Factors Influencing Attitudes toward Euthanasia

by

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ABSTRACT

Over recent decades, euthanasia has been a topic of increasing debate. With legalization of euthanasia in the states of Oregon and Washington and attempted reform in several other U.S. states and nations worldwide, it has become increasingly important to understand the roles and values of helping professionals who might be working with clients considering this option. The current study targeted 85 undergraduate students, 54 doctoral students in counseling psychology, and 53 doctoral-level professionals in psychology to assess both their personal values regarding euthanasia and their willingness to allow a client the autonomy to make a decision about euthanasia. Several factors were analyzed in regards to their relation to client autonomy and attitudes toward euthanasia, including age of client and sex of client. These variables were manipulated in vignettes to create four scenarios: a 24 year old male, 24 year old female, 80 year old male, 80 year old female. Other factors included level of education of the participant, spirituality and strength of religiosity of the participant, and personal experiences with deaths of friends or family members. Results indicated that more education was associated with greater support for euthanasia and that stronger religiosity and spirituality were related to less support for euthanasia. This study also found that participants did not exhibit differential levels of support based solely on the age or the sex of the client depicted in the vignette. Results further indicated that for doctoral students and professionals the loss of a loved one, regardless of cause of death, did not have a significant effect on their attitudes toward euthanasia. It is important for training programs to be aware of these findings in order to monitor trainees in terms of personal biases in the therapy relationship. With objectivity a high priority while working with

clients, it is necessary to be aware of outside factors potentially influencing one's work with clients surrounding this value-laden issue.

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The Problem in Perspective

Few topics can be considered as controversial as those that surround life and death. In particular, euthanasia is an extremely value-laden topic in that its focus is on an individual making his or her own end-of-life decision. This situation becomes increasingly precarious when individuals seek out various helping professionals, be they doctors, nurses, or psychologists, to aid them in this decision-making process. It is important that the focus of the decision-making process remain on the client and be as minimally influenced by the professional as possible. With objectivity on behalf of the helping professional of most importance, the current study analyzed several factors believed to be related to individuals' attitudes toward euthanasia and acceptance of client autonomy.

Helping professionals must be careful not impose their values onto their clients or allow these values to leak into the counseling relationship (Koocher & Keith-Spiegel, 2008). Laungani (2002) described being neutral and objective as "the hallmark of a professional counselor" (p. 109). It is the lack of bias and judgment about the client that allows the client to speak freely about his or her concerns, without fear of retaliation. However, Laungani also claimed that, despite best efforts, it is impossible for counselors to free themselves completely from natural human tendencies of first impressions, judgments, and biases. Instead, he proposed that the counselor aim to heighten his or her own awareness of the characteristics and values that he or she brings to the therapeutic relationship and to use them as assumptions or working hypotheses in the relationship.

Laungani's claim is that this would be a much more open, honest, and fair approach to the client, rather than pretending there are no reactions to the information being shared.

Despite potentially varying opinions on how helping professionals should approach work with clients, the American Psychological Association (APA) has established guidelines for objective behavior. As stated in APA's Ethical Principles for Psychologists and Code of Conduct (APA, 2002), psychologists should:

> evaluate how their personal experiences, attitudes, values, social context, individual differences, stresses, and specific training influence their activities and thinking, integrating this awareness into all attempts to be objective and unbiased in their research, service, and other activities.

It is imperative that helping professionals do not have clouded judgment when it comes to working with clients, especially in value-rich topic areas such as suicide and euthanasia that are being examined here. This standard encompasses all areas of practice (research, service, etc.). The current study, however, focused on evaluating the extent to which personal experiences, attitudes, and values of a therapist might influence the decision-making process of a client.

As Werth (1999) explained in his paper analyzing professional practice guidelines and ethical obligations, it is the continuous duty of the counselor to self-examine his or her own values and to evaluate if and how those values might be affecting work with a particular client. In any instance, but especially in cases where a client is contemplating active euthanasia, the only values that matter are those of the client. It is the role of the counselor to help the client through this decision-making process by making sure that

courses of action are in line with the client's values, not the counselor's. In this way, it is obligatory that a counselor seek professional consultation or supervision if he or she is concerned that personal values are influencing the counseling relationship and, therefore, the client's decision-making process. Werth continued by stating that if such professional guidance is insufficient to clear any biases that may be operating, it is the obligation of the therapist to refer the client to another professional who might be able to fulfill that role better.

Historical Perspective on Euthanasia

Active euthanasia, defined as "causing the death of a person through a direct action, in response to a request from that person" (Legal Dictionary, 2009), enjoys limited legalization. Currently, Switzerland, Belgium, and the Netherlands are the only nations whose laws allow for such an act to take place (Humphry, 2005). Several other nations, such as Finland, Germany, France, Denmark, Luxembourg, and Uruguay, have no specific anti-euthanasia regulations, meaning those assisting others in death might be punished under less harsh laws. Nations such as France and Italy have been at the forefront of seeing activist groups working toward legalization of active euthanasia. The Northern Territory of Australia has experienced the most change as a result of right-to-die movements, as it legalized voluntary euthanasia and assisted suicide in 1997. This only lasted for seven months, however, as the Federal Parliament later repealed the ruling. South Australia has also experienced strong movements in favor of legalization but thus far to no avail (Humphry, 2005).

In the United States, the state of Oregon legalized euthanasia in 1997 (Humphry,

2005), while the state of Washington passed a similar act in 2008 (Callahan, 2008). Despite Oregon and Washington currently being the only two states in the United States with an accepting position on euthanasia, many other states have activist groups advocating for legalization as well. California, Michigan, Maine, Hawaii, and Vermont have all experienced attempts at legalization, all without success to this point. Although legalization is limited at this time, health care professionals are already beginning to see an increasing number of clients seeking this option, as is evident from the reports from Oregon, where, in 2008, 88 patients were prescribed lethal medications (State of Oregon – Death with Dignity Act, 2009).

Perhaps the most well-known name associated with physician-assisted suicide is Dr. Jack Kevorkian. Dr. Kevorkian, a doctor in Michigan for several decades, admitted to aiding the deaths of nearly 130 ill and suffering patients (Humphry, 2007). In 1997, Dr. Kevorkian was convicted of second-degree murder for the video-taped assisted death of Thomas Youk, a man suffering from Amyotrophic Lateral Sclerosis (ALS), often referred to as "Lou Gehrig's Disease." While public support for Dr. Kevorkian was far from unanimous, he undoubtedly brought to the forefront the issue of an individual's right to die. With the impact of a single individual, Dr. Kevorkian, being so prominent and with the topic of euthanasia continuing to become increasingly popular, it is imperative to look at the personal opinions held by the helping professionals with whom future euthanasia-seeking clients might be working.

The present study assessed various personal factors and experiences as they might be related to attitudes toward euthanasia in psychology professionals and psychologist

trainees. Also, the present study examined a possible distinction between these respondents' personal values and those ideals they hold within the role of the counseling relationship. The importance of this has been outlined above in the discussion of objectivity and how personal attitudes and values of the therapist should not influence the helping relationship. Further, as active euthanasia becomes legal in more areas, it is likely that helping professionals will see an increase in the numbers of clients who bring this issue into counseling. First, however, it is important to understand the current state of euthanasia from legal and values-conflict perspectives in order to appreciate the difficulty helping professionals face when working with such clientele.

Client Autonomy

The Oregon Death with Dignity Act had its inception in November of 1997, when physician-assisted suicide became legal (State of Oregon – Death with Dignity Act, 2009). The Oregon Department of Human Services, required to collect and distribute statistics regarding adherence to this Act, publishes an annual report each spring covering related statistics, including number of prescriptions sought and ingested, the reasons for doing so as indicated by the patient, among other pieces of valuable information to monitor the use of this legality. A couple of themes have emerged since active euthanasia was legalized. First, the number of lethal prescriptions written by physicians has risen slowly and steadily (with little fluctuation) from 24 in 1998 (the first full year) to 88 in 2008. This is an extremely modest number as compared to the nearly 90,000 Oregon residents who suffered from the same underlying illnesses as those seeking physician-assisted suicide (PAS) during this time. Furthermore, there has been some discrepancy

between the number of lethal prescriptions written and the number that have been taken for their intended purpose. Consistently across years, only about two-thirds of all patients who were granted their desired medication in fact ingested it (State of Oregon – Death with Dignity Act, 2009). For instance, only 60 of 88 prescribed lethal medications were actually ingested in 2008. The low rate of prescriptions sought compared to the numbers of persons afflicted and the ratio of prescriptions ingested compared to those granted are two indications that Oregon residents are not abusing the privilege of choice they were given through this law. The granting of a lethal prescription hardly seems to be an automatic death sentence, as some were fearful that it might be.

Additional support for how autonomy plays out in end-of-life decisions can be found in reports from the patients themselves. These patients, at a rate of 95%, cited 'loss of autonomy' as the most common reason for seeking a lethal medication (State of Oregon – Death with Dignity Act, 2009). It seems as though the desire is not solely focused on dying but instead on regaining some control over how and when one's life will end. Helping professionals, first and foremost, must respect client autonomy (Koocher & Keith-Spiegel, 2008). One of the main core principles of psychotherapy is that an individual has the right to choose how to live his or her own life, so long as those decisions do not interfere with the welfare of others (APA, 2002). A goal of counseling is ultimately to build a client's self-reliance so that he or she is capable of making independent decisions. It is imperative that an individual's autonomy not only be respected, but also fostered, during this process.

It is crucial that professionals and psychology trainees (doctoral students) remain

open to the desires of the client without imposing their personal values. This study examined whether age and gender of the client who was seeking euthanasia were related to differential levels of acceptance of client autonomy in an end of life situation.

Previous Assessments of Support for Euthanasia

A limited number of empirical studies were found that looked at various populations in terms of assessing their attitudes toward euthanasia. This limited research provides a framework for the current study that examined select factors found to be related to euthanasia endorsement (or opposition).

A Gallup poll (Carroll, 2006) of over 1000 United States adults found that 69% of respondents were in favor of legally allowing a physician to aid the death of a terminally ill patient. A number of demographic factors were considered in this report. Examination of the age of respondents revealed those who were 65 years of age and older had the lowest rate of endorsement (47% in favor). The highest rate of support was seen in 20 to 49 year olds (63%), followed by 50 to 64 year olds (60%), and then 18 to 19 year olds (56%). Sex of the respondent was not found to be related to differential levels of euthanasia endorsement (57% and 58% for males and females, respectively). Different racial affiliations were found to be associated with differing levels of support, however. Overall, Whites [sic.] showed much more positive support as compared to Blacks [sic.], 60% to 38%, respectively (Carroll, 2006). Similar results were also reported by MacDonald (1998) and Wasserman, Clair, and Ritchey (2005-2006). MacDonald hypothesized that lower socioeconomic status and lower educational level, more so than any true cultural difference, might be underlying factors related to this difference. Carroll

provided at least partial support for this hypothesis in showing differential levels of support for euthanasia were related to levels of education. Only 48% of those respondents in the Gallup poll with a high school education or less were found to be supportive of active euthanasia, as compared to 60% of those with some college education, and 70% for college graduates and 69% for post-graduates.

