-old woman, drawing out theoretical and practice implications. We show that unconscious factors and motives lie behind apparently rational requests for assisted suicide, and attention to these through psychoanalytically informed treatment can bring about therapeutic change.

KEYWORDS

Assisted suicide; euthanasia; terminal illness; palliative care; depression; suicide

Introduction

The legalization of assisted dying, including by euthanasia and physician-assisted suicide (PAS), is increasing across the world. It constitutes a key contemporary debate, exciting fierce and partisan views, indicating social and medical transformations of attitudes to death, extension of liberalization and self-determination in relation to the body. Underpinning legislation for assisted suicide is an emphasis on autonomous, rational decision making that may oversimplify the complexities of assessment and decision making, as medical, psychiatric and psychosocial factors intermingle. Arguments about the

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rationality of assisted suicide are countered and, perhaps, contradicted by the presence of ambivalence towards living and dying, and a tension about how suffering – physical and mental – can be relieved in these situations. The ambivalent conflict has several, usually unconscious, motifs, including between desire for autonomy and a need for companionship and closeness; between fears of helplessly depending on another and anxieties about being overwhelmed or destroyed by the other. Thus there is a tension when considering assisted suicide, between, on the one hand, suicide arising through the need for relief from physical and mental suffering, preserving feelings of dignity, and, on the other hand, that suicide represents escape from difficult and disturbing internal and unconscious conflicts.

In this paper we aim to explore the unconscious motives and meanings of requests for assisted suicide, including how these influence psychoanalytically informed treatments. Initially, we briefly describe the current contexts, including legalization in some countries, and we discuss psychoanalytic contributions to understanding this subject. We develop the view that unconscious factors are crucial to understanding requests for assisted suicide and we provide an illustrative case example of psychodynamic psychotherapy with a 94-year-old woman, Mrs W. From this we discuss the theoretical and practice implications, including the ethics and aims of psychoanalytic treatment. We show that unconscious factors and motives lie behind apparently rational requests for assisted suicide, and that attention to these in the course of treatment can bring about therapeutic change.

Assisted dying, suicide and euthanasia

An increasing number of countries have legalized assisted dying, and in other countries, public opinion is frequently in favour of such legislation[1] (MDMD/NatCen 2019). Assisted dying, through active euthanasia – in which a doctor administers a lethal dose of medication to a patient) and physician-assisted death, or PAS,[2] in which the fatal drug is taken by patients themselves – are, at the time of writing, legal in 28 countries worldwide and 9 US states (10 including the District of Columbia). This marks a significant increase since 2015. As the number of countries legalizing people dying through either euthanasia or PAS is thus increasing, so too are the number of deaths. In 2017, more than 13,000 patients died through either method of assisted death in countries where these practices are permitted. Rates have risen in countries where the practice has been legalized, with highest rates being recorded in the Netherlands, with 4.5% of all deaths (Borasio, Jox, and Gamondi 2019).

The debate about assisted death, or suicide, is one of several contemporary issues that are transforming the relationship between the individual and the state, and its representative organizations. Socially, the debate on assisted death is part of the extension of individual rights and autonomies. Changing social, legal and ethical landscapes impact on therapeutic relationships, through the attitudes, values and beliefs held consciously or

[1]For example, in the UK, in a recent poll over 90% expressed the view that assisted death was acceptable, in at least some situations where the person was suffering an incurable illness that would lead to their death (MDMD/NatCen 2019).

[2]In German-speaking countries these terms are respectively "killing on demand" (Tötung auf Verlangen) and "assisted suicide" (assistierter Suizid), because the term "euthanasia" is associated with the Nazi killing of about 200,000 persons with mental disorders and disabilities. This history continues to influence attitudes towards, and legislation of, physician-assisted death.

unconsciously by both patients and therapists/analysts, as illustrated by the parallel impacts on therapeutic practices of changing views and legislation on sexuality, and gender and racial equality. The legal, ethical and social relationships to the body are thus the locus of this transformational liberalization: its sex, skin colour and its living and dying. As the secular trend is clearly towards increased legalization of assisted dying, the landscape has irrevocably changed over the past 20 years; the question of assisted death has become a present and unavoidable feature of practice, primarily for end of life care, including people with severe disabilities, but also, in some countries, for mental disorders. Self-determination, autonomy and exercising control over where and when death takes place are cornerstones of the argument for assisted death, alongside the de-medicalization of death, and the idea of a "good death", and dying with dignity.

This suggests a view of assisted death as stemming from a rational appraisal; however, requests for assisted death do not comply with this view. It has been shown that, first, requests for assisted suicide are closely connected with mental health. Up to 60% people requesting assisted death were diagnosed with depression (Hendin 1998; MacLeod 2012). Second, alongside this is the evidence that the request for assisted death is not stable: up to half of terminally ill patients seriously considering PAS changed their minds over time with improved symptom control and psychological support (Sperling 2019; Sprung et al. 2018). Thus in territories where some forms of assisted death, through assisted suicide and euthanasia, have been legalized, applying criteria for inclusion and clinical judgement are important mediators in practice. The request for assisted suicide thus involves complex and multifactorial reasons (MacLeod 2012; Sprung et al. 2018); the constellation of "psychological, existential, and social motives" (Sprung et al. 2018) include:

> fears of dependence, loss of autonomy, loss of dignity, being a burden on others, and social isolation (Marquet et al. 2003). Loss of control appeared to be a core influencing factor. (MacLeod 2012, 938)

This configuration intersects with the problem of suicide; suicidal thoughts are expressed, often fleetingly, by around 60% of people wishing to hasten death, and these are more common for people who have a mental health disorder (MacLeod 2012). The notion of rational suicide conflicts with the arousal of suicidal feelings and thoughts that are situational and embedded in psychosocial factors; Macleod concludes:

> The oscillations of the wish to die of the terminally ill, the difficulties of diagnosing major depression toward the end of life, the effect of depression and demoralisation on euthanasia requests, and of what constitutes fitness to commit on rational suicide are significant and as yet unresolved clinical issues. (MacLeod 2012, 942)

These issues occur whether assisted dying is legalized or not. In both settings, end of life care, including palliative care, has an important role in mediating suffering and preparing for death. In territories where it is legalized, clinical assessment is through the administration of criteria and safeguards. In the Netherlands, which has arguably the most liberal legislation, the criteria are:

- The patient's request must be voluntary, enduring and well considered.
- The patient's suffering must be lasting and unbearable.

