religions

MDPI

Article

Psychological Suffering and the Right to Die: An Islamic Legal Assessment of Euthanasia Requests

Tuba Erkoç Baydar [1,*] and Rakia Erkoç Çelik [2,3]

[1] School of Islamic Studies, Ibn Haldun University, Istanbul 34494, Turkey
[2] Department of Psychology, Ibn Haldun University, Istanbul 34494, Turkey; rakia.erkoc@erzurum.edu.tr
[3] Department of Psychology, Erzurum Technical University, Erzurum 25050, Turkey
* Correspondence: tuba.baydar@ihu.edu.tr

Abstract

This study offers a critical re-examination of contemporary euthanasia debates through an Islamic legal lens, with particular focus on requests for euthanasia arising from psychological suffering within the context of mental disorders. Within bioethical discourse, advocates of euthanasia predominantly justify their position on the grounds of individual autonomy and the alleviation of unbearable suffering, framing it as consistent with modern medicine's aspiration to optimize quality of life. Yet, by elevating autonomy and self-determination as supreme moral values, it risks reducing the human condition to its cognitive and volitional dimensions, thereby overlooking the existential, spiritual, and affective aspects of suffering. In contrast, Islamic law regards life as a divine trust bestowed by God. Human beings are understood as stewards—rather than absolute proprietors—of their lives and are thus accountable before God for their preservation. From this perspective, psychological pain—akin to physical pain—may serve as a means of moral refinement, spiritual purification, and divine testing. Methodologically, the study conducts a textual and analytical examination of Islamic legal sources, complemented by practical examples that illustrate how psychological suffering transforms into requests for euthanasia, thereby examining how these sources ought to be understood through concrete cases. Furthermore, the study aims to examine whether appeals to a "right to die," grounded in experiences of psychological suffering, can find any juridical legitimacy within the framework of Islamic law.

Keywords: Islamic law; euthanasia; right to die; psychological pain; mental disorders

Academic Editor: Tuba Işik

Received: 15 October 2025
Revised: 12 May 2026
Accepted: 14 May 2026
Published: 25 May 2026

1. Introduction

Mental disorders constitute a heterogeneous group of conditions characterized by persistent disturbances in cognition, affect regulation, and behavior, which collectively undermine adaptive functioning and result in clinically significant distress or impairment (American Psychiatric Association 2013). Individuals with chronic, severe, or treatment-resistant forms of mental illness frequently experience profound and often unbearable psychological suffering, defined as a form of distress arising from perceived threats to one's psychological integrity, identity coherence, or sense of meaning (Cassell 1998). This suffering may be further accompanied by pervasive states of despair, inner emptiness, and a marked diminution of the will to live. Within such clinical and existential configurations, the intensity of psychological anguish may progressively intensify, reaching a threshold

at which life itself is experienced as an intolerable burden, thereby leading some individuals to contemplate euthanasia, understood as the deliberate and intentional termination of one's own life at the request of the patient or with their explicit consent. The clinical reality of this condition raises profound ethical questions at both individual and societal levels, demanding not only a medical response but also theological and legal engagement.

In recent decades, euthanasia requested in the context of mental disorders has emerged as a significant and increasingly contested issue within bioethical and legal discourse. Contemporary debate was notably catalyzed by the involvement of Dutch psychiatrist Dr. Chabot in assisting the suicide of a woman suffering from severe depression in 1993. The subsequent legal proceedings generated extensive deliberation concerning professional responsibility, ethical boundaries, and the legitimacy of euthanasia grounded in psychological suffering (Burgess and Hawton 1998).

A review of the existing literature in English, Arabic, and Turkish reveals a relatively substantial body of work addressing euthanasia in relation to physical illness and pain; however, studies that engage with euthanasia specifically from an Islamic perspective and through the lens of psychological suffering remain considerably limited (Sachedina 2009; Erkoç Baydar 2021; Shabana 2023; Ghaly 2023). This gap constitutes not merely an academic deficiency but also a form of structural silence that leaves clinicians, religious authorities, and policymakers without adequate practical guidance, particularly within Muslim-majority societies and among Muslim minority communities in Europe.

In general, and analogously to physical illnesses, whether euthanasia should be permitted in psychiatric conditions is discussed in relation to the fulfilment of stringent clinical and ethical criteria; moreover, such cases are considered even more controversial than those based on physical suffering. Within this framework, unbearable suffering and medically established irremediability are typically regarded as core conditions, while the patient's request is additionally required to be voluntary, well-considered, and consistently reiterated, alongside the requirement that the individual possesses adequate legal decision-making capacity (Bersani et al. 2025). However, the extension of this normative framework to mental disorders introduces substantial conceptual, diagnostic, and clinical complexities. In particular, both the operational definition of "irremediability" in mental disorders and the evaluation of whether a request is genuinely autonomous, sufficiently deliberated, and fully voluntary remain deeply contested. Accordingly, euthanasia requests from individuals with mental disorders are situated within a domain characterized by substantial epistemic uncertainty and interpretative variability in both clinical evaluation and ethical justification.

The limitations of the prevailing normative framework—particularly its foregrounding of individual autonomy as the primary, and often sole, ethical criterion, and its comparative neglect of the relational, communal, and existential dimensions of suffering—raise foundational questions about the adequacy of liberal bioethical reasoning as a universal framework. These limitations, moreover, suggest the need to engage more seriously with alternative normative traditions capable of addressing dimensions of human suffering that remain insufficiently theorized within dominant bioethical discourse. At this juncture, Islamic law (fiqh) present themselves not simply as repositories of religious prohibition, but as a structured intellectual tradition that articulates a distinctive conception of human agency, the moral significance of suffering, and the relationship between creaturely life and divine authority—a tradition whose internal resources remain underutilized in mainstream bioethical debate.

The theological anthropology underlying Islamic approaches to end-of-life ethics differs structurally from its liberal counterpart in ways that bear directly on the question of euthanasia. Central to the Islamic framework is the concept of amānah—divine trust or

stewardship—derived from Qurʾānic sources (Q. 33:72) and elaborated extensively in classical jurisprudence, according to which human life is held not as an autonomous possession but as a trust from God, entailing obligations of preservation and care (Erkoç Baydar 2021) This conceptualization structurally circumscribes individual sovereignty over life and death: the individual is a steward, not an owner, of the life entrusted to them. Within this framework, suffering (alam, balāʾ) is not reducible to a pathological state requiring elimination; classical scholarship—drawing on both Qurʾānic narrative (e.g., Q. 2:155–157; Q. 39:10) and ḥadīth literature—interprets affliction as morally and spiritually significant, capable of functioning as expiatory and of deepening the believer's relational orientation toward the divine. At the same time, this tradition does not valorize suffering for its own sake: the obligation to seek medical treatment is affirmed in juristic literature across the classical schools, and the relief of pain through lawful means is consistently endorsed (Erkoç Baydar and İlkılıç 2022). The resulting normative structure holds the alleviation of worldly suffering and the recognition of its potential spiritual significance in a productive tension—one that resists both passive resignation and the reduction of suffering to a technical problem amenable to a medical solution.

This study endeavors to critically examine euthanasia requests arising in the context of mental disorders through a comprehensive, multidisciplinary framework integrating psychological and Islamic perspectives. The primary orientation of this study is theoretical: it aims to establish a coherent Islamic legal framework for evaluating euthanasia requests arising from psychological suffering. Nevertheless, the analysis also incorporates practical recommendations where appropriate, with the intention of offering actionable guidance for chaplaincy practice and interdisciplinary clinical cooperation. Given the profound interrelation between personal autonomy, the meaning and value of suffering, and the ethical implications of end-of-life decisions, the analysis also draws on Islamic Practical Theology to elucidate how these principles are internalized, experienced, and enacted within the lived realities of Muslim patients. The case examples and clinical scenarios employed are intended solely for conceptual illustration rather than generalization.

The present study adopts a qualitative, text-based methodology grounded in the systematic analysis of classical Islamic jurisprudential sources. The primary corpus comprises canonical works of fiqh literature across the four Sunnī legal schools, examined through close reading and interpretive synthesis with the aim of constructing a coherent normative framework for evaluating euthanasia requests from individuals with mental disorders. The scope of inquiry is deliberately circumscribed to the classical tradition — a delimitation that reflects a principled methodological commitment to establishing the doctrinal foundations upon which engagement with contemporary Islamic bioethical scholarship must necessarily rest, and not an oversight of that scholarship. It should be noted that classical fiqh literature does not address the concept of euthanasia in explicit terms. Classical jurists engaged instead with cognate questions: the absolute prohibition of suicide (al-intiḥār), the moral status of causing or hastening one's own death (qatl al-nafs), and debates over the permissibility of abandoning medical treatment—discussions conducted across the major legal compendia with sustained analytical rigour. The methodological strategy adopted here involves identifying the relevant classical discussions, articulating their underlying legal rationale, and applying analogical reasoning to the contemporary case of psychiatric euthanasia—a procedure consistent with established conventions of Islamic legal derivation. The case examples and clinical scenarios employed throughout the analysis are intended solely for conceptual illustration and do not aspire to empirical generalization.

The manuscript is structured into two principal sections. The first delineates the foundations of psychological suffering in relation to contemporary ethical debates on euthana-

sia. It examines how intense psychological suffering stemming from psychopathology may evolve into a desire for death, and subsequently evaluates whether mental disorders can, in principle, constitute a sufficient justification for euthanasia. The second situates the discussion within the Islamic intellectual tradition, with particular emphasis on Islamic law, addressing the sanctity of life, the moral and spiritual significance of suffering, and the conceptualization of a "right to die." Particular attention is devoted to assessing whether psychological suffering culminating in a desire for death can, from an interdisciplinary standpoint, be construed as a legitimate justification for euthanasia. This bipartite structure deliberately reflects a dialogical logic. The first section elucidates the empirical and clinical reality of euthanasia requests, while the second examines how this reality is reinterpreted and assessed within the framework of Islamic law. The tension between these two sections constitutes a central driver of the article's main argument: neither clinical analysis nor normative frameworks are sufficient in isolation; rather, each serves to deepen, refine, and critically interrogate the other.