Ogden and Young (2003) asked 862 social workers in the state of Washington about their support for the legalization of both voluntary euthanasia and assisted suicide. In general, the respondents were found to be very supportive of these options, with similar levels of support for voluntary euthanasia (72.4%) and assisted suicide (77.6%). It is important to note that this study was conducted a number of years prior to active euthanasia becoming legalized in Washington, with no additional studies conducted in Washington specifically since the passage of its new law.

Age and Gender

While gender of the respondent has previously been taken into account, Bevacqua and Robinson-Kurpius (2009) assessed whether the gender of the client looking to end his or her life was related to differential levels of support from counselors. This study used vignettes of an individual with a unisex name considering euthanasia and asked graduate students in counseling and counseling psychology to identify the *perceived* sex of that client. The groups formed (those that perceived the client as male, and those that perceived the client as female) were then compared on scores of acceptance of client autonomy. No significant difference was found. However, this finding may have been confounded by the imbalanced numbers of participants who perceived the client in the

vignette to be female (*n* =74) and those who perceived the client to be male (*n* =9). Therefore, sex was manipulated in the current study to assess more accurately amount of euthanasia support.

While the manipulation of the sex of the client in the vignettes was exploratory in nature, the manipulation of age and its associated hypotheses has a foundation in Developmental Theory. Erik Erikson posed the idea of eight separate psychosocial stages, or 'crises,' each of which must be completed in succession (Erikson, 1997). In line with developmental theories, Erikson's stages occur at a prescribed point in the lifespan, and necessarily occur in order, with an inability to move on to the next stage without a completion of the stage prior. In infancy, Erikson posits that individuals go through a crisis of Basic Trust vs. Basis Mistrust, culminating in Hope with a successful reconciliation of this crisis. In early childhood an individual navigates Autonomy vs. Shame and Doubt, resulting in Will. Next, a play-aged child, around four to six years of age, works through Initiative vs. Guilt, leading to Purpose. The Industry vs. Inferiority crisis comes next in school-aged children, with a reconciliation resulting in Competence. Adolescents then work toward Fidelity by navigating Identity vs. Identity Confusion. Young adults must then work toward Love as an outcome of Intimacy vs. Isolation, followed by Care after resolving Generativity vs. Stagnation in adulthood. Finally, older adults work toward resolving Integrity vs. Despair, culminating in Wisdom (Erikson, 1997).

When choosing ages to be represented in the vignettes in the current study, Erikson's theory was taken into account. Ages were chosen purposefully to represent

opposite ends of the adult spectrum; adult ages were decided upon so that the clients in the vignette would be of legal age to make their own end-of-life decisions. At the older end, the age of 80 was chosen for two reasons. First, this age falls clearly in Erikson's final stage of Integrity vs. Despair (Erikson, 1997). Erikson explained that a person who achieves Wisdom at the end of this struggle is "informed and [has a] detached concern with life itself in the face of death itself." (p. 61). This person represents someone who is concerned with imparting Wisdom to younger generations, not focused on their personal journey, except in the ways that their journey provides lessons for those they are leaving behind. Erikson also explained that the end of this stage marks the "total end of life," albeit an unpredictable end. Therefore, the age of 80 years old was chosen specifically to represent the average life expectancy of an individual at the time of the study.

At the younger end, the age of 24 years old was also chosen purposefully. As mentioned previously, it was desired that both individuals be of adult age so that they may legally be making their own decisions. That requires a minimum age of 18 years old. However, the age of 18 is still very much in the category of Adolescence, and according to Erikson (1997), individuals at this age are struggling with Identity vs. Identity Confusion. Therefore adolescents are still working toward finding out who they are, what is important to them, what values they hold, and what decisions regarding their own lives should be made. An individual who is still considered to be in adolescence may not be looked upon as having the life experience or the maturity to be making such a delicate end-of-life decision on his or her own. Erikson posits that Fidelity is achieved after successful mastery of this stage. This includes fidelity to oneself and one's values.

Therefore, the age of 24 was chosen to represent an individual who is in young adulthood and in the next stage of Erikson's developmental theory. Someone this age is closer to mastering the challenges of adolescence, and establishing a clearer identity and amassing a level of fidelity that allows him or her to make responsible and appropriate decisions.

Impact of Death of Loved Ones

One life event that can have a profound effect on human beings is the loss of a loved one. Some research has focused on potential outcomes for survivors after losing family members or friends, based on the various factors associated with the death. One such study (Marks, Jun, & Song, 2007), conducted with over 13,000 non-institutionalized United States adults aged 19 and older, assessed physical and psychological well-being and alcohol abuse following the death of a parent. Psychological well-being encompassed such factors as depressive symptoms, happiness, and self-esteem. A longitudinal analysis revealed more long-term negative effects for adults following the death of the same sex parent. It was found that the death of a father led to a greater increase in depressive symptoms and decline in psychological well-being for sons as compared to daughters. In contrast, while the death of a mother often led to a decrease in psychological well-being for daughters and sons, the loss of a mother for daughters lead to a greater propensity toward binge drinking and a greater decline in self-esteem. It was also more common for men to report feelings of declining physical health (It is important to note that physical health was measured by a single 5 point Likert scale item measure asking 'compared to other people your age, how would you describe your health?' *1 = poor, 5 = excellent*). Physical health that was poorer was the most common correlate for those who

experienced some form of complicated grief, including depression, thoughts of suicide, or other psychiatric problems. The death of both parents within a five-year period, although rare (occurring in about one out of every 100 respondents), was found to affect sons and daughters similarly, with sons additionally exhibiting more binge drinking behaviors and a greater decline in physical health. Despite adverse physical and psychological consequences following parental deaths, this study did not assess any potential changes in attitude toward others' deaths, or choice thereabout.

A recent study by Feigelman, Jordan, and Gorman (2008-2009) assessed 540 bereaved parents following the death of a child, where 462 had lost a child to suicide, 54 to a traumatic death circumstance, and 24 by natural causes. While the associations were weak, results indicated that parents who had lost a child to suicide exhibited more grief difficulties and general mental health problems. Most comparisons failed to yield differences among grief responses of the various groups of bereaved parents. It did seem, however, that parents who lost a child to some untimely death (suicide, or other traumatic death such as car accident or drug overdose) experienced more strain in their interpersonal relationships. It was hypothesized by the researchers that untimely deaths (as opposed to death through illness) were associated with social problems such as isolation and stigmatization, and relationships with significant others often became strained. It was these byproducts of the death that were believed to exacerbate the experienced grief.

Further, Feigelman et al. (2008-2009) found that in the first years following the loss of a child through suicide, repeated prior suicide attempts, as well as strained

relationships with the deceased prior to suicide were associated with greater grief difficulties. Again, hypothesized reasons for the difficulties included feelings of rejection or abandonment by the deceased, as well as a potentially high sense of responsibility for the death. The researchers indicated that it is often difficult to assess for these factors associated with grief difficulties, especially using generic measures. They caution against assumptions about reasons for complicated grief without qualitative interviews of the survivors to yield more accurate information.

A study by Maple, Plummer, Edwards, and Minichello's (2007) of bereaved Australian parents found results similar to Feigelman et al.'s (2008-2009) hypotheses for complicated grief. Maple et al. found that more distress and grief difficulties were associated with less preparedness for the death. The more shocking the death, meaning those suicides that were a result of a first attempt, was related to the most difficult aftermath for survivors. Similarly, Currier, Holland, Coleman, and Neimeyer (2006), in a study conducted among college students who experienced the loss of a family member or friend, found that greater grief distress was associated with sudden traumatic deaths (homicide, suicide, and accidental deaths).

One study was found that looked at the effects of a patient's death on helping professionals. Thomyangkoon and Leenaars (2008) conducted a study in which the impact of patient death was assessed in Thai psychiatrists. Of the 167 psychiatrists who responded to the mailed survey, it was found that 94 (56.28%) had had a patient die through suicide. More than 50% of these psychiatrists reported personal feelings of sadness, depression, hopelessness, and guilt in response to the loss. Nearly three-quarters

(74.5%) reported some form of professional reaction, most commonly the aggressiveness with which suicidality was assessed in future patients (93.4%). Working through the loss with colleagues and having supportive family members and friends, as well as performing some form of 'merit' for the deceased patient (such as attending the funeral), were among the most commonly cited actions by the psychiatrist in helping to recover from the loss.

Overall, these studies suggest a couple of findings. First, while males and females appear to experience different forms of complicated grief in response to a loss, complicated grief was not necessarily more prevalent in one sex over the other. Also, the most negative of grief outcomes appear to be associated with a death of the traumatic or 'surprise' variety. Finally, psychiatrists appear to have similar responses to death by suicide in patients, experiencing both personal and professional repercussions. It is unclear, however, what effect these personal and professional losses might have on attitudes toward euthanasia-seeking clients. The present study explored potential attitudinal differences toward euthanasia-seeking clients for those individuals who have had a significant personal loss through death within the last five years.

Factors Related to Attitudes toward Death and Euthanasia

Butt, Overholser, and Danielson (2003) examined psychological factors as they related to attitudes toward physician-assisted suicide (PAS) among 136 United States college students. A multiple regression model indicated that age and race of participants, as well as hopelessness scores, were all significant predictors of attitudes toward PAS. The younger the respondents, the more likely they were to be supportive of physician-

assisted suicide, as were non-minorities. A three-month follow-up showed constancy of these findings, which was dissimilar from other studies that found fluctuation in attitudes toward PAS over time. For instance, Blank, Robison, Prigerson, and Schwartz (2001) found that in 154 non-hospitalized, terminally ill patients (all over the age of 60), attitudes toward physician-assisted suicide were not consistent across time. In a six month follow-up to the original assessment, up to 26% of respondents changed their attitudes toward PAS, most often in the direction from initial acceptance toward rejection of this option. This was more likely to hold true for the depressed participants, as opposed to the non-depressed participants.

Research by Kopp (2008/2009) also examined attitudes toward physician assisted suicide. Approximately 300 adults were surveyed on attitudes toward PAS, knowledge about their state's assisted suicide laws, demographics, and attitudes toward death. This study found that the more knowledgeable individuals were about the end-of-life options available, the less supportive they were of PAS. No potential explanation was offered to help understand this finding. However, it was consistent with previous findings that revealed that the less knowledge physicians had about end-of-life care options, the more support they showed for euthanasia. For instance, Emanuel et al., (2000) conducted a study on 3299 oncologists and found that as knowledge of end-of-life care options increased, along with that doctor's ability to provide this care for patients, the less in favor they seemed to be of physician-assisted suicide.

Further, Kopp (2008/2009) found that the strongest Death Attitude Profile (DAP-R) measure related to attitudes toward PAS was that of Approach Acceptance. In general,

this construct measures attitudes individuals hold about a pleasant afterlife. It was found that higher scores on this measure were associated with less support for physician-assisted suicide. At first glance this might seem counterintuitive. It would seem to make sense that individuals who believed a 'better life' was awaiting them following death would not be opposed to reaching it sooner. However, belief in an afterlife has a strong religious underpinning. When viewed from this framework, this makes more sense, as greater religiosity has been repeatedly shown to be related to lower support for euthanasia. Religiosity has been a relatively well-researched area in regards to end-of-life issues and deserves attention with respect to both traditional views and its influence on personal values.