- The patient must be well informed about the current situation and prospects.
- All other options for care must have been exhausted or refused by the patient.[3]

These require clinical judgement and assessment, and hold the potential for "slippery slopes" towards increases in suicide (Sprung et al. 2018, 198). That requests for PAS need to be evidenced as enduring, in the Netherlands, for example, suggests repeated consultations with a competent practitioner; and whether suffering is "lasting or unbearable" involves, at least to an extent, the subjective view of the doctor, as there are no formal legal definitions to fall back on.

The relief of suffering is a crucial part of care for terminal illnesses; there are, however, disagreements about what are acceptable and unacceptable interventions (Sprung et al. 2018). Palliative care is now an established medical discipline in many countries with sophisticated practices that include pharmacological and psychosocial interventions, with the aim of increasing dignity and reducing suffering (Milicevic 2002; Wenzel, Heller, and Heller 2016; Wiesli 2016). Good palliative care aims to restore a sense of autonomy and maximizes quality of life for people (Sprung et al. 2018). Palliative sedation is part of these practices, to control symptoms of delirium, pain, and dyspnoea as death approaches, and also to relieve or reduce psychological issues, including the sense of helplessness, fear of loss of control and fear of death. The intent of palliative sedation is relief of unremitting and intractable suffering achieved by sedation, and not the patient's death (MacLeod 2012). Although there is a risk of hastening death through palliative sedation (Olsen, Swetz, and Mueller 2010), there is also the possibility that life is prolonged (MacLeod 2012). It is not as yet well evidenced how practitioners reach decisions in the more marginal or contentious areas, how they reach decisions about "differences between assisted dying, voluntary refusal of food or fluids, or continuous deep sedation" (Gerson et al. 2019, 10), and thus how to work with patients who report a desire to hasten death.

The multidisciplinary health care team is thus identified as having a key role in addressing the multiple factors – psychological, psychosocial and medical – that pertain to end of life care. Especially in palliative care, psychodynamic thinking has been drawn upon in order to inform assessments and interventions. This includes taking account of both conscious and unconscious motives for seeking assisted or hastened death; these include the relationship between suicidal wishes and the presence of mental disorders, notably depression, and how suicidal wishes interplay with feelings and states of mind when contending with painful experiences, fears of loss of control, dependency, helplessness and hopelessness. Additionally, the practice of care for the terminally ill constitutes a powerful emotional field; it is distressing for the practitioner, whose risks range from prosecution for hastening death where assisted death is not legalized, to collusion with the patient's suicide in countries where it is legal. Inherent, therefore, to these relationships is the powerful emotional field that exerts significant pressures on clinicians. A survey of Dutch psychiatrists found that transference and countertransference influenced decision making in 25% of assisted suicide requests (Hicks 2006), and this highlights the importance of thinking reflectively about the transference and countertransference in individual requests for suicide assistance.

[3]These criteria are consistent with some definitions of "rational suicide" (Gramaglia, Calatti, and Zeppegno 2019).

Psychoanalysis, euthanasia and assisted suicide

There is very little psychoanalytic writing about PAS or euthanasia, despite its current importance. In particular, there is an absence of psychoanalytic clinical case studies, which epitomize the development of psychoanalytic knowledge (Rustin 2006). Possibly this absence stems from psychotherapy with patients requesting assisted death/suicide not usually taking place in the traditional setting of a consulting room with a couch; more often it happens in healthcare settings and is delivered by healthcare professionals applying psychoanalytic principles within their professional roles. Noting this allows for the extension of available sources in the literature, through searching the field of palliative and end of life care for studies that apply psychoanalytic approaches.

Psychoanalytic writing on PAS connects with key themes discussed in the previous section; notably, these focus on understanding the emotional, psychological and developmental experiences of facing death; the importance of understanding the meaning and nature of individual suffering; the clinical task of exploring meaning; and the qualities experienced in clinical relationships, including transference and countertransference.

The intermingling of physical and psychological factors in the request for PAS lead Muskin (1998) to emphasize the importance of addressing the potential meanings contained in the request to die. The request in itself should be treated as a communication, which may be inviting a response that provides reasons for living. Kelly and Varghese (2016) assert that not exploring the meanings of the request to die can indicate professionals' problems with death and illness. Therefore, they identify the crucial importance of understanding the patient's suffering, exploring the psychosocial factors that influence the patient's decisions and examining the impact of the relationship between the patient and therapist/physician/healthcare staff.

Hendin (1998), a psychoanalytic practitioner and psychiatrist, whose social view is, as he describes it, "to avoid the Scylla of either excessive or neglectful medical care and the Charybdis of euthanasia" (28), describes the fear of death displaced on to the circumstances of dying, and the consequent pain, dependence and loss of dignity. It leads to desperation as an overarching state of mind that demands action and the wish for some control. Muskin (1998) echoes this, and illustrates that assertion of rights can mean, for a patient, an attempt to gain control, and avoid the terrors and desperation of dying.