2. Euthanasia and Psychopathology: The Transformation of Psychological Suffering into a Desire for Death

2.1. Psychological Determinants of Euthanasia Requests in Mental Disorders

A pivotal psychological determinant driving the inclination to request euthanasia among individuals with mental disorders is the profound loss of faith in the treatability and recoverability of their condition—that is, the experience of hopelessness. Hopelessness exerts a powerful influence on patients' perceptions of illness trajectory and recovery potential, substantially undermining both engagement with therapeutic interventions and the intrinsic motivation to continue living. In this context, hopelessness functions as a central and mediating mechanism in the formation of euthanasia requests. Empirical evidence consistently identifies hopelessness as one of the most compelling predictors of euthanasia requests across both physical and mental health conditions (Verhofstadt et al. 2017).

The influence of hopelessness is particularly pronounced in depressive disorders. Depression ranks among the mental disorders most frequently associated with euthanasia requests (Thienpont et al. 2015) and engenders profound hopelessness, a perceived loss of meaning in life, and pervasive feelings of helplessness (American Psychiatric Association 2013; Maier and Seligman 1976). Over time, these psychological states may escalate into a desire for suicide. Research demonstrates a robust association between depressive disorders and suicidal behavior, emphasizing that the risk of suicide increases with the chronicity of depression. For instance, Ryan et al. (1987) reported that adolescents experiencing depression for two years or longer exhibited significantly higher rates of suicidal ideation, intentions, and attempts compared to peers with shorter depressive episodes (Carlson and Cantwell 1982).

The feelings of hopelessness and helplessness arising from depression also contribute substantially to euthanasia requests in the context of physical illness. Studies of terminally ill patients reveal a strong correlation between depressive symptoms and the desire to die, with depression influencing 98–99% of patients' requests for euthanasia (Jackson and Keown 2012). Similarly, research focusing on cancer patients indicates that approximately 44% of those experiencing depression expressed a request for euthanasia.

Difficulties in regulating emotions and controlling drives constitute another significant factor underlying euthanasia requests in mental disorders. Borderline personality disorder is frequently linked to such requests (Thienpont et al. 2015). This disorder is characterized by marked impairments in emotional regulation and the management of drives (Lieb et al. 2004), which substantially compromise an individual's capacity to cope with stress and adversity, potentially fostering a desire for death. Empirical evidence further

demonstrates that suicidal behavior occurs at considerably higher rates in individuals with borderline personality disorder compared to the general population (Pompili et al. 2005).

Weak social bonds and the absence of supportive social networks constitute salient factors that may facilitate the emergence of a desire for death among individuals experiencing mental disorders. Social support functions as a crucial protective mechanism, bolstering coping capacities, enhancing resilience, and fostering overall well-being (Boehm and Lyubomirsky 2008; Myers and Diener 1995; Southwick 2014). The absence of such protective structures can amplify emotional and psychological vulnerabilities, thereby heightening the likelihood of disengagement from life. Notably, experiences of loneliness and social isolation—particularly when compounded by the affective and cognitive disturbances inherent in mental disorders—create an environment conducive to the development of suicidal ideation. Empirical evidence substantiates this association, demonstrating that a considerable proportion of psychiatric patients requesting euthanasia are socially isolated or unmarried, highlighting the pivotal role of deficient social support in shaping these outcomes (Kammeraat et al. 2023; Kim and Lemmens 2016). This dimension is particularly significant for the Islamic analysis that follows: classical Islamic jurisprudence presupposes a communal fabric of relational obligation, and the social isolation characteristic of many psychiatric patients today represents a structural rupture in precisely those bonds that Islamic ethics regards as constitutive of human flourishing and moral accountability.

Additionally, a history of trauma may constitute a critical antecedent to euthanasia requests among individuals with mental disorders. Adverse experiences encountered during childhood can engender enduring alterations in the cognitive–affective frameworks through which individuals interpret themselves, others, and their environment. As a result, individuals may develop pervasive core beliefs of inadequacy, worthlessness, and unlovability, while simultaneously perceiving others as potentially threatening and the world as fundamentally unsafe (Beck 2020). These trauma-induced cognitive distortions, compounded by the intrinsic vulnerabilities associated with mental disorders, can intensify existential reflections on the perceived futility of life and the value of one's own existence, thereby precipitating profound existential distress. In this regard, extant literature conceptualizes trauma as an existential injury, wherein individuals are confronted with foundational questions concerning life's meaning and are compelled to endure the subjective experience of existential suffering (Thompson and Walsh 2010). Such existential deliberations may catalyze a desire for death; indeed, existential suffering has been identified as a principal impetus underlying euthanasia requests in the scholarly literature (Verhofstadt et al. 2021).

Moreover, mental disorders frequently engender multifaceted functional impairments that further diminish quality of life. Conditions such as depression and anxiety are associated with familial conflict, impaired social functioning, and difficulties in academic or occupational adaptation. Additionally, they increase vulnerability to adverse outcomes including diminished performance, sleep disturbances, substance use, and engagement in high-risk behaviors, some of which may pose direct threats to life (Alfano et al. 2007; Essau et al. 2014; Mazzone et al. 2007; Petersen et al. 1993; Wagner 1997; Woodward and Fergusson 2001). Such cumulative burdens are strongly associated with reductions in overall life satisfaction. Longitudinal evidence further substantiates that mental disorders precipitate significant declines in life satisfaction (Fergusson et al. 2015). In this context, diminished life satisfaction, compounded by psychological distress and the pervasive impact of mental disorders, may contribute to the emergence of euthanasia requests. Beyond diagnostic formulations, euthanasia requests often reveal an existential and spiritual struggle—ambivalence toward God, feelings of abandonment, and crises of meaning—that cannot be

captured by symptom checklists alone. These dimensions should therefore be addressed through spiritually informed, interdisciplinary care.

The psychological determinants discussed in Section 2.1—namely hopelessness, affective dysregulation, social isolation, trauma history, and functional deterioration—indicate that euthanasia requests among individuals with mental disorders emerge within an interconnected and mutually reinforcing causal network rather than as isolated phenomena. While each factor, when considered individually, may appear amenable to clinical intervention, their cumulative interaction generates a complex structure of vulnerability that gradually erodes the individual's meaning-making system, future orientation, and relational attachment to life. Over time, this dynamic fosters an internalized perception of therapeutic futility and a progressively entrenched desire for death. Indeed, the relevant literature demonstrates that these determinants represent not merely clinical symptoms but also profound existential and relational forms of suffering: the condition is experienced less as a constellation of pathological signs and more as a crisis of meaning, with euthanasia requests emerging as the clinical articulation of this existential rupture.

Against this background, the question to be addressed in the following section arises directly from this conceptual and empirical foundation: can psychological suffering—regardless of its intensity, chronicity, or perceived intolerability—constitute a sufficient and legitimate justification for euthanasia? The answer to this question extends beyond a purely clinical assessment and is intrinsically linked to fundamental ethical and legal considerations concerning autonomy, decisional capacity, and the limits of self-determination. The subsequent section will examine these dimensions in detail, elucidating the tension between clinical reality and normative frameworks through an integrated analysis of psychological suffering from both medical and Islamic perspectives.

2.2. Psychological Suffering as Grounds for Euthanasia: Autonomy, Capacity, and the Limits of Self-Determination

Building upon the psychopathological determinants outlined in Section 2.1, this section engages with a more explicitly normative question: can such a complex constellation of psychological suffering constitute a legitimate basis for euthanasia within the framework of individual autonomy? Addressing this question requires not only the consideration of clinical data, but also a critical examination of the profound ethical tensions surrounding autonomy, decisional capacity, and the limits of self-determination.

Individuals with mental disorders, akin to patients suffering from terminal physical illnesses, may request euthanasia, a phenomenon consistently documented in empirical studies. For instance, De Hert et al. (2015) reported that psychiatric nurses in Belgium frequently encountered euthanasia requests either directly (N = 329, 53%) or via colleagues (N = 427, 69%). At present, euthanasia or physician-assisted death based on mental disorders is legally sanctioned and practiced in Belgium, the Netherlands, and Luxembourg, albeit in limited numbers and under stringent regulatory frameworks (Denys 2018; Dierickx et al. 2017; Grassi et al. 2022; Groenewoud et al. 1997; Naudts et al. 2006). Thienpont et al. (2015) further demonstrated that among 100 patients requesting euthanasia due to mental disorders, 48 requests were approved and 35 were executed.

One of the primary justifications for euthanasia in the context of physical illness is the alleviation of "unbearable suffering" (Dees et al. 2010; Verhofstadt et al. 2017). By analogy, the psychological suffering experienced in association with mental disorders may attain levels that individuals perceive as intolerable. Psychological pain—characterized by its persistent, aversive, and unsustainable nature—has been shown to engage neurobiological mechanisms that overlap with those underlying physical pain (Conejero et al. 2018). Nevertheless, the evaluation of such psychological distress poses substantial challenges, as clinicians must predominantly rely on patients' subjective accounts in the absence of objec-

tive metrics (Deschepper et al. 2014; Raus and Sterckx 2015). Furthermore, compromised decision-making capacity among psychologically distressed individuals complicates the distinction between euthanasia requests that stem from enduring psychological pain and those that manifest as symptomatic expressions of severe depression. Whether suffering reaches the threshold of "unbearable" is not only a clinical question; as the Islamic tradition insists, it is also a question of meaning—one that medicine alone is structurally ill-equipped to resolve.

Another commonly cited rationale is the perception of the illness as "untreatable" (Evenblij et al. 2019; Nicolini et al. 2023; Ramos-Pozón et al. 2023). In the context of mental disorders, however, designating a condition as untreatable is inherently complex. The etiologies of prevalent psychiatric disorders, including depression and schizophrenia, remain incompletely understood, and the trajectories of spontaneous recovery are far less predictable than in physical illnesses (Nicolini et al. 2023). Consequently, labeling a psychiatric disorder as untreatable often lacks empirical justification (Kelly and McLoughlin 2002). Depressive mood and pervasive hopelessness, frequently intrinsic to psychiatric conditions, further increase the risk of patients perceiving themselves as beyond help, potentially resulting in the withholding or rejection of effective interventions. Patients may consequently request termination of life due to symptoms that could otherwise be alleviated through appropriate treatment (Appelbaum 2017). Furthermore, considering a patient entirely hopeless when some interventions remain effective neglects the psychiatrist's fundamental responsibility to safeguard and foster the individual's recovery potential (Claes et al. 2015). Therefore, employing the label "untreatable" in mental disorders may be both scientifically unfounded and critically undermine the reliability of euthanasia decisions based on such assessments.