Religion and Euthanasia and Suicide

One particular demographic that has been consistently shown to be related to attitudes toward euthanasia is religiosity. There has been a great deal of evidence that religiosity is related to levels of euthanasia support. First, in a Gallup poll of over 1000 United States adults in the general population, Carroll (2006) found that Catholic respondents had a lower rate of support (62%) than did those who did not indicate a religious preference (81%). Similarly, church attendance, which is believed to be an indicator of strength of religiosity, also showed a comparable trend. Those who attended religious services on a weekly or near-weekly basis were much less in favor of legalizing euthanasia (39%) in comparison to those who reported attending religious services 'seldom' or 'never' (72%).

Other empirical studies have also assessed the relationship between personal religiosity and levels of euthanasia support. For instance, Miller et al. (2004) conducted a study with Oregon hospice workers and found that religiosity was again related to amount of support for clients seeking euthanasia. Respondents were asked to respond on a 10-point Likert scale the extent of importance that spirituality plays in their life. Results indicated that greater support for euthanasia was associated with self-reports of lower importance of spirituality. Suarez-Almazor et al. (2004), in a study of terminally ill cancer patients, also found that a lack of religious beliefs surfaced as being correlated with higher rates of euthanasia acceptance.

The findings related to religiosity and euthanasia appear consistently throughout the literature. Still, it might be beneficial to examine some of the traditional views of a few of the most widespread religions in order to have some foundation for understanding the range of beliefs one may hold. The Roman Catholic Church has long been opposed to both suicide and euthanasia as moral options (Albright & Hazler, 1995). The Catholic Church views dying as a natural process and a time for repentance; therefore, it should not be interfered with by any individual (Engelhardt & Smith Iltis, 2005). Utilizing medical advances for purposes of sedation and pain control are considered acceptable practices, however, as is discontinuing extreme life-sustaining treatments (Richards & Bergin, 2000). In this way, passive euthanasia is viewed as acceptable, while active euthanasia is not. With the magnitude of medical advances that have been made in recent decades, there needs to be a balance, however, between keeping one alive and a consideration for the quality of life (Engelhardt & Smith Iltis). Other Christian religions,

namely Protestants and Latter-day Saints, share similar views to the Catholic Church: Suicide and active euthanasia are morally opposed, while the removal of life support is considered an acceptable option (Richards & Bergin, 2000).

Judaism is similar in its views on suicide and euthanasia (Kinzbrunner, 2004). Jewish law is unwaveringly against the taking of another human life, as the preservation of life should be revered above all else. Premature death is viewed as unacceptable, because it is counter to the high esteem in which human life should be regarded. Jewish law, however, does not require that an individual's life be artificially lengthened (Richards & Bergin, 2000). The removal of life-sustaining treatment is allowed if that treatment is the only thing likely keeping a person alive. Again, passive euthanasia is viewed as acceptable while active euthanasia is not.

Judaism also posits that it is not up to the individual to dispose of his or her life as he or she wishes. Even saving someone from pain near the end of life is not an acceptable reason to aid in the ending of that person's life. Regardless of reason or expressed intent to die by an individual, Jewish law regards active euthanasia as murder. Every moment of life is equal in value to every other moment; Judaism forbids an artificial truncation of those moments (Kinzbrunner, 2004). Further, Judaism firmly believes that life is a gift from God, included with it are all of the difficulties life may bring (Albright & Hazler, 1995).

The Islamic faith is similarly opposed to euthanasia. Believing that all human life is sacred, granted by a higher power, it is accepted that Allah chooses how long each person will live. Humans should not alter this determination (Hussein Rassool, 2004).

Like the other religions examined thus far, the Islamic faith states that hastening one's death, through either euthanasia or suicide, is unacceptable. Again, passive euthanasia is acceptable. In the same way that an individual is expected not to shorten life, the same expectation holds that he or she will also not artificially extend it (Richards & Bergin, 2000). Illness is believed to be atonement for sins and is a journey that needs to be completed, with a promise of eventual relief from such pain and suffering (Hussein Rassool, 2004).

Buddhism places high priority on the end of life, but with difficulty in defining 'death' as there is a strong belief in afterlife in which the soul continues to live (Keown, 2005). Buddhists believe in a transition process from this life to the next and that this process should proceed without interruption. While instances of prolonged suffering and terminal illness might justify "mercy killing," this practice is generally regarded as unacceptable. Again, there is no expectation of artificial preservation of life. Thus passive euthanasia, a refusal or removal of food or medical treatments that would otherwise sustain life, is acceptable (Richards & Bergin, 2000). Similar to the Judeo-Christian view, Buddhism believes in necessary suffering, claiming that suffering improves karma and thus guarantees a better reincarnation (Albright & Hazler, 1995)

Finally, Hinduism has similar tenets as Buddhism related to reincarnation and karma (Richards and Bergin, 2000). Suicide, although not strictly forbidden, is strongly discouraged in Hinduism as it disrupts the natural death process and, therefore, yields bad karma. Suicide is only available as an option of religious merit; it is not approved as an option to escape pain and suffering. Hinduism does not allow individuals to seek assisted

suicide as a relief from terminal illness. Further, Hinduism strictly forbids the killing of anyone or anything. Therefore, while the individual may not end his or her own life, assisting someone else in this act is also forbidden.

Overall, it appears as though each of the major world religions, while expressing their views differently, share a common aversion to any form of active euthanasia, while passive euthanasia appears to be commonly accepted as a way of letting nature take its course. Consistent with the views of these most popular religions, there is evidence supporting religiosity as a strong influence in one's end-of-life decision making process. Stronger feelings of religiosity are most often associated with less support for active euthanasia as an end-of-life option.

Factors Related to Attitudes toward Euthanasia-Seeking Clients

As Carroll (2006) demonstrated, higher acceptance of euthanasia decisions was related to having a higher level of education. However, the acceptance rate appears to plateau upon completion of a bachelor's degree (60% acceptance rate by individuals with some college education, 70% for college graduates, and 69% for post-graduates). If there is to be any change in level of acceptance of euthanasia decisions beyond an undergraduate degree, then other factors would likely need to be related to this change. In the helping professions, it is a possibility that the specific training and clinical experiences that one undertakes might affect his or her personal and/or professional opinions surrounding a value-laden topic such as euthanasia.

While no studies were found that directly assessed how training or clinical

experience might be related to professionals' attitudes toward euthanasia, a study by White and Robinson-Kurpius (1999) did look at how clinical experience was related to attitudes toward rape victims. This study found that the more experienced the clinicians were, especially female clinicians, the less likely they were to blame the victim, and the more positive feelings they held about the victim. This suggests that, in general, more clinical experience is related to a greater degree of acceptance of a client's situation, more positive attitudes toward the client, and greater respect for client autonomy. Similarly, Bevacqua and Robinson-Kurpius (2009), while examining counselor trainees' attitudes toward euthanasia, found a positive correlation between clinical experience and acceptance of client autonomy. Therefore, similar patterns might emerge when looking at how clinical experience relates to attitudes towards clients considering euthanasia as an end of life option.

Helping professionals were assessed in other research as well. DiPasquale and Gluck (2001) conducted research with psychologists and psychiatrists, from a single U.S. state, in regards to their attitudes toward physician-assisted suicide and the relationship between various underlying beliefs and associated professional behavior. One of the conditions set up in this study included a willingness to take part in PAS, assuming it was legal within the state in which one practices. Found to be related to a willingness to participate in this situation (or, in the case of psychologists, an openness to refer to a medical professional who could) included several personal factors including a desire for PAS to be available as a legal option for themselves should they ever personally be in a similar terminally-ill situation. Further, two other factors were found to be related to

higher levels of support for PAS. First, those who held the belief that suicide, in some form, can be a rational choice in some situations were more likely to feel more supportive of a decision to seek PAS. Second, lower levels of religiosity were also found to be related to higher support for PAS. Additionally, these professionals cited a 'change of heart,' in the direction of increased acceptance of PAS, following a personal encounter with someone close who had suffered through a terminal illness. DiPasquale and Gluck's finding was not consistent with findings from other studies. For example, a study of Michigan physicians and adult citizens, Bachman et al. (1996) found no relationship between personal experience with terminal illness and support for PAS. Despite two-thirds of the sample in the study having been through the experience of a family member or close friend facing a terminal illness, this experience did not appear linked to any differential levels of support for the legalization of euthanasia. Similarly, having this experience did not appear related to the likelihood of requesting physician-assisted suicide. With this study taking place at the height of Dr. Kevorkian's infamy in Michigan, it is unclear to what extent that might have played a role in the responses of the participants.

Not all professionals are fully supportive of legalizing euthanasia or even altering their own personal or professional views despite what might be going on around them. On the opposite side of the debate, then, are those who claim they would be unwilling to participate in physician-assisted suicide, even if it were to become legal in their practicing state. The strongest attitude related to this stance was an unwillingness to alter one's personal practice to match new legal standards (DiPasquale & Gluck, 2001).

Overall, it appears that the personal values of the professionals surveyed can have an impact on how they might work with clients seeking physician-assisted suicide.

More in depth information is presented in a qualitative study conducted with 18 Australian medical practitioners and nurses (White, Wise, Young, & Hyde, 2008/2009). Information was gathered based on the respondents' attitudes toward active voluntary euthanasia (AVE). Although not currently legal in Australia, the Northern Territory had legalized physician-assisted suicide for a short time in 1995 (Kitchener, 1998). Results of this study revealed that there were a number of benefits identified by the respondents of having the option of requesting AVE for themselves if they were ever in that situation. Some of these identified benefits included having the control over one's own end-of-life and a number of factors associated with dying peacefully and with dignity. Also, respondents identified that taking control over their own end-of-life would remove burdens from familial and professional caretakers. Negative outcomes were identified as well. These included disagreements with others involved in and complications with the decision-making process, potentially missing out on the opportunity for a cure, and living a longer life (White et al.).

Miller et al.'s (2004) study, mentioned above, found that Oregon hospice workers (306 nurses and 85 social workers) were 95% in favor of hospice centers supporting, or at least not impeding, patients' right to make their own end-of-life decision. There were no differences in level of support between nurses and social workers. Additionally, 72% of social workers were in favor of the Oregon Death with Dignity Act, along with 48% of nurses. Although only 13% of the nurses were opposed, 39% were neutral.

A large scale study was conducted in the Netherlands (Rurup et al., 2005) with various individuals and their feelings toward the existence of a 'suicide pill.' Specifically, 410 physicians, 1379 people in the general population, and 87 relatives of patients who had died from euthanasia or physician-assisted suicide were involved in this study. When asked generally if people should have a right to decide about their own life and death, 56% of physicians were in agreement, compared to 68% of the general population and 74% of relatives. Each of the three groups of people was further broken down in their responses based on several demographic characteristics. Of note, the only significant difference based on the gender of the respondent was found in the 'relative' category, with females supporting patient autonomy at a 93% rate compared to males at 77%. When asked if very old people (defined as such in the study, with no further age description offered) should be granted a pill to end their lives if they so choose, the general public was much more in favor of this (45%) than were physicians (25%). Relatives did not respond to this question. Again of note, whether or not an individual ascribed to religious beliefs was related to endorsement for each of these two questions. Across all groups and both questions, significant differences were found such that those responding 'no' to religious beliefs were consistently more in favor than were those responding 'yes.'

