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PSYCHOLOGISTS AND PSYCHOLOGISTS-IN-TRAINING: PREDICTORS OF ATTITUDES TOWARD RATIONAL SUICIDE

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Abstract

Predictors of attitudes toward rational suicide were explored for psychologists and psychologists-in-training. Political ideology, rate of religious attendance, and experience with rationally suicidal clients were statistically significant predictors of attitudes toward rational suicide. In contrast, participant professional status, whether identifying as a psychologist or a psychologist-in-training, failed to reach statistical significance. It was also found that extent of efforts to prevent suicide did not have a relationship with attitudes toward the right to engage in rational suicide. Given that two of the three significant predictors of attitudes toward rational suicide concerned personal values suggested that professional training may have little impact on opinions on the topic.

Keywords: suicide, rational suicide

Chapter 1

Introduction

A psychologist will naturally exhaust whatever resources he or she has to ensure the ultimate safety of a suicidal client. The implicit assumption that anyone considering the act is clearly impaired provides the impetus to take action. Suicide is simply not the behavior of someone considered to be of sound mind. However, when faced with a client whose desire to take his or her own life actually sounds *reasonable* on some level, simple conclusions on the correct course of action may become more elusive.

Statement of the Problem

Indeed, while suicide is generally regarded as an irrational act, "rational suicide" means that "following a sound decision making process, a person has decided, without being coerced by others, to end his or her life because of unbearable suffering associated with a terminal illness" (Werth & Holdwick, 2000, p. 513). Often times, the rationale for ending one's life is extended well beyond physical illness to include other circumstances deemed intolerable to the individual (Werth & Cobia, 1995).

Interestingly, research shows that about four out of five psychologists believe it is possible for an individual to make a rational decision to commit suicide (Albright, 1995; Aulbach, 1997; Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001; Werth & Liddle, 1994). Furthermore, a good number of psychologists will in fact encounter clients who they ultimately view to be *rationally* suicidal. Werth (1996b) found that 39% of a sample of members from the American Psychological Association (APA) Division 41 (Psychology-Law Society) indicated they "had worked with a rationally suicidal client" (as cited in Werth & Holdwick, 2000, p. 518). Another study on the topic indicated that

20% of a national sample of psychologists had served at least one individual who they considered to be rationally suicidal (Werth, 1996b, as cited in Werth, 1996a). More recently, Johnson (2004) found that roughly one quarter of Oregon psychologists reported having worked with a client that considered engaging in rational suicide. Furthermore, Miller (2001) reported that 10% of a sample of psychologists had actually received requests from clients for assistance with suicide.

Psychologists are in an important position to address the matter of suicide. Their general support of the concept of rational suicide, coupled with the fact they may very well encounter individuals who are rationally suicidal, makes their attitudes toward the topic an important matter for investigation. Perhaps the strongest evidence of the importance of psychologists' attitudes is that more accepting views toward suicide have been linked with *less action* to prevent a client from committing the act (Hammond, 1991; Werth & Liddle, 1994).

Significance of the Study

As it stands, the research on mental health professionals' attitudes toward rational suicide and its acceptability is lacking. Only a few published empirical studies on the topic exist, along with a few dissertations. This is the case despite the fact that "research demonstrates that rational suicide is an important concept that must be addressed in the literature because it is being faced by practitioners" (Werth, 1996a, p. 293).

Virtually all research on the topic to date has been exploratory in nature, or else conducted with hypotheses based on the findings of a few prior studies. While the purpose of this research is not to test any particular theory, applying previously unexplored variables so as to gauge their influence on attitudes toward rational suicide

among psychologists is of clear value given the potential to increase known predictors.

In addition, Werth and Holdwick (2000) have stressed the importance of continued research on the topic of rational suicide among mental health professionals, in this case, counseling psychologists. Westefeld, Sikes, Ansley, and Yi (2004) noted the need to actually expand research on the topic to other groups of individuals. To date, no research on attitudes toward rational suicide among a national sample of *psychologists-in-training* has been conducted nor does research exist that compares and contrasts the attitudes of such a group with those of professional psychologists. This may be seen as especially intriguing given the aforementioned researchers noted the "profound implications" in terms of training for current and future psychologists based on the likelihood of them encountering individuals who appear rational in their desire to commit suicide (Werth & Holdwick, 2000, p. 523). Among other factors, having to deal with complicated ethical dilemmas may prove to be quite challenging for seasoned counselors, let alone novice practitioners or those still in training. This problem is only compounded when considering that mental health professionals (in this case, counseling psychologists) are likely not trained to assess for whether a suicidal person is actually rational, or even to discuss matters of hastened death with them (Werth & Holdwick, 2000).

Another value of the intended study is querying how many psychologists and psychologists-in-training have come across clients they perceive as *rationally* suicidal. Werth and Holdwick (2000) have noted the importance of continuing to examine this matter so as to better understand how common the issue may truly be to those in clinical practice.

Finally, further exploring the link between attitudes toward suicide and professional behaviors is another benefit to the study. Gaining additional data on whether more approving attitudes are linked with taking less action to prevent suicide, as has been previously observed, is critical. It seems particularly interesting to explore the extent of action that psychologists-in-training indicate they would take to prevent suicide as this group may soon be working independently in the mental health field, no doubt encountering suicidal individuals, some of whom may be considered rational.

This study aims to include a national sample of psychologists, as well as psychologists-in-training (i.e., graduate students in community counseling, counseling psychology, clinical psychology, or doctorate of psychology programs) in exploration of attitudes toward rational suicide. Not only will the study include a previously overlooked population, but it will provide for analysis using a host of predictor variables, some never before applied to the study of attitudes toward suicide among mental health professionals. Data on the clinical experiences of psychologists and psychologists-in-training will also be collected for analysis.

Chapter 2

Review of the Literature

Defining Suicide

Suicide comes from a combination of the Latin words *sui* which means *of oneself* and *cidium* which means to kill (Hewitt & Edwards, 2006). It has been noted that while most everyone has an understanding of the term *suicide* many do not recognize the actual complexity in creating a proper distinction of the behavior. One comprehensive definition suggests, "Suicide is an act with fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes" (De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006, p. 12).

If defining *suicide* is a challenging endeavor then defining *rational suicide* is perhaps even more difficult. Among the first to introduce the term in the professional literature was Siegel (1982). The author advocated for great caution when working with an individual presenting as rationally suicidal. She noted that professional intervention was clearly appropriate when such an individual seeks therapy services as this would presumably suggest they are "ambivalent" and thus not resolved to go through with the act (p. 83). In addition, the author reported that a second aspect calling for intervention is whether the client is able to accurately gauge their current difficulties, as well as what their future will look like.

Siegel (1986) later offered three "defining characteristics" of rational suicide (p. 407). These included the client having a "realistic assessment" of their situation, as well as the capacity for sound decisional processes. Additionally, it was added that the basis

for pursuing the act "would be understandable to the majority of uninvolved observers" from the client's culture (p. 407).

Werth (1995) expanded upon Siegel's three factors supplementing them with two of his own. Namely, there should be a period of time where the act is considered prior to being exacted (Werth, 1992, as cited in Werth, 1995), and the friends and family of the individual committing suicide should be involved in reaching a determination on the correct course of action. Werth (1995) further commented that the five total components to *rational suicide* are not "hard and fast rules" but are rather "sufficiently ambiguous" while still providing a rough framework for discourse on the topic (p. 71).

Given a desire to better define the boundaries of rational suicide, Werth and Cobia (1995) went about surveying mental health professionals in an attempt to create an empirically based definition of the act:

1. The person considering suicide has an unremitting hopeless condition. Hopeless conditions include, but are not necessarily limited to, terminal illnesses, severe physical and/or psychological pain, physically or mentally debilitating and/or deteriorating conditions, or quality of life no longer acceptable to the individual.
2. The person makes the decision as a free choice (i.e., is not pressured by others to chose suicide).
3. The person has engaged in a sound decision-making process. This process should include the following:
    a. Consultation with a mental health professional who can make an assessment of psychological competence.
    b. Nonimpulsive consideration of all alternatives.
    c. Consideration of the congruence of the act with one's personal values.
    d. Consideration of the impact on significant others.
    e. Consultation with objective others (e.g., medical and religious professionals) and with significant others. (p. 238)

Werth (1998) noted that the inclusion of *hopeless condition* is indeed quite controversial as there are a multitude of feelings on what can be subsumed under the term. He also

noted that in addition to careful and deliberate rational thought processes, no *coercion* may play a role in coming to a decision on the act.

Gallagher-Thompson and Osgood (1997) included the idea of suicide due to emotional reasons as acceptable given their definition: "a sane, well-thought-out decision by an individual who is mentally competent, and who is capable of reasoning and choosing the best alternative among the many available" (p. 29). And, well before the creation of an empirically based definition, others argued for a broader interpretation of the conditions under which suicide should be acceptable. Kjervik (1984) noted that emotional suffering should be given weight in similar fashion to more objective physical pain and thus included under the umbrella of rational suicide.

A definition notwithstanding, controversy in determining what the act *is* and *is not* still exists. One complication is that some feel *rational suicide* isn't even an appropriate term to describe the action by which someone experiencing unrelenting pain takes his or her own life. Indeed, others prefer the term "hastened death" which subsumes rational suicide and some other forms of suicide (i.e., "aid-in-dying") where the actual suicidal action is still exacted by the individual as opposed to a physician (i.e., physician-assisted suicide) (Werth & Holdwick, 2000, p. 513).

In contrast, Finnerty (1987), who spoke of the act as simply "a terminal case of the right to be left alone" (p. 88), noted the following:

> Suicide connotes madness, prohibition, sin, crime or other forms of inhumanity and is an ill fitting term for anything but a forbidden action. Nevertheless, this article uses the word because it is ingrained in our language and because it is more significant to study the real meaning of these human actions than to find an exchange word for it. (p. 87)

The extent of the debate does not end with deciding on the correct term to define the act or even in settling on a satisfying definition for the action. Indeed, some

researchers have denounced the very concept of rational suicide altogether (Callahan, 1994; Wrobleski, 1999). All this is no doubt a product of the multitude of ethical perspectives resulting from a discussion on the controversial act of an individual taking his or her life.

The Debate on Suicide

A central difficulty in the complex ethical issue of suicide is that of determining *rationality*. It has been questioned, "How can suicide be considered a rational decision when judgment may be clouded and individuals do not see any other option?" (Abeles & Barlev, 1999, p. 232). It does indeed seem common to assume that suicidal thoughts are the manifestation of a mental illness, such as depression. Further, it has been noted that many of the signs of depression can be masked to appear as symptoms of poor physical health, such as weight loss or difficulty sleeping. This calls attention to the complications involved in attempting to determine whether, for instance, a terminally ill individual contemplating rational suicide is truly thinking clearly amidst physical illness, or whether an inconspicuous mental illness is affecting their thought processes (Range, 1998).

A strident supporter of not engaging in coercive suicide prevention, Szasz (1987) pointed out the mistake in viewing suicide as part of an illness, attempting to make the argument of determining rationality moot. He stated that suicide should be viewed more as an "act" rather than as a "disease" given that society relates homicide to this same moral standard (p. 886). To those that still insist on attempting to gauge the rationality of the act, Szasz acknowledged that some suicides can clearly appear to lack rationality to onlookers. Still, he pointed to the difficulty inherent in who exactly can decide which suicides should be considered *rational* and which should be considered *irrational*. In the

absence of any such external authority, Szasz (1987) stated, “My position, flowing from the general principle of respect for persons, is that whatever a person thinks or does is, by definition, reasonable to him or her” (p. 886).

Not only is there difficulty in deciding what is *rational*, but there is also difficulty in determining exactly what is *too much* pain, and hence whether a person’s decision to engage in suicide could be considered *reasonable* given their degree of suffering. The extent to which others can even begin to understand the subjective pain of another individual, or argue against their desire for death without an appreciation of their unique state is questionable to some (Motto, 1972).

Furthering the argument for freedom to commit suicide, Szasz (1986) stated that if individuals are truly to be free and in control of their destinies, then they should be permitted to take their own lives if they so choose, otherwise they have *no* freedom or responsibility. In contrast, opponents of suicide have argued that individuals who are suicidal cannot see other courses of action, and as such, their inability to perceive alternatives diminishes their freedom, which consequently diminishes their responsibility. Thereby, only in assisting these individuals in seeing such available alternatives can they be allowed to *truly* be free. Thus, coercive prevention of suicide should not be seen as denying the individual their autonomy (Clum, 1987).

Clarifying suicidal *intent* is also a rather complicated matter. It may be unclear whether or not the suicidal individual clearly wants to die, or whether there is a part of them that is actually crying out for help. He further pondered to what degree feelings of suicide are in fact transient. It was noted that people change personal values frequently

through growth and that, "Commonly, we are not sure what we believe" (Maltsberger, 1998, Premises in the Rational Suicide Argument section, para. 21).

Continuing with the idea that a suicidal individual may not really be seeking death, researchers have noted that many individuals contemplating hastened death are in situations where they have lost their sense of dignity. "A deterioration in one's appearance, a sense of being a burden to others, needing assistance with bathing, requiring inpatient hospital care, and having pain, were the most significant issues related to a fracturing of sense of dignity" (Chochinov et al., 2002, p. 2029). The question then becomes whether or not such circumstances can be overcome, providing the individual with a greater sense of dignity, thus presumably diminishing their desire to hasten death. Those on the other side of the suicide debate have argued that unless mental health professionals are supportive of discussing rational suicide as a viable option, then we might never fully understand the individual's desire to hasten death (Werth, 1998).