Respect for individual autonomy and life choices constitutes another frequently cited rationale for euthanasia requests. Nevertheless, in individuals with mental disorders, the degree to which these decisions are truly autonomous and informed is subject to significant ethical and clinical scrutiny. Empirical evidence indicates that mental disorders can substantially impair decision-making capacity (Vergallo et al. 2020). Clinically, individuals experiencing an active phase of psychiatric illness are generally advised against making critical life decisions, such as divorce or career changes. Thus, attributing irreversible decision-making authority to individuals with mental disorders in the context of life termination introduces profound ethical and clinical challenges. In addition, mental disorders and their accompanying affective states can compromise the stability and continuity of decisions. Patients with suicidal tendencies often oscillate between the desire to live and the desire to die and may revise initial requests; Thienpont et al. (2015) reported that eight out of 48 patients whose requests were initially approved subsequently postponed or canceled the procedure. Moreover, for most individuals, suicidal ideation does not necessarily translate into suicidal behavior, and the statistical association between mental disorders and suicide attempts diminishes when suicidal thoughts are controlled for (Olié and Courtet 2016). Consequently, the "decision to die" articulated by individuals with mental disorders does not invariably reflect a genuine desire for death, but may instead signify a call for assistance, a search for hope, or an indirect expression of the will to live. This clinical instability of the "decision to die" resonates with a foundational principle in Islamic law: that moral and legal responsibility (taklīf) presupposes sound reason (ʿaql), and that decisions made under conditions of severe psychological disturbance occupy a categorically different—and legally significant—space within the Islamic jurisprudential tradition.

In a context where decisional capacity is itself highly contested, positioning autonomy as the primary justification for euthanasia generates a circular argument: if the patient is sufficiently autonomous, their decision must be respected; if they are not sufficiently

autonomous, the decision is already invalid. The resolution of this circularity, however, requires a critical re-examination of the concept of autonomy itself. Islamic law offers a distinctive contribution at this juncture by reframing autonomy not as an absolute starting point, but as a conditional capacity understood within the framework of moral responsibility and divine trust. In doing so, it avoids absolutizing the decisions of individuals whose capacity is uncertain, and instead situates such decisions within a broader ethical horizon that allows for accompaniment, guidance, and moral contextualization.

These clinical and ethical complexities reveal that euthanasia requests in the context of mental disorders cannot be adequately resolved within a framework that privileges individual autonomy alone. When decision-making capacity is compromised, when the desire to die oscillates with the will to live, and when suffering resists straightforward medical categorization, the need for a broader evaluative horizon becomes evident. It is precisely at this juncture that Islamic thought offers a distinct and substantive contribution—not merely as a set of legal prohibitions, but as a comprehensive anthropological and spiritual framework that reframes the meaning of suffering, the nature of human agency, and the ultimate ground of human dignity. The following section examines how Islamic theology and law approach the experience of pain and affliction, and what this tradition reveals about the moral and existential dimensions of the desire for death.

3. Suffering, Sovereignty, and the Sanctity of Life: An Islamic Jurisprudential Perspective

3.1. Suffering as Trial and Purification: The Islamic Framework of Ṣabr, Tawakkul, and Meaning

Islamic thought does not confine its reflection on suffering to bodily affliction alone. The Qur'anic terms balā' and muṣībah encompass the full spectrum of human distress—physical, relational, and psychological alike—and thus carry a broad semantic range. This breadth is theologically significant: the framework of divine trial, patience, and meaning-making developed within Islamic thought applies not only to conditions that manifest in the body, but equally to those that profoundly affect the inner life—to the despair, hopelessness, and existential emptiness that lie at the heart of many euthanasia requests. The following discussion therefore engages with the Islamic understanding of suffering in its moral, spiritual, and communal dimensions, demonstrating that what holds true for physical pain holds no less true for psychological suffering.

In the Qur'an, human suffering—expressed through terms like balā' and muṣībah—is closely linked to the concept of divine trial, with balā' signifying both grief or calamity and, in technical usage, being subjected to a test or hardship. For instance, in al-Baqarah 2:155, it is stated: "We will certainly test you with fear, hunger, and loss of wealth, lives, and fruits; but give glad tidings to those who are patient." Likewise, Āl ʿImrān 3:186 declares: "You will surely be tested in your possessions and your persons." These verses imply that earthly adversities and human suffering are not simply random misfortunes, but function as mechanisms for moral evaluation and the cultivation of spiritual growth.

As emphasized in the Qur'an and hadiths (Bukhārī 2000, Riqāq 28), the idea that worldly suffering constitutes part of a divine trial has been widely affirmed by Muslim scholars. Al-Zamakhsharī (d. 538/1144), for example, explicitly states that muṣībahs are sent to human beings for the purpose of testing them (Zamakhsharī 1947, vol. I, pp. 232–33). Theologians who reflected on the meaning of tribulations such as illness considered them as occasions for moral instruction, trial, and reflection—not only for those afflicted but also for their relatives and surrounding community (Māturīdī 2003, pp. 351–458). Like the theologians, the Sufis interpreted suffering as means of trial and purification (Sarrāj al-Tūsī 1996, p. 345).

In Islamic thought, illnesses, afflictions, and calamities are regarded not merely as tests, but also as events imbued with deeper wisdom. Some of these meanings include: God's drawing His beloved servant closer to Himself; reminding the servant of the ultimate purpose of earthly existence; expiation of sins; spiritual elevation; and receiving recompense for errors in this world rather than in the Hereafter. Through suffering, a person's patience, sincerity, faith, and devotion to God are tested. Hence, within Islamic thought, believers are advised to endure pain and hardship with patience rather than rebellion, based on the awareness that suffering sent by God carries divine wisdom and pedagogical purpose. For example, the Prophet Muhammad (peace be upon him) described the plague (ṭāʿūn) as a punishment that God inflicts upon whomever He wills, but for the believer, it becomes a source of mercy. Whoever endures it with patience and hopes for God's reward is granted the status of a martyr (Tirmidhī 2001, Zuhd 57). Similarly, various hadiths promise that every misfortune a Muslim face—be it fatigue, illness, sorrow, pain, anxiety, or even a thorn that pricks him—serves as atonement for sins (Bukhārī 2000, Marḍā 3).

Like the scriptural sources, Muslim scholars unanimously affirmed that worldly suffering can serve as expiation for sins (Ālūsī 1999, vol. V, p. 152). Al-Māturīdī stated that "those who endure trials will ultimately attain mercy" (Māturīdī 2007, vol. II, p. 505). Therefore, according to Islam, viewing illness and worldly suffering as purely evil results in a mistaken evaluation. True benefit and harm must be assessed considering the eternal Hereafter. The Qur'an and Sunnah frequently invoke the concepts of good (khayr) and evil (sharr) because individual, this-worldly criteria of utility or harm do not capture the religious and metaphysical dimensions of moral value. The Qur'an reminds believers not to judge good and evil merely by outward appearances: "But perhaps you hate a thing and it is good for you; and perhaps you love a thing and it is bad for you" (Qur'an 2:216).

In assessing the legal dimensions of human experience, classical Islamic jurists and legal theorists recognize that notions of good, harm, benefit, and corruption (maṣlaḥah–mafsadah) are not always fixed or absolute. As al-Ghazālī observed, since objective and universal measures of good, harm, benefit, and corruption are not always available, these notions are inherently relative and context-dependent (Ghazālī 1988, vol. I, pp. 56–57). In this sense, euthanasia may indeed spare a person from worldly suffering; yet does what is good for the body or the mind necessarily equate to what is good for the totality of the human being? Whether physical or psychological in nature, suffering acquires spiritual meaning and significance once the Hereafter is acknowledged. Accordingly, the criteria for good and evil must be examined with far greater care in relation to both forms of suffering (Erkoç Baydar and İlkılıç 2022).

While pain and suffering occupy a central position in contemporary euthanasia discourse, Islamic thought resists any reductive account of these phenomena. Rather than construing suffering as an unqualified evil to be eliminated, the Islamic tradition recognizes its multidimensional character—encompassing patience (ṣabr), divine trial (ibtilāʾ), and spiritual purification (tazkiyah)—thereby precluding any one-dimensional moral assessment of physical pain, psychological distress, or existential anguish. This does not, however, imply indifference to human suffering; on the contrary, Islam places a strong imperative on the alleviation of pain through lawful and compassionate means. Yet the relief of suffering, however morally urgent, does not in itself license euthanasia as a remedy. Accordingly, while arguments from suffering merit serious moral and legal consideration, they do not, within the Islamic legal framework, constitute sufficient grounds for endorsing euthanasia. This raises, in turn, a more fundamental question that underlies the entire debate: whether the human being possesses sovereign authority over his or her own life—a question that cannot be resolved by appeals to suffering alone, but demands

engagement with the Islamic conception of human existence as a divine trust, and with the theological and jurisprudential boundaries within which the notion of a "right to die" must be critically evaluated. It is with this aim that the following section examines the foundational positions of Islamic law on the sanctity of life and the right to die, thereby laying the groundwork for assessing whether psychological suffering may legitimately be brought within the scope of this framework. While concepts such as patience (ṣabr), trust in divine decree (tawakkul), and the framework of life as a divine test illuminate the moral and spiritual dimensions of suffering, the decisive juridical question remains unanswered: whether such suffering, regardless of its depth or intensity, grants the individual an absolute right of disposition over their own life. It is precisely this question that constitutes the focal point of the normative framework in Islamic jurisprudence, which is constructed around the principles of divine sovereignty, entrusted human agency (amānah), and the inviolability of life.