While a number of studies have assessed various professionals' attitudes toward euthanasia, perhaps it is most important to be aware of how those who are in the population most likely to be seeking this option feel about it. In a study of terminally ill cancer patients, Suarez-Almazor et al., (2004) found that 69% of the patients supported at

least one instance of physician-assisted suicide. This study also indicated a differential level of support between men and women, with men reporting more support for PAS. This is contrary to other assessments that have yielded no differences in euthanasia support based on the sex of the respondent (Carroll, 2006).

Summary and Purpose of this Study

General support for euthanasia has been seen in several places. Not only has Oregon passed the first pro-euthanasia law in the United States, but this has also been followed by a majority support from the doctors, nurses, and social workers who have been assessed on their attitudes toward euthanasia-seeking clients (White et al., 2008/2009; Miller et al., 2004). A number of demographic factors have been found to be consistently related to differential levels of support of euthanasia. The demographics most associated with higher levels of support include being Caucasian, in the 20 to 49 year old age bracket, having a higher education, and self-report of relatively weaker religious affiliation than their less-accepting counterparts.

Further, several factors have been found to be related to attitudes toward death and end-of-life concerns, as well, including personal experiences with suicide and euthanasia of loved ones. Several adverse affects were identified as related to the death of a parent, including binge drinking behaviors and physical and psychological problems. Also, there are potential negative impacts that the suicide and other sudden deaths of a child can have on the parents, including social stigmatization, social isolation, and strained relationships among survivors.

The current study examined selected factors that have been found to be related to euthanasia support among helping professionals. Specifically, this study addressed the question "What are the relationships among deaths of close friends and family, spirituality, support for euthanasia, and acceptance of client autonomy?" Seven hypotheses were posed:

H1: Professionals and doctoral students in psychology will endorse similar acceptance of client autonomy, and both professionals and doctoral students will endorse greater acceptance of client autonomy than will undergraduate students.

H2: Professionals and doctoral students will exhibit similar levels of acceptance of client autonomy for a 24 year old individual and for an 80 year old individual, regardless of sex; however, undergraduate students will report greater acceptance for client autonomy for an 80 year old individual than for a 24 year old individual.

H3: There will be no differences between professionals and doctoral students in acceptance of client autonomy for male and female clients; however, a relationship will exist between acceptance of client autonomy and sex of the client among undergraduate students.

H4: For both professionals and doctoral students, there will be no relationship between attitudes toward euthanasia and acceptance of client autonomy; however, there will be a positive correlation between attitudes toward euthanasia and acceptance of client autonomy for undergraduate students.

H5: For all participants, attitudes toward euthanasia will be negatively related to religiosity/spirituality.

H6: Professionals and doctoral students who experienced a friend or family member commit suicide in the last five years will differ in attitudes toward euthanasia from those who have not experienced a friend or family member commit suicide within the last five years.

H7: Professionals and doctoral students who lost a friend or family member through some form of traumatic death in the last five years will not differ in attitudes toward euthanasia from those who have not lost a friend or family member through some form of traumatic death in the last five years.

H8: Professionals and doctoral students who lost a friend or family member through a terminal illness in the last five years will differ in attitudes toward euthanasia from those who have not lost a friend or family member through terminal illness in the last five years.

H9: Professionals and doctoral students who lost a friend or family member through removal of life support in the last five years will not differ in attitudes toward euthanasia from those who have not lost a friend or family member through removal of life support in the last five years.

Chapter 2

Pilot Study

A review of the literature did not yield any instruments that assessed an individual's acceptance of a client's right to choose euthanasia. A pilot study was conducted to create such an instrument to be used in the current study.

Participants for Pilot Study

Participants for this pilot study included 53 students from a Master in Counseling training program at a large southwestern university. The sample included 11 (20.8%) males, and 41 (77.4%) females, with one individual not responding to this question. The range of ages of participants extended from 22 to 54, with a median age of 26 years. Most participants (n = 45; 84.9%) had achieved a bachelor's degree as their highest degree, while five (9.4%) had another master's degree, one (1.9%) had a Ph.D./M.D., and one (1.9%) had earned a J.D. Out of the 41 respondents who indicated the major/concentration of their highest degree achieved, more than half (n =23; 56.1%) had an undergraduate psychology background.

Other demographic data included the following: 37 (69.8%) identified as Caucasian, while four (7.5%) identified as African American, four (7.5%) identified as Multi-Ethnic, three (5.7%) identified as Latino/Hispanic, one (1.9%) identified as Native American, and three (5.7%) indicated "Other." One individual did not respond to this question. Similarly, religious affiliation was also assessed. Twenty-four (45.3%) individuals identified themselves as Christian, six (11.3%) identified themselves as

Buddhist, six (11.3%) as Jewish, 12 (22.6%) indicated “None,” while four (7.5%) indicated “Other.” One participant did not respond to this question.

Pilot Vignettes

Four vignettes were created that manipulated two variables - age (24 or 80 years old) and gender (male, “Mark,” or female, “Ruth,”) of the individual considering euthanasia. All other situational information did not vary across vignettes. The resulting four vignettes presented Mark as a 24 year old contemplating active euthanasia, Mark as an 80 year old contemplating active euthanasia, Ruth as a 24 year old contemplating active euthanasia, and Ruth as an 80 year old contemplating active euthanasia. These vignettes are presented in Appendix B. Each counselor trainee was randomly assigned to just one vignette.

Procedures

Participants were recruited in their graduate level counselor training classes by the researcher and were asked to take part in a short study about euthanasia. Confidentiality of individual data was ensured, and informed consent (see Appendix A) was obtained before the counselor trainees read the vignette and completed the demographic sheet and other instruments. Participants were instructed not to turn back to any previous page as they proceeded through the study. Participants completed the study in their classroom during class time while the researcher remained in the room to answer questions. The completed research packet was placed in an envelope and returned to the researcher. The informed consent forms were kept separate from the responses. The study took approximately 10 minutes to complete.

The order of the contents of the study packets remained consistent across vignette groups. First, the trainees read the informed consent and then the assigned vignette. After reading the vignette, trainees responded to acceptance of client autonomy questions, the Attitude Towards Euthanasia scale (Wasserman et al., 2005), questions about personal experiences with death and euthanasia, and finally a demographic sheet that also included a religiosity scale. As a manipulation check, trainees were also asked the age and type of euthanasia presented in the vignette they read.

Creation of Instrument

After reading the vignette, participants responded to 16 questions assessing acceptance of autonomy granted to the client in the euthanasia situation. These items were responded to on a 6-point Likert type scale (0 = Strongly Disagree to 5 = Strongly Agree).

A Principle Axis Factor Analysis was run on the responses to these 16 items. This analysis yielded five separate factors represented. This is presented in Table 1. Through this factor analysis, the final scale consisted of nine statements. The nine statements that were chosen were those that loaded the highest on factor one. These statements were: “I would encourage Mark(/Ruth) to make whichever decision he(/she) wishes,” “I would support Mark(/Ruth) in whichever decision he(/she) makes,” “Mark(/Ruth) should have the right to decide how his(/her) life ends,” “I would feel comfortable working with Mark(/Ruth) regardless of which decision he(/she) made,” “I would be able to prevent my personal opinions from affecting Mark’s(/Ruth’s) decision,” “I would feel comfortable working with Mark(/Ruth) regardless of the decision made,” “I would feel responsible if I

allowed Mark(/Ruth) to engage in physician-assisted suicide," "It is important to me that Mark(/Ruth) understand my opinion on the issue before making his(/her) final decision," and "I would refer Mark(/Ruth) to someone else if he(/she) was leaning toward a decision with which I did not feel comfortable."

Table 1. Factor Matrix of Pilot Study Items

	Factor				
	1	2	3	4	5
co1	***.781***	-.260	.423	-.035	-.200
co2	***.705***	-.241	.188	.090	-.122
co3	***.697***	-.274	.262	.115	-.305
co4	.244	.500	-.010	.106	-.112
co5	***.788***	-.316	-.354	-.284	.169
co6	.294	.612	.392	-.305	-.017
co7	***.627***	-.340	.096	.034	-.018
co8	.325	.684	.314	-.418	.023
co9	***.747***	-.327	-.322	-.331	.178
co10	***.546***	-.162	-.167	.098	.225
co11	***.450***	.068	.305	.418	.187
co12	.282	.233	.083	.448	.273
co13	.351	.219	.047	.052	.152
co14	.403	.485	-.016	.023	.353
co15	.444	.494	-.503	.155	-.269
co16	***.526***	.467	-.490	.131	-.257

Extraction Method: Principal Axis Factoring.

a. 5 factors extracted. 18 iterations required.

After completion of the factor analysis, an internal consistency check was run on these nine items. This yielded a Cronbach's alpha of .86. These nine items were deemed to be appropriate to create the Acceptance of Client Autonomy scale to be used in the current study.

Another scale to be used in the current study was also tested for internal reliability. The counselor trainees also completed the *Attitudes Towards Euthanasia* (ATE; Wasserman, Clair, & Ritchey, 2005) scale. This 10-item scale measured an individual's acceptance of euthanasia across various situations. An internal reliability check of this instrument yielded a Cronbach's alpha of .84.

Chapter 3

Method

Participants

Participants were 85 undergraduate students from a large university in the southwestern United States, 54 graduate students currently enrolled in doctoral counseling program throughout the United States, 53 doctoral level helping professionals (45 individuals with a Ph.D. in Counseling Psychology, seven individuals with a Psy.D. in Clinical Psychology, and one individual with an M.D./J.D.), all throughout the United States. These participants were purposefully targeted in order to encompass a wide range of education and clinical experience. Informed consent was obtained prior to participation (See Appendix B). All respondents were entered into a drawing to win one of three $25 VISA gift cards.

As mentioned previously, participants fell into one of three categories based on education level. Of the 85 undergraduates in the current study, 37 (44%) were male and 47 (56%) were female, with one individual not identifying his or her sex. Undergraduate student participant ages ranged from 18 to 36 years old, with a mean age of 21.54 years and a standard deviation of 3.78. Of the 54 doctoral students, nine (16.7%) were male while 45 (83.3%) were female. Graduate student participant ages ranged from 22 to 52, with a mean age of 29 years, and a standard deviation of 6.54. Of the 53 professionals, 16 (30.2%) were male and 37 (69.8%) were female. Professional participant ages ranged from 25 to 70, with a mean age of 42.25 years and a standard deviation of 11.65. The mean age for all participants was 29.35 years with a standard deviation of 11.33. The

demographic sheet used to gather this information is presented with the remainder of the survey in Appendix B.

Questions about religious affiliation revealed that 93 (38.8%) reported being Christian, 35 (14.6%) responded “None,” 33 (13.8%) responded “Other,” six (2.5%) ascribed to Judaism, three (1.3%) to Buddhism, and one (.4%) to Islam. Sixty-six individuals either did not answer this question or dropped out of the study before reaching this question. Due to data gathering of all participants taking place on the internet, the U.S. state in which the individual completed the survey was documented. Just over half, (*n* = 123; 51.3%) were in the state of Arizona. The next most popular states were Texas (*n* = 15; 16.3%) and California (*n* = 10; 4.2%). In all, 26 states were represented. Of note, only one individual (.4%) completed the survey in a state (Washington) where physician-assisted suicide is currently legal.