It has been pointed out that some individuals with a terminal illness purposefully choose *not* to engage in the act of suicide, demonstrating that despite feelings of powerlessness, they do in fact have ultimate control of their life (Kleespies, Hughes, & Gallacher, 2000). The other side of the argument is that the choice to take one's life may in fact be the very last sense of control for a terminally ill individual (Mayo, 1998). Mayo elaborates:

> Ironically, assuring that control by providing such patients with the means to end their lives may do more than anything else within our power to dispel their sense of hopelessness and despair and to restore their interest in embracing life for as long as medicine can sustain it. (Conclusion section, para. 3)

Opponents of rational suicide have often addressed the degree to which coercion may play into the decision to commit suicide and how this could potentially alter the

integrity of the decision making process. However, the extent to which coercion can even be quantified given its multiple potential sources is questioned, not to mention the degree to which such coercion could even be eradicated (Maltsberger, 1998). At issue is the difficulty in discerning what external factors might be causing one to consider suicide, which can subsequently make or break the rationality of such a decision.

Werth (1998) offered his opinion on coercion, "Only by giving clients permission to discuss their thoughts of suicide with us can we help them determine whether their decision is being unduly influenced by societal or familial pressure or internal rejection" (Salient Points section, para 1). Essentially, to deny a person the opportunity to speak about rational suicide out of fear of the topic is denying them the option to explore, and perhaps reject, the very idea opponents of rational suicide fear they will choose (Werth, 1998).

Availability of resources is still another variable that cannot be dismissed. Some researchers have questioned the extent to which particular members of society may be subtly forced into considering assisted death as a result of an inability to pay for appropriate treatment (Lokhandwala & Westefeld, 1998). It was argued that assisted death might then be presented as an option specifically for those with limited abilities to pay for expensive life sustaining treatment, should rational suicide be seen as ethical and acceptable.

Also, suicide cannot help but bring to mind the feelings of family members and friends of the individual taking his or her own life. It has been reported that the family and friends of those that commit suicide experience a more complicated grieving process

than if their loved one had died by natural causes due to the stigma associated with the act (Cvinar, 2005).

And to those who believe they have foresight with respect to their present actions, some have wondered to what degree a person may actually fully consider the effect that his or her suicide could potentially have on others (Maltsberger, 1998). Indeed, "We belong to our families, to our professions, to our societies, and to much more" (Maris, 1983, p. 225). As such, the researcher argued that each of us have an obligation to consider the effects of our actions on others. Still, to supporters of free suicide the matter may be irrelevant. Szasz (1986) argued that individuals should have the right to commit suicide under virtually any circumstances as if one allows his or her self to be affected by the potential consequences of his or her actions on others, perhaps he or she is not acting completely autonomously.

The consequences of suicide becoming more permissible may have very serious but perhaps ultimately beneficial consequences. To allow for suicide in society might actually cause a decrease in the act. "If I know something is available to me and will remain available till I am moved to seize it, the chances of my seizing it now are thereby much reduced" (Motto, 1972, p. 188). The Oregon Death with Dignity Act (ODDA) came into existence in the 1990s and has served as an example of how allowing physician-assisted suicide might actually affect society. It has been argued that the relatively small amount of individuals opting to kill themselves with medically prescribed lethal doses of medication is proof that making suicide legal has not created a flux of suicides, although the authors noted the ODDA was still relatively young (at the time of publication) (Werth & Wineberg, 2005). In contrast, if in fact rational suicide and other forms of hastened

death were deemed even more permissible, hindsight might indeed prove that a more accepting attitude toward suicide would have dire consequences (Rogers & Britton, 1994).

Still, given the aforementioned arguments, what exactly is the correct course of action for the psychologist? Even if self-determination is respected, the client considering rational suicide may be functioning in a state of diminished autonomy, which furthermore can fluctuate over the course of treatment. Therefore, the argument was made that not adhering to the principle of respect for people's rights and dignity is acceptable given the absence of a client's full autonomy (Snipe, 1988)

In similar fashion to prevent death would constitute acting under the principle of beneficence, just as to fail to prevent a client's suicide would be seen as failing to uphold the principle of nonmaleficence. Also, to break confidentiality under such circumstances would not be seen as a failure to adhere to the principle of fidelity and responsibility because the duty to protect a client would take precedence (Snipe, 1988).

In contrast, it has been argued that to reject the idea of talking about rational suicide with a client is to "abandon" them based on incongruency with the therapist's value system (Werth, 1998, Meta-issues: Clarifying the Therapist's Role section, para. 1). Indeed, Werth (1996a) noted that those practitioners that are so quick to dismiss the notion of rational suicide suffer from their own manner of distorted cognitions in coming to such "knee-jerk" responses to clients (p. 297). Furthermore, in not allowing a client to discuss rational suicide openly, psychologists take away their autonomy; such an act is then "justified as an act of benevolent paternalism" (Werth, 1995, p. 76).

Psychologists have much to consider when it comes to establishing their perspectives about suicide. Even for those individuals that feel they have a firm stance on

the topic, the true complexities that can be present in any particular instance of suicidal intent may potentially give cause for thoughtful reanalysis.

Prevalence and Impact of Client Suicide for Practitioners

As noted, there is minimal research on whether or not professionals can expect to encounter *rationally* suicidal clients in their work (Johnson, 2004; Werth, 1996b). However, there is a good amount of research on psychologists experiencing clients that are suicidal (yet not necessarily rational in their desire for death). It was found in a sample of psychologists that 22% had experienced the death of a client by suicide; the chance of experiencing a second suicide thereafter was 39%. There was no significant difference in experiencing client suicide based on practitioner age, gender, nor even the number of years spent in the field (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). Other research indicated that 28% of psychologists experienced the death of a client by suicide. Again, therapist characteristics including age and gender did not correlate with an increased risk of having a client commit suicide, nor did the practitioner's theoretical orientation, although factors such as work setting did (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989).

Rogers et al. (2001) found similar numbers in that 28% of a sample of American Mental Health Counselors Association members (AMHCA), over 40% of whom identified as either clinical or counseling psychologists, experienced a client commit suicide; 71% of the sample experienced a client attempt suicide. Albright (1995) found among a sample of counseling psychologists that 37.4% had lost a client to suicide. In a random sample of 511 APA members, Miller (2001) found that 48.7% had experienced a client commit

suicide. Finch (1992) found that 73.4% of a sample of APA members reported having worked with at least nine clients with some manner of suicidal behavior.

Research on suicide has also been completed in relation to mental health professionals who are in training. Kleespies, Penk, and Forsyth (1993) found that of 282 psychologists that 40% either experienced a client suicide attempt or completion while in training. In another study of 54 pre-doctoral interns in clinical psychology 16.7% reported having had a client commit suicide during their training; 18.5% had a client make a suicide attempt (Kleespies, Smith, & Becker, 1990). Dexter-Mazza and Freeman (2003) observed that of 238 pre-doctoral interns roughly 5% had experienced the death of a client by suicide; over 99% had worked with a suicidal client.

Not surprisingly, suicide can have serious ramifications on mental health professionals. Chemtob et al. (1988) reported "suicides should be acknowledged as an occupational hazard for psychologists not only because of their frequency of occurrence but also because of their impact on psychologists' professional and personal lives" (p. 419). Foster and McAdams (1999) noted that those in training are likely to feel as though they are a personal and professional failure if unable to anticipate and prevent client suicide. Indeed, in a qualitative study of 13 pre-licensure psychologists that experienced a client suicide while under supervision it was found that the respondents experienced anger and sadness, and questioned their ability to work effectively with clients following the event (Knox, Burkard, Jackson, Schaak, & Hess, 2006).

Other research has shown that simply experiencing a client *attempt* suicide resulted in the same negative feelings that accompanied experiencing a client actually *commit*

suicide, though the latter group had the added complication of dealing with feelings of guilt (Kleespies et al., 1990).

The Impact of Psychologists' Attitudes

An attitude can be defined as the potential to evaluate any "concrete object" or "abstract issue" (Maio, Olson, Bernard, & Luke, 2006, p. 284). An additional definition suggests an increasingly broad interpretation, "Attitude is a psychological tendency that is expressed by evaluating a particular entity with some degree of favor or disfavor" (Eagly & Chaiken, 1993). "In contrast, *values* [italics added] focus entirely on abstract ideals, such as freedom, helpfulness, and equality" (p. 284). Indeed, values and beliefs are similar. Aiken (2002) stated that "value is interpreted as an attitude toward ideals, customs, or institutions of a society" (p. 5). Attitudes and values, though they differ, hold many similar properties, the former being conceptualized in some ways as a component of the latter. It is important to note that both attitudes and values can operate on unconscious, as well as conscious levels, and that each can exert an impact on the other (Maio et al., 2006).

Not surprisingly, the role of attitudes has been investigated in the context of counseling. "If, as is maintained herein, psychotherapy can be accepted as an attitude persuasion process, it is clear that therapists need to take greater cognizance of their own personal values as determiners of therapeutic gains" (Beutler, 1979, p. 438). Indeed, attitudes and their impact on the counseling process should not be overlooked. While other research has questioned the extent to which attitudes and values directly and consistently impact what occurs in therapy, noting the likelihood of significant variability across contexts, it has still been observed that, "Values play a role in the process, outcome,

and even assessment of therapy" (Kelly & Strupp, 1992, p. 39).

Even if one disagrees that part of the therapeutic process involves the manipulation of attitudes, it is difficult to argue that personal values are not present within therapy sessions.

> We can consider the idea that values are embedded in therapeutic theory and practice to be no longer a matter of opinion. It is a fact attested to by a major sampling of the views mental health professionals hold concerning their practices. (Jensen & Bergin, 1988, p. 296)

Indeed, personal values are inherently important and permeate the therapeutic atmosphere.

It is true that certain factors, such as situational demands, can strengthen or weaken the relationship between attitudes and behaviors (Maio et al., 2006). For example, a psychologist who is highly supportive of individual autonomy may not necessarily behave in a way that is consistent with such an attitude or value. "Strong situational norms" (Maio et al., p. 297) may serve to propel a psychologist toward protecting the safety of a suicidal client rather than acting in a way that is more consistent with his or her own personal beliefs. Additional factors accounting for the strength of the link between attitudes and behaviors include immediate accessibility of the attitude, knowledge of and experience with the phenomenon, and perception of a link between one's attitudes and the behavior in question (Eagly & Chaiken, 1993). Other important factors include one's need for cognition and the extent to which one is able to self-monitor and consider whether their behaviors are consistent with their attitudes (Aiken, 2002). These factors notwithstanding, even if the specific and ultimate impact of attitudes is not, or even cannot be, consistently accounted for or completely understood, exploration is still warranted given their ubiquitous presence.

Furthermore, as Hoffman (2000) noted, "In cases of helping clients explore rational suicide, it is likely that the counselor's attitudes about death and the dying process are important in both the process and outcome of the decision" (p. 565). Indeed, it seems only reasonable to suspect that the attitudes a psychologist has toward issues, specifically those of such a serious matter as mortality, may very well prove to have an impact on their work, at least in subtle ways. For a matter as critical as the taking of one's life, the potential for even a small impact should be given its due weight. Additionally, in speaking of the research on rational suicide, Werth and Holdwick (2000) have reported "it is apparent that personal values can and do affect professional actions" (p. 526). In the context of rational suicide, exploration of one's own attitudes on suicide is then a professional obligation. "We do a disservice to our clients if we do not prepare ourselves to deal with these issues with them or at least know to whom we can refer them so they can receive the services they need" (Werth & Holdwick, 2000, p. 533).

Psychologists' Attitudes toward Suicide and Commonly Explored Variables

Only a handful of published empirical studies, along with a few dissertations, exist that explore the attitudes of therapists toward suicide. While there are some fairly consistent findings, gaps and inconsistencies do exist.

General Acceptability. Research suggests that the clear majority of mental health professionals feel there are conditions under which suicide is an acceptable option. Werth and Liddle (1994) found among a survey of APA Division 29 (Psychotherapy) members that 81% of the participants indicated agreement on a seven-point Likert-scale with the question, "Do you believe in the idea of rational suicide?" (p. 446). In a later study by Rogers et al. (2001) asking the same question of 241 American Mental Health Counselors

Association (AMHCA) members from 40 different states, again 81% of participants indicated at least moderate belief in the act. These numbers were similar to those found by Albright (1995) among an APA sample of counseling psychologists. Eighty-eight percent of the participants reported that individuals have the right to engage in suicide *at least sometimes*. Aulbach (1997) found in a study of APA members from several different divisions that 79.5% expressed acceptance of rational suicide for various vignette conditions, all of which involved terminal illness.