3.2. The Limits of Human Agency over Life: Sovereignty, Trust, and the Islamic Legal Framework

At the heart of the Islamic worldview lies a foundational conviction: human life is neither accidental nor purposeless, but divinely ordained—bounded by death, yet oriented toward resurrection and an eternal existence that transcends the temporal order. This awareness not only endows life with ultimate meaning but simultaneously constitutes the human being as a morally responsible agent. Within the Islamic framework, responsibility is not an external constraint imposed upon freedom, but its very foundation—for freedom, properly understood, is inseparable from accountability before the divine. The human being, sent to this world for a divinely ordained purpose, is held accountable in the Hereafter for his or her actions and decisions, and therefore bears obligations both toward the Creator and toward other human beings. Accordingly, individual freedom in Islam is relational, encompassing duties toward family, society, and community; it cannot be reduced to the pursuit of personal desires or autonomous preferences. From an Islamic law perspective, autonomy is relational and conditional: one's authority extends only to what God has permitted. The unavailability of life therefore derives from legal, not merely moral, grounds.

In Islamic law, human autonomy operates within boundaries delineated by divine sovereignty and public interest (maṣlaḥa). Yet this autonomy covers a broad domain of legal agency. Because human acts are believed to affect not only the self but also the community, Islamic law constantly mediates between individual freedom and collective welfare. Endowed with reason, the human being is tasked with cultivating and sustaining the world, discerning good from evil, and exercising stewardship within the divinely granted sphere of agency. The capacity for such agency—reason, freedom, and volition—is a precondition for moral responsibility and for the validity of legal acts such as ownership or contractual agreement (Ghazālī 1988, p. 137). Hence, in Islamic law literature, especially in discussions on coercion (ikrāh), it is explicit that moral and legal responsibility (taklīf) requires the exercise of autonomous will.

The concept of "right" lies at the heart of the debate: can the "right to die" legitimately exist within the framework of Islamic jurisprudence? To address this question, one must first clarify the legal and moral semantics of ḥaqq in Islamic law. In general, ḥaqq refers to a power or entitlement conferred upon a person by law. A review of classical sources reveals that the scope of ḥaqq does not extend to authorizing death. For example, knowingly exposing oneself to fatal danger is forbidden, and it is likewise impermissible to abstain from lawful sustenance to the point of self-destruction. The eminent Ḥanafī jurist al-Jaṣṣāṣ (d. 370/981) states that a person who refrains from lawful nourishment and thereby causes his own death is considered to have rebelled against God's decree (Jassāṣ 1996, vol. I, p. 157). Similarly, Ḥanafī jurist al-Kāsānī (d. 587/1191), rules that one threat-

ened with death or bodily harm may not deliberately endanger his own life by resisting the threat (Kāsānī vol. VI, p. 185).

An example reported by the Ḥanafī jurist Imām Muḥammad ibn al-Ḥasan al-Shaybānī (d. 189/805) illustrates the sensitivity of this issue. He questions whether a condemned prisoner who obeys the executioner's command to extend his neck for beheading thereby becomes a participant in his own death. Although Imām Muḥammad finds no sin in the prisoner's compliance, his very inquiry signals the profound ethical tension at stake. As Ḥanafī jurist Shams al-A'imma al-Sarakhsī (d. 483/1090) explains, no blame attaches to the prisoner because he acts under compulsion and is certain to die regardless (Sarakhsī 1971, vol. IV, p. 1496). Yet the discussion implies that even minimal cooperation in one's own death carries grave moral weight (Erkoç Baydar 2021).

In another passage, al-Sarakhsī offers a striking scenario: Muslims aboard a burning ship attacked by enemies must decide between perishing in flames or drowning by leaping into the sea. If survival is possible through either choice, they are obligated to take the path that preserves life, for the human being is commanded to protect life to the utmost of his capacity. However, if no hope of survival exists in either case, Abū Ḥanīfa and Abū Yūsuf permit either choice, whereas Imām Muḥammad holds that one must remain aboard, since voluntary participation in one's death—even symbolically—is impermissible. For him, dying through one's own act differs from dying by another's act, and the former cannot be sanctioned (Sarakhsī 1971, vol. X, pp. 76–77).

Although rooted in the exigencies of physical danger and immediate mortal threat, this classical scenario carries profound implications for contemporary debates on euthanasia among individuals with mental disorders. The juristic disagreement between Abū Ḥanīfa, Abū Yūsuf, and Imām Muḥammad is instructive precisely because even in a situation of absolute certainty of death—where no path of survival exists—Imām Muḥammad refuses to sanction the act of voluntarily hastening one's own end. If Islamic law withholds permission to hasten death even under such conditions of genuine and inescapable mortal inevitability, it follows with compelling logical force that it cannot sanction the deliberate termination of life in response to psychological suffering, whose trajectory remains—by jurisprudential standards—genuinely open.

Preservation of life (ḥifẓ al-nafs), one of the ḍarūriyyāt al-dīniyya (the five essential objectives of the Sharīʿa), belongs to the category of rights combining divine and human claims. It is not left solely to individual discretion, for its violation threatens both spiritual and social order. According to Shāfiʿī jurist and theologian al-Āmidī (d. 631/1233), when divine and human rights coincide, their infringement is doubly grave, and the duty to preserve life becomes paramount (Āmidī 1914, vol. IV, p. 377). Consequently, any self-destructive act—suicide or self-endangerment—is categorically impermissible. The jurists' extensive discussion on consent to be killed further illuminates the limits of autonomy in Islamic law. They maintain that a person's consent is valid only within the bounds of a right over which they have legitimate authority. One cannot authorize another to perform an act that one is not permitted to do oneself. Thus, as al-Sarakhsī notes, consent to being killed carries no legal validity precisely because one lacks the right to take one's own life (Sarakhsī 1982, vol. XVI, p. 14). Even if a person commands, "Kill me," the killer remains subject to criminal liability. In the Ḥanafī school, for instance, the killer must pay diyya (blood compensation) despite the victim's consent (Ibn ʿĀbidīn 1994, vol. X, p. 193). The persistence of legal sanction demonstrates that consent cannot render the act lawful. The Shāfiʿī school similarly debates whether qiṣāṣ (retaliation) or diyyah (blood money) is applicable, but the consensus remains that consent does not nullify culpability (Ghazālī 1997, vol. VI, pp. 264–65). The absolute prohibition of suicide in Islam thus signifies that the individual possesses no ultimate authority over his or her own life. The terminology

used in Islamic law—qatl (killing) or halāk (destruction)—echoes Qurʾānic and Prophetic language that enjoins believers: "Do not kill yourselves" (Qurʾān 4:29). As al-Māwardī (d. 450/1058) explains, the same divine prohibition that forbids killing another extends to oneself (Māwardī 1994, vol. II, p. 388). Hence, within the Islamic legal worldview, life belongs ultimately to God, and human agency over it is divinely delimited rather than sovereign.

In Islamic law, suicide is categorically prohibited as one of the major sins (kabāʾir), regardless of whether it is motivated by physical pain or psychological suffering, and this prohibition provides a decisive framework for evaluating the notion of a "right to die" from an Islamic perspective. The Qurʾānic injunctions "Do not throw yourselves into destruction with your own hands" (al-Baqara 2:195) and "Do not kill yourselves; indeed, Allah is ever merciful to you" (al-Nisāʾ 4:29) are accepted by the majority of jurists as explicit textual evidence against suicide and all forms of self-harm, a prohibition further reinforced in prophetic tradition by the Prophet's declaration that Quzmān—who took his own life during the Battle of Khaybar, unable to endure the pain of his wounds—was among the people of Hell (Bukhārī 2000, Maghāzī 39). Ibn Ḥajar al-ʿAsqalānī underscores that taking one's own life is equivalent to committing murder against another, since human life constitutes a divine trust belonging to God and may only be disposed of within the limits He has prescribed (Ibn Ḥajar, vol. XI, p. 539). Given that Islamic law is structured around responsibility-based rights rather than individual autonomy, it becomes evident that neither bodily suffering nor psychological distress can furnish a legitimate ground for suicide; for the authority to terminate a life held as a divine trust cannot be reduced to a variable discretion determined by one's subjective pain threshold or psychological state.

In conclusion, as the preceding discussions indicate, an individual does not possess absolute authority or ownership over his or her own life. This principle is not merely a moral aspiration within Islamic thought but finds concrete expression in the binding rules of Islamic law. The categorical prohibition of suicide (qatl al-nafs) constitutes one of the most unambiguous manifestations of this foundational principle: the deliberate termination of one's own life is classified as a grave legal transgression, irrespective of the circumstances that motivate it. Equally instructive is the classical juristic position regarding assisted killing: Islamic law imposes penal liability upon one who kills another at that person's own explicit request. The fact that consent—and even active solicitation—on the part of the victim does not extinguish criminal responsibility on the part of the perpetrator demonstrates with particular clarity that the human being does not hold a legally cognizable right to die, nor is such a right transferable to another. Life, in this framework, is not a personal possession that may be surrendered at will, but a divine trust (amānah) held in stewardship, the termination of which falls outside the boundaries of individual authority. It follows, therefore, that Islamic jurisprudence does not recognize suffering—whether physical or psychological—or any other grounds whatsoever as constituting sufficient justification for terminating one's own life or relinquishing this divine trust. Although the classical juristic discourse predominantly addresses questions of physical suffering in relation to human agency over life and the body, the underlying legal principles admit of no categorical distinction between physical and psychological pain in this regard: neither form of suffering, however intense or persistent, nor any other invoked rationale, generates a right to die within the Islamic legal framework.

4. Pastoral Encounters with Mental Disorders: Illustrative Clinical Case Vignettes

The preceding sections have examined, first, the clinical and psychopathological landscape in which euthanasia requests emerge among individuals with mental disorders, and second, the Islamic theological and legal framework that addresses suffering, human

agency, and the sanctity of life. Together, these two dimensions—the empirical and the normative—establish the conceptual coordinates within which Muslim patients, their families, and the professionals who care for them must navigate some of the most demanding existential questions a human being can face. Yet between the legal ruling and the lived moment of crisis lies a space that neither clinical diagnosis nor juridical reasoning alone can fully inhabit: the relational, embodied, and spiritually charged encounter between a suffering person and a care provider. It is precisely in this space that Islamic Practical Theology becomes indispensable—not as a repetition of doctrinal positions, but as a practice of presence, meaning-making, and accompaniment. The following illustrative vignettes, drawn from hospital chaplaincy and psychosocial counseling contexts, are offered not for generalization but for conceptual clarification: they illuminate how the principles of ṣabr, tawakkul, and amānah are enacted—or struggled toward—in the texture of actual pastoral encounters with psychiatric suffering.