The fear of death has a complex history within psychoanalytic conceptualizations. Freud frequently disputed that the fear of death existed in the unconscious; "the unconscious seems to contain nothing that could give any content to our concept of the annihilation of life" (Freud 1926, 129). This did not deny that the fear of death exists, nor that it has significant impacts for the individual, but that as a core source of anxiety, leading to neurotic symptoms, it was an inadequate explanation (Blass 2014). Klein, in contrast, gave a central place to the fear of annihilation: "anxiety has its origin in the fear of death" (Klein [1948] 1975, 28). Bion's (1962) model of container–contained is based on the mother recognizing, and taking in, the infant's terror of death. The confrontation with death generates various defences against these fears (Razinsky 2013, 261); defences include ideas of symbolic continuation of life, or immortality, feelings of omnipotence or phantasies about "an ultimate rescuer" (261).

Freud's[4] physician, Deutsch (1936), explored the mental anguish of facing death: the fear of loss of others, and fear of abandonment by them. He drew on Freud's formulation of the life and death instincts in a study of euthanasia, which he understood to mean the "psychological understanding of peaceful dying" (347), or "the art of happy dying" (from the Greek, *eu* – happy; *thanatos* – death), and wrote, before – or while – the term "euthanasia" was being perverted by the Nazis,[5] to provide a host of vignettes from the many patients he had tended at the point of death. However, Deutsch argued, dying beautifully, peacefully or happily is not simple, and is rarely achieved. "Euthanasia (happy death) occurs when all aggressive reactions subside, when the fear of death has been dispelled, and when there is no further question of a sense of guilt" (Deutsch 1936, 367).[6] The fear of death, and of dying, leads more often to mental anguish that varies between individuals, depending on the conflict between life and death impulses. So Deutsch lists, and illustrates with case examples, defences against the mental anguish of death, through aggression towards others and the self, melancholic turning away from others, regression, suicide. Through regression, the relationships "to the objects of infantile love – in early childhood apparently associated with intense sense of guilt – can be retrodden without any feeling of guilt" (Deutsch 1936, 368). Anxieties aroused by the meaning of death include fear of loss of others (objects) and, reciprocally, their abandonment of the self. Michel de M'Uzan (2013) makes a similar emphasis when he discusses the "libidinal expansion" and the "exaltation of the desire for relationships" in an intensification of the need for relationships, for companionship on facing death.

Psychoanalytic therapy can help the dying patient modulate the catastrophic experience of object loss. For Lazar, Oechslein, and Jörgensen (2012) the actualization of an existential encounter in the analytic process with a dying patient can be understood, using Bion's thinking, as a definitive, inconceivable experience of an "ultimate truth". Deutsch's work prefigured psychoanalytic developmental approaches to the end of life. Wittenberg (2013) – writing in her late eighties – describes "facing the end of our life evokes earlier, undigested, primitive anxieties related to loss" (166). Such catastrophic anxieties,

> in the face of decline and death can so easily lead to us demanding attention from others, complaining that they do not care enough, don't show enough love. And if they don't we may turn against them, punish them, rob them of their freedom and happiness. Such attacks on the outer and inner world may result in being thrown into the wilderness where hatred and persecution reign, falling into despair, descending into madness, unable to distinguish good from bad, truth from lies, raging against fate or alternatively feeling punished. (Wittenberg 2013, 160)

Following Muskin a key aspect of the meaning of the communication of a request for PAS can be understood as a reaction to the fear of death, accompanied by painful desperation, fear of dependence, loss of control, helplessness and shame, and feeling overwhelmed, as physical, cognitive and emotional resources feel diminished, reactivating early,

[4]Freud's own death has been widely debated as an example of assisted dying (Akhtar 2015; Alt 2016; Bernstein 2001; Gay 1988; Jones 1957; MacLeod 2016; Schur 1972). Despite the debate, the key facts are the experience of palliation of his final moments and his courage in facing illness and multiple operations over 16 years.

[5]See footnote 2, above.

[6]This perspective has its precursor in Francois Maynard's (1582–1646) saying: "C'est ici que j'attends la mort sans la désirer n'y la craindre" (It is here where I await death, without desire and without fear) (Bruzen de la Martinière 1720).

unresolved development and defences. This might include the narcissistic retreat through phantasies of a peaceful death (Henseler 1974).

Understanding and working with transference and countertransference is a key theme in the psychoanalytic literature of assisted suicide. In an interesting film review, Sabbadini (2015) refers to Deutsch's work while discussing assisted suicide in the Italian film *Miele*, 2013.[7] The film, *Miele*, is a study of an unusual purveyor of assisted suicide, and Sabbadini focuses on identifying her unconscious motives for undertaking this role, motives of omnipotence – "playing God" – and rescue fantasies. Sabbadini comments on the intense dilemma for practitioners of achieving a balance between the principle of autonomy and protecting the vulnerable, and the importance of finding a "sceptical space" rather than succumbing to inflexible and ideological attitudes for and against assisted dying.

Bernstein (2001) takes the view that the therapist's own fears of death and loss influence considerations about living and dying; the "spectre of death" generates "a powerful mixture of transference and countertransference feelings". He describes "countertransference resistance" and concludes that "the source of the difficulty we have in allowing others to die by their own choice, lies in the fact that we do not want them to die because of the effect their demise will have on us" (Bernstein 2001, 264). In contrast, Kelly and Varghese (2016) explore the qualities of countertransference experienced in working with terminal illness including requests for assisted death. Attention is paid here to the therapist's often intense emotions, and the recognition and examination of projective identification. They discuss how the patient's angry, hopeless, overwhelmed and desperate feelings projected into the therapist/practitioner can lead to enactments, especially if the therapist/practitioner dismisses and denies these feelings, and if the ethic of autonomy pressures the therapist to comply with requests to die. These influence and can distort attempts to understand as a communication the request for assisted death. Violent, uncaring, cruel and frustrated feelings in response to a patient, conscious and unconscious, are often aroused and require thinking and containment.