Other studies have investigated the attitudes of psychologists toward suicide, while including participants from other professions who likely have experience with hastened death. In a study that included clinical psychologists (N = 115), psychiatrists (N = 81), and oncologists (N = 167), Hammond (1991) found that, "Ninety percent of the respondents agreed that it is possible to make a rational decision to commit suicide" (p. 48). In research that included psychologists (N = 58), as well as nurses (N = 37) and state legislators (N = 43) from a Midwestern state, 61% of participants agreed with the idea of rational suicide defined by Werth and Cobia (1995) as, "The process by which a person who has an unremitting helpless condition makes a free choice decision to end his/her life and has engaged in sound decision making" (Westefeld et al., 2004, p. 360). A total of 57% of the participants agreed that rational suicide is *generally* acceptable. It is important to note that response options to the query consisted of simply "yes" or "no" rather than several choices (i.e., a Likert scale) as typically found in other previously mentioned studies. The response options, along with the specific wording of the question, may have caused the reduced percentage of supporters of rational suicide in this particular study.

Precipitating Conditions. Specific contextual circumstances often prove critical in psychologists making decisions on the acceptability of suicide. For example, mental health professionals are inclined to view the suicide of someone experiencing a terminal illness as more acceptable than suicide occurring under other conditions (Werth & Liddle, 1994). Westefeld et al. (2004) helped to confirm this finding with their study of psychologists, nurses, and state legislators. It was observed that having terminal cancer or being on life support following a car accident were considered more acceptable reasons to engage in rational suicide than being severely depressed or quadriplegic. Hammond (1991) found similar results in an earlier study including clinical psychologists, psychiatrists, and oncologists. "Most of the sample did not agree that suicide can be condoned in cases of being tired of living, bankruptcy, family dishonor, or mental illness" (p. 48). However, nearly 75% of the participants found that suicide could be supported in situations of terminal physical illness. Miller (2001) also found that various forms of hastened death were more acceptable for those with medical conditions as opposed to mental health concerns. The study included both physicians and psychologists. Those seeking death based on medical conditions were considered by participants to be more rational. Participants were also more sympathetic to such clients and viewed themselves as more likely to engage in suicide under the same conditions as compared to characters in vignettes that were suffering from a non-medical concern (i.e., posttraumatic stress disorder, extreme grief, panic disorder, or marital problems). While Aulbach (1997) found no significant differences based on precipitating conditions, as hypothesized, each one of the conditions in the researcher's study involved physical pain, thus the participants

may not have differentiated much among suffering resulting from either old age, bone cancer, or AIDS.

Character Status. Age of the character has been an important factor in attitudes toward suicide among mental health professionals. (The term *character* can be used to refer to individuals appearing in vignettes and their unique accompanying characteristics). Westefeld et al. (2004) found that participants viewed rational suicide as more acceptable for adults than for children. Similar results have been found among psychologists where the suicide of a 70-year-old has been found as more acceptable than the suicide of a 45-year-old (Hammond, 1991). Miller (2001) also found that psychologists, as well as physicians, were slightly more supportive of older individuals engaging in suicidal behaviors than they were of middle-aged individuals depicted in vignettes, although they noted the effect size was quite small. Also of interest is the fact that suicide has been found to be more acceptable for those characters having been said to have suffered for greater lengths of time (Westefeld et al., 2004). Aulbach (1997) found that a sample of psychologists did not differ in their attitudes based on character age. Vignettes included characters either 45 or 70 years of age. As previously noted, in each of the conditions presented the character had a terminal physical health problem. It may be that terminal physical illness can trump age in terms of importance in reaching an opinion on suicide.

Additionally, Aulbach (1997) found no difference in the acceptability of character suicide based on their gender. Rogers et al. (2001) also found that gender of the character did not have a significant relationship with the degree to which a participant would attempt to prevent their suicide. This was true whether the participant was answering from the perspective of a professional therapist or a friend of the character.

In contrast, Miller (2001) found that the gender of the character had a significant relationship with attitudes toward hastened death among a sample of psychologists and physicians. "Respondents were more sympathetic toward the female protagonists. They regarded them as more rational, and they were more likely to engage in the same behaviors as the female protagonists" (p. 109). However, the researcher noted that no vignettes differed exclusively by gender. Thus, "It is unclear, however, whether the differences are due to response bias or due to the context of the vignette" (p. 169).

Werth and Liddle (1994) found little differentiation among attitudes as a function of whether or not a character was considered to be a client of the mental health professional participating in the study. However, the researchers noted that their results supporting the lack of differentiation could have been the result of poor wording on survey materials. In some contexts a particular character was specified as a *client* of the participant while in other contexts the character was not specified as such. The results were viewed with some degree of skepticism given that participants may have naturally answered ambiguously worded questions from the perspective that the character was their client. However, Rogers et al. (2001) later found support for the matter. Generally speaking, it was observed that counselors become more accepting of rational suicide as characters move from a client or friend, and then to the actual participant.

Religion. Of course, religion and spirituality have been explored. Religious affiliation was indeed found to have a significant relationship with approval of rational suicide, Catholics generally being the least approving of the act (Rogers et al., 2001). In studying psychologists, nurses, and state legislators, again it was found that those with some manner of religious affiliation were less supportive of the idea of rational suicide.

Among the specific religions identified, Methodists were more approving of rational suicide than were Catholics, general Protestants, or Lutherans (Westefeld et al., 2004).

Hammond (1991) examined the impact of actual religious participation and found the variable to be meaningful. The greater the extent of religious participation the less supportive one is of suicide. Among other factors, Hammond (1991) found viewing suicide as morally wrong to be one of the most important predictors of attitudes toward suicide. Also, participation in APA Division 36 (Psychologists Interested in Religious Issues) or holding a theological degree was found to correlate with attitudes toward suicide. Psychologists without such distinction were more approving of the act (Finch, 1992). Finch (1992) also operationalized religion based on the response to a single item meant to gauge intrinsic or extrinsic religiousity. There was a statistically significant relationship between the variable and attitudes toward suicide; more intrinsic religious views were negatively correlated with attitudes toward suicide.

In contrast, other research on mental health professionals' attitudes toward suicide has failed to find a relationship with religious variables. In one particular study, the factor of "extent of religious participation" was not found to have a significant relationship in terms of attitudes toward suicide, the extent to which someone would take action to prevent another person from committing suicide, or the degree to which one believes that suicide is acceptable (Werth & Liddle, 1994, p. 443). Another study using the Suicide Attitudes Questionnaire (SUIATT) found that the variable of religious preference, which included: Protestant (33%), Agnostic (15%), Jewish (17%), Catholic (12%), and Other (23%) categories did not have a significant relationship with attitudes toward suicide (Baker, 1998).

Gender. Gender of the respondent has been found not to be a determinant of attitudes toward suicide among mental health professionals across several studies (Albright, 1995; Aulbach, 1997; Baker, 1998; Finch, 1992; Hammond, 1991; Miller, 2001; Rogers et al., 2001; Werth & Liddle, 1994; Westefeld et al., 2004). Werth and Liddle (1994) used a sample that included roughly 2/3 men. Finch's (1992) study included 72.6% men and 27.4% women, but noted the numbers were commensurate with actual APA membership. Hammond (1991) noted nearly 80% of her respondents being men, yet there were significantly more women psychologists than women psychiatrists or oncologists in the study. In contrast, Rogers et al. had a sample that included 73% women respondents. Other studies that included equivalent or roughly equivalent proportions of gender also failed to find a significant difference in attitudes toward suicide based on this variable (Albright, 1995; Aulbach, 1997; Baker, 1998; Westefeld et al.).

Age. Albright (1995), Aulbach (1997), Baker (1998), Hammond (1991), and Finch (1992) all looked at the impact of participant age on attitudes toward suicide. This variable failed to have a significant relationship with attitudes toward suicide in each of the studies. However, Miller (2001) found a significant relationship between participant age and a measure of general attitudes toward right-to-die issues, but viewed the finding as unsubstantial given the variable accounted for only 1% of total variance in the scores. Age was found *not* to correlate with respondent sympathy toward characters, how rational they viewed the character to be, or the probability they would engage in the same act if they put themselves in the position of the character.

Race and Geographic Region. Baker (1998) and Rogers et al. (2001) found that race of respondents was not a significant predictor of attitudes toward assisted suicide, and

suicide, respectively. Interestingly, Werth and Liddle (1994) found that the variable of geographic region participants came from did not predict attitudes toward suicide either.

Personal Experience. Aulbach (1997) found that personal experience with terminal illness was not a determinant of attitudes toward rational suicide; a total of 66.5% of respondents noted having such experience. Also, personal history of suicidal ideation failed to have a significant relationship with attitudes toward suicide (Rogers et al., 2001; Werth & Liddle, 1994). The former study found that 20% of their sample of AMHCA members had "seriously considered suicide" (p. 367). Hammond (1991) also reached this same conclusion about the impact of personal suicidal ideation but noted the relatively small percentage of participants who reported experiencing such, just 15%, could have made finding significance difficult. Albright (1995) also found that experience with suicide, which included having lost a close friend or family member, as well as having lost a client, did not have a relationship with attitudes toward suicide.

In contrast, Finch (1992) observed that those individuals having experienced the suicide of "personal friends or family members" were more accepting of suicide (p. 151). In the study over 30% of participants reported having experienced such an event. Hammond (1991) also investigated this same issue. Just over 35% of participants knew at least one "family member, friend, or acquaintance" that had attempted suicide. Roughly half of the participants knew at least one such individual that actually committed suicide (p. 57). These participants were asked whether they suspected the event, or the most *salient* one if there were multiple instances, impacted their attitudes toward suicide; a 6-point Likert scale with "None" at one end of the spectrum and "Extreme" at the other end was utilized (p. 57). In both the attempted and committed suicide cases about 55% of the

participants reported at least some perceived impact on their own attitudes toward suicide, although the study did not provide for indication of whether the impact was positive or negative. However, these same variables were included in a subsequent multiple regression and proved not to be significant predictors of attitudes toward suicide.

Professional Experience. Professional experience has been operationalized in numerous ways and virtually always fails to be a significant predictor of attitudes toward suicide. Neither licensure status (Rogers et al., 2001), type of degree held, nor training program (Werth & Liddle, 1994) have proven to be significant predictors of attitudes toward rational suicide. Westefeld et al. (2004) and Baker (1998) also found that education level was not a predictor of attitudes toward suicide. Additionally, Westefeld et al. found in their study, which included multiple professions, that neither occupation nor years spent in participants' respective fields were significant predictors of attitudes toward suicide. Also, identifying oneself as a counselor, social worker, clinical psychologist or counseling psychologist failed to have a significant relationship with attitudes toward suicide (Rogers et al., 2001), nor did the type of professional setting in which participants operate (Rogers et al., 2001; Werth & Liddle, 1994). Aulbach (1997) failed to find a significant difference among psychologists of various APA divisions based on whether the participants identified themselves as mental health professionals or not. Additionally, Aulbach (1997) found no difference in attitudes toward suicide based on professional experience with terminal illness; 47.7% of the participants reported having such experience. Baker (1998) also found that formal training in suicide and formal training in matters related to death were not determinants of attitudes toward suicide; 60% of participants attended a course on the former and 68% of participants attended a course on

the latter. As mentioned, Albright (1995) found that experience with suicide, which was operationalized as including both professional and personal experience, was not a predictor of attitudes toward suicide. The researcher used a t-test to compare those that experienced suicide with those who had not in comparison to total mean scores on the SUIATT.

Baker (1998) noted "the number of previous suicidal clients that were considered rational is not a predictor of attitudes toward suicide" (p. 33). Rogers et al. (2001) also found that the number of past clients attempting or completing suicide failed to be significant determinants of attitudes toward the act; 71% of the study's participants had a client attempt suicide and 28% experienced a client actually complete suicide. This was consistent with the findings of Werth and Liddle (1994) that the number of clients that had completed suicide did not have a significant relationship with attitudes toward the matter. In Hammond's (1991) study, it was observed that over 75% of the respondents experienced at least one client suicide attempt; 58% of the respondents experienced at least one completed client suicide. It is important to bear in mind that this study included psychiatrists and oncologists in addition to psychologists with the former being significantly more likely to experience both suicide attempts and suicide completions than both oncologists and psychologists. Neither number of client attempts nor completions proved to be significant predictors of attitudes toward suicide when included in a multiple regression. This caused the researcher to note the following:

> Perhaps values or beliefs that are ingrained during childhood or through religious training (e.g., concerning the sanctity of life vs. the quality of life) play a larger role in the formation of our attitudes toward suicide than does experience with suicidal individuals. (p. 80)

Miller (2001) observed in her study of psychologists and physicians that neither the number of clients that committed or attempted suicide, nor amount of requests for assistance with suicide were predictors of general attitudes toward suicide or right-to-die matters. While there was a correlation between general attitudes and having answered a request for physician-assisted suicide and active euthanasia, the latter only accounted for 1% of the variance and was not considered meaningful. These same measures of professional experience were also unrelated to sympathy toward vignette characters, how rational they viewed the characters' decisions to be, as well as whether they could see themselves engaging in the same behavior.

However, Werth and Liddle (1994) found experience did indeed have an impact on attitudes toward suicide. Participants with 30 or more years experience in practice were significantly more approving of the act than were those with 0-15 or 16-29 years of experience. However, the researchers questioned whether the significant result was actually a product of the large number of statistical tests performed on the data, and thus were appropriately wary of the conclusion.