Vignette 1: Noelia Castillo Ramos

Noelia Castillo Ramos's life trajectory was shaped by severe early-life psychosocial trauma. At the age of 13, following her parents' separation, she was placed under state care, during which she reportedly experienced various forms of abuse, including sexual assault. These traumatic experiences are considered to have played a significant role in the development of chronic and progressively worsening psychopathological symptoms in later years.

In October 2022, amid a severe psychological crisis, she attempted suicide by jumping from the fifth floor of a building. As a result of this attempt, she sustained paraplegia. The combination of permanent physical disability and severe ongoing psychological distress led her to request euthanasia.

Her application was assessed by the competent health authorities in Catalonia within the legal framework governing assisted dying and was approved as meeting the required criteria. However, following a legal challenge filed by her father and a conservative legal advocacy group, the process was suspended by court decisions for approximately 601 days. Subsequent judicial review reaffirmed the legal validity of her request, and all legal barriers were removed. After the completion of all procedural requirements, Noelia Castillo Ramos died on 26 March 2026 at the age of 25 (El País 2026).

This case raises a number of analytically significant questions that intersect with the Islamic framework developed in the preceding sections. Noelia's trajectory—from childhood trauma and state neglect, through suicide attempt and acquired disability, to an approved euthanasia request—illustrates how systemic failures in care, protection, and relational support can become constitutive of the suffering that is later adjudicated as grounds for death. From an Islamic perspective, the absence of protective communal and familial structure at the most formative stages of her life represents precisely the rupture in relational obligation that Islam regards as a precondition for human flourishing. The case also foregrounds the complex entanglement of psychological and physical suffering: her paraplegia was itself the consequence of a suicide attempt, raising the question of whether the conditions that generated the desire for death were ever adequately addressed, or merely legally processed. A spiritually informed model of care would insist that this distinction is not merely procedural but profoundly moral.

Vignette 2: Shanti De Corte

Shanti De Corte was exposed to the Brussels Airport bombing at the age of 17. Although she did not sustain any physical injuries, the traumatic event led to the development of chronic and severe psychiatric conditions, including persistent depressive symptoms and recurrent panic attacks. In the subsequent years, she engaged in multiple suicide

attempts and reported profound emotional numbness, as well as limited relief from pharmacological interventions.

At the age of 23, De Corte requested and was granted euthanasia under Belgian law, following the approval of two psychiatrists. Her death in May 2022 prompted public and professional scrutiny, particularly regarding the adequacy and timing of the decision-making process. Although concerns were raised—most notably by a neurologist who argued that the decision may have been premature—subsequent legal review concluded that all procedural requirements had been met, and the case was officially closed without findings of misconduct (Bersani et al. 2022; New York Post 2022).

Several considerations are pertinent in this regard. First, De Corte's suffering, however genuine and clinically significant, does not constitute a legally cognizable ground for the termination of life within Islamic jurisprudence. As established above, neither physical nor psychological suffering—nor any other invoked rationale—generates a right to die, irrespective of its severity or chronicity. Second, the granting of euthanasia on the basis of psychiatric conditions raises acute concerns regarding the irremediability criterion: De Corte was twenty-three years of age at the time of her death, and the trajectory of her condition remained, by any clinically honest assessment, genuinely open. The objection raised by the neurologist who characterized the decision as premature resonates, in this respect, with the Islamic jurisprudential insistence that uncertainty over prognosis weighs decisively against any irreversible act. Third, and most fundamentally, the consent and explicit request of the patient—however voluntarily and consistently expressed—do not, within the Islamic legal framework, confer legitimacy upon the termination of life. As the classical juristic position on assisted killing demonstrates, neither the victim's solicitation nor the perpetrator's ostensibly compassionate intent extinguishes the legal and moral prohibition that governs such acts. Life, understood as a divine trust (amānah), remains beyond the reach of individual will, professional authorization, or procedural compliance.

Vignette 3: Geneviève Lhermitte

Geneviève Lhermitte, a Belgian woman, was convicted in 2007 for the premeditated killing of her five minor children and sentenced to life imprisonment. Although initial psychiatric evaluations raised questions regarding criminal responsibility due to potential mental illness, the court ultimately determined her to be criminally responsible. Prior to the offence, she had a documented history of psychiatric vulnerability, including outpatient psychiatric treatment beginning in 2005 and a subsequent diagnosis of puerperal depression in 2011. Following her conviction, she was transferred to a psychiatric facility under conditions of semi-liberty.

Within this context, her later request for euthanasia appears to have emerged from a state of profound and enduring psychological suffering, closely intertwined with persistent feelings of guilt and remorse related to her actions. In 2023, Lhermitte was granted euthanasia on the grounds of "irreversible psychological suffering" (Bersani et al. 2025). The Lhermitte case introduces a dimension absent from the preceding two vignettes: the relationship between moral guilt, legal punishment, and the medicalization of suffering. Her euthanasia was granted on grounds of "irreversible psychological suffering"—yet that suffering was inseparable from remorse for an act of extreme violence against her own children. From an Islamic legal perspective, this case invites careful reflection on the distinction between suffering that calls for healing and suffering that is bound up with moral accountability before God and community. Islamic thought does not regard guilt-induced suffering as a condition to be eliminated; it may, within the tradition's logic of tawbah (repentance) and divine mercy, constitute the very terrain on which spiritual restoration becomes possible.

5. Muslim Chaplaincy Within European Clinical and Legal Frameworks and Pragmatic Implications

Within European healthcare systems, Muslim chaplaincy has emerged as a vital interface between religious life and secular institutional ethics, collaborating with interdisciplinary teams and ethics committees that operate under the principles of autonomy, dignity, and equality. The increasing prevalence of euthanasia requests grounded in psychological suffering—as illustrated by cases such as that of Shanti De Corte—renders this interface not only practically significant but ethically urgent, particularly for Muslim patients navigating end-of-life decisions within legal frameworks that operate from fundamentally different anthropological premises than those of Islamic law. Migration, linguistic diversity, and cultural pluralism introduce layers of vulnerability, such as social isolation and miscommunication, rendering the chaplain not merely a spiritual caregiver but a cultural–theological mediator who interprets faith within the procedural and ethical constraints of modern medicine. Within these interdisciplinary structures, Islamic Practical Theology operates as a translational framework that converts faith concepts—such as tawakkul, amānah, and karāma—into actionable ethical language for healthcare teams. In practice, this mediation entails:

(a) Translating Islamic moral language—tawakkul, amānah, and karāma—into a discourse comprehensible to bioethical committees and institutional bodies; this includes articulating the Islamic conception of life as a divine trust (amānah) and the jurisprudential grounds upon which euthanasia—whether motivated by physical or psychological suffering—remains impermissible;
(b) Ensuring institutional access to ritual and spiritual resources, including designated spaces for prayer and recitation, accommodation for modesty, and the provision of halal nutrition;
(c) Establishing interprofessional referral pathways linking chaplaincy, psychiatry, social work, and community organizations with particular attention to cases in which patients express a desire for death or formally request euthanasia.

Within this context, Islamic Practical Theology (IPT) operates as a form of public theology, transforming lived religion into an instrument of institutional cooperation that balances confessional integrity with pluralistic accountability. This hybrid model—integrating ritual care, ethical advocacy, and spiritually grounded counseling—clarifies professional boundaries within clinical teams and enhances the moral coherence of care for Muslim patients (Long and Ansari 2018). Empirical evidence further demonstrates that generic interfaith paradigms often fail to address faith-specific requirements, including gender-sensitive encounters, ritual observances at birth and death, and the ethical exemptions related to fasting. Muslim chaplains respond by offering Qur'anic recitation, reframing illness as a process of spiritual purification or jihad al-nafs (inner striving) and advocating for equitable treatment within institutional systems. This reframing is of particular significance in the context of psychiatric suffering: as the preceding analysis has demonstrated, Islamic jurisprudence does not construe psychological distress—however severe or chronic—as a ground for terminating life, but rather as an experience that carries moral and spiritual significance, susceptible to alleviation through lawful and compassionate means. The chaplain's role, in this respect, is to embody and communicate this alternative horizon of meaning within clinical settings that may otherwise reduce the patient's condition to a diagnostic category amenable to euthanasia. Their presence not only mitigates implicit bias and fosters interreligious literacy among staff but also embodies a dialogical theology of care—one that integrates clinical professionalism with the spiritual anthropology of Islam (Abu-Ras and Laird 2011).

The findings of this study demonstrate that euthanasia requests cannot be understood solely through clinical diagnosis, legal criteria, or individual autonomy. As established in the preceding sections, the Islamic legal framework—grounded in the prohibition of suicide (qatl al-nafs), the doctrine of life as divine trust, and the classical juristic positions on assisted killing—categorically resists any reduction in such requests to individual preference or clinical irremediability. Because such requests are deeply intertwined with the spiritual, relational, and existential dimensions of human life, clinical and legal approaches must be complemented by frameworks that acknowledge these additional layers of meaning. In this context, three practical domains require attention: (1) spiritual care and ritual resources, (2) education and training, and (3) interdisciplinary clinical cooperation.