Kelly and Varghese (2016) additionally identify the danger of inaccurate empathy – "countertransference enactment in disguise" – in which the therapist's own feelings, attitudes and principles are attributed to the patient. These problems of countertransference echo classic accounts in psychoanalysis: Winnicott's (1947) "Hate in the Counter Transference", and in the suicide literature, Maltsberger and Buie's (1974) "Countertransference Hate in the Treatment of Suicidal Patients". The powerful force field of terminal illness and death may fuel the intensities of the therapeutic relationship, and potentially push the therapist further to the realms of acting out the role of a hidden executioner (Asch 1980). Similarly, Straker (1958) pointed to collusional aspects of interpersonal interference between the patient wishing to die and the person involved in this unbearable struggle. The purpose of attending to countertransference is, of course, to increase accuracy and understanding; in working with requests for assisted death, the existing literature emphasizes the importance of countertransference: for maintaining a balance between the wish for autonomy and the relief of suffering; to create a space in the clinician's mind that can

[7]Irene, the protagonist of the film (directed by Valeria Golino) smuggles a drug, Lamputol, to provide euthanasia for very ill people who want to die, which she does apparently motivated by compassion. Irene is challenged by discovering one of her clients is not, as he maintained, physically ill but depressed and suicidal.

relate to rather than be dominated by different ideological and ethical opinions; and to support a clinical position that allows for exploration of potential meanings of the request for assisted suicide.

Psychoanalysis and suicide

In exploring these potential meanings, it is important to consider whether it is valid to apply psychoanalytic understanding of suicide to consideration of assisted suicide. As discussed earlier, the evidence suggests that individuals fluctuate in their intentions and decision making over time, and requests for suicide assistance may be ambivalent and complex. Therefore, we argue that the psychoanalytic understanding of suicide can be substantially helpful in exploring the meaning of the communication when there is a request for assisted suicide.

Psychoanalytic understanding of suicide proposes that suicidal thoughts and actions are generated by an internal conflict; in Freud's original (1917) discussion in "Mourning and Melancholia", this represents the struggle of an internal relationship with an ambivalently loved and hated object. Suicide is therefore experienced as a pressure to act that occurs when the internal relational conflict, between love and hate, becomes overwhelming. As Freud (1923) described in "The Ego and the Id", the suicidal conflict rages between a hostile superego and an ego that is overwhelmed by the intensity of feelings. Thus, suicide involves a dyadic process of "who is hurting or killing whom?" (Bell 2008); "Underlying all suicides … there is an attack upon the self, that is a self that is identified with a hated object" (Bell 2008, 47). Or, as Götze stated, "Suicide is the psychic murder of an object representation in the subject by killing oneself in reality" (Götze 1995, 215). This dynamic runs through all therapeutic work with suicidal people of all ages.

Driving the suicidal conflict are underlying "suicidal fantasies" (Campbell and Hale 1991; Maltsberger and Buie 1980) that indicate the aims and motive force of these internal relationships; the suicide fantasy is realized by killing the self's body, identified as dispensable, and under the influence of a distortion of reality. When the internal conflict is projected on to another, who then becomes engaged in the suicidal struggle, they are "enlisted" to play a part in the suicidal conflict; cruelty drives the attacks on the object with which the self is identified. The effect of suicide on others mirrors the internal conflict; it is essentially sadomasochistic, and revengeful; others are meant to realize their shortcomings, culminating in the attitude of, "If only you had loved me better it would not have led to this." Suicides are followed by almost irreparable pain and self-recriminations for the bereaved, demonstrating the projected emotion and internalized object relationship.

The unconscious conflict, thus conceptualized, contrasts with the concept of rational suicide. However, Akhtar (2015) proposed a notion of a "'morally clean' or altruistic suicide" (261). Supported by citations from Klein[8] and Winnicott, Akhtar proposes that "self-destruction is undertaken because it appears undignified to go on burdening others with one's needs and demands" (Akhtar 2015, 261); this might equally be conceptualized as a suicide fantasy of (self) punishment (Campbell and Hale 2017). Suicide can

[8]The citation is truncated to omit reference to the contradictory motives of killing bad objects and preserving good ones (Klein [1935] 1975).

be, he further suggests, the "only way left to preserve one's dignity" (Akhtar 2015, 260) when faced with the "indignities" of old age and terminal illness. This ultimately confuses the task of supporting the dignity of the patient with a judgement that has potential far-reaching effects, and invites analytic omnipotence and rescue fantasies, as Sabbadini (2015) and Razinsky (2013) discussed (see above).

Akhtar's proposal for a rational suicide avoids the existence of two powerful factors that are always present in suicide: ambivalence and the conflict between dependency and autonomy. Ambivalence towards the object is crucial to Freud's and subsequent formulations of suicide: the expression of a wish to die, including for those who make serious suicide attempts, exists alongside a wish to find reasons to live. In later life, along with advancing frailty, the loss of independence and the changes in experiencing oneself due to illnesses reactualize lifelong, encumbering patterns in relationships and the ideas contained therein about oneself and others. This leads to an increasing powerful experience of a burden, a pressure to act, that can push the person towards suicidal fantasies on the one hand and the desire for companionship accompaniment and connection on the other (Lindner 2006). This internal conflict can manifest itself precisely in the desire for assisted suicide, when overwhelmed by fears about dying in agony, slowly and without influence, the desire for companionship and the relief of suffering, and the frustrations of increasing lack of independence. Applying these formulations to assisted suicide, the primary aim is to try to understand the meaning of the suicidal conflict in each case, that is, the nature of the internal conflict, how this leads to the need to act, and the potential effects on both the patient and the therapist in order to assess and identify appropriate treatment aims.