Professional Behavior. Werth and Liddle (1994) also found a significant relationship between attitudes toward suicide and one's professional behavior. That is, more accepting attitudes toward suicide were linked with taking less action to prevent a client from attempting suicide. The specific query gauging participant professional behavior was: "How much action would you take to prevent John from killing himself?" (p. 442). The questions varied, of course, based on the sex (and name) of the character in the particular vignettes. A seven-point Likert scale accompanied the query with potential responses ranging from "nothing" to "anything and everything (including involuntary

hospitalization)" (p. 443). Hammond (1991) found similar results where overall acceptability was correlated with total scores of seven questions also gauging the extent to which a practitioner would "deter a patient who is contemplating suicide" (p. 105). The variable was also statistically significant when placed in a multiple regression predicting attitudes toward suicide.

Gaps in the Understanding of Psychologists' Attitudes toward Suicide

The Impact of Religion. The question of whether or not religion is a factor in attitudes toward suicide among psychologists has not been clearly answered. As noted, Baker (1998) found that religious affiliation did not have a significant relationship with attitudes toward suicide. The variable of religious preference in the study provided for choosing one of the following responses: Protestant, Buddhist, Agnostic, Catholic, Hindu, Atheist, Jewish, or Other. In contrast, Westefeld et al. (2004) found that religious affiliation was in fact a determinant of attitudes toward suicide with those individuals indicating some manner of religious affiliation being less accepting of suicide overall, as well as under a number of certain conditions. Respondents were asked whether they had a religious affiliation and if so, to identify it. Hammond (1991) explored religion through a measure of religious affiliation including the option of Catholic, Jewish, Moslem, Protestant, Buddhist, and Other, and found the variable to be significant, as well. Again, Hammond (1991) also found that feeling suicide was sinful had a very strong relationship with attitudes toward suicide.

Werth and Liddle (1994) who did not find religion to have a statistically significant relationship with attitudes toward suicide operationalized the variable as "extent of religious participation" (p. 443). In contrast, Hammond (1991), who also operationalized

religion via extent of attendance, found that participation in religious services did indeed have a significant relationship with attitudes toward suicide.

The Impact of Age. It is interesting that while age is consistently included as a variable, it tends to have a rather limited range, no doubt due in part to the natural characteristics of those being investigated. In Baker's (1998) study of APA member's attitudes toward assisted suicide only 13% of the participants were under 40 years of age. As noted previously, age was not found to have a relationship with attitudes toward suicide. This result was the opposite of what was anticipated as the researchers hypothesized that "as psychologists gained more experience over time with the topic of suicide their attitudes would be different than those who are young" (Baker, 1998, p. 37). Perhaps of even greater interest was that the developer of the dependent variable used in the study, the SUIATT, also incorrectly suspected that age would be a significant predictor. Hammond (1991) also found that age was not a significant determinant. (This researcher, too, had predicted that younger participants would be more accepting of suicide). However, this sample was also restricted with 74% of the participants being 40 years or older. Only one participant was below 30 years of age. The restriction in age notwithstanding, the researcher noted "the occupational role of health professional may be more salient in shaping attitudes toward suicide than the age of the respondent" (p. 80). In addition, 40% of the participants in Finch's (1992) study were between 40 and 49 years of age. Only five of the more than 400 participants were below 30 years of age. Neither age, nor gender, nor an interaction between the two variables were of significance. Only 4.2% of the 430 participants in Aulbach's (1997) study were under 35 years of age. No significant difference was found in attitudes based on age in this study. Neither age, nor

gender, nor an interaction between the two variables had a significant relationship with attitudes toward suicide among psychologists in Albright's (1995) study. The average age of the participants was about 46 with a standard deviation of 8.28 years and a range of 30-72.

The Impact of Personal Experience. In terms of personal experience, personal suicidal ideation has failed to be statistically significant in several studies (Hammond, 1991; Rogers et al., 2001; Werth & Liddle, 1994). In addition, having known someone suffering with a terminal illness has not been a significant predictor. Interestingly, Finch's (1992) finding that experience with a close other that committed suicide *is* predictive of more accepting attitudes toward suicide suggests the potential importance of this variable.

Yet, Hammond (1991) found no relationship to exist between the variable of knowing someone that had attempted or committed suicide and their attitudes toward the act. However, as noted, the researcher did find that over half of the participants who experienced such an event did in fact indicate in a follow up question that they perceived the event did have at least some impact on them. Albright (1995) also found that personal experience with suicide in the form of losing a family member or close friend (as well as a client) was not related to attitudes toward suicide as measured by the SUIATT. About one quarter of the psychologists sampled had lost someone to suicide. These results may prove difficult to interpret because the suicide of non-clients and the suicide of clients may have very different impacts on mental health professionals. Again, the fact that this study, too, did not explore the perceived directional impact of the loss may further cloud the results.

The Impact of Professional Experience. The variable of professional experience continually fails to have a relationship with attitudes toward suicide. The exception has been Werth and Liddle's (1994) study who hypothesized the following in response to the tenuous finding that more experienced therapists were more accepting of suicide:

> A possible explanation for this could be that as psychotherapists age they become more appreciative and respectful of individual rights and autonomy. Another reason may be that as therapists become more experienced and are further from graduate school they realize that there are shades of grey in what they had been taught was a black-and-white issue (i.e., more experienced therapists may see that the dictum that it is the therapist's ethical responsibility to always prevent suicide is not applicable in the "real" world). (p. 445)

Measurement of Attitudes toward Suicide

Albright (1995), Baker (1998), and Finch (1992) used the SUIATT to gauge attitudes toward suicide in their studies. The instrument has over 90 total items and is said to have solid psychometric properties. It includes questions related to both cognitive and affective components of attitudes toward suicide, as well as questions regarding the probability particular individuals would commit suicide. Items are explored from the perspective of oneself, a close other, and individuals in general (Diekstra & Kerkhof, 1989).

Vignettes are also used quite frequently, presumably as multiple contextual factors can be placed into one specific scenario. Hammond (1991) used a vignette that was modeled after Deluty's (1988-89b). In the former study, age, gender, and type of precipitating condition were varied. Werth and Liddle (1994) used a vignette based on Deluty's (1988-89a) work as well as those of other researchers. Vignettes were also used by Aulbach (1997), with age, gender, and manner of illness being variable within the particular study. In both the Aulbach (1997), Hammond (1991), and Werth and Liddle

(1994) studies, the Suicidal Semantic Differential Scale (SDSS) was used as an accompanying dependent measure so as to gauge the attitudes of participants toward the characters in question. The SDSS, also developed by Deluty (1988-89a), contains several dichotomous adjectives associated with particular instances of suicide. Rogers et al. (2001) also used vignettes based on Deluty's (1988-89a) work; however, the SDSS was not used as the researchers were not interested in "counselors' judgments of the personal characteristics of the individual depicted in the vignette" (p. 367). Hammond (1991) included yet another dependent measure in her study. Questions on the general acceptability of suicide such as whether or not suicide is a sin were found to correlate strongly with the SDSS. This was seen as proof of convergent validity for the former instrument.

Westefeld et al. (2004) approached the topic by developing their own instrument that included 18 brief questions varying by gender, age, length of suffering, and type of ailment. Participants were asked to respond on a scale of 1-5 with whether they agreed the particular character should or should not have the right to commit rational suicide. The inventory also included information on what constitutes rational suicide as limited information was provided for the items.

Sociological Research on Attitudes toward Suicide

Additional research on attitudes toward suicide among the general public has been conducted. Agnew (1998) used comprehensive data from the 1990 and 1991 General Social Survey to explore attitudes toward suicide based on different crime/deviance theories including those that fell under strain theory, social control theory, and social learning theory. The dependent variable in this case was a "yes" or "no" response to the

question, "Do you think a person has the right to end his or her own life if the person: (a) has an incurable disease, (b) has gone bankrupt, (c) has dishonored his or her family, and (d) is tired of living and ready to die?" (p. 211). A regression analysis indicated the following:

> We find that many of the sociodemographic variables no longer have a significant effect on Suicide Approval ($p > .05$). In particular, the effect of sex, age, income, socioeconomic status, community size, marital status, number of children, and number of siblings is insignificant. The effects of education, race, region, and work status are reduced in size, in most cases by a substantial amount. The standardized regression coefficients reveal that the most important independent variables are Liberalism, education, and the religion variables – especially interpretation of the Bible – although each religion variable continues to have a significant effect on Suicide Approval when the others are controlled. (p. 217-218)

Agnew (1998) noted that the importance of the Liberalism Scale (which included questions on topics such as marijuana use, birth control, and approval of pornography). Liberalism had a standard effect size of .21 and was in fact the largest predictor of attitudes toward suicide among the general public. Overall, the study was able to account for 24% of the variance in attitudes toward suicide.

Other suicide researchers have found results similar to those of Agnew (1998). Stack (1998) found that religiousity, along with a measure of liberalism, which included both political liberalism and education, were among the best predictors of attitudes toward suicide. Stack and Kposowa (2008) also noted the importance of religion and liberalism in a study that included data from 31 different countries. Identifying as religious and extent of religious participation were significant negative predictors of attitudes toward suicide. Individual liberalism was an important positive predictor of attitudes toward suicide.

Still, there is further empirical basis for including the aforementioned variables as predictors. Religious fundamentalism has been found to correlate very strongly with right-wing authoritarianism (Altemeyer & Hunsberger, 2004). Indeed, Altemeyer (2006) stated that religious fundamentalists are "highly likely to be authoritarian followers" (p. 140). Further, "the authoritarian follower's penchants for illogical thinking, compartmentalized minds, double standards, hypocrisy and dogmatism apply to religious fundamentalists as well" (Altemeyer, 2006, p. 115). Feldman (2003) conceptualized authoritarianism succinctly as tending to favor conformity and even noted the propensity of authoritarians to consider their own personal view of appropriate social norms as highly accurate.

While some researchers have likened right-wing authoritarianism with political conservatism, other researchers have doubted this claim (Altemeyer, 2006; Crowson, Thoma, & Hestevold, 2005). Although the aforementioned characteristics of right-wing authoritarians may not be directly attributable to conservatives, plenty of research on conservatism exists which can stand on its own. Researchers have explained conservatism simply as "adherence to traditional values and norms" (Van Hiel & Kossoskowa, 2007, p. 19). In distinguishing conservatives from liberals it has been suggested that "conservatives are viewed as relatively traditional, dogmatic and conforming, whereas liberals are viewed as more unconventional and flexible" (Shook & Fazio, 2009). Research on the personality and cognitive styles associated with conservatism shows the construct is correlated with "uncertainty avoidance; integrative complexity; needs for order, structure, and closure; and fear of threat in general" (Jost, Glasser, Kruglanski, &

Sulloway, 2003, p. 366). The aforementioned research also found dogmatism and intolerance of ambiguity to have even stronger correlations with conservatism.

If those high in religious fundamentalist beliefs and high in conservative ideology are viewed as conforming to established norms, whether religious or cultural, it is likely that support of rational suicide will be low. Suicide, and more specifically, rational suicide, is no doubt a behavior that goes against religious teaching, as well as one which carries a significant social stigma, making the act something of which religious fundamentalists and conservatives would strongly disapprove.

Summary of Literature Review

Research clearly suggests that client suicide is something for which psychologists and psychologists-in-training should be prepared. It is a matter that can have significant ramifications on their personal and professional lives, to say nothing of the impact on family and friends who lose a loved one to the act. In addition, mental health professionals are indeed encountering individuals that are *rationally* suicidal; such individuals pose a greater challenge in that their circumstances for wanting to end their life may seem more reasonable than a client experiencing fleeting depressive symptoms or a situational, yet resolvable, life crisis.

The various arguments for and against suicide provide psychologists with multiple perspectives on the topic. While the specific impact of attitudes toward suicide is difficult to parcel out, evidence suggests they are indeed important. Not only are the attitudes and values of psychologists a critical factor with respect to what transpires in therapy, but research suggests that more accepting attitudes toward suicide are linked with less efforts to prevent a client from engaging in suicide (Hammond, 1991; Werth & Liddle, 1994).

The total amount of research to date on the topic is modest. Still, consistent findings suggest that suicide is more acceptable for those who are older, are adults, have suffered for greater lengths in time, and are suffering via a terminal physical illness as opposed to mental illness or other lesser concern. Additionally, participant age, gender, race, professional experiences, as well as the majority of respondent personal experiences are not related to attitudes toward suicide.

The impact of religion has been shown to be significant in some studies and insignificant in others. In addition, findings that suggest the importance of personal experience with close others who have committed suicide also warrants further investigation, namely the perceived impact of the event. The limited age range of those sampled in the literature exposes another gap in what can be deduced about psychologists' attitudes about rational suicide. Perhaps most importantly, there has yet to be any research studies regarding current psychologists-in-training and their attitudes about suicide.

Interestingly, the research on psychologists' attitudes has tended to overlook findings from other disciplines. Sociological research completed on attitudes among the general population has suggested the importance of liberalism-conservatism and religious fundamentalist beliefs as predictors of attitudes toward suicide, which suggests the potential importance of adding these variables to research on psychologists and psychologists-in-training.