Spiritual care and ritual practices, such as prayer, Qur'ān recitation, dhikr, supplication, and shared silence, can serve as therapeutic resources that cultivate hope, resilience, and meaning-making for patients in crisis. Within the Islamic tradition, suffering—whether physical or psychological—is interpreted not as an unqualified evil to be eliminated, but as a multidimensional experience encompassing patience (ṣabr), divine trial (ibtilāʾ), and spiritual purification (tazkiyah); it is precisely this reinterpretive capacity that spiritual care practices seek to mobilize. Clinical teams should remain attentive to these lived religious practices and facilitate access to spiritual care whenever appropriate. In parallel, healthcare professionals—including chaplains, psychiatrists, clinical psychologists, nurses, social workers, and legal actors—should receive training in crisis communication, ethical reasoning, and the religious–existential dimensions of suffering. Muslim spiritual care providers, in particular, need to be equipped with up-to-date knowledge of mental disorders, clinical guidelines, and relevant legal frameworks— including the euthanasia legislation operative in their respective jurisdictions—so as to engage meaningfully and critically with institutional decision-making processes on behalf of Muslim patients. Addressing end-of-life issues effectively also requires genuine interdisciplinary cooperation. Psychology, spiritual care, medical ethics, Islamic law, sociology, and related social sciences must contribute in a coordinated manner to ensure that clinical, ethical, and legal dimensions are considered as an integrated whole. Families should be actively involved, with careful attention to existential, relational, and religious needs, while respecting individual autonomy. It bears emphasizing, however, that within the Islamic framework, autonomy is not conceived as an unrestricted right but as the exercise of free will within the boundaries of moral and divine responsibility—a conception that reframes human freedom not as the right to end life, but as the obligation to preserve it in accordance with divine trust. This approach emphasizes a relational and context-sensitive model of care over reductive, individualistic decision-making and fosters the development of ethically coherent, informed, and culturally responsive interventions at both institutional and societal levels.

Ultimately, any ethically responsible approach to euthanasia requests rooted in psychological suffering must be guided by a holistic anthropology that affirms life as a divine trust and human dignity (karāma) as inviolable. When legal and clinical practices ignore the spiritual and relational dimensions of suffering, the patient is reduced to an isolated decision-maker, severed from faith, belonging, and transcendence. A model shaped by the Islamic ethos of mercy (raḥma), hope (rajāʾ), and steadfast perseverance (ṣabr)—supported through interdisciplinary cooperation, ritual accompaniment, and compassionate care—offers a more humane and meaningful horizon of response.

6. Conclusions

Euthanasia requests among individuals with mental disorders have increasingly become a subject of sustained debate within contemporary psychiatry, clinical psychology and bioethical scholarship, emerging as a conceptually contested and normatively com-

plex domain. In this context, the present study examines euthanasia requests arising in the context of mental disorders and analyses how such claims are interpreted within Islamic legal frameworks. Similar to somatic conditions, euthanasia requests grounded in psychological suffering are predominantly justified on the basis of two criteria: "unbearable suffering" and "medically intractable illness." Indeed, in certain jurisdictions, a limited number of cases meeting these criteria have reportedly been approved and implemented. However, the application of these criteria in psychiatric contexts introduces substantial epistemic and clinical uncertainties.

The criteria used to define psychological suffering as "unbearable" are not based on objective, measurable, or standardised indicators comparable to those in somatic medicine. Likewise, the classification of a mental disorder as "untreatable" is not a stable diagnostic category, but rather a dynamic clinical judgment shaped by heterogeneity in treatment response, variability in disease trajectories, and context-dependent assessment processes. In psychiatric practice, the widespread availability and application of pharmacotherapy, psychotherapy, and multimodal psychosocial interventions, alongside demonstrated potential for clinically meaningful improvement across a broad range of disorders, suggest that claims of "treatment resistance" often reflect incomplete, suboptimal, or prematurely terminated therapeutic processes rather than definitive clinical futility.

Euthanasia arguments are predominantly grounded in the principle of individual autonomy, understood as the sovereign capacity of individuals to determine the conditions and termination of their existence. In contrast, Islamic law conceptualizes autonomy not as absolute sovereignty, but as a constrained and relational form of agency embedded within moral accountability and divine will. Accordingly, ultimate authority over life and death is not attributed to individual volition, but to divine sovereignty. In addition, decisional capacity and autonomy in psychiatric populations constitute a critical area of ethical and clinical concern. In severe mental disorders, particularly major depressive disorder, impairments in cognitive functioning, concentration difficulties, pervasive hopelessness, and marked disturbances in decision-making processes are frequently observed. These features further problematize whether euthanasia decisions can genuinely be regarded as expressions of free, informed, and fully autonomous agency.

From an Islamic law perspective, life is not conceptualized as an object of absolute individual ownership, but rather as a divinely entrusted reality (amānah). Within this framework, suffering, illness, and psychological suffering are not merely pathological states to be eliminated, but are understood as part of a divinely ordained process of trial (ibtilāʾ), in which patience (ṣabr) and submission (taslīm) constitute central moral responses. Accordingly, suffering does not, in itself, provide a sufficient justification for the termination of life; rather, endurance under such conditions is construed as a constitutive dimension of moral and existential meaning-making.

In conclusion, euthanasia requests among individuals with mental disorders constitute a multidimensional ethical, clinical, and epistemological problem space that cannot be reduced to individual experiences of suffering and autonomy alone. Rather, they emerge at the intersection of structural limitations in psychiatric knowledge production, persistent uncertainties in the assessment of decisional capacity and treatment refractoriness, and divergent ontological commitments within Islamic thought and liberal bioethical theory. Cases such as that of Shanti De Corte illustrate with particular force how procedural compliance within secular legal frameworks—however rigorously observed—cannot substitute for the deeper anthropological and jurisprudential questions that such requests inevitably raise. Within this configuration, Islamic law—grounded in the categorical prohibition of suicide, the classical juristic doctrine on complicity in killing, and the foundational conception of life as a divine trust (amānah) held beyond the reach of individual will, pro-

fessional authorization, or procedural compliance—by foregrounding the entrusted nature of life and the trial-based structure of suffering (ibtilāʾ) maintains that psychological distress alone, nor any other invoked rationale, however compelling within a secular bioethical framework, cannot and does not constitute sufficient legal or normative justification for the termination of life. This position is not reducible to a mere moral preference: as the preceding analysis has demonstrated, it is anchored in binding jurisprudential rules—most notably the impermissibility of hastening death even under conditions of inescapable mortal inevitability—whose logical force extends, by analogy, to the domain of psychological suffering.

At the same time, the increasing clinical complexity of mental disorders and the evolving ethical pluralism surrounding end-of-life decision-making underscore the need for continuous interdisciplinary re-evaluation in which Muslim chaplains, Islamic legal scholars, psychiatrists, clinical psychologists, and institutional ethics committees engage in structured and sustained dialogue. The multidimensional model of care outlined in this study—integrating spiritual care and ritual accompaniment (ṣabr, rajāʾ, raḥma), robust interdisciplinary cooperation, and a relational anthropology grounded in the inviolability of human dignity (karāma)—represents one such model: one that affirms the moral urgency of alleviating suffering through lawful and compassionate means while categorically resisting its instrumentalization as a justification for the termination of life. Ultimately, this debate should not be understood as a static opposition between irreconcilable moral systems, but as an evolving field of inquiry in which epistemic limits, clinical ambiguity, and normative plurality co-produce an inherently unsettled yet analytically productive space for future scholarship and policy development—a space in which the Islamic legal tradition has not only a legitimate but an indispensable voice.

7. Limitations and Future Directions

This study adopts an interpretive–normative framework situated at the intersection of Islamic jurisprudence, bioethics, and psychology. The analysis is based on a hermeneutic approach employing iterative interpretive reading and intertextual comparison of classical Islamic legal texts and selected contemporary bioethical discussions addressing end-of-life ethics. In line with this methodological orientation, the study does not claim empirical generalizability; rather, it seeks to generate analytical and context-sensitive transferability within an interdisciplinary framework.

The primary limitation of the study is the absence of empirical data, which constrains the direct examination of lived experiences and clinical decision-making processes associated with euthanasia requests among psychiatric patients. Case illustrations, such as that of Shanti De Corte, a widely documented contemporary clinical case discussed in the medical and bioethical literature, are employed exclusively as conceptual exemplars and do not allow for empirical generalization; their inclusion is intended solely to demonstrate how normative arguments derived from Islamic law may be applied to concrete clinical contexts and should not be interpreted as constituting clinical or legal evaluations of the cases discussed. In addition, decision-making capacity was not operationalized through structured clinical assessment frameworks or standardized diagnostic instruments, due to the conceptual and non-empirical nature of the study. Consequently, the study does not advance a clinically applicable decision-making model; instead, it proposes a conceptual and ethical analytical framework designed to inform scholarly reflection and interdisciplinary bioethical deliberation rather than clinical practice.

Additionally, a significant gap in the literature concerns the marked lack of empirical evidence on whether Muslim individuals with mental disorders seek euthanasia through formal medical channels in a manner comparable to that observed in secular European

contexts, particularly in countries such as Belgium and the Netherlands where physician-assisted dying is legally regulated. At present, there is insufficient empirical basis to determine whether similar patterns of euthanasia requests exist among Muslim populations, either in minority settings within Europe or in Muslim-majority societies. Religious prohibitions concerning suicide, varying levels of trust in secular healthcare systems, culturally embedded understandings of suffering, and reliance on religious coping strategies may all shape how psychological distress and end-of-life wishes are expressed, suggesting that suicidality and end-of-life decision-making may not be directly comparable across cultural and religious contexts. Consequently, robust cross-cultural empirical research is required to establish whether Muslim patients exhibit comparable patterns of euthanasia-related requests or whether fundamentally distinct sociocultural and religious frameworks shape end-of-life decision-making. This lacuna further underscores the methodological limitations of extrapolating findings derived from predominantly European regulatory and clinical settings to culturally and religiously heterogeneous populations, particularly those embedded within Islamic moral and legal worldviews.

This study adopts a deliberate methodological approach with respect to intra-Islamic jurisprudential plurality. The analysis primarily draws upon the positions of the four major Sunni legal schools (Ḥanafī, Shāfiʿī, Mālikī, and Ḥanbalī), presenting their views through authoritative works possessing high representative status within each respective tradition. The selection of sources has been guided by the principle of doctrinal centrality, privileging classical texts that embody the mature jurisprudential reasoning of each school over more peripheral or idiosyncratic opinions. The absence of detailed engagement with modern scholars represents a principled methodological commitment rather than an oversight: the primary objective of this study is to establish the classical Islamic legal framework on euthanasia and suffering, grounding contemporary debates in the foundational doctrinal architecture from which all subsequent interpretations must necessarily derive. This approach reflects the conviction that any responsible engagement with modern Islamic bioethical thought requires prior clarity regarding the classical positions upon which such thought builds, critiques, or departs. Future research may productively extend this foundation by incorporating modern juristic perspectives, examining how contemporary Muslim scholars navigate the tension between received doctrine and novel biomedical contexts, and exploring the diverse hermeneutical strategies employed in applying classical principles to psychiatric euthanasia.