Participants were also asked about their personal experiences with particular forms of death. Participants responded to four of these questions: “Have you ever had a family member or close friend commit suicide?” “Have you ever lost a family member or close friend through some other form of traumatic death (e.g., car accident, accidental drug overdose)?” “Have you ever had a family member or close friend die of a terminal illness?” and “Have you ever had a family member or close friend die through the removal of life support?”

Design

This study used a 3 (educational level) by 2 (client sex) by 2 (client age) factorial

design. Vignettes manipulated the two independent variables related to the client, sex and age. Respondents read one of four randomly assigned vignettes, depicting either a male or female terminally ill cancer patient, who is either 24 years old or 80 years old. Further, an ex post facto component included fixed factors of whether or not a respondent has had a family member or friend commit suicide, die through some other traumatic death, die from terminal illness, or seek out physician-assisted suicide. Responses to these questions were each categorized dichotomously into 'yes' and 'no' for those who had had and had not had those experiences, respectively. When asked if they had ever had a family member or close friend commit suicide, 33 (18.6%) responded yes: 10 (13%) undergraduates, 11 (20.8%) doctoral students and 12 (25.5%) professionals. When asked if they had ever lost a family member or close friend to some other form of traumatic death (e.g., car accident, accidental drug overdose), 60 (33.7%) said yes: 34 (43.6%) undergraduates, 11 (21.2%) doctoral students, and 15 (31.3%) professionals. When asked if they had ever had a family member or close friend die of a terminal illness (e.g. Cancer), 120 (65.9%) said yes: 41 (51.9%) undergraduates, 40 (75.5%) doctoral students, and 39 (78%) professionals indicated that they had. When asked if they had ever had a family member or close friend die through the removal of life support, 33 (18.6%) said yes: 6 (7.9%) undergraduates, 12 (22.6%) doctoral students, and 15 (31.3%) professionals.

Additionally, three dependent measures were included. These were an Acceptance of Client Autonomy measure, an Attitude toward Euthanasia scale, and a Religiosity scale.

Vignettes

As stated above, vignettes manipulated two factors: age (either 24 or 80 years old) and sex of client (male and female, named 'Mark' and 'Ruth' respectively). In every instance, the client was facing terminal cancer with less than six months to live and was considering physician-assisted suicide. The four vignettes are presented in Appendix A. Below is an example of one of the vignettes:

> Mark is 24 years old and has been battling terminal cancer for almost a year. Despite aggressive chemotherapy, doctors feel that Mark has only six months to live. Between the cancer and chemotherapy, he is left feeling sick often and is in a great deal of pain throughout each day. Mark has considered physician's assistance in order to end his life and be free from the pain and suffering. Mark has come to you to talk about this possible decision.

Instrumentation

Wasserman, Clair, and Ritchey (2005) developed the Attitudes Towards Euthanasia (ATE) scale (See Appendix A). This is a 10 item instrument, scored on a 5 point Likert scale (1 – Strongly Disagree, 2 – Disagree, 3 – Undecided, 4 – Agree, 5 – Strongly Agree), with items six and nine reverse scored. This scale assesses personal values toward euthanasia. This scale was selected for two reasons. First, it offered a brief and general way of assessing personal attitudes toward euthanasia across situations. Also, the scale seemed to offer good internal consistency. At the time of scale development, a pretest of the scale on 47 college students yielded a Cronbach's alpha of .91, while a follow up sample (n = 176) resulted in a Cronbach's alpha of .87 (Wasserman et al.,

2005). The internal consistency for responses to this scale for the current study was .88.

In response to the vignette, participants' acceptance of client autonomy was assessed. A pilot study was conducted in order to create this measure (presented above). The nine items that emerged from the pilot study were used to assess Acceptance of Client Autonomy. (See Appendix A for vignettes and instrument items). A check of the internal consistency for responses revealed a Cronbach's alpha of .90 for the study sample.

Next, all participants answered questions exploring their personal experiences with death. These questions asked about experiences with close friends and family members who have committed suicide, died through some other form of traumatic death, died of a terminal illness, or sought physician-assistance at the time of death. For each type of death they experienced, participants were asked who the deceased individual was in relation to themselves, the closeness of relationship with the deceased at the time of death, and the amount of time since that death occurred. Participants were instructed to answer these questions only about the most recent death in a given category if they had experienced more than one.

Next, all participants reported their religious/spiritual affiliation and completed a 10-item measure of Spirituality. This scale, the Religious Commitment Inventory-10, was developed by Worthington Jr. et al. (2003). This scale was chosen for two reasons. First, it offered a concise way to measure the extent of one's religious involvement. Second, the scale appeared to have undergone extensive reliability and validity testing. At the time of scale development, Worthington Jr. and colleagues found an internal consistency of .93

for the full 10 items, as well as a test-retest reliability of .87 over a three week period. Further, criterion validity testing revealed a .70 correlation ($p < .0001$) between the RCI-10 and frequency of attendance of religious activities. Construct validity testing revealed significantly higher scores on the RCI-10 for those individuals who ranked salvation as one of their top five values on Rokeach's Value Survey than for those who ranked salvation lower (position six through 18; $F = 60.93$, $p < .0001$) (Worthington Jr. et al.) (See Appendix A for scale items.) The internal consistency for the current sample was .96.

Additionally, participants responded to a 5-item measure of religiosity. These items are "How often do you attend religious services?", "How strong are your religious/spiritual beliefs?", "How often do you engage in prayer/spiritual meditation?", "How important is religion/spirituality in your life?", "How much has your faith helped you to cope with problems?" This measure was used in a study by Bevacqua and Robinson-Kurpius (2009) and yielded an internal consistency of .91. While all five items were responded to on a six point Likert scale, it was realized that the response choices to the first question of frequency of religious attendance did not have the same 'distance' between options as the other four items. Therefore, it was excluded from the analysis. In the current study, this scale yielded an internal consistency of .95 after the first item was removed.

Finally, all participants were asked to complete a short demographic questionnaire. This encompassed information such as age, sex, highest degree achieved and major/concentration, whether or not they are a current student, and current

occupation. Following the demographic questionnaire there was a memory check on the vignette. Respondents were asked to identify the age and the sex of the client in the vignette they read. This assessed the relative effectiveness of the manipulated variables.

Procedures

All participants were recruited to complete an online form of the current study. An informed consent document (See Appendix B) was e-mailed to all training directors of counseling psychology doctoral programs who forwarded it to the students in each program. Students and faculty members were asked to participate. Additionally, to recruit professionals, e-mails with the informed consent document were sent to practicum supervisors affiliated with the researcher's graduate program. These individuals were also asked to forward the request for participation to other colleagues. Finally, undergraduates were recruited through classes and offered extra credit to participate by their graduate student instructors. A wide range of undergraduate courses were targeted in order to yield a sample of students representing a multitude of majors and all class years.

Within each informed consent e-mail were four separate links to surveys loaded on QuestionPro.com. The only difference in each survey was the age and sex of the individual in the vignette. All of the other information and questions, including the ordering of those questions, remained constant across all four surveys. In order to create random assignment of these variables, potential participants were asked to click on the first link offered if their birthday was in January, February, or March, the second link if their birthday was in April, May, or June, the third link if their birthday was in July, August, or September, and the fourth link if their birthday was in October, November, or

December. Also included in the informed consent document was an e-mail address to which participants could send their contact information upon completion of the survey in order to be considered for one of the three incentives offered. This prevented identifying information from being linked to specific survey responses. The entire study required about 10 minutes for completion.

Chapter 4

Results

Preliminary Analyses

Prior to testing the study hypotheses, the internal consistencies for the outcome variables were calculated. These are reported in the Method section and in Table 2. A manipulation check indicated that 170 (94.4%) of the participants accurately reported the age of the client in the vignette they had read and 173 (95.6%) accurately reported the type of euthanasia vignette they had read. This was deemed an acceptable percentage for the effectiveness of the independent variable manipulation.

Table 2. Internal Consistencies, Means, and Standard Deviations of Measures

Construct	α	*M*	*SD*
Attitudes toward Euthanasia	.88	27.27	7.95
Acceptance of Client Autonomy	.90	38.61	9.157
Religiosity	.96	21.98	11.86
Spirituality	.95	14.72	6.64

There was no significant difference across educational levels in the number of individuals who had a friend or family member commit suicide, χ^2 (2, N = 177) = 3.25, p = .197. A Chi-Square test revealed a significant difference, χ^2 (2, N = 178) = 7.21, p =.027, across educational levels in the number of individuals who had lost a family member or close friend through some form of traumatic death. More undergraduates (n = 34, expected n = 26.3) and fewer doctoral students (n = 11, expected n = 17.5) than expected had experienced the traumatic death of a friend or family member, and fewer

undergraduates (n = 44, expected n = 51.7) and more doctoral students (n = 41, expected n = 34.5) than expected had not experienced the traumatic death of a friend or family member. There was also a significant difference across educational levels in the number of individuals who had lost a family member or close friend through terminal illness, χ^2 (2, N = 182) = 12.32, p = .002. More doctoral students (n = 40, expected n = 34.9) and more professionals (n = 39, expected n = 33) and fewer undergraduates (n = 41, expected n = 52.1) had lost a family member or close friend to a terminal illness. Fewer doctoral students (n = 13, expected n = 18.1) and fewer professionals (n = 11, expected n = 17) and more undergraduates (n = 38, expected n = 26.9) had not lost a family member or close friend to a terminal illness. Finally, there was a significant difference across educational levels in the number of individuals who had experienced the loss of a family member or close friend through the removal of life support, χ^2 (2, N = 177) = 11.38, p = .003. More professionals (n = 15, expected n = 8.9) and fewer undergraduates (n = 6, expected n = 14.2) than expected had lost a family member or close friend through the removal of life support. Fewer professionals (n = 33, expected n = 39.1) and more undergraduates (n = 70, expected n = 61.8) than expected had not lost a family member or close friend through the removal of life support.

Hypotheses Testing

Hypotheses one, two, and three were tested simultaneously in a 2 (sex of client in vignette: male or female) by 2 (age of client in vignette: 24 or 80 years old) by 3 (educational level: undergraduates, doctoral students, or professionals) analysis of variance (ANOVA). The error rate for each main effect and interaction effect was set as

.05. Hypothesis one predicted that professionals and doctoral students in psychology would endorse the same level of autonomy regardless of the client's age or sex; however, both doctoral students and professionals would endorse greater autonomy than will undergraduate students. The main effect for educational level was significant, $F(2, 170) = 19.67$, $p < .001$. Pairwise comparisons revealed that doctoral students ($M = 40.49$, $SD = 1.2$) and professionals ($M = 43.47$, $SD = 1.2$) granted more autonomy to the client than did undergraduates ($M = 34.12$, $SD = 1.0$). There was no difference in the amount of autonomy granted by doctoral students and professionals; therefore, hypothesis one was supported.