Current Study

Problem Statement

The existing data on mental health professionals' attitudes toward suicide is lacking. First, work thus far has neglected to investigate potentially important predictor

variables that have been of significance in other studies on suicide. Therefore, those factors currently understood to account for attitudes toward rational suicide may not be portraying the topic in its true entirety. Additionally, the impact of religion on psychologists' attitudes toward suicide is currently inconclusive; in some studies it is significant, while in others it is not. Also, there is virtually no information on the attitudes of psychologists-in-training toward the topic. Given that these individuals may soon be working independently with clients experiencing suicidal ideation, some of whom may appear rational, it is important to investigate their views. In addition, only two studies exist which have explored the link between attitudes toward suicide and professional behaviors (i.e., more accepting attitudes leading to less effort to prevent a suicide). Adding to the limited data on the relationship between these variables is subsequently of great value. The perceived impact of suicide attempts and completions, both personally and professionally, could also stand to be clarified. Furthermore, the research that exists on the frequency of encountering *rationally* suicidal individuals in clinical work is sparse. Obtaining data on the rates of experience with rational suicide is consequently important.

Research Questions

(1) What variables best predict attitudes toward rational suicide among psychologists and psychologists-in-training?

(2) How does the addition of liberalism-conservatism and religious fundamentalism variables contribute to the variance accounted for in attitudes toward rational suicide?

(3) Do psychologists and psychologists-in-training differ in their attitudes toward rational suicide?

(4) To what extent do psychologists and psychologists-in-training experience rationally suicidal clients in their work?

(5) Are there differences between psychologists and psychologists-in-training in the extent to which they would go to prevent a client from committing suicide if he or she were viewed as rational?

Objectives

The objective of this study is to explore predictors of attitudes toward rational suicide. Not only will new predictor variables be introduced into the study but additional information on the frequency of encountering *rationally* suicidal clients will also be obtained. An additional interest is the extent to which psychologists and psychologists-in-training differ with respect to their attitudes toward suicide. Finally, attitudes toward suicide among psychologists and psychologists-in-training will be compared with the degree of intervention that they would exact in order to prevent a client from committing suicide to see if any relationship exists.

Chapter 3

Methods

Overview

This study aimed to explore predictors of attitudes toward rational suicide among a national random sample of psychologists and psychologists-in-training. Additional information related to clinical experience with rationally suicidal individuals was also sought.

Participants

Participants consisted of members of the Association for Psychological Science (APS). The APS has over 20,000 members and includes "scientists and academics, clinicians, researchers, teachers, and administrators" as well as graduate students studying psychology. The overall mission of the APS is "to promote, protect, and advance the interests of scientifically oriented psychology in research, application, teaching, and the improvement of human welfare" (http://www.psychologicalscience.org/about/).

Measures

Demographics Questionnaire. There were two separate Demographics Questionnaires (DQ), one for psychologists (Appendix A) and one for psychology graduate students (Appendix B). The two DQs differed in questions related to professional experience as certain questions (e.g. how many years experience one has as a psychologist) would not have been relevant to the graduate student group and vice versa. Several pieces of information were requested from each participant. This information included: age, sex, race, relationship status, religious affiliation, rate of religious service

attendance, educational status and experience, professional experience with suicide, and personal experience with suicide.

Some of the specific questions from the DQ warrant some additional explanation. Querying whether or not participants have experienced rationally suicidal clients in their professional/academic work has been advocated for in previous research (Werth & Holdwick, 2000). Doing so via the DQ subsequently helped to further clarify the extent to which this phenomenon is occurring in clinical practice. Another notable facet of the DQ is that it asked clients to identify the perceived impact that particular suicides have had on them, as well as the direction. Prior research explored whether psychologists felt there was an effect on their attitudes toward suicide based on having personal or professional experience with the phenomenon (whether it be a client, friend, family member, or acquaintance) (Hammond, 1991). The DQ included questions gauging the actual *directional* impact of the event on one's subsequent attitudes. In addition the DQ had an item based on the work of Rogers et al. (2001) in that it queried whether or not participants have ever "seriously considered suicide" (p. 368).

Rational Suicide Questionnaire. Each participant was asked to complete the Rational Suicide Questionnaire (RSQ) (Appendix C). This inventory has been used in prior research that included psychologists (Westefeld et al., 2004). It has been observed to have one clearly interpretable factor accounting for 77% of the total variability in scores; two other factors were found to not be interpretable by the authors. The alpha reliability of the instrument has been observed at .97 and all of the factor loadings on the single interpretable factor were found to be .63 or above. The researchers concluded the RSQ "appears to be psychometrically sound" (p. 367-368). This represented the dependent

variable and was the tool by which participants' overall attitudes toward the acceptability of rational suicide was assessed.

In addition to the 18 statements regarding the acceptability of rational suicide, the inventory included guidelines for what constitutes rational suicide based on the work of Werth and Cobia (1995). Indeed, the RSQ acknowledges in the instructions that the brief nature of the queries inherently excludes a good deal of contextual information that a respondent would naturally seek out. Yet by including the details that the act has been thoroughly analyzed without outside pressures it answers those questions which might be among the most salient in assisting an individual in coming to a decision. For example, to ask whether an individual *generally* finds it acceptable for a person to commit suicide because of losing his or her job, a response might simply be "no" based primarily on a lack of contextual information. By including the aforementioned details it likely allows participants to arrive at a more firm conclusion with respect to different items on the instrument. In addition, the fact the RSQ is significantly shorter than other suicide-attitude inventories, such as the 94-item SUIATT, was another practical benefit of using this specific instrument. It also precluded the need for lengthy yet still nebulous vignettes.

Prior to the 18 items on acceptability of rational suicide under specific conditions, the RSQ asked whether individuals typically find rational suicide acceptable. Although the original creators of the instrument provided for respondents to choose between "yes" or "no" responses, for the purposes of this research a Likert scale was utilized as opinions on the topic were suspected to likely fluctuate in a midrange between absolute approval or disproval of rational suicide.

Also, the RSQ was supplemented with a question based on the work of Hammond (1991) and Werth and Liddle (1994) that assessed the degree to which participants would prevent a rationally suicidal individual from committing suicide. This provided information on the extent to which attitudes toward rational suicide have a relationship with action taken to prevent the act by participants.

Revised 12-Item Religious Fundamentalism Scale. The Revised 12-Item Religious Fundamentalism Scale (RFS) was used so as to gauge the degree of fundamentalist religious views of the participants (Appendix D). The scale is intended to measure "attitudes about one's religious beliefs" (Altemeyer & Hunsberger, 2004, p. 49). The construct is defined more clearly:

> By "fundamentalism" we mean the belief that there is one set of religious teachings that clearly contains the fundamental, basic, intrinsic, essential, inerrant truth about humanity and deity; that this essential truth is fundamentally opposed by forces of evil which must be vigorously fought; that this truth must be followed today according to the fundamental, unchangeable practices of the past; and that those who believe and follow these fundamental teachings have a special relationship with the deity. (Altemeyer & Hunsberger, 1992, p. 118)

The scale has a one-dimensional factor structure and is psychometrically sound. Religion has at times been shown to be a predictor of psychologists' attitudes toward suicide, hence its inclusion. While other studies have focused primarily on participants' religious preference or rate of participation, this measurement was meant to tap directly into fundamentalist religious beliefs, and the conviction with which these beliefs are held, thus adding a new dimension to the study of attitudes toward rational suicide among psychologists. The fact that interpretation of the Bible has been shown to be among the strongest predictors of attitudes toward suicide also supported the inclusion of this

particular variable (Agnew, 1998). The finding that Hammond (1991) found viewing suicide to be a sin was a significant predictor was another basis for its inclusion.

Political Ideology Inventory. The rationale for the inclusion of such a measure was that the variable of conservatism-liberalism has proven to be one of the strongest predictors of attitudes toward suicide among the general public (Agnew, 1998; Stack 1998; Stack & Kposowa , 2008). In addition, Agnew (1998) found that supplementing the single conservatism/liberalism item with questions on social topics (e.g., drug use) resulted in more variance accounted for than if just using the one item, alone. Shook and Fazio (2009) created their own political ideology scale, referred to in this study as the Political Ideology Inventory (PII) (Appendix E). The researchers found that the measure of 13 items had "satisfactory internal consistency" with a .71 alpha level. They also noted that it had a significant correlation with a subsequent single conservatism-liberalism item. The researchers conceptualized political ideology as spanning from conservatism to liberalism. In distinguishing the two political stances the researchers noted, "Generally speaking, conservatives are viewed as relatively traditional, dogmatic, and conforming, whereas liberals are viewed as more unconventional and flexible" (p. 995). A measure of conservatism-liberalism had not previously been introduced into the study of attitudes toward suicide among psychologists, hence its inclusion.

Suicide Intervention Self-Efficacy Scale. The Suicide Intervention Self-Efficacy Scale (SISS) was created as a means of gauging the level of self-efficacy that mental health professional have in working with suicidal clients (Appendix F). The SISS was piloted by the author with a small group including master's and doctoral level mental health professionals, as well as doctoral and master's level graduate students in the field of

mental health. This scale was included in the study for the purpose of looking at differences in the efficacy level between psychologists and psychologists-in-training working with suicidal individuals.

Research Design and Procedures

Potential participants included specific APS members. Among the thousands of members there are various categories of membership and classification. To be classified as an APS *member* an individual "must possess a doctoral degree in psychology (or related field) from an accredited institution or be able to show evidence of sustained contributions to scientific psychology." To be classified as a *graduate student affiliate* of the APS an individual "must have received a Bachelor's degree (or equivalent) and is (or expects to be) enrolled as a full-time student pursuing an advanced degree (Master's or Doctorate) in psychology or any related field at an accredited degree-granting institution" (http://www.psychologicalscience.org/join/).

To allow for further delineation both members and graduate student affiliates are required to designate a *major field* to which they belong. Options include: biological/physiological, clinical, cognitive, developmental, educational, experimental, general, industrial/organizational, social/personality, and quantitative. Over 17,000 total members are accessible via the APS online directory. Of these individuals over 1,400 were classified as members, with a mailing address in the United States, and with a concentration in the major field of *clinical* psychology. In addition, there were over 700 individuals designated as graduate student affiliates, within the U. S., with a major field of clinical psychology when 350 members from each group were chosen at random by the researcher to take part in the study.

Packets included the appropriate DQ (either designed specifically for psychologists (Appendix G) or psychology graduate students (Appendix H)), the RSQ, RFS, PII, and SISS. Each packet also included a self-addressed stamped envelope with the researcher's school address in which participants could place completed survey instruments to return to the researcher. The survey packet naturally also included appropriate Institutional Review Board information (Appendix I).

Participants were asked to complete the survey instrument as honestly as possible and were reminded that no materials would contain identifiers that would allow the researcher to link the participant with the packet that they completed. They were told that it would take no longer than 20 minutes to finish the survey, and that they should complete it in one sitting.

The RSQ, as well as portions of the DQ which included questions about personal and professional experience with suicide, were included at the end of the packet so as not to taint prior responses to less reactive items. Indeed, according to terror management theory (TMT) fear of death has an impact on our everyday functioning (Rosenblatt, Greenberg, Solomon, Pyszczynski, & Lyon, 1989). Death is something that is feared, even though it may seem distant. While there are ways in which individuals make an effort to avoid thinking about death, when defenses fail attitudes tend to become strikingly conservative and efforts are made to support social mores (Rosenblatt et al. 1989).

Data Analysis

A simultaneous multiple regression was performed on the data. The purpose was to see how well certain independent variables predicted attitudes toward rational suicide.

Independent variables included the RFS and PII. Additional variables in the regression included age, sex, professional experience with suicide, and personal experience with suicide. These DQ items were not suspected to have a relationship with attitudes toward rational suicide but rather were added as controls. Professional status was also included as a predictor to gauge whether identifying as a psychologist or a psychologist-in-training had a relationship with the criterion variable. Additionally, a single conservatism/liberalism item was included to observe whether it would rival the PII in terms of significance. Also, having a religious affiliation (AFF) and rate of religious attendance (ATT) were added to observe their significance relative to the RFS. Finally, extent of efforts to prevent suicide was included in the model so as to observe its relationship with attitudes toward rational suicide. The criterion variable was attitudes toward rational suicide, as measured by the RSQ (not including item A or item 19).

Hypothesis 1: The regression model, including the RFS, PII, and items from the DQ, would account for a statistically significant portion of the variance in attitudes toward rational suicide.

Hypothesis 2: Religious beliefs, as measured by the RFS, would be a significant negative predictor of attitudes toward rational suicide. As participants' degree of religious fundamentalism increase their approval of rational suicide should decrease.

Religion is virtually always included in studies that explore attitudes toward suicide among psychologists. This variable is typically a significant predictor of attitudes, although at other times it is not. It was assumed that a measure which specifically explored the extent to which a participant adheres to religious beliefs, and not just their affiliation or participation, would prove to be both a strong predictor of attitudes toward

rational suicide among psychologists and psychologists-in-training, and perhaps a stronger variable than religious affiliation or participation, alone. This hypothesis was consistent with Agnew's (1998) finding on the importance of the inclusion of queries regarding interpretation of religious text.

Hypothesis 3: Political ideology, as measured by the PII, would be a significant negative predictor of attitudes suicide. It was predicted that as conservatism increases a participants' approval of suicide should decrease.

Political ideology had not been previously used in studies of psychologists' attitudes toward suicide. Research suggests that this variable is a significant predictor of attitudes toward suicide among the general public (Agnew, 1998; Stack, 2008; Stack & Kposowa, 2008). As religiosity has been a variable that has been a strong predictor of attitudes toward suicide among the general public, as well as among psychologists at times, it was hoped that a measure of political ideology would also retain its strength as a predictor when applied to a more specific population. Furthermore, the fact that those who are conservative tend to be more rigid and conforming in their beliefs also supported the inclusion of this variable (Jost et al., 2003; Shook & Fazio, 2009; Van Hiel & Kossoskowa, 2007).