Case example

The request for assisted suicide

Until a year ago, a 94-year-old, Mrs W lived independently in a supervised housing, at which point she developed frailty syndrome after several falls, an upper arm fracture, multiple pulmonary embolisms, progressive macular degeneration and frequent nausea and vomiting. She was admitted to hospital on several occasions, but as her frailty increased she was admitted longer term to a geriatric clinic. Her underlying medical condition was heart failure with hypertension, but with a very good systolic function of the left ventricle.

After this admission, Mrs W's daughter-in-law requested a psychiatric consultation, and I[9] (R.L.) met with her in hospital. Before meeting her I learned from the nursing staff that Mrs W had requested assisted suicide. In this first meeting Mrs W complained about her visual impairment, which, she said, meant that she was very dependent on the help of nurses, by whom she felt disrespected and badly treated. The illnesses of the last one and a half years had meant she had lost her previously, for someone of her age, active life, especially her love of tournament-level bridge. Now, as she told me regretfully, perhaps shamefully, she was reduced to playing at a beginner's level, and she was not even able to fully participate at this level because of being in hospital. She said that for a year and a half she had been in a "death struggle", and she was very afraid of

[9]In describing the case example, we will use the first person, for clarity and to enhance the immediacy of the interactions.

approaching this "very last struggle". She asked me frankly and directly if I could give her the opportunity to put an end to her life by giving her a deadly medicine. If such a thing could be given to her, she would take it without hesitation. I acknowledged that this was a serious request, that she felt she was clearly suffering, and I said that I would like to understand the background to this. Her response here was crucial, as Mrs W proceeded to give me a detailed account of her life.[10]

She said she had been a journalist in her working life, and had a "good childhood", conveying the impression of a secure, protected life. Currently, her son and daughter-in-law, although separated, took care of her "touchingly". The son had moved to a city quite far away following his divorce, but his former wife still lived nearby and maintained a relationship with Mrs W. As she continued with her story, however, Mrs W began to give glimpses of more problematic relationships, especially with her father, whom she described as highly authoritarian. He had "locked her away from the world", she said, during her adolescence. She felt her lack of worldly knowledge, of sexuality in particular, led to becoming a mother at the age of 20. With the child's father, her first husband, she "did not fit at all". They were soon divorced and she "wasted no time" in meeting and marrying a second husband, who turned out to be a violent and alcoholic man, abusing her and refusing to contribute financially to the family. Eventually, she was able to leave him and found herself homeless with two small children. Later, she married for a third time and, with this man, she said she had lived a "great love" for the only time in her life; sadly, the marriage ended suddenly, after seven years, when he died of emphysema.

The suggestion that Mrs W tell me something of the background to her request for assisted suicide appeared thus to have initiated a therapeutic relationship, and she agreed to my offer to meet with her regularly over the next few weeks. In the following four sessions in the hospital, where I met her for 50 min in her single-bedded room, she lying in bed and me wearing my hospital white coat, Mrs W continued to talk freely about her relationships. A pattern clearly emerged of her search for idealized, "wonderful" people, predominantly men, and her wish to be the "angel" for the man. Often, however, she felt helplessly at the mercy of these men. During the course of these consultations she told me she began to feel more comfortable on the ward with the nurses, and idealized me as a "wonderful listener". Interpreting the transference, I drew a parallel between her sense of helplessness in her romantic relations and her current experience, in which she also felt helpless. I suggested that perhaps now, as well as in previous times, she was afraid of mistreatment by another (man) whom she felt held power over her.[11] Her response was to speak openly about her wish to die, because she felt weak, neglected and dependent on others whom she feared might mistreat her, and therefore she wanted to die. I acknowledged that the feelings of helplessness were very difficult for her, and yet also familiar to her from other experiences in her life. I was able to say to her

[10]It is important to add that the role of the clinician, and clinical team, in response to the request for assisted suicide is contextualized by local legislation and practice guidance. Ethical issues are, of course, present; as discussed above, different legal requirements and conditions apply. Further, considering the appropriate responses to suffering and the meaning of the request is a crucial aspect of treatment. The former can include medication to relieve suffering, and the treatment plan is usually best considered in the multidisciplinary team.

[11]The sense of power would have a different meaning if the clinician literally held the power to agree or not to the request for assisted suicide; this was not the case here. As discussed above, requests for assisted suicide are bounded by legislation and practice guidance and safeguards in countries where assisted suicide is legalized. In the country where this case took place, assisted suicide is forbidden to physicians by their Professional Code of Conduct.

that the last phase of her life had begun, to acknowledge the reality of her speaking about dying; she showed agreement, and our interactions became more serious and connected.

Multiple, entangled factors with layers of meaning appeared thus to drive the request for assisted suicide: Mrs W's fear of death and of malignant dependency on others, and the repetition in the transference of split object relatedness, "the angel" and the victim. Perhaps in her state of frailty, her internal relatedness had regressed to a fearful, split state of mind, and yet also there was a sense of some central unconscious relational questions in her life, that, as death approached, had not so far been resolved. These conflicts are closely related to the history of important relationship experiences and unresolved developmental issues. Mrs W therefore projected an ambivalent wish to die and to live.

Suicidal feelings occur throughout the life cycle when certain triggering events, such as the loss of independence and the changes in experiencing oneself due to illness at the end of life, reactualize lifelong, encumbering patterns in relationships and the ideas contained therein about oneself and others. This leads, especially as conflicts between dependency and autonomy, to an increasingly powerful experience of a burden, a pressure to act, that can push towards suicidal fantasies on the one hand, and the desire for companionship and connection on the other (Lindner 2006). Here, two aspects were forming an alliance: the desire not to die in agony, slowly, alone, helpless and without influence, and the desire for companionship. Mrs W sought to rid herself of her fears of death when these intense anxieties became too powerful for her to contain within herself, and she split them off and deposited them into me (Pichon-Rivière 2017). I found myself pushed to hold within myself these deposited fears, and, under this pressure, I aimed to try to think about them and return them in modified and more digestible form (Bion 1962). Here it became possible to speak about the last phase of her life beginning; thus what had seemed so intensely unbearable and unthinkable could now be named, faced and thought about between us.