The second hypothesis predicted that professionals and doctoral students would endorse the same level of autonomy for a 24 year old individual and for an 80 year old individual, regardless of sex; however, undergraduate students would endorse greater autonomy for an 80 year old individual than for a 24 year old individual. There was no educational level by age interaction; therefore, this hypothesis was not supported, $F(2, 170) = .19$, $p = .83$. Regardless of educational level, the same amount of autonomy was granted to a 24 year old individual as to an 80 year old individual.

Hypothesis three predicted that professionals and doctoral students would endorse the same level of autonomy for males as for females, regardless of age; however, undergraduate students would differ in levels of autonomy endorsed for males and for females. The educational level by sex ANOVA was not significant, $F(1, 170) = .71$, $p = .49$; therefore, this hypothesis was not supported,. There were no differences in amount of autonomy granted to a male or a female across education levels.

The first part of hypothesis four stated that, for both professionals and doctoral students, there would be no relationship between their attitudes toward euthanasia and their endorsement of autonomy. For professionals, no relationship was found, $r = .24$, $p = .10$. However, for doctoral students, a positive relationship was observed between attitudes toward euthanasia scores and endorsement of autonomy, $r = .47$, $p < .001$. To explore age as a potential confound, a follow-up analysis revealed that for doctoral students their age was positively correlated with autonomy scores, $r = .43$, $p = .001$, but was not correlated with their attitude toward euthanasia scores, $r = -.03$, $p = .83$. Older doctoral students were more accepting of the client's right to make his or her own decision about euthanasia. The second part of hypothesis four stated that there would be a positive relationship between attitudes toward euthanasia and endorsement of autonomy among undergraduate students. This hypothesis was supported, as a positive correlation was found between the two measures, $r = .68$, $p < .001$.

Hypothesis five predicted that, for all participants, attitudes toward euthanasia would be negatively related to religiosity/spirituality. It was found that attitudes toward euthanasia scores were negatively related to strength of religiosity, $r = -.24$, $p < .001$, and negatively related to spirituality, $r = -.23$, $p = .001$. It was also determined that the strength of religiosity scale and spirituality scale were positively related, $r = .79$, $p < .001$. Follow-up tests with just doctoral students revealed that attitude toward euthanasia scores were not related to strength of religiosity scores, $r = -.10$, $p = .239$, but were related to spirituality scores, $r = -.26$, $p = .03$.

The final hypotheses (six through nine) were analyzed using only the primary populations of interest, doctoral students and professionals. Hypothesis six stated that professionals and doctoral students who experienced a friend or family member commit suicide in the last five years would differ in attitudes toward euthanasia from those who had not experienced a friend or family member commit suicide within the last five years. This hypothesis was not supported. A 2 (educational level) by 2 ('yes' or 'no' to having had a family member or close friend commit suicide) ANOVA with attitude toward euthanasia as the dependent variable yielded no main effect for educational level, F (1, 95) = .97, p = .32, or for suicide, F (1, 95) = 2.27, p = .14, and no interaction effect, F (1, 95) = .08, p = .78. Exploratory analyses examined whether time since death and quality of the relationship at the time of death would be related to attitude toward euthanasia scores for those doctoral students and professionals who had experienced a family member or close friend commit suicide. No relationships were found. However, there was a positive correlation between attitudes toward euthanasia and acceptance of autonomy, r = .61, p = .004, for these professionals and doctoral students.

Hypothesis seven stated that professionals and doctoral students who had lost a friend or family member through some form of traumatic death in the last five years would not differ in attitudes toward euthanasia from those who had not lost a friend or family member through some form of traumatic death in the last five years. A 2 (educational level) by 2 ('yes' or 'no' to having lost a family member or close friend to some form of traumatic death within the last five years) ANOVA did not yield significant main effects for educational level, F (1, 95) = 2.82, p = .097, or for traumatic death, F (1,

95) = 3.10, p = .082. Also, there was no interaction effect, F (1, 95) = 1.33, p = .25. Follow-up correlations on doctoral students and professionals who had experienced a traumatic death within the last five years did not yield any significant relationships between attitudes toward euthanasia and either time since the death, r = .09, p = .67, or the quality of the relationship at the time of death, r = -.06, p = .77. Furthermore, there was no relationship between attitude toward euthanasia and acceptance of autonomy for doctoral students and professionals.

Hypothesis eight stated that professionals and doctoral students who had lost a friend or family member through terminal illness within the last five years would differ in attitudes toward euthanasia from those who had not lost a friend or family member through terminal illness in the last five years. A 2 (educational level) by 2 (‘yes’ or ‘no’ to having had a friend or family member die by terminal illness) ANOVA failed to reveal significant differences for educational level, F(1, 98) = 1.96, p = .17, for ‘yes’ or ‘no’ to having lost someone to terminal illness, F(1, 98) = .24, p = .63, and for the interaction, F(1, 98) = .46, p = .50. Follow up tests on those who had lost someone to terminal illness yielded similar results as previous hypotheses. There was no correlation found between attitude toward euthanasia and either the amount of time since death or the quality of the relationship at the time of death, nor between acceptance of autonomy and either amount of time since death or the quality of the relationship at the time of death. However, for these doctoral students and professionals, there was a positive correlation between attitude toward euthanasia and acceptance of autonomy, r = .35, p = .002.

The final hypothesis stated that professionals and doctoral students who had lost a friend or family member through removal of life support in the last five years would not differ in attitudes toward euthanasia from those who had not lost a friend or family member through removal of life support in the last five years. A 2 (education level) by 2 (‘yes’ and ‘no’ to having lost someone through removal of life support) ANOVA did not support this hypothesis, F (1, 95) = 1.19, p = .28 for educational level, F(1, 95) = 1.82, p = .18 for ‘yes’ or ‘no’ to losing someone through life support removal, and F (1, 95) = .19, p = .66 for the interaction. Follow-up correlations were conducted for individuals that had lost someone through the removal of life support. There were no relationships among attitudes toward euthanasia, acceptance of autonomy, amount of time since the experienced death, or the quality of the relationship with the deceased at the time of death.

Chapter 5

Discussion

Several hypotheses were tested in the current study. Hypothesis one postulated that helping professionals and doctoral students in psychology would endorse the same level of acceptance of client autonomy and that both of these groups would endorse a level of acceptance that was greater than that endorsed by undergraduate students. Differential levels of support were found across educational levels, and follow-up tests revealed this difference to exist between undergraduates and doctoral students and between undergraduates and professionals, with the least autonomy endorsed by undergraduates. A significant difference was not revealed in the amount of autonomy granted between doctoral students and professionals, supporting both components of this hypothesis.

Little empirical research has examined the relationship between level of education and acceptance of client autonomy in an end-of-life situation. MacDonald (1998), attempting to explain why Whites endorsed a higher level of acceptance of euthanasia than Blacks as a result of his research, theorized that lower socioeconomic status and lower education might explain these differences as opposed to a true race difference. Some years later, Carroll's (2006) Gallup Poll lent support to MacDonald's explanation. It was found that 60% of adults in the United States with some college education supported euthanasia as an end-of-life option. This number increased and plateaued for college graduates (70%) and post-graduates (69%).

Hypothesis one predicted that undergraduate students (some college) would endorse less a client's autonomy to choose euthanasia as compared to levels of autonomy endorsed by both doctoral students and professionals, both of which can be considered college graduates or post-graduates. Although this pattern was followed, the implication this finding has for the helping profession is of most interest. Carroll's poll was not focused on adults who had some education and/or training in psychology- or counseling-related fields. Therefore, it seems as though the specific trainings received in the helping professions are not necessarily responsible for the increases in autonomy granted as amount of formal education increases.

Just as MacDonald (1998) attempted to explain race differences with socioeconomic and education level factors, perhaps there are other factors related to education level that better explain the differences in granting client autonomy in end-of-life decisions. It is possible that a self-selection bias exists, in that those who choose to continue to seek higher levels of education might also possess a higher level of intelligence or a more sophisticated decision-making process that is refined through higher education, regardless of the field. White and Robinson-Kurpius (1999) found that increased clinical experience was associated with greater acceptance of the client and his or her situation. With the current finding in mind, however, it is unclear if this is related to more experience specifically, or some combination of experience, age, and other factors. It seems likely that there are variables that are related to higher levels of education that are also related to increased acceptance of euthanasia and client autonomy. These connections might be more informative for explaining attitudinal differences than

solely differences in level of education.

The second hypothesis predicted that doctoral students and professionals would exhibit similar levels of acceptance of client autonomy for a 24 year old client and an 80 year old client, while undergraduate students would report higher acceptance for the older client. Similarly, the third hypothesis predicted that the sex of the client would not result in differential amounts of autonomy granted for doctoral students and professionals, while it was predicted that there would be some differential level of acceptance for undergraduate students. No differences were found between the amount of client autonomy granted to the young and old clients or to male or female clients, within any of the educational levels.

Previously, only one study was found that examined the effect of the age of a client on the amount of autonomy granted to clients in end-of-life decisions (Bevacqua & Robinson-Kurpius, 2008). Age of client presented in vignettes was not a significant factor for the counselor trainees studied. Type of euthanasia sought, either active or passive, was also manipulated in these vignettes. While the manipulation of age alone did not reveal any differences in amount of autonomy granted, an interaction between age and type of euthanasia existed, with significantly less autonomy granted to a young client seeking active euthanasia than to any other age-euthanasia combination.

The current study also did not find any differences based on age of client alone. This is surprising when developmental theory is taken into consideration. A 24 year old and 80 year old are, in theory, very different. A 24 year old, statistically, has a great deal of living ahead, and thus it would make sense if individuals were more hesitant to grant

as much autonomy to this younger person when he or she expresses an interest in ending his or her life. However, the driving factor in this instance might be that, in all vignettes, the client is depicted as terminally ill, with a doctor's prediction of six months to live. This imminent death may have served to level the playing field, so-to-speak, rendering the actual age of the client less relevant.

Bevacqua and Robinson-Kurpius (2008) also looked at the effect of sex of the client on the amount of autonomy granted. However, sex was not a controlled or experimentally manipulated variable. Instead, a gender neutral name was used for the clients in the vignettes, and participants were asked at the end of the study to indicate retrospectively if they had imagined the client to be a male or female. Participant scores were categorized based on this response to compare the amount of autonomy granted to a perceived male client and to a perceived female client. There were no differences found based on perceived sex of the client; however, there was a significant imbalance in the perception of sex of the client, with considerably more participants perceiving the client to be male. Therefore, the current study specifically manipulated the sex of the client to target gender differences: No difference, however, was found in amount of autonomy granted based on sex of the client, indicating that the sex of the client does not appear to influence the amount of autonomy granted.

Hypothesis four predicted that, for doctoral students and professionals, there would not be a significant relationship between their attitudes toward euthanasia and their acceptance of client autonomy. For undergraduates, however, it was predicted that there would be a positive relationship between these two scores. There was no relationship

found between these two measures for professionals, which suggests that for professionals personal biases (attitudes toward euthanasia) are not related to their work in a helping professional role (acceptance of client autonomy).