Subsequent exploratory analyses also took place. Of interest was the perceived impact of personal experience with suicide on participants. In addition, assessing for differences in the degree to which psychologists and psychologists-in-training would go to prevent a client from committing suicide was also of interest. It was also desired to explore scores from the SISS to look at differences between psychologists and psychologists-in-training. Finally, potential differences between psychologists and

psychologists-in-training in terms of attitudes toward rational suicide were also investigated via regression analysis.

Fifteen subjects per variable were required in order to help protect against shrinkage when conducting the multiple regression (Stevens, 1999). Surveys were sent out to 700 participants to help ensure a sound subject to variable ratio.

Indeed, the typical response rates for research on psychologists' attitudes toward suicide have been relatively strong. Werth and Liddle (1994) had a useable response rate of 50.5% from 400 randomly selected members of APA Division 29 (Psychotherapy). Rogers et al. (2001) obtained a response rate of 24% after surveying members of the American Mental Health Counselors Association (AMHCA), over 40% of whom identified as either counseling or clinical psychologists; the authors noted that they did *not* use any follow-up reminders after the initial contact with respondents via mail. In another study of clinical psychologists affiliated with the APA a response rate of 41% was achieved (Hammond, 1991). Another study of a sample of 1000 APA members yielded 407 total responses (Finch, 1992). Johnson (2004) noted a total response rate of 15% from a sample of 500 licensed psychologists in Oregon; this researcher also did *not* provide any follow-up reminders to participants. Albright (1995) had a useable response rate of 34.8% among APA Division 17 (Counseling Psychology) members; reminders were used. Finally, in a study of a sample of 1000 members from five different APA divisions, 430 useable surveys were returned (Aulbach, 1997). In light on this information participants in this study were provided a reminder one week after initially receiving the survey packet (Appendix J).

In April of 2009 the APA stopped allowing access to members by other APA members for the purposes of independent research. No previous published research on attitudes toward suicide had been conducted that utilized a sample of APS members. It was hoped that rates of return among APS members would be similar to or surpass those of prior samples using APA members. As no prior research using psychologists-in-training had ever been used, it was unclear how participants from this sample would respond. As the topic is an important one in the field it was hoped that graduate students would have comparable response rates to the psychologist participants.

Chapter 4

Results

Descriptive Statistics and Correlations

Of the 700 total surveys mailed out, nine were returned to the researcher due to the address being inaccurate or else no longer up to date and without a known forwarding address. Another seven surveys were returned entirely blank, as well as one with only an extremely small portion of questions answered. Several of these returned surveys indicated that the participant did not feel qualified to take part in the study because they primarily conducted research as opposed to doing clinical work. Another one of these participants who received the Psychology Graduate Student Questionnaire reported he or she had recently graduated and thus felt she did not fit the researcher's intended criteria for inclusion in the sample. Despite being APS graduate student affiliates, four participants were not actually enrolled in any graduate program, (nor were they professionals); they all presumably were anticipating applying to and being accepted to graduate programs in the near future. Another individual reported having completed a graduate degree in mental health yet was not currently enrolled in a graduate program. Because this individual, who was listed as a graduate student affiliate member of the APS, was not in a program, nor did he have any direct service hours, he was also excluded from the analysis. Another five individuals were removed from the final analysis as they were over 64 years of age and fell beyond the bound approved of by the University of Oklahoma Institutional Review Board. In all, a total of 163 useable surveys were returned out of the original 700, resulting in an overall response rate of 23.1%.

The overall average participant age was 37.8 years. Among those identifying as psychologists the average age was 48.1, while among the psychologist-in-training group the average was 29.4.

The total sample included 66.3% women compared to 33.7% men. The distribution of gender among the psychologists was fairly even, 46.6% male and 53.4% female. In contrast, the psychologist-in-training group contained mostly women (76.7%).

The majority of the sample (84.7%) identified as being of White/Caucasian/European ancestry. Table 1 indicates the total breakdown for race/ethnicity. Both the psychologist and psychologist-in-training groups contained over 80% White/Caucasian/European ancestry.

Table 1
Demographics

Race/Ethnicity	N	% of sample
American Indian	2	1.2%
Asian American	2	1.2%
Bi-racial	9	5.5%
Black/African American	3	1.8%
Hispanic/Latino/a	5	3.1%
Middle Eastern	1	.6%
South Asian/Asian Indian	3	1.8%
White/Caucasian/European	138	84.7%

Just over 55.2% of the sample reported having a specific religious affiliation. Of those reporting having a specific religious affiliation, 70% identified being Christian. Just less than 25% of participants with a religious affiliation identified as Jewish (13.5% of the total 163 participants). Of the remaining participants with an affiliation, two identified as Buddhist, two as Hindu, and one as Muslim. Contrasting the psychologist and psychologist-in-training groups, the latter had 56.2% of members reporting having a religious affiliation, the former had a very similar percentage, 54.4%.

In response to the query of average rate of religious service attendance per month, 72.3% of the total respondents (N = 159) reported not attending whatsoever. Just 11.9% reported weekly (or greater) participation. Only one participant who indicated not having a specific religious affiliation reported attending religious services (an average of once per month). A small number of individuals (N = 4) responded to the query using a less than sign (e.g., >1) and could not be appropriately included in the average. Nearly 75% of the psychologists reported not attending religious services in the average month. Just over 70% of the psychologist-in-training group reported not attending religious services at all in the average month.

The majority of participants were married or in a committed long-term relationship. Table 2 shows a breakdown of the variable of relationship status.

Table 2
Relationship Status

Status	N	% of sample
Committed Long-term Relationship	42	25.8%
Dating	8	4.9%
Divorced	6	3.7%
Married	72	44.2%
Single	32	19.6%
Separated	2	1.2%
Widowed	1	.6%

A total of 44.8% of participants identified as psychologists (or professional members of a closely related field). The remaining 55.2% were psychologists-in-training (or graduate students in a closely related field).

Of the 73 professionals taking part in the study the majority were doctoral level clinical psychologists (84.5%). Three individuals marked the “Other” option provided for this item and indicated a non specific psychology doctorate or some manner of dual

psychology doctorate. Table 3 shows the professional degrees of the group. Table 4 illustrates psychologists' years of experience.

Table 3
Psychologist Training

Degree	N	% of sample
Clinical Psychology PhD	60	84.5%
Counseling Psychology PhD	6	5.6%
Doctorate of Psychology	3	4.2%
MS-LMFT	1	1.4%
Other	3	4.2%

Table 4
Years of Experience

Years	N	% of sample
Less than 1	1	1.4%
1-5	9	12.7%
6-10	17	23.9%
11-15	12	16.9%
16-20	10	14.1%
21-25	8	11.2%
26-30	8	11.2%
31-35	6	8.5%

The average amount of experience as a psychologist was just over 16 years. The average number of hours spent offering therapy was 6.8, although 41.2% noted not currently engaging in any individual therapy in the average week. Accompanying responses suggested these participants only offered supervision, conducted research exclusively, or in one case, was retired for an unspecified period of time. Table 5 illustrates the average number of hours the psychologist currently spends conducting therapy services each week.

Among psychologists-in-training, 73.3% of the 90 participants indicated currently working on a doctorate in clinical psychology. One individual indicated being "in between degrees" having completed a master's degree in the field of mental health and anticipating beginning an unspecified doctoral program in the near future. As this

particular individual had earned a number of direct service hours he was included in the analyses. Table 6 indicates the breakdown of graduate programs. Three individuals indicated "Other" as a response and reflected a doctorate in a closely related field.

Table 5
Therapy per Week

Hours	N	% of sample
0	28	41.2%
>0-5	18	26.5%
6-10	5	7.4%
11-15	4	5.9%
16-20	9	13.2%
21-25	1	1.5%
26-30	2	2.9%
31-35	0	0%
36-40	0	0%
>40	1	1.5%

Table 6
Psychologist-in-Training Program of Study

Degree	N	% of sample
Clinical Psychology	66	73.3%
Counseling Psychology	4	4.4%
Doctorate of Psychology	6	6.7%
"In between degrees"	1	1.1%
Master's Degree in Counseling	2	2.2%
Master's Degree in Psychology/Related Area	8	8.9%
Other	3	3.3%

The average amount of direct contact hours among graduate students (not including assessment or group therapy) was 480. However, it is important to note that 34.5% of respondents had 100 or fewer hours. In addition, one participant reported having 4500 direct contact hours, by far the most reported by any psychologist-in-training. Therefore, a more meaningful indicator of the experience of the professionals-in-training is the median, 200 hours. Table 7 depicts the years of graduate level training. Note that

year in program is reflective of both doctoral and master's level students. Table 8 depicts the number of direct service hours for the psychologists-in-training.

Table 7
Length in Program

Year	N	% of sample
1st	9	10.2%
2nd	24	27.3%
3rd	18	20.5%
4th	16	18.2%
5th	14	15.9%
6th	4	4.5%
7th	2	2.3%
8th	1	1.1%

Table 8
Direct Service Experience

Hours	N	% of sample
0	6	6.8%
1-100	24	27.3%
101-200	16	18.2%
201-300	8	9.1%
301-400	4	4.5%
401-500	8	8.5%
501-600	3	3.4%
601-700	2	2.3%
701-800	1	1.1%
801-900	1	1.1%
901-1000	4	4.5%
1001-1100	0	0%
1101-1200	4	4.5%
1201-1300	0	0%
1301-1400	0	0%
1401-1500	1	1.1%
More than 1500	6	6.8%

Roughly four out of five participants (82.8%) reported having worked with a client that voiced suicidal ideation. Of the psychologist-in-training group 71.1% reported having experience this phenomenon. In contrast, 97.3% of the psychologist group members experienced a client voice suicidal ideation.

In addition, 40.4% reported having experienced at least one client suicide attempt during their work with them. Two of these participants reported having experienced 10 client suicide attempts during their work. Roughly 60% of the psychologist group experienced a client attempt suicide. About one quarter of participants in the psychologist-in-training group had experienced a client attempt suicide.

A total of 14.3% of participants stated they had experienced the completed suicide of a client during the course of their work with them. Nineteen reported one client suicide attempt, three members reported losing two clients, and one participant reported having had three clients commit suicide. In terms of the psychologist group, 21.9% reported having experienced at least one client suicide during the course of their career. Only 8% of those in the psychologist-in-training group reported having experienced a client commit suicide. Five of these participants reported having one client commit suicide while two experienced two clients commit suicide.

Of those individuals having experienced a client attempt suicide, 73.8% reported that it did not have any impact of their attitudes toward suicide. Almost 8% reported the event had a negative impact on their attitudes toward suicide. Only two individuals reported the event increased their approval of suicide. For the psychologist-in-training group the majority (42.9%) indicated the event had no impact on their attitudes toward suicide. None of these participants indicated the event had a positive impact on their attitudes toward suicide. Among the psychologist group members roughly three quarters reported the event did not have an impact of their attitudes toward suicide. Only one participant having experienced a client suicide attempt reported that it increased their support of suicide.

For individuals having experienced the completed suicide of a client, 56.5% reported that the event did not impact their attitudes toward suicide. About 39% reported the event (or events) decreased their approval of the act. Only one participant who experienced the suicide of a client reported that it actually increased their approval of the act. Psychologists reported that the experience of having lost a client to suicide either did not have an impact on their approval of the act (62.5%) or else it decreased their approval (31.3%). Only one of the psychologists having experienced a client suicide attempt felt that the event increased their approval of suicide. Among the psychologists-in-training, three of the eight reported having lost a client or clients to suicide indicated the event had no impact on their approval or disproval of the act. The remainder reported the event decreased their approval of suicide.

In terms of experience with rational suicide, 23% of participants reported having worked with a client voicing suicidal ideation that appeared rational in their desire to end his or her life. Just under 9% reported having worked with a client that either attempted or completed suicide and appeared rational in doing so. One-third of the psychologists reported having worked with a client that voiced suicidal ideation and was rational. Among the psychologists-in-training, 14.6% reported having experienced a client voice suicidal ideation while appearing rational. In terms of experiencing a client attempt or commit suicide while appearing rational, 15.5% of psychologists reported having experienced this phenomenon while just 3.4% of psychologists-in-training reported having experienced this. Table 9 illustrates the differences between psychologists and psychologists-in-training with respect to professional experience with suicide.

Table 9
Professional Experience with Suicide

	Psychologists		Psychologists-in-Training	
Experience	N	Sample	N	Sample
Client suicidal ideation	71	97.3%	64	71.1%
Client suicide attempt	43	60.6%	22	24.4%
Client suicide	16	21.9%	7	8%
RS ideation	24	33.3%	13	14.6%
RS attempt/completion	11	15.5%	3	3.4%

Note. RS = Rational Suicide

With respect to friends and family, 34.6% of participants reported having experienced a close friend or family member attempt suicide. Roughly 60% reported the experience did not have an impact on their attitudes toward suicide. In contrast, 35.7% reported it decreased their approval of the act. Just two participants (3.6%) reported that it increased their approval of the act. About 25% of participants reported having experienced a close friend or family member actually commit suicide. Fifty-five percent reported the event had no impact on them. Thirty-seven and a half reported it had a negative impact on their attitudes, while three participants (7.5%) reported it increased their approval of suicide.