"Astonishment" at life continuing

Mrs W was discharged to our nursing home next to the hospital, and I continued to see her for weekly psychotherapy. She was unhappy and was afraid of suffocation, and we spoke about her fears. Both her emotional and physical suffering required palliation and the professional team decided an appropriate course of medication, of opiates and lorazepam, that would relieve some of her anxiety (MacLeod 2012). Repeatedly, she told me that her heart was so heavy that she felt so undignified and wanted to die. With the palliation she said she had less physical pain, but suffered from feeling helpless. Yet I learned from the nursing home staff that she was active in making frequent phone calls to her son and her daughter-in-law. The staff had a different view of her, experiencing her as greedy and demanding, and Mrs W's interactions with them seemed hostile. The nurses asked me why I was visiting just this patient, and they seemed to entertain envious ideas about the luxurious privileges of the psychotherapist, to see just one patient, while others may have greater needs, be more ill and more worthy. I was mindful therefore that to protect the "angel" transference, Mrs W split off her hostile and aggressive feelings and projected them into the nursing staff, as occurs in other settings, and with other types of patients (Mishan 2005, 141).

At the instigation of her children, Mrs W was then transferred to a different ward, a beautiful single room, which indeed served in this nursing home as a dying-room. Gradually, she let me see a more active side of her; for example, she told me she had organized an ENT consultation, and she appeared to experience herself as more effective. Then she was relocated again, this time into a single room of the nursing home, to which her own furniture was gradually delivered. She talked about having to be "satisfied" with these arrangements, but I repeatedly spoke of the difficulties and privations she had to face, for example to live with so few material possessions. New to our conversations was that she spoke to me precisely about her likes and dislikes of certain people on the ward, again suggesting the longing for an ideal world, and in response I talked about her way of dealing with conflicts in her life. She said she had always put much emphasis on harmony and good living, on courtesy and doing the right thing, which I understood as an aspect of her defence of splitting good and bad. When I asked her about her current expectations, she said there was nothing left, but then she mentioned that she did still have the games of bridge.

Accepting her idealization on the one hand, but also addressing unpleasant but realistic themes on the other hand, may well have encouraged Mrs W's ability to see her situation more realistically. Clearly, some aggression was available to her, mainly, it seems, directed towards the nursing staff, rather than towards herself, through suicide, alongside some energy, involving her family members, in furnishing her nursing room. She was still living, and expressing "astonishment" about her remaining lifetime.

The last phase of dying

At this point there was a gap in the treatment as I took a planned holiday. On my return, I found her in her room watering plants that had not previously been there. I was astonished at how well she seemed, but Mrs W told me about the enormous changes she was experiencing: she had lost weight, and the food did not taste of anything any more. She was very preoccupied with her sense of helplessness, which I took to mean her lack of influence and being at the mercy of the helpers, in general, and her experience of my absence, in particular. She said she could not get everything she wanted, but we wondered together that she has not died, and she expressed a degree of contentment that she still could do so many things, and that she experienced joy when she could lie down to sleep in the night.

Ten days later, she fell and fractured her hip, and she underwent reparative surgery. When I visited her again in her room, she was lying in bed with dyspnoea – difficulty breathing – while resting, and her cardiac insufficiency had increased. She greedily drank some orange juice. She said people were so unreliable and that bothered her a lot. She did not want to live any more, and she did not know why she was still alive. I said I did not know that either. She replied that she wanted to close her eyes. I said, she could do that. She then asked me if I knew how to do that, to die. I told her, that "if you do not eat any more and hardly drink any more, you would die in your situation within 14 days". But just as I said this sentence, she reached for the cup, drank, again. I said there was something that bound her to life. She wanted me to repeat these words, which I did. Then she said I should not stay any longer. Poignantly, we said goodbye, and I said I would return in a few days. She said "farewell" and thanked me. I left her with a feeling of an intense, touching and heavy encounter.

Three days later, when I visited her, she lay sleeping, without her teeth in. I sat down and took her hand carefully. She awoke, the dyspnoea became noticeably worse. She was restless, looking for her teeth, and she seemed embarrassed to talk to me. She took some of the sips of coffee – "Hm, it's a pleasure to drink the cashmere," she said, reaching for her neck, apparently searching for a cashmere scarf. "It is a strange condition," she said, "why I have to experience life in this way, why is my heart still beating?" I did not feel a direct pressure to act. I told her, apparently, that there was something that bound her to life, perhaps shame, anger, the taste of coffee. I left her hoping, but uncertain, that I would meet her again. Three days later Mrs W died during the night; when I heard this, I felt a mixture of sorrow and release.

Mrs W's astonishment at still living led into the last phase of dying after the fall, the hip fracture and the worsening of her cardiac insufficiency. The question again arose of how to die. But unlike earlier this was not linked to an imperative plea for suicide. Instead this question could be negotiated, first, by directly addressing the dying process, and second, by concrete action, which is often understood as projective identification, but here can possibly be better understood as enactment (Klüwer 2001), to identify a process through which the analyst, in receipt of the patient's unconscious material, experiences a psychic change that leads to engagement, a partial enactment of the early object relationships, and to which the analyst must surrender himself. Our acting with me sitting beside her bed seemed to represent her attachment to life, which became more and more concrete, even closer to life with her dying: the orange juice, the coffee, the cashmere scarf, but also the shame, "sans teeth", as Shakespeare's evoked approaching death in *As You Like It* (Shakespeare [1599] 2006). Profoundly, rather than by suicide, the patient, Mrs W, has to engage with understanding what binds an individual to life, and what it takes to free these bonds.