For doctoral students, however, a positive relationship between the two variables was found. This suggests that doctoral students may be less able to prevent personal values from entering into their professional judgments. It is also possible that they have not yet had the professional experiences that reinforce the need to keep personal values separate from clinical work in order to be most effective therapeutically. As predicted, undergraduates also exhibited a positive relationship between the two. This was an expected result for two reasons. Carroll (2006) found that 18 to 19 year olds were less in favor of euthanasia (56%) than 20 to 49 year olds (63%). Many undergraduates in the current study fell into the younger age category. Also, because undergraduate students, spread across numerous class years and majors, do not necessarily have any knowledge of a psychologist-client relationship or loyalty to uphold the ethical standards in place for those in the counseling profession. The APA (2002) has explicit guidelines for objective professional behaviors, and Koocher and Keith-Speigel (2008) also reiterated the need for helping professionals to remain objective and not impose their values on clients. However, it is not anticipated that undergraduate students, most of whom are pursuing other fields, would know this or would uphold this expectation.

In contrast, helping professionals seem to be better at separating personal values from their professional role thus acting in accordance with APA (2002) standards. However, it is expected that doctoral students in psychology would follow the behaviors

of professionals as they are trained to work with clients in a manner consistent with APA's guidelines. In an attempt to explain why doctoral students exhibited a relationship between personal values and professional duties, follow-up tests were conducted to look at age of the respondent as a potential confound. Looking at only doctoral students, it was found that there was a positive correlation between age and acceptance of client autonomy scores, but no relationship between age and attitudes toward euthanasia scores. This is an indication that while more life experience alone does not affect one's personal values regarding euthanasia, there does seem to be a relationship between being older and being more accepting of client autonomy. This could also be at least part of the reason why there was no relationship between autonomy scores and attitudes toward euthanasia scores in the older and more experienced professionals.

Hypothesis five predicted that for all participants there would be a negative relationship between attitudes toward euthanasia and religiosity/spirituality. Consistent with the literature, it was found that attitudes toward euthanasia were negatively related to both religiosity and spirituality scores.

Active euthanasia is not supported by any major religion. While there are some variations in what different religions deemed as acceptable, the one constant is forbidding anyone from intentionally ending his or her own life or assisting someone else the same way (Richards & Bergin, 2000). This is consistent with the findings from the current study. The Attitudes toward Euthanasia scale asks questions surrounding various aspects of euthanasia, several of which relate specifically to active euthanasia. In fact, six of the 10 questions relate either directly or implicitly to a physician actively aiding a patient to

die. The remaining four questions refer to a physician removing some form of life-sustaining treatment (passive euthanasia). Given the content of the questions and the demographics of the sample (only 14.6% indicating no religious affiliation), it makes sense that individuals with stronger ties to religions that do not support euthanasia would feel less positively about someone considering ending his or her life.

Further, the current finding supports previous research. Carroll (2006) demonstrated that those individuals who did not indicate any religious preference had the highest rate of support for euthanasia. Further, those who attended religious services most often were less in favor of euthanasia than those who attended religious services least often, 39% to 72% respectively. Miller et al. (2004) and Suarez-Almazor et al. (2004) also found similar results that indicated that strength of religious beliefs was related to amount of support for euthanasia.

The current study found that both religiosity and spirituality, which were positively related, were negatively related to attitudes toward euthanasia. This finding related to spirituality potentially suggests that it is not necessarily a particular religious affiliation that is of most importance, but instead any belief in a greater power might be the driving force behind a lower acceptance of one ending his or her life.

A follow-up test with only doctoral students yielded a different pattern, however. With just this population, attitude toward euthanasia scores were significantly related to spirituality scores, but not to religiosity scores. There appears to be, for doctoral students at least, a difference in the way religiosity and spirituality are viewed. However, further research is needed to explore potential explanations for this finding.

Hypotheses six through nine examined personal experiences with various causes of death of loved ones and their potential impact on attitudes toward euthanasia. Only the doctoral students and helping professionals were included in theses analyses because, as future and current mental health care providers, the relationship between their experiences and their values were of primary interest. These hypotheses predicted that doctoral students and professionals who experienced the traumatic death or death through removal of life support (hypotheses seven and nine, respectively) of a family member or close friend within the last five years would exhibit similar attitudes toward euthanasia to those who had not experienced such deaths. Conversely, it was predicted that doctoral students and professionals who experienced the suicide or death through terminal illness (hypotheses six and eight, respectively) of a family member or close friend within the last five years would differ in their attitudes toward euthanasia from those that had not. Across all of these hypotheses, no main effects were found that indicated any differences in attitudes between those that had or had not experienced any of the four types of death.

While a review of the literature did not yield any studies that examined these relationships directly, some research was found that explored some of the effects of various forms of death of a loved one on survivors. Feigelman, Jordan, and Gorman (2008-2009) found that parents who lost a child to suicide (compared to another form of traumatic death or natural causes) had the most grief difficulties. The authors believed that the suddenness of the death, coupled with the stigma of the method, could potentially cause social and interpersonal problems, exacerbating the grief. Strained relationships between survivors and deceased were also found to be related to greater grief difficulties.

It was hypothesized that participants in the mental health field who had this same experience might view future death situations differently from those who had not, being either more or less accepting of euthanasia than those who had not.

Maple, Plummer, Edwards, and Minichello (2007) found similar results to Feigelman et al. (2008-2009) in that the more sudden the death (suicide, accident, etc.), the greater the resulting survivor grief. Holland, Coleman, and Neimeyer (2006) found the same result with a group of college students who had lost a family member or friend.

A more general look at the effects on survivors of death is provided by Marks, Jun, and Song, (2007) who examined the effects of the death of a parent. Despite the detailed findings of effects of this death based on several factors, this study, as well as the aforementioned research, did not explain any potential effects of a death of a loved one on future experiences. The current study, designed to examine those effects, did not yield significant results indicating that any of these forms of death affected the way in which these individuals viewed euthanasia situations. It would seem as though the experiences of death themselves, nor the grief associated with these losses did not have a bearing on how one would view an individual in the future contemplating the ending of his or her own life. For helping professionals, this is especially important. As individuals (Werth, 2000) and ethics committees (American Psychological Association, 2002) have stressed, personal experiences, values, and attitudes need to be brought to awareness, and all attempts must be taken to prevent these from influencing the counseling relationship (Koocher & Keith-Spiegal, 2008).

Perhaps the most surprising finding was that having an experience with passive euthanasia (the removal of life support) was not associated with any differential levels of euthanasia acceptance, as this is clearly the form of death most closely related to the situation the client faced in the presented vignettes. Perhaps individuals, specifically those in and training to be in the helping professions, are in fact able to separate personal experiences from professional attitudes, regardless of how similar the situations may be. Thomyangkoon and Leenaars (2008) found that psychiatrists who had experienced the death of a patient, most commonly through suicide, experienced both personal and professional effects. However, the most commonly reported professional change was a more thorough assessment of suicidality with future patients. This appears to be a logical and related response and makes no mention of attitudinal changes toward future depressed and suicidal patients, only a change in professional procedures. The same pattern might have emerged in the current study. Despite the most impactful personal experiences, attitudinal changes toward future experiences, regardless of situation similarity, have not taken place. Future research might examine whether or not this finding is unique to helping professionals or is consistent across multiple populations.

The current study has limitations that need to be noted. First, although participants were recruited for participation all throughout the United States, only one individual was in a state in which active euthanasia is currently legal. Before broad generalizations are made about the field as a whole, for both students and professionals, future research might focus on assessing those that are currently studying or practicing in an area of the

country in which euthanasia has been legalized. This will provide a more complete picture of helping professionals and how they are thinking about this controversial issue.

Another limitation of the study was the method by which participants were recruited and assessed. While undergraduates were recruited in classrooms and offered extra credit as an incentive to participate, doctoral students and professionals were recruited through e-mail and offered incentives with a cash value. It is possible that the latter groups might represent a self-selection bias, in which only those that had an interest in or a strong opinion about the topic of euthanasia chose to participate, while undergraduate students who were recruited in person may not have exhibited this interest.

All participants, regardless of the method of recruitment, completed the survey online. This served to assess all of the participants in an equal manner. However, for such a complex issue, and one that is related very much to the counseling process, perhaps vignette manipulations of variables might not be the most comprehensive way of assessing attitudes or attitude changes. Ideally, an opportunity to assess these individuals in a much broader context would be the focus of future research. This might include client report, self-report, and/or supervisor report, while working with a specific individual who was considering euthanasia or with a role-play client. Live observations and transcriptions of such sessions, or interviews with the therapist about the work being done, could lend themselves to qualitative analysis potentially unlocking other themes or relevant factors related to working with a client considering euthanasia.

As mentioned earlier, future research also might examine more closely the relationship between higher education and acceptance of client autonomy in a euthanasia-

seeking situation. Results from the current study indicate that there may be self-selection factors that are related both to the choice to seek higher education and to be more accepting of euthanasia.

The current study supported a number of patterns from previous research. Among these were the findings that increased levels of education were associated with greater support for euthanasia, reaching a plateau after the undergraduate level, as well as stronger religiosity and spirituality being related to less support for euthanasia. This study also found that participants did not exhibit differential levels of support for client autonomy based solely on the age or the sex of the client depicted in the vignette. Finally, the current study found that for professionals no relationship between their attitudes toward euthanasia and their acceptance of client autonomy was manifested. These results were all consistent with previous findings. However, for doctoral students, a relationship between these two variables, which is not consistent with a previous finding, was found.

This study also assessed relationships that had not been previously examined. Specifically, the current study considered whether or not personal experiences with various forms of deaths of loved ones (suicide, traumatic death, terminal illness, or death through removal of life support) affected one's attitudes toward euthanasia. It was found that, for the helping populations of interest, this was not the case. It seems as though these experiences have not influenced these individuals' opinions toward euthanasia-seeking clients specifically. This is an important finding for those involved with training and supervising these current and future psychologists. With objectivity a high priority when working with clients, especially around such a value-laden topic, it is important to

know whether personal experiences affect one's therapeutic work (American Psychological Association, 2002). Awareness of these events and of their potential impact is most important for helping individuals in order to prevent those biases from entering the helping relationship. However, with these experiences not found to be related, there remains unaccounted for variance in attitudes toward euthanasia. It is important for future research to explore factors that are related to these attitudinal differences. The same way it is now well understood the extent to which one's religious affiliation, and strength thereof, affects the way one might work with a client, so too is it important to bring awareness to other factors that might have the same effect. Doctoral training programs and clinical supervisors especially would benefit from this knowledge, as they work to foster the adherence to professional expectations and ethical codes. This information has and will continue to help to develop and promote objective work especially with this growing population of euthanasia-seeking clientele.

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APPENDIX A

SURVEY

Please circle your response below each question. Please circle one number for each item.