With respect to suicidal thoughts and behaviors, seven of the participants reported they had attempted suicide, 4.4% of the sample (N = 160). (Note that three participants did not respond to this item.) Of those participants reporting they had never attempted suicide, 40% stated they had never considered doing so; 6.4% marked down a "7" as a response indicating they had seriously considered ending their lives at some point. Table 10 illustrates the total spread of scores. Notably, a significant number of individuals reporting they had never attempted suicide declined to mark down whether or not they had seriously considered doing so or not. In fact, 31 individuals failed to answer this question,

20% of participants (not including those seven who reported they had actually attempted suicide).

Table 10
Suicidal Thoughts

Considered Suicide	N	% of sample
1 = Never considered suicide	50	40%
2	28	22.4%
3	14	11.2%
4	9	7.2%
5	9	7.2%
6	7	5.6%
7 = Gave suicide serious consideration	8	6.4%

Data on the general acceptability of suicide is presented in Table 11. As is evident, the majority of participants, 73.3%, felt that rational suicide is acceptable to some degree (i.e., responded with either a "1", "2", or "3"). The three least endorsed responses all involved participants disproving of the idea of rational suicide.

Table 11
Acceptability of Rational Suicide

Score	N	% of sample
-3 = Completely Unacceptable	7	4.3%
-2	13	8.1%
-1	6	3.7%
0	17	10.6%
1	45	28%
2	48	29.8%
3 = Completely Acceptable	25	15.5%

Simultaneous Multiple Regression Predicting Attitudes toward Rational Suicide

A simultaneous multiple regression was conducted to explore predictors of attitudes toward rational suicide. The predictors included the Religious Fundamentalism Scale (RFS), Political Ideology Inventory (PII), religious affiliation (AFF), rate of religious attendance per month (ATT), conservatism/liberalism (CL), professional status (PS), age (AG), gender (SX), professional experience with suicide (SU), professional

experience with rational suicide (RS), personal experience with suicide (FF), and extent of efforts to prevent suicide (PRE).

Normality of Predictors. Histograms for the predictor variables were observed. The RFS appeared particularly skewed (Appendix K). Indeed, the skewness statistic for the variable was 1.765. Because it was above |1.5| it was decided to transform the variable so that it would more closely approximate normality as variables with skew greater than |1.5| or |2.0| can have significant impacts on the regression coefficients (Lomax, 2001). After transformation (Log 10) the new skewness statistic for the RFS was .638. The histogram of the variable also suggested a significant increase toward normality (Appendix L).

Another predictor observed to have considerable skew was rate of religious attendance per month (ATT) (Appendix M). With a skewness statistic of 6.352 is was decided to modify this variable, as well. The result of transforming (Log 10) ATT was to bring the skewness down to a more reasonable 2.156, though still higher than the desired high end cutoff of |2.0| (Appendix N).

Other predictors were observed to be skewed, such as the single item conservatism/liberalism measure (CL) at -1.291, but were still less than the lower cutoff (|1.5|) and thus were not modified (Appendix O). Participant age (AG) was observed to be normally distributed with a skew of .595 (Appendix P). Extent of efforts to prevent suicide (PRE) was negatively skewed, but still within the appropriate bounds at -1.010 (Appendix Q).

Additional variables in the study were dichotomous and thus naturally defied normal distribution, thus their histograms were not evaluated. Religious affiliation (AFF)

was dummy coded with a value of "0" indicating having a religious affiliation and a value of "1" indicating not having a religious affiliation. Professional status (PS) was also dummy coded in similar fashion such that "0" referred to psychologists and "1" referred to psychologists-in-training. Professional experience with suicide (SU) (having experienced a client attempt or commit suicide during one's work with them), professional experience with rational suicide (RS) (having experienced a client voice suicidal ideation and having considering them to be rational, and/or having experienced a client attempt or commit suicide), and personal experience with suicide (FF) (having experienced a close friend or family member attempt or commit suicide), were all dummy coded, as well; a "0" indicated having experience with the particular phenomenon while a "1" indicated not having experience with the particular phenomenon.

Reliability of Measures. Additionally, a reliability analysis of the inventories used in the multiple regression, the RSQ, RFS, and PII, was conducted. The results suggested each was psychometrically sound. Incidentally, higher scores on the criterion variable, the RSQ reflected greater approval of suicide, lower scores on the RFS reflected fewer fundamentalist beliefs, and lower scores on the PII indicated more liberal views. Table 12 shows descriptives for the three inventories.

Table 12
Descriptive Statistic for Inventories

Variable	M	SD	A
RSQ	2.98	.97	.97
RFS	-2.46	1.74	.94
PII	-.96	.62	.81

Pairwise Correlations. The correlations between all variables were evaluated to explore for the presence of multicollinearity. The largest pairwise correlation was

between the PII and CL (.78). Table 13 shows the pairwise correlations for the variables in the multiple regression.

Table 13 (Continued on Following Page)
Pairwise Correlations for Simultaneous Multiple Regression for Variables Predicting Attitudes toward Rational Suicide

Variable	RSQ	RFS	PII	AFF	ATT	CL	PS
1. RSQ	-	-.36****	-.46****	.21***	-.33****	.45****	-.19**
2. RFS		-	.68****	-.41****	.50****	-.68****	.11
3. PII			-	-.24***	.33****	-.78****	.18*
4. AFF				-	-.44****	.30****	.02
5. ATT					-	-.42****	.05
6. CL						-	-.13
7. PS							-

Note. Table continues on next page. RSQ = Rational Suicide Questionnaire; RFS = Religious Fundamentalism Scale; PII = Political Ideology Inventory; AFF = Religious Affiliation; ATT = Religious Attendance per Month; CL = Conservatism/Liberalism Scale; PS = Professional Status.
*$p \leq .05$, one-tailed
**$p \leq .01$, one-tailed
***$p \leq .005$, one-tailed
****$p < .001$, one-tailed

Table 13 (Continued from Previous Page)
Pairwise Correlations for Simultaneous Multiple Regression for Variables Predicting Attitudes toward Rational Suicide

Variable	AG	SX	SU	RS	FF	PRE
1. RSQ	.06	.05	.04	-.26****	.01	.18*
2. RFS	.02	-.10	-.26****	-.13*	-.02	-.23***
3. PII	.00	-.03	-.18**	-.10	.09	-.28****
4. AFF	-.02	.10	.04	.10	-.08	.11
5. ATT	.11	-.14*	-.04	-.10	-.09	-.13*
6. CL	-.04	.09	.21***	.06	-.03	.19**
7. PS	-.74****	.24***	.34****	.25***	.07	-.20**
8. AG	-	-.36****	-.33****	-.33****	-.09	.17*
9. SX		-	.05	.18**	-.13	-.04
10. SU			-	.32****	.08	.02
11. RS				-	.06	-.02
12. FF					-	.05
13. PRE						-

Note. RSQ = Rational Suicide Questionnaire; RFS = Religious Fundamentalism Scale; PII = Political Ideology Inventory; AFF = Religious Affiliation; ATT = Religious Attendance per Month; CL = Conservatism/Liberalism Scale; PS = Professional Status; AG = Age; SX = Gender; SU = Professional Experience with Suicide; RS = Professional Experience with Rational Suicide; FF = Personal Experience with Suicide; PRE = Extent of Efforts to Prevent Suicide.
*p ≤ .05, one-tailed
**p ≤ .01, one-tailed
***p ≤ .005, one-tailed
****p < .001, one-tailed

Simultaneous Multiple Regression Results. The analysis indicated a statistically significant model accounting for 37.6% of the variance in attitudes toward suicide (Adjusted R^2 = .327), $F(12, 163) = 7.546$, $p = .000$. Three of the 12 predictors were significant at the .05 level. After controlling for the effects of the other predictors ATT accounted for about 1.8% of the variance in attitudes toward suicide ($p = .037$). The PII accounted for 3.6% of the variance in attitudes toward rational suicide ($p = .004$), and RS accounted for 9.9% of the variance in attitudes toward rational suicude ($p = .000$). None of the Variance Inflation Factors were above 10 nor were any of the Tolerance Statistics less than .10. This suggested that multicollinearity was not a factor in the regression

analysis (Stevens, 2002). Table 14 illustrates the unstandardized and standardized regression coefficients.

Table 14
Summary of Simultaneous Multiple Regression Analysis for Variables Predicting Attitudes toward Rational Suicide (N=163)

Variable	*B*	*SE b*	*B*	95% CI
RFS	0.254	0.406	.065	[-.549, 1.057]
PII	-0.518	0.176	-.334**	[-.866, -.170]
AFF	0.148	0.143	.078	[-.135, .431]
ATT	-0.563	0.268	-.171*	[-1.094, -.033]
CL	0.082	0.080	.113	[-.076, .239]
PS	-0.250	0.195	-.132	[-.635, .135]
AG	-0.006	0.008	-.078	[-.021, .010]
SX	0.158	0.142	.079	[-.124, .439]
SU	0.152	0.147	.079	[-.140, .443]
RS	-0.769	0.158	-.348***	[-1.081, -.457]
FF	0.120	0.130	.063	[-.136, .377]
PRE	0.100	0.243	.028	[-.380, .581]

Note. RFS = Religious Fundamentalism Scale; PII = Political Ideology Inventory; AFF = Religious Affiliation; ATT = Religious Attendance per Month; CL = Conservatism/Liberalism Scale; PS = Professional Status; AG = Age; SX = Gender; SU = Professional Experience with Suicide; RS = Professional Experience with Rational Suicide; FF = Personal Experience with Suicide; PRE = Extent of Efforts to Prevent Suicide; CI = Confidence Interval; no predictors in any of the models had significance values $\geq .05$ and $< .10$ thus no one-tailed significance tests were conducted.
*$p \leq .05$, two-tailed
**$p \leq .005$, two-tailed
***$p < .001$, two-tailed

Additional Assumptions of Multiple Regression. Observation of the scatterplots of the standardized residuals versus the unstandardized predictors and the standardized residuals versus each individual predictor were explored to help confirm the assumptions for multiple regression being met. Results suggested the assumptions of linearity and homoskedasticity were satisfied as errors were scattered randomly throughout the plot and generally fell within +/- two standard errors (Appendix R). The exception seemed to be extent of efforts to prevent suicide which appeared to display a very clear fan-shaped pattern. In an effort to attenuate the extent of the impact of heteroskedasticity the variable

was transformed (Log 10) (Stevens, 1999). To do so the individual scores of the variable were all first reversed such that a score of "1" became a score of "7" and so on. Note that the multiple regression results for the model presented earlier included the reversed and transformed PRE variable.

To further examine the data both the standardized residual and hat element values were evaluated. No standardized residuals had a value surpassing |3.0| suggesting no outliers on the criterion variable. For the hat elements a cutoff of 3p/n was used. One hat element exceeded the cutoff of .24 by .002. An evaluation of the predictor values for this participant did not show any particularly unusual scores thus its statistical basis for being considered an outlier was not understood. An evaluation of Cook's D showed that no values greater than 1.0 were found suggesting the absence of particularly influential data points (Stevens, 2002).

Psychologists and Psychologists-in-Training: Extent of Efforts to Prevent Rational Suicide

Another research question included the degree of action that participants would take to prevent a client from engaging in rational suicide. An independent samples t-test was conducted with extent of efforts to prevent suicide (PRE) as the testing variable and professional status (PS) as the grouping variable. Levene's statistic indicated that the population variances were unequal. This, in combination with the unequal sample size resulted in the Welch statistic being used. The subsequent results indicated a significant difference between the psychologist and psychologist-in-training group at the .05 level (p = .004). Psychologists indicated they would take less action to prevent the suicide of a

client considered to be rationally suicidal (M = 5.18) than would psychologists-in-training (M = 5.92).

Psychologists and Psychologists-in-Training: Suicide Intervention Self-Efficacy

Whether or not psychologists felt more equipped to work with suicidal clients than psychologists-in-training was a research question. Observation of the histogram indicated the assumption of normality for the Suicide Intervention Self-Efficacy Scale (SISS) was met (Appendix S). An independent samples t-test (homogeneity of variance assumption met) confirmed that there was a statistically significant difference between the two groups (p = .020). The psychologist group (M = .509) indicated they had greater self-efficacy with respect to working with suicidal clients than the psychologist-in-training group (M = .260).

Chapter 5

Discussion

Hypothesis 1 predicted that the model including the RFS, PII, and items from the DQ, would account for a statistically significant portion of the variance in attitudes toward rational suicide. The complete model with all 12 predictors did in fact account for a statistically significant portion of the variance in attitudes toward rational suicide (p = .000). (It should be noted that a model including only the RFS, PII, age, gender, and personal and professional experience with suicide, accounted for a statistically significant amount of variance in attitudes toward suicide (Adjusted R^2 = .301), $F(6, 156) = 12.605$, p = .000.))

Hypothesis 2 stated that religious fundamentalist beliefs as measured by the RFS would be a significant negative predictor of attitudes toward suicide with greater levels of religious fundamentalism being linked with less approval of rational suicide. This hypothesis was not supported (p = .533) suggesting the limited value of the RFS in predicting attitudes toward rational suicide among psychologists and psychologists-in-training relative to the other measures. The fact this variable was not significant was surprising in light of the research of Agnew (1998) which noted interpretation of the Bible being a strong predictor of attitudes toward the right to engage in suicide and Hammond's (1991) finding that believing committing suicide is a sin was a significant predictor of attitudes toward suicide.