Concluding comments

The case example of Mrs W expresses many concepts and conflicts intrinsic in end-of-life decisions; the sense of helplessness and shame about feeling so dependent are factors that contribute to her suffering, and her request for assisted suicide clearly conveys a meaning of how intolerable she experienced these feelings, alongside her physical decline and her fear of death. Mrs W became more tolerant of ambivalence as the therapeutic work progressed, and suicide as a solution to this unconscious conflict became less urgent for her. The suicidal solution could be thus clearly identified as a dangerous retreat from ambivalence. Requests for assisted suicide, such as in this example, involve ambivalence about dying or living, making an important link with psychoanalytic thinking about suicide, characterized by ambivalence, reflecting internal conflictual relationships. Within these exist tensions between autonomy and the need for companionship, and facing or being overwhelmed by anxieties of being at the mercy of others, who may be perceived as benign or malicious. Thus it is important not to confuse notions of autonomy with unrelated freedom. The concept of being in need of others, which can be so negatively interpreted in the Western world, ought not to be understood as a catastrophic helplessness. From a developmental psychological perspective, however, it can be formulated that existential dependency is also successful if it is based on trust in being held and on the ability to face loss, and to say goodbye.

From this it is important to reflect further on the ethics and aims of psychoanalytic treatment with people near the end of life requesting assisted suicide. We have to ask whether psychoanalytic or psychodynamic psychotherapy is possible in such conditions. In practical terms this does mean working within the legislative frameworks that pertain, in any given place, and the conditions, procedures and safeguards. Such individual requests always bear complex dilemmas, which generate emotional tensions, including, for example, the palliation of physical pain, on the one hand, and the aim of supporting the patient's internal resources through therapeutic exploration and containment of anxieties, on the other hand.

An important theme in the therapeutic relationship, including in the transference, in the case of Mrs W was her ambivalence to powerful others, especially men. An integrative view is necessary, to reflect on the actual, limited powers of the therapist in the setting, alongside understanding the transferential meaning originating from the patient's unconscious, early and long-standing relational patterns. The current sense of power is affected, as we note, by the legal and practice contexts, taking account of the responsibilities to professionally respond to requests for assisted suicide; the therapist has to relate to the legal contexts and requirements for practice. In this respect, links should be made with applications of psychoanalytically informed practice on macro levels, such as public health contexts in which responsibilities for safeguarding and risk assessment and management apply (Steiner 2020). Thus, taking an analytic attitude and management coexist consistent with the psychoanalytic ethics of acting in a way that is in the best interests of our patients, to maintain the paramountcy of the patient's welfare and to ensure the patient is not exploited in any way (BPC 2011).

We argue that, in cases of assisted suicide, a psychoanalytic stance supports the attainment of an ethical position. Through the reflection of the motives behind requested actions, psychoanalytically oriented professionals may withstand the emotional pressure and search for alternative meanings and needs of persons wishing to die. Psychoanalysts and psychoanalytically informed psychotherapists might have a significant contribution to make to debates and policy formulation on assisted suicide as the trend towards legalization of assisted suicide is likely to continue. This might be thought of as a social commitment, and an application of psychoanalysis outside the consulting room. Our experiences include participation and leadership in the development of national guidelines that take account of psychoanalytically informed principles.

It is unlikely – but not impossible – that, for most cases of assisted suicide involving end of life care, the treatments will be long term or will involve the traditional setting of the consulting room. The application of psychoanalytically informed end of life encounters is likely to take place in different settings, such as with Mrs W, in the hospital and nursing home. Psychoanalytically informed professionals will likely hold multiple roles, again as here, of psychiatrist and psychotherapist, frequently working in multidisciplinary teams, alongside nurses, doctors, psychiatrists and colleagues in the wider administrative, management and legal contexts. This circumstance raises the question of the aims and goals of psychoanalytic or psychodynamic treatment.

At its simplest, a psychoanalytically informed treatment in end of life contexts provides an entry to thinking about the meaning of the request for assisted suicide and understanding the request as a communication involving both conscious and unconscious aspects. It provides the opportunity for understanding the unconscious factors, anxieties,

defences and internal relational patterns that influence the request. However, as the case of Mrs W shows, psychoanalytically informed treatment has the further aim of working to resolve these internal conflicts by means of understanding and the work with transference and countertransference. The aim of resolving the suicidal conflict, and thus increasing the capacity to tolerate ambivalence, is facilitated by understanding suicide as dynamic internal conflict, alongside the recognition of the individual's fears, and their needs for dignity. Psychoanalytically informed treatment in end-of-life situations aims to provide containment for intense and conflictual anxieties about dying, helplessness, dependency on others, loss of independence and the associated affects including shame and anger. It contributes to understanding how these emotions relate to internal relational patterns and object relations. The relatively short duration of most treatments in such contexts means that full working-through might possibly not occur, but nevertheless significant therapeutic gains may be possible. The field of assisted suicide is, as we have discussed, a key, emerging and contentious current societal issue; psychoanalytically informed psychotherapy and the application of psychoanalytic thinking are important in developing thoughtful and helpful interventions.