1. If a patient in severe pain requests it, a doctor should remove life support and allow that patient to die.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

2. It is okay for a doctor to administer enough medicine to end a patient's life if the doctor does not believe that they will recover.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

3. If a patient in severe pain requests it, a doctor should prescribe that patient enough medicine to end their life.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

4. It is okay for a doctor to remove life-support and let a patient die if the doctor does not believe the patient will recover.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

5. It is okay for a doctor to administer enough medicine to a suffering patient to end that patient's life if the doctor thinks that the patient's pain is too severe.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

6. Even if a doctor does not think that a patient will recover, it would be wrong for the doctor to end the life of a patient.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

7. It is okay for a doctor to remove a patient's life-support and let them die if the doctor thinks that the patient's pain is too severe.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

8. If a dying patient requests it, a doctor should prescribe enough medicine to end their life.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

9. Even if a doctor knows that a patient is in severe, uncontrollable pain, it would be wrong for the doctor to end the life of that patient.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

10. If a dying patient requests it, a doctor should remove their life support and allow them to die.

Strongly Disagree		Undecided		Strongly Agree
1	2	3	4	5

Please read the following scenario and circle the number reflecting your level of agreement:

Mark is 24 years old and has been battling terminal cancer for almost a year. Despite aggressive chemotherapy, doctors believe that Mark has only a matter of months to live. Between the cancer and chemotherapy, Mark is left feeling nauseated and weak, and he is in a great deal of pain every day. Mark has considered physician's assistance in order to end his life and be free from the pain and suffering. Mark has come to you to talk about this possible decision.

Based on the above scenario, when talking with Mark:

1. I would encourage Mark to make whichever decision he wishes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

2. I would support Mark in whichever decision he makes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

3. Mark should have the right to decide how his life ends.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

4. I would feel comfortable working with Mark regardless of which decision he made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

5. I would be able to prevent my personal opinions from affecting Mark's decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

6. I would feel comfortable working with Mark regardless of the decision made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

7. I would feel responsible if I allowed Mark to engage in physician-assisted suicide.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

8. It is important that Mark understand my opinion on the issue before making his final decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

9. I would refer Mark to someone else if he was leaning toward a decision with which I did not feel comfortable.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

Please read the following scenario:
Mark is 80 years old and has been battling terminal cancer for almost a year. Despite aggressive chemotherapy, doctors feel that Mark has only a matter of months to live. Between the cancer and chemotherapy, he is left feeling nauseated, weak, and in a great deal of pain throughout each day. Mark has considered physician's assistance in order to end his life and be free from the pain and suffering. Mark has come to you to talk about this decision-making process.

Based on the above scenario, when talking with Mark:

1. I would encourage Mark to make whichever decision he wishes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

2. I would support Mark in whichever decision he makes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

3. Mark should have the right to decide how his life ends.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

4. I would feel comfortable working with Mark regardless of which decision he made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

5. I would be able to prevent my personal opinions from affecting Mark's decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

6. I would feel comfortable working with Mark regardless of the decision made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

7. I would feel responsible if I allowed Mark to engage in physician-assisted suicide.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

8. It is important that Mark understand my opinion on the issue before making his final decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

9. I would refer Mark to someone else if he was leaning toward a decision with which I did not feel comfortable.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

Please read the following scenario:
Ruth is 24 years old and has been battling terminal cancer for almost a year. Despite aggressive chemotherapy, doctors feel that Ruth has only a matter of months to live. Between the cancer and chemotherapy, she is left feeling nauseated, weak, and in a great deal of pain throughout each day. Ruth has considered physician's assistance in order to end her life and be free from the pain and suffering. Ruth has come to you to talk about this decision-making process.

Based on the above scenario, when talking with Ruth:

1. I would encourage Ruth to make whichever decision she wishes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

2. I would support Ruth in whichever decision she makes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

3. Ruth should have the right to decide how her life ends.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

4. I would feel comfortable working with Ruth regardless of which decision she made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

5. I would be able to prevent my personal opinions from affecting Ruth's decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

6. I would feel comfortable working with Ruth regardless of the decision made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

7. I would feel responsible if I allowed Ruth to engage in physician-assisted suicide.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

8. It is important that Ruth understand my opinion on the issue before making her final decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

9. I would refer Ruth to someone else if she was leaning toward a decision with which I did not feel comfortable.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

Please read the following scenario:
Ruth is 80 years old and has been battling terminal cancer for almost a year. Despite aggressive chemotherapy, doctors feel that Ruth has only a matter of months to live. Between the cancer and chemotherapy, she is left feeling nauseated, weak, and in a great deal of pain throughout each day. Ruth has considered physician's assistance in order to end her life and be free from the pain and suffering. Ruth has come to you to talk about this decision-making process.

Based on the above scenario, when talking with Ruth:

1. I would encourage Ruth to make whichever decision she wishes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

2. I would support Ruth in whichever decision she makes.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

3. Ruth should have the right to decide how her life ends.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

4. I would feel comfortable working with Ruth regardless of which decision she made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

5. I would be able to prevent my personal opinions from affecting Ruth's decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

6. I would feel comfortable working with Ruth regardless of the decision made.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

7. I would feel responsible if I allowed Ruth to engage in physician-assisted suicide.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

8. It is important that Ruth understand my opinion on the issue before making her final decision.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

9. I would refer Ruth to someone else if she was leaning toward a decision with which I did not feel comfortable.

Strongly Disagree					Strongly Agree
0	1	2	3	4	5

Personal Experiences with Death and Euthanasia

1. Have you ever had a family member or close friend commit suicide? ___Yes ___ No
(If 'no', go to #2. If 'yes,' and there has been more than one instance, please answer the following questions according to the *most recent* incident)

a. This person was my:
__ Mother __ Child
__ Father __ Other Relative (please specify): _____
__ Spouse __ Friend

b. How long has it been since this person's death?
__ Less than 1 year __ 4 Years
__ 1 Year __ 5 Years
__ 2 Years __ More than 5 years
__ 3 Years

c. How would you rate the quality of your relationship with the deceased at the time of his or her death?

0 1 2 3 4 5
Extremely Strained Extremely Harmonious

2. Have you lost a family member or close friend to some other form of traumatic death (car accident, accidental drug overdoes, etc.)? ___Yes ___ No
(If 'no', go to #3. If 'yes,' please answer the following questions. If there has been more than one instance, please answer the following questions according to the *most recent* incident)

a. This person was my:
__ Mother __ Child
__ Father __ Other Relative (please specify): _____
__ Spouse __ Friend

b. How long has it been since this person's death?
__ Less than 1 year __ 4 Years
__ 1 Year __ 5 Years
__ 2 Years __ More than 5 years
__ 3 Years

c. How would you rate the quality of your relationship with the deceased at the time of his or her death?

0 1 2 3 4 5
Extremely Strained Extremely Harmonious

3. Have you had a family member or close friend die of a terminal illness? (Cancer, etc.)
___Yes ___ No
(If 'no', go to #4. If 'yes,' and there has been more than one instance, please answer the following questions according to the *most recent* incident)

a. This person was my:
__ Mother __ Child
__ Father __ Other Relative (please specify): _____
__ Spouse __ Friend

b. How long has it been since this person's death?
__ Less than 1 year __ 4 Years
__ 1 Year __ 5 Years
__ 2 Years __ More than 5 years
__ 3 Years

c. How would you rate the quality of your relationship with the deceased at the time of his or her death?

0 1 2 3 4 5
Extremely Strained Extremely Harmonious

4. Have you had a family member/close friend die through the removal of life support?
__Yes ___ No
(If 'no,' go to the next page. If 'yes,' and there has been more than one instance, please answer the following questions according to the *most recent* incident)

a. This person was my:
__ Mother __ Child
__ Father __ Other Relative (please specify): _____
__ Spouse __ Friend

b. How long has it been since this person's death?
__ Less than 1 year __ 4 Years
__ 1 Year __ 5 Years
__ 2 Years __ More than 5 years
__ 3 Years

c. How would you rate the quality of your relationship with the deceased at the time of his or her death?

0	1	2	3	4	5
Extremely Strained					Extremely Harmonious

Religiosity

1. My religious beliefs lie behind my whole approach to life.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

2. I spend time trying to grow in understanding of my faith.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

3. It is important to me to spend periods of time in private religious thought and reflection.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

4. Religious beliefs influence all my dealings in life.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

5. Religion is especially important to me because it answers many questions about the meaning of life.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

6. I often read books and magazines about my faith.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

7. I enjoy working in the activities of my religious organization.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

8. I enjoy spending time with others of my religious affiliation.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

9. I keep well informed about my local religious group and have some influence in its decisions.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

10. I make financial contributions to my religious organization.

Not at all true of me		Moderately true of me		Totally true of me
1	2	3	4	5

Religious/Spiritual Affiliation:
____ Christian ____ Judaism ____ Islam ____ Buddhism
____ None ____ Other (please specify) _____

How often do you attend religious services?
____ I do not attend ____ on religious holidays ____ about once a month
____ about 2 times a month ____ once a week ____ more than once a week

How strong are your religious/spiritual beliefs?

Not at all					Extremely
0	1	2	3	4	5

How often do you engage in prayer/spiritual meditation?

Never					Very frequently
0	1	2	3	4	5

How important is religion/spirituality in your life?

Not at all					Extremely
0	1	2	3	4	5

How much has your faith helped you to cope with problems?

Not at all					Extremely
0	1	2	3	4	5

Demographic Information

Please provide the following information about yourself:

Age: ___ Sex: __M __F Highest degree: ___ H.S. Diploma ___ BA/BS ___ Master ___ PhD ___PsyD ___MD/JD

What was the Major or Concentration of your highest degree?_____

Are you currently a student? ___Yes ___No

If "yes," what degree are you pursuing?_____

What is your current occupation?_____

Vignette Checklist (Please check the most appropriate answer):

The age of the person in the vignette was: ___ 24 years old ___ 80 years old.

The person in the vignette was: ___ Male ___ Female

APPENDIX B

INFORMED CONSENT

Dear Participant:

I am a graduate student under the direction of Dr. Robinson-Kurpius in the Counseling Psychology program at Arizona State University.

I am conducting a research study to examine attitudes about euthanasia. I am inviting your participation, which will involve answering a few short questionnaires and a demographic information sheet. This should take approximately 10 minutes.

Your participation in this study is voluntary. You can skip questions if you wish. If you choose not to participate or to withdraw from the study at any time, there will be no penalty. You must be 18 years of age or older to participate.

There are no foreseeable risks or discomforts to your participation.

No identifying information is requested at any time; your responses will be completely anonymous. Upon completion of the survey, please send an e-mail to euthanasiadissertation@gmail.com with your name and contact information to be considered for one of three $25 VISA gift cards. Your name and contact information will never be associated with your survey responses. All hard copies of survey data will be maintained in a locked office, with access only by the co-investigators. The results of this study may be used in reports, presentations, or publications but your name will not be known or attached to your specific responses.

If you have any questions concerning the research study, please contact the research team at: Sharon.Kurpius@asu.edu or Frank.Bevacqua@asu.edu. If you have any questions about your rights as a subject/participant in this research, or if you feel you have been placed at risk, you can contact the Chair of the Human Subjects Institutional

Review Board, through the ASU Office of Research Integrity and Assurance, at (480) 965-6788.

Completion of the questionnaire will be considered your consent to participate.

Please follow the appropriate link below to access the survey:

If your birthday is in January, February, or March, click here: http://questionpro.com/t/ADkIfZG3z1

If your birthday is in April, May, or June, click here: http://questionpro.com/t/ADkIfZG34j

If your birthday is in July, August, or September, click here: http://questionpro.com/t/ADkIfZG34k

If your birthday is in October, November, or December, click here: http://questionpro.com/t/ADkIfZG34q

Sincerely,

Frank Bevacqua