The reliance on predominantly Eurocentric bioethical literature also limits the transferability of the findings to diverse Muslim sociocultural and legal contexts. Moreover, the temporal dynamics of euthanasia decision-making and its multi-actor structure (patients, families, clinical teams, and ethics committees) have only partially been integrated into the analytical framework. The roles of Muslim psychologists, psychiatrists and chaplains, Islamic legal scholars, and interdisciplinary ethics committees in decision-making processes have been addressed at a conceptual level; however, the institutional functioning of these actors in clinical practice has not been empirically examined. This results in a limited representation of the relational and systemic nature of decision-making processes. These limitations collectively indicate a structural epistemic divergence between Islamic normative theology jurisprudence, psychiatry, clinical psychology and contemporary bioethics.

Nevertheless, the study offers an integrative interpretive framework that brings these domains into a unified analytical structure in the context of euthanasia. This framework addresses a gap in the literature by integrating Islamic jurisprudential reasoning with ethical decision-making in mental health care within euthanasia contexts, thereby offering a unified analytical model. In doing so, it contributes conceptually to the integration of previously fragmented discussions across Islamic legal thought, clinical ethics, and psy-

chiatric decision-making literature. Future research should adopt multi-center, empirical, and mixed-method designs. The integration of qualitative fieldwork with structured clinical assessment instruments would enhance both external validity and contextual sensitivity. Within this context, the relevant concept should be understood as a non-clinical, non-diagnostic construct situated within an exploratory and theoretical framework, and should be further examined through future empirical validation studies.

Finally, strengthening interdisciplinary integration between Islamic psychology and bioethics would facilitate the development of culturally sensitive and clinically applicable evaluative frameworks. Comparative studies conducted across diverse Muslim-majority sociocultural and legal settings would further enhance the analytical transferability of findings by capturing cultural, legal, and institutional variability. Within this agenda, the empirical testing of the normative inferences derived—through analogical reasoning— from classical jurisprudential discussions on physical suffering and extended to cases of psychological distress represents a particularly pressing research priority deserving of dedicated scholarly attention.

Author Contributions: Conceptualization, T.E.B.; methodology, T.E.B. and R.E.Ç.; validation, T.E.B. and R.E.Ç.; formal analysis, T.E.B. and R.E.Ç.; investigation, T.E.B. and R.E.Ç.; resources, T.E.B. and R.E.Ç.; writing—original draft preparation, T.E.B.; writing—review and editing, T.E.B. and R.E.Ç. All authors have read and agreed to the published version of the manuscript.

Funding: This research received no external funding.

Institutional Review Board Statement: Not applicable.

Informed Consent Statement: Not applicable.

Data Availability Statement: No new data were created or analyzed in this study. Data sharing is not applicable to this article.

Acknowledgments: Artificial intelligence-assisted language tools were utilized for the purposes of translation and linguistic refinement from Turkish into English.

Conflicts of Interest: The authors declare no conflicts of interest.

References

Abu-Ras, Wahiba, and Lance Laird. 2011. How Muslim and non-Muslim chaplains serve Muslim patients: Does the interfaith chaplaincy model have room for Muslims' experiences? *Journal of Religion and Health* 50: 46–61. [CrossRef]

Alfano, Candice A., Golda S. Ginsburg, and Julie Newman Kingery. 2007. Sleep-related problems among children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry* 46: 224–32. [CrossRef] [PubMed]

American Psychiatric Association. 2013. *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. Arlington: American Psychiatric Publishing.

Appelbaum, Paul S. 2017. Should mental disorders be a basis for physician-assisted death? *Psychiatric Services* 68: 315–17. [CrossRef]

Ālūsī, Abū al-Sanā Shahāb al-Dīn Maḥmūd b. ʿAbdullāh b. Maḥmūd. 1999. *Rūḥ al-maʿānī*. Beirut: Dār al-Kutub al-'Ilmiyya, vol. 5.

Āmidī, Abū al-Ḥasan Sayf al-Dīn 'Alī b. Muḥammad b. Sālim. 1914. *Al-Iḥkām Fī Uṣūl al-Aḥkām*. Cairo: Dār al-Kutub al-Ḥidawiyya.

Beck, Judith S. 2020. *Cognitive Behavior Therapy: Basics and Beyond*. New York: Guilford Publications.

Bersani, Giuseppe, Angela Iannitelli, Pascual Pimpinella, Francesco Sessa, Monica Salerno, Mario Chisari, and Raffaella Rinaldi. 2025. Euthanasia in mental disorders: Clinical and ethical issues in the cases of two women suffering from depression. *Healthcare* 13: 2019. [CrossRef] [PubMed]

Bersani, Giuseppe, Raffaella Rinaldi, and Angela Iannitelli. 2022. The Shanti De Corte case. Euthanasia for mental disorder between clinic and bioethics, between law and medico-legal implications. *Rivista di Psichiatria* 57: 303–7. [CrossRef] [PubMed]

Boehm, Julia K., and Sonja Lyubomirsky. 2008. Does happiness promote health? *Psychological Bulletin* 134: 949–79. [CrossRef]

Bukhārī, ʿAbd al-ʿAzīz ʿAlā al-Dīn ʿAbd al-ʿAzīz b. Aḥmad b. Muḥammad. 2000. *Ṣaḥīḥ al-Bukhārī*. Beirut: Dār al-Ma'rifa.

Burgess, Sally, and Keith Hawton. 1998. Suicide, euthanasia, and the psychiatrist. *Philosophy, Psychiatry, & Psychology* 5: 113–26.

Carlson, Gabrielle A., and Dennis P. Cantwell. 1982. Suicidal behavior and depression in children and adolescents. *Journal of the American Academy of child Psychiatry* 21: 361–68. [CrossRef]

Cassell, Eric J. 1998. The nature of suffering and the goals of medicine. *Loss, Grief & Care* 8: 129–42.

Claes, Stephan, Ludi Vanbouwel, An Haekens, Marc Eneman, Georges Otte, Jan De Lepeleire, Marc Calmeyn, Ariane Bazane, and Willem Lemmens. 2015. Euthanasia for psychiatric patients: Ethical and legal concerns about the Belgian practice. *BMJ Open* 5: e007454.

Conejero, Ismael, Emilie Olié, Raffaella Calati, Déborah Ducasse, and Philippe Courtet. 2018. Psychological pain, depression, and suicide: Recent evidences and future directions. *Current Psychiatry Reports* 20: 33. [CrossRef] [PubMed]

Dees, Marianne, Myrra Vernooij-Dassen, Wim Dekkers, and Chris van Weel. 2010. Unbearable suffering of patients with a request for euthanasia or physician-assisted suicide: An integrative review. *Psycho-Oncology* 19: 339–52.

De Hert, Marc, Liesbet Van Bos, Kim Sweers, Martien Wampers, Jan De Lepeleire, and Christophe U. Correll. 2015. Attitudes of psychiatric nurses about the request for euthanasia on the basis of unbearable mental suffering (UMS). *PLoS ONE* 10: e0144749. [CrossRef]

Denys, Damiaan. 2018. Is euthanasia psychiatric treatment? The struggle with death on request in The Netherlands. *American Journal of Psychiatry* 175: 822–23. [CrossRef]

Deschepper, Reginald, Wim Distelmans, and Johan Bilsen. 2014. Requests for euthanasia/physician-assisted suicide on the basis of mental suffering: Vulnerable patients or vulnerable physicians? *JAMA Psychiatry* 71: 617–18. [CrossRef] [PubMed]

Dierickx, Sigrid, Luc Deliens, Joachim Cohen, and Kenneth Chambaere. 2017. Euthanasia for people with psychiatric disorders or dementia in Belgium: Analysis of officially reported cases. *BMC Psychiatry* 17: 203. [CrossRef]

El País. 2026. Noelia Castillo, the Young Woman Who Fought Her Parents for Her Right to Die: "I Can't Take This Family Anymore". Available online: https://english.elpais.com/international/2026-03-26/noelia-castillo-the-young-woman-who-fought-her-parents-for-her-right-to-die-i-cant-take-this-family-anymore.html (accessed on 26 March 2026).

Erkoç Baydar, Tuba. 2021. *Bu Can Kimin: Ötanazi ve Tedavinin Sonlandırmasına Müslümanca Bakış*. Istanbul: İz Yayıncılık.

Erkoç Baydar, Tuba, and İlhan İlkılıç. 2022. Suffering in the Islamic tradition and its meaning for intercultural medical ethics. In *Suffering in Theology and Medical Ethics*. Paderborn: Brill Schöning.

Essau, Cecilia A., Peter M. Lewinsohn, Beatriz Olaya, and John R. Seeley. 2014. Anxiety disorders in adolescents and psychosocial outcomes at age 30. *Journal of Affective Disorders* 163: 125–32. [CrossRef]

Evenblij, Kirsten, H. Roeline W. Pasman, Rosalie Pronk, and Bregje D. Onwuteaka-Philipsen. 2019. Euthanasia and physician-assisted suicide in patients suffering from psychiatric disorders: A cross-sectional study exploring the experiences of Dutch psychiatrists. *BMC Psychiatry* 19: 74. [CrossRef] [PubMed]

Fergusson, David M., Geraldine F. H. McLeod, L. John Horwood, Nigel R. Swain, Simon Chapple, and Richie Poulton. 2015. Life satisfaction and mental health problems (18 to 35 years). *Psychological Medicine* 45: 2427–36. [CrossRef]

Ghaly, Mohammed, ed. 2023. *End-of-Life Care, Dying and Death in the Islamic Moral Tradition*. Boston: Brill.

Ghazālī, Muhammad b. Muhammad. 1988. *Al-Mustasfā*. Beirut: Dār al-Kutub al-'Ilmiyya.

Ghazālī, Muhammad b. Muhammad. 1997. *Al-Wasīṭ fī al-madhhab*. Edited by Aḥmad Maḥmūd Ibrāhīm and Muḥammad Muḥammad Tamīr. Cairo: Dār al-Salām.

Grassi, Luigi, Federica Folesani, Marco Marella, Elisa Tiberto, Michelle B. Riba, Lisa Bortolotti, Tommaso Toffanin, Laura Palagini, Martino Belvederi Murri, Bruno Biancosino, and et al. 2022. Debating euthanasia and physician-assisted death in people with psychiatric disorders. *Current Psychiatry Reports* 24: 325–35. [CrossRef]

Groenewoud, Johanna H., Paul J. van der Maas, Gerrit van der Wal, Michiel W. Hengeveld, Alfons J. Tholen, Willem J. Schudel, and Agnes van der Heide. 1997. Physician-assisted death in psychiatric practice in the Netherlands. *New England Journal of Medicine* 336: 1795–801. [CrossRef]

Ibn ʿĀbidīn, Muḥammad Amīn b. ʿUmar b. ʿAbd al-ʿAzīz al-Ḥusaynī. 1994. *Radd al-Mukhtār ʿalā al-Durr al-Mukhtār*. Edited by ʿĀdil Aḥmad ʿAbd al-Mawjūd and ʿAlī Muḥammad Muʿawwiz. Beirut: Dār al-Kutub al-ʿIlmiyya.

Jackson, Emiily, and John Keown. 2012. *Debating Euthanasia*. Oxford and Portland: Hart Publishing.

Jassās, Aḥmad ibn ʿAlī al-Rāzī. 1996. *Aḥkām al-Qurʾān*. Edited by Muḥammad al-Sādiq al-Kamhawī. Beirut: Dār Iḥyāʾ al-Turāth al-ʿArabī.

Kammeraat, Monique, Geeske van Rooijen, Lisette Kuijper, Julian D. Kiverstein, and Damiaan A. J. P. Denys. 2023. Patients requesting and receiving euthanasia for psychiatric disorders in The Netherlands. *BMJ Mental Health* 26: 1–8. [CrossRef]

Kelly, Brendan D., and Declan M. McLoughlin. 2002. Euthanasia, assisted suicide and psychiatry: A Pandora's box. *The* British Journal of Psychiatry 181: 278–79. [CrossRef]

Kim, Scott Y. H., and Trudo Lemmens. 2016. Should assisted dying for psychiatric disorders be legalized in Canada? *Cmaj* 188: E337–39. [CrossRef]

Lieb, Klaus, Mary C Zanarini, Christian Schmahl, Marsha M. Linehan, and Martin Bohus. 2004. Borderline personality disorder. *The Lancet* 364: 453–61. [CrossRef]

Long, Ibrahim, and Bilal Ansari. 2018. Islamic pastoral care and the development of Muslim chaplaincy. *Journal of Muslim Mental Health* 12. [CrossRef]

Maier, Steven, and Martin E. Seligman. 1976. Learned helplessness: Theory and evidence. *Journal of Experimental Psychology: General* 105: 3. [CrossRef]

Mazzone, Luigi, Francesca Ducci, Maria Cristina Scoto, Eleonora Passaniti, Valentina Genitori D'Arrigo, and Benedetto Vitiello. 2007. The role of anxiety symptoms in school performance in a community sample of children and adolescents. *BMC Public Health 7*, 1–6. [CrossRef] [PubMed]

Māturīdī, Abū Manṣūr Muḥammad b. Muḥammad. 2003. *Kitāb al-tawḥīd*. Edited by Muḥammad Aruçi. Ankara: TDV Publications.

Māturīdī, Abū Manṣūr Muḥammad b. Muḥammad. 2007. *Ta'wīlāt al-Qur'ān*. Ankara: TDV Publications.

Māwardī, Abū'l-Ḥasan ʿAlī b. Muḥammad b. Ḥabīb. 1994. *al-Ḥāwī al-Kabīr*. Edited by ʿAlī Muḥammad Muʿawwaḍ and ʿĀdil Aḥmad ʿAbd al-Mawjūd. Beirut: Dār al-Kutub al-ʿIlmiyya.

Myers, David G., and Ed Diener. 1995. Who is happy? *Psychological Science* 6: 10–19. [CrossRef]

Naudts, Kris, Caroline Ducatelle, Jozsef Kovacs, Kristin Laurens, Frederique Van Den Eynde, and Cornelis Van Heeringen. 2006. Euthanasia: The role of the psychiatrist. *The British Journal of Psychiatry* 188: 405–9. [CrossRef] [PubMed]

New York Post. 2022. Brussels Bombing Survivor Shanti De Corte, 23, Euthanasia. *New York Post*, October 8. Available online: https://nypost.com/2022/10/08/brussels-bombing-survivor-shanti-de-corte-23-dead-by-euthanasia (accessed on 8 October 2022).

Nicolini, Marie E., EJ Jardas, Carlos A. Zarate, Chris Gastmans, and Scott Y. H. Kim. 2023. Irremediability in psychiatric euthanasia: Examining the objective standard. *Psychological Medicine* 53: 5729–47. [CrossRef]

Olié, Emilie, and Philippe Courtet. 2016. Euthanasia or assisted suicide in patients with psychiatric illness—Reply. *JAMA* 316: 2154–55. [CrossRef] [PubMed]

Petersen, Anne C., Bruce E. Compas, Jeanne Brooks-Gunn, Mark Stemmler, Sydney Ey, and Kathryn E. Grant. 1993. Depression in adolescence. *American Psychologist* 48: 155–68. [CrossRef] [PubMed]

Pompili, Maurizio, Paolo Girardi, Amedeo Ruberto, and Roberto Tatarelli. 2005. Suicide in borderline personality disorder: A meta-analysis. *Nordic Journal of Psychiatry* 59: 319–24. [CrossRef]

Ramos-Pozón, Sergio, Núria Terribas-Sala, Anna Falcó-Pegueroles, and Begoña Román-Maestre. 2023. Persons with mental disorders and assisted dying practices in Spain: An overview. *International Journal of Law and Psychiatry* 87: 101871. [CrossRef] [PubMed]

Raus, Kasper, and Sigrid Sterckx. 2015. Euthanasia for mental suffering. In *New Directions in the Ethics of Assisted Suicide and Euthanasia*. Cham: Springer International Publishing. [CrossRef]

Ryan, Neal D., Joaquim Puig-Antich, Paul Ambrosini, Harris Rabinovich, Delbert Robinson, Beverly Nelson, Satish Iyengar, and Jan Twomey. 1987. The clinical picture of major depression in children and adolescents. *Archives of General Psychiatry* 44: 854–61. [CrossRef]

Sachedina, Abdulaziz. 2009. *Islamic Biomedical Ethics: Principles and Application*. Oxford and New York: Oxford University Press.

Sarakhsī, Shams al-Imām Abū Sahl Abū Bakr Muḥammad b. Aḥmad. 1971. *Sharḥ al-Siyar al-Kabīr*. Edited by ʿAbd al-ʿAzīz Aḥmad. Cairo: Jāmiʿat al-Duwal al-'Arabiyya.

Sarakhsī, Shams al-Imām Abū Sahl Abū Bakr Muḥammad b. Aḥmad. 1982. *Al-Mabsūṭ*. Istanbul: Çağrı Yayınları.

Sarrāj al-Tūsī, Abū Naṣr. 1996. *al-Lumāʿ*. Translated by Ḥasan Kāmil Yılmaz. Istanbul: Altınoluk.

Shabana, Ayman. 2023. Limits to personal autonomy in Islamic bioethical deliberations on end-of-life issues in light of the debate on euthanasia. In *End-of-Life Care, Dying and Death in the Islamic Moral Tradition*. Edited by Mohammed Ghaly. Boston: Brill.

Southwick, S. M. 2014. *Resilience: The Science of Mastering Life's Greatest Challenges*, 2nd ed. Cambridge: Cambridge University Press.

Thienpont, Lieve, Monica Verhofstadt, Tony Van Loon, Wim Distelmans, Kurt Audenaert, and Peter P. De Deyn. 2015. Euthanasia requests, procedures and outcomes for 100 Belgian patients suffering from psychiatric disorders: A retrospective, descriptive study. *BMJ Open* 5: e007454. [CrossRef]

Thompson, Neil, and Mary Walsh. 2010. The existential basis of trauma. *Journal of Social Work Practice* 24: 377–89. [CrossRef]

Tirmidhī, Muḥammad ibn ʿĪsā. 2001. *Sunan al-Tirmidhī, Zühd, 57*. Beirut: Dār al-Kutub al-'Ilmiyya.

Vergallo, Gianluca M., Matteo Gulino, Giuseppe Bersani, and Raffaella Rinaldi. 2020. Euthanasia and physician-assisted suicide for patients with depression: Thought-provoking remarks. *Rivista di Psichiatria* 55: 119–28.

Verhofstadt, Monica, Kurt Audenaert, Kris Van den Broeck, Luc Deliens, Freddy Mortier, Koen Titeca, Dirk De Bacquer, and Kenneth Chambaere. 2021. Euthanasia in adults with psychiatric conditions: A descriptive study of the experiences of Belgian psychiatrists. *Science Progress* 104: 00368504211029775. [CrossRef]

Verhofstadt, Monica, Lieve Thienpont, and Gjalt-Jorn Ygram Peters. 2017. When unbearable suffering incites psychiatric patients to request euthanasia: Qualitative study. *The British Journal of Psychiatry* 211: 238–45. [CrossRef] [PubMed]

Wagner, Barry M. 1997. Family risk factors for child and adolescent suicidal behavior. *Psychological Bulletin* 121: 246–98. [CrossRef] [PubMed]

Woodward, Lianne J., and David M. Fergusson. 2001. Life course outcomes of young people with anxiety disorders in adolescence. *Journal of the American Academy of Child & Adolescent Psychiatry* 40: 1086–93. [CrossRef] [PubMed]
Zamakhsharī. 1947. *Al-Kashshāf ʿan Ḥaqāʾiq*. Lebanon: Dār al-Maʿrifa.