One concern regarding the RFS is that at least one individual completing it reported that it did not necessarily tap into their personal religious/spiritual beliefs as they felt it was geared specifically toward Christians. Additional comments on the RFS

criticized the "double-barreled" nature of some of the items. Finally, the fact that so few individuals (roughly 9%) endorsed religious fundamentalist views suggested that the inventory may not have been fine enough to adequately tap into the uniqueness of religious values among the participants, instead lumping the overwhelming majority of the sample into the non-fundamentalist range. Another more significant problem was the instrument's high correlation with other measures, and vice versa. The strong statistical relationship between the RFS, PII, and even the CL, is suggestive of the advantage of potentially combining these variables together as one construct in future research. Thus, to say that religious fundamentalism has no relationship with attitudes toward rational suicide may not be telling the whole story.

Hypothesis 3 predicted that political ideology as measured by the PII would be a significant negative predictor of attitudes toward suicide such that greater levels of conservatism would be associated with less approval of suicide. The results of the multiple regression did in fact indicate that the PII was a significant negative predictor, thus the hypothesis was supported.

The PII accounted for 3.6% of the unique variance in attitudes toward rational suicide when controlling for the other variables ($p = .004$). The results clearly suggested the significance of political ideology in predicting attitudes toward rational suicide. This finding was consistent with previous research on attitudes toward suicide among the public (Agnew, 1998; Stack, 1998; Stack & Kposowa, 2008).

Religious attendance (ATT) was found to be statistically significant, accounting uniquely for 1.8% of the variance in attitudes toward rational suicide when controlling for the other variables ($p = .037$). This was consistent with the work of Hammond (1991)

who found the variable to be of significance, yet was at odds with the findings of Werth and Liddle (1994) who did not find rate of attendance to be meaningful. Also of interest was the finding that simply having a religious affiliation (AFF) was not a predictor suggesting that simply identifying with a particular religion does not necessarily connote following the precepts of the faith. This was another variable where some studies have found meaning in the use of this particular construct in studying suicide (Hammond, 1991; Westefeld et al., 2001) while others have not (Baker, 1998).

The conservatism/liberalism (CL) variable did not result in statistical significance when included in the model. The PII being significant while the CL was not was consistent with Agnew's finding that a measure of conservatism/liberalism which included attitudes toward specific social issues was a greater predictor than a single item, alone, measuring political attitude. Still, it should again be noted that the CL had a very strong correlation with the PII and thus combing the measures together may be of benefit in the future.

With respect to the demographic, professional, and personal variables, the finding that experience with a suicidal client considered to be rational (RS) was significant was clearly unexpected. Even more surprising was that it was in fact the strongest predictor accounting for nearly 10% of the variance in attitudes toward rational suicide. Research consistently shows professional experience with suicide fails to be a predictor of attitudes toward the matter (Baker, 1998; Hammond, 1991; Werth & Liddle, 1994). In addition, as noted previously, Baker (1998) reported "the number of previous suicidal clients that were considered rational is not a predictor of attitudes toward suicide" (p. 33). A closer inspection of the researcher's definition indicates that she defined rationality on the part of

the client as being "logical, consistent, and competent in their reasoning" (p. 67). One possible basis for the discrepancy in the power of the predictor then could be that participants in the current study responded to the query of experience with rationally suicidal clients given the strict guidelines mentioned in the RSQ (as desired) as opposed to the more general *rational* definition used in Baker's (1998) study. Furthermore, the question as it appeared in this study essentially asked whether one had worked with someone meeting the criteria for rational suicide. To in fact agree that one has worked with such a client implies at least an implicit endorsement of the possibility that the act of suicide can be rational. Just as someone who does not believe in ghosts is likely to deny ever having seen one, someone not believing in rational suicide is likely to deny ever having worked with a client that they personally considered to be rationally suicidal.

In contrast, age (AG) was not a significant predictor of attitudes toward suicide. This was expected as research virtually always points to this variable failing to be meaningful (Albright,1995; Aulbach,1997; Baker,1998; Hammond, 1991; Finch, 1992; Westefeld et al., 2004). Nor was gender (SX) significant, as anticipated. Research generally finds that participant sex is not a predictor of attitudes toward suicide (Albright, 1995; Aulbach, 1997; Baker, 1998; Finch, 1992; Hammond, 1991; Miller, 2001; Rogers et al., 2001; Werth & Liddle, 1994; Westefeld et al.). Professional experience with suicide (SU) also failed to be a predictor as expected, as studies prove that this variable, too, fails to reach significance (Albright, 1995; Baker, 1998; Hammond, 1991; Rogers et al.; Werth & Liddle, 1994). Personal experience with suicide (FF), operationalized as having experienced a close friend or family member commit suicide, was not a significant predictor of attitudes toward rational suicide. This finding was in opposition to Finch's

(1992) finding that experience with a close other that committed suicide had a relationship with attitudes toward the act. Interestingly, the fact that hardly any participants having experienced the suicide of a close friend or family member found the event to increase their approval of the act is in further contrast with Finch's (1992) finding that experience with the suicide of close others was actually related to more approving attitudes toward the act.

Perhaps the most interesting finding was that attitudes toward rational suicide are not impacted by professional training, as the variable of professional status (PS) was not significant within the model. This would suggest that professional training on the topic may have little impact on the attitudinal positions of trainees. This could mean the potential for psychologists to be rather rigid in their personal stance on the topic regardless of the idiosyncrasies of the particular clinical situation involving rational suicide. For those trying to further their respective viewpoints on the debate on rational suicide it also suggests potential difficulty in bringing practitioners to change their minds on this often controversial topic.

Interestingly, attitudes toward rational suicide were found not to have a relationship with the extent to which individuals would attempt to prevent a suicide (PRE). This was surprising as previous pieces of research indicated a connection between the two variables. Hammond (1991) included extent of efforts to prevent suicide in a hierarchical regression and found the variable to be significant. Werth and Liddle (1994) observed that those with greater professional experience were more accepting of attitudes toward suicide, and were also inclined to take less action to prevent a client suicide.

Another subtle point may shed light on the above findings. The work of researchers such as Hammond (1991) and Werth and Liddle (1994) explored attitudes toward suicide as it relates to *acceptability*. The researchers did not focus so much on whether a character in a vignette has the *right* to commit suicide, as much as whether the participant finds doing so to be *acceptable* given the character's circumstances. The same is true of the SUIATT in that it contains 90 items, only one having to do with the right to commit suicide. There is arguably a difference in exploring attitudes toward an action versus attitudes toward another's right to commit that particular action.

Furthermore, it would seem that measuring a mental health professional's view toward *rights* is in some ways more meaningful than measuring *acceptability*. A psychologist may not feel that rational suicide is acceptable, yet may feel strongly in an individual's right to commit rational suicide based out of respect for autonomy. Thus, the finding that extent of efforts to prevent suicide is not related to *rights* may have meaning beyond that of prior findings that extent of efforts to prevent suicide are related to *acceptability* of the action.

And although the purpose of this research was not to explore characteristics of individuals in vignettes or their precipitating circumstances, the finding that an older woman on life support had the highest overall rating on the RSQ and a child experiencing depression had the lowest overall rating was consistent with the research on factors influencing the approval of suicide (Hammond, 1991; Miller, 2001; Westefeld et al., 2004).

Also, with respect to this SISS, those with less experience gave themselves lower ratings in terms of self-efficacy than did more experienced participants. Interestingly, it

suggested some honesty on the part of psychologists-in-training reporting not currently feeling as comfortable as professionals are in their future work dealing with crisis clients. The fact that psychologists-in-training rated themselves in the positive range is consistent with the work of Dexter-Mazza and Freeman (2003) who found graduate student participants rating themselves an average of 4.92 on a 7-point scale with respect to their ability "to effectively work with or manage a suicidal client" (p. 216). Given that the individuals in the study were all interns it could be argued that the relatively high overall score of the psychologists-in-training in this study is an overly optimistic appraisal of their true abilities.

Another notable finding was that, generally speaking, psychologists and psychologists-in-training find suicide to be acceptable. In fact, nearly 75% found it at least somewhat acceptable. This was consistent with the overall research which finds acceptability rates near 80% (Albright, 1995; Aulbach, 1997; Rogers et al., 2001; Werth & Liddle, 1994). Interestingly, using a Likert-scale to assess responses to the acceptability of rational suicide resulted in a larger percentage of participants supporting the act than in the previous study using the question with a simple "yes"/"no" response option. It should also be considered that the previous study used a sample that included legislative members and medical professionals in addition to mental health professionals and thus the difference in acceptability could have been the result of the population sampled as opposed to the wording of the response option itself.

Roughly 33% of the psychologists sampled reported having worked with at least one client who voiced suicidal ideation and appeared rational in doing so. This appeared consistent with research indicating anywhere from 20-39% of mental health professionals

reporting having worked with a suicidal client deemed to be rational (Werth, 1996b). Notably, nearly 15% of the psychologists-in-training group reported having worked with a client they considered rationally suicidal. Several of the psychologists-in-training had prior mental health work. Thus it was unclear whether they encountered such individuals after years of work in the field, or after having just started doctoral work.

The data on experiencing client suicide (although not necessarily rational suicide) was supported by this study which found about 22% of the psychologists experienced a client take his or her own life. Previous research had found numbers ranging from 22% (Chemtob et al., 1988) to nearly 50% (Miller, 2001). The finding that 8% of the psychologists-in-training in this sample experienced a client commit suicide was consistent with extant research indicating ranges from 5% (Dexter-Mazza & Freeman, 2003) to over 15% (Kleespies et al., 1990).

Virtually none of the individuals having experienced a client attempt or commit suicide reported the event increased their approval of the act. Indeed, most reported the event had no impact, perhaps suggesting that mental health professionals may compartmentalize such events in their minds. It also appears to be in contrast to research which suggests that the loss of a client can have serious emotional consequences (Chemtob et al., 1988). Still, it could be that the individuals did have negative reactions, but that their approval of the act did not necessarily increase or decrease. It could also be the case that individuals experiencing a client attempt or complete suicide already fully endorsed or opposed suicide and thus their approval could not have either decreased or increased in response to the suicide of a client.

Another finding was the lack of individuals opting to respond to whether or not they had seriously considered suicide. In all, 20% of respondents not reporting having attempted suicide neglected to respond to a subsequent question asking whether or not they had ever *considered* doing so. This may reflect participants having found the question too intrusive. However, no comments were written on the questionnaire which indicated any participants felt this was the case. A more acceptable hypothesis could be that a number of participants choose to purposefully ignore this option out of discomfort on reflecting on this somewhat morbid, but relevant, topic.

Finally, research suggested that psychologists would take less effort to prevent the suicide of an individual they felt had a right to take his or her life than a psychologist-in-training. This was consistent with the work of Werth and Liddle (1994) in some ways as these researchers found those professionals with greater than 30 years experience were more approving of suicide. However, the relationship was found via a t-test; a more comprehensive future examination of the topic may prove other variables better accounting for what appears to be a relationship with extent of efforts to prevent suicide based on professional status.

Limitations of the Study

Several caveats might be considered regarding the findings of the study. A concern with any study that accesses participants via mail is the response rate. The 23.1% useable response rate could have included primarily those with particularly strong views on the topic and may not be representative of the population as a whole. This factor must be taken into consideration when attempting to generalize the results.

Also, the notion of 'rational' suicide is a complicated one as some individuals simply do not agree with the concept (Callahan, 1994; Wrobleski, 1999). What is considered to be a 'rational' decision by some may not be by another's own personal standards. Despite providing a definition for the term with the survey instrument, the notion of what truly encompasses "sound decision making" may still be quite variable among participants, making the construct perhaps slightly nebulous (Werth & Cobia, 1995, p. 238).

Another concern is that many of the participants did not have a good amount of clinical experience. This is certainly true of the psychologist-in-training group, many of whom had not completed any direct service hours. Still, this is to be expected to some extent given the natural characteristics of the population. Perhaps a larger concern then is that the psychologist group reported, on average, being currently involved in minimal clinical work. It could be that these individuals differ in attitudes toward rational suicide compared to those whose work involves much more client contact. Still, the fact that such a large percentage of the psychologist group reported having worked with a client voicing suicidal ideation suggests that at least at some point in their careers they were offering therapy services and are thus experienced in the area. Additionally, APS members could have attitudes different than those psychologists and psychologists-in-training not opting to be members of this group with such a highly scientific focus.

Another caveat is specific to an item used. The question regarding extent of efforts to prevent suicide did not clarify a specific situation for which individuals were to offer their opinion. Rather, participants were asked to respond to the question based on their feelings related to the previously mentioned scenario in the RSQ they felt was *most*

understandable. Having had participants respond in this way could have artificially created a larger relationship than there would have otherwise been if asking them to respond to a single specific scenario they may or may not have viewed as acceptable at all.

In addition, it should also be noted that the model had slightly less than the desired 15:1 ratio based on the response rate. It was closer to 14:1 and thus the extent of shrinkage could rightfully be questioned if exploring another sample of psychologists and psychologists-in-training. Also, the number of statistical tests performed on the data no doubt caused an increase in the chance for Type I error. Interpreting given *p* values at a more conservative degree