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Translations of summary

La compréhension psychanalytique de la demande de suicide assisté. La légalisation de la mort assistée, y compris l'euthanasie et le suicide médicalement assisté, va croissant à travers le monde et constitue un débat contemporain majeur qui, reflétant des changements sociaux, voit s'opposer deux points de vue sur le suicide : (1) des motifs rationnels justifient le suicide assisté et permettent de mourir dans la dignité et d'exercer un contrôle sur une maladie en phase terminale ; (2) les désirs suicidaires sont sous-tendus par des conflits intérieurs inconscients et perturbants. Les auteurs de cet article explorent les motivations et les significations inconscientes des demandes de suicide assisté. Bien que cette thématique soit rarement abordée dans la littérature psychanalytique et que les exemples cliniques soient quasiment inexistants, les auteurs établissent deux liens, premièrement avec la littérature sur les soins palliatifs et de fin de vie, et deuxièmement avec la compréhension psychanalytique du suicide, afin d'asseoir le point de vue que les facteurs inconscients sont indispensables à la compréhension des demandes de suicide assisté. Ils présentent un cas clinique illustrant la psychothérapie psychodynamique d'une femme âgée de 94 ans, et en dégagent des implications théoriques et pratiques. Ils montrent que des facteurs et des motivations inconscients reposent derrière les demandes apparemment rationnelles de suicide assisté, et que l'attention que l'on porte à ces facteurs par le biais d'un traitement psychanalytique peut permettre un changement thérapeutique.

Psychoanalytisches Verstehen des Wunschs nach assistiertem Suizid. Die Legalisierung des assistierten Sterbens, einschließlich der Euthanasie und des ärztlich assistierten Suizids, nimmt weltweit zu und begründet eine zentrale aktuelle Debatte, die gesellschaftliche Veränderungen abbildet, bei denen zwei unterschiedliche Auffassungen von Suizid im Widerstreit sind; dass (1) rationale Gründe den assistierten Suizid rechtfertigen, da die Würde gewahrt und eine unheilbare Krankheit kontrollierbar gemacht wird und dass (2) suizidale Wünsche von unbewussten und verstörenden inneren Konflikten angetrieben sind. In diesem Beitrag untersuchen wir die unbewussten Motive und Bedeutungen der Wünsche nach assistiertem Suizid. Obwohl es nur wenig psychoanalytische Literatur zum Thema gibt und Beispiele aus der Praxis fehlen, stellen wir zwei Beziehungen her – zum einen mit der Literatur zur Palliativmedizin und Sterbebegleitung, und zum zweiten mit

dem psychoanalytischen Verstehen von Suizid – um zu der Auffassung zu gelangen, dass unbewusste Faktoren für das Verstehen von Bitten um einen assistierten Suizid von wesentlicher Bedeutung sind. Wir präsentieren ein anschauliches Fallbeispiel psychodynamischer Psychotherapie mit einer 94 Jahre alten Frau und leiten daraus Schlussfolgerungen für Theorie und Praxis ab. Wir zeigen, dass unbewusste Faktoren und Motive sich hinter augenscheinlich rationalen Wünschen nach einem assistierten Suizid verbergen und dass die Aufmerksamkeit gegenüber diesen Faktoren im Rahmen einer psychoanalytisch geprägten Behandlung einen therapeutischen Wandel herbeiführen kann.

Comprendere psicoanaliticamente la richiesta di suicidio assistito. La legalizzazione delle pratiche di morte assistita, tra cui l'eutanasia e il suicidio assistito da un medico, si sta diffondendo nel mondo in un numero sempre maggiore di paesi e rappresenta un tema chiave del dibattito contemporaneo - un dibattito che riflette a sua volta dei cambiamenti nella società, e all'interno del quale esistono due prospettive sul suicidio in conflitto tra loro. Stando al primo modo di vedere, il suicidio assistito sarebbe giustificato da ragioni razionali nella misura in cui esso salvaguarda la dignità dei pazienti e offre loro un margine di controllo su una malattia in fase terminale; il secondo punto di vista sostiene invece che ai desideri suicidi sottostanno conflitti interni inconsci e disturbanti. Nel presente articolo ci proponiamo di esplorare le motivazioni inconsce e i significati che stanno alla base delle richieste di suicidio assistito. Essendo la letteratura psicoanalitica sull'argomento assai ridotta, e non essendo noti esempi di pratica clinica in questo ambito, ci collegheremo da un lato alla letteratura sulle cure palliative e di fine vita e dall'altro al modo in cui la psicoanalisi comprende il suicidio, sostenendo in conclusione che i fattori inconsci sono essenziali per capire le richieste di suicidio assistito. Proporremo un'illustrazione clinica di quanto argomentato presentando il caso di una psicoterapia psicodinamica con una paziente di 94 anni, e sottolineandone una serie di implicazioni teoriche e pratiche. Mostreremo infine come dietro a richieste apparentenente razionali di suicidio assistito possano esserci fattori e motivazioni inconsce, e come un trattamento orientato psicoanaliticamente e attento a queste determinanti possa portare dei cambiamenti terapeutici.

Comprensión psicoanalítica de la solicitud de suicidio asistido. La legalización de la muerte asistida, en particular la eutanasia y el suicidio asistido por un médico o médica, está aumentando por todo el mundo y constituye un debate contemporáneo muy importante, que refleja cambios sociales, en el que dos visiones del suicidio entran en conflicto: (1) la que considera que motivos racionales justifican el suicidio asistido, y proporcionan dignidad y control de la enfermedad terminal, y (2) aquella que considera que los deseos suicidas son impulsados por conflictos internos inconscientes y perturbadores. En este artículo se exploran los motivos y significados inconscientes de la solicitud de suicidio asistido. Aunque hay escasa literatura psicoanalítica sobre el tema y una ausencia de ejemplos prácticos, los autores, a fin de desarrollar la visión de que los factores inconscientes son cruciales para comprender la solicitud de suicidio asistido, establecen dos conexiones: primero, con la literatura sobre cuidados paliativos y final de la vida, y luego, con la comprensión psicoanalítica del suicidio. Presentan, como ejemplo, el caso de la psicoterapia psicodinámica con una mujer de 94 años, y sus implicaciones teóricas y prácticas. Y muestran que tras la solicitud aparentemente racional de suicidio asistido subyacen factores y motivos inconscientes, y que la atención a estos mediante un tratamiento psicoanalíticamente informado puede generar un cambio terapéutico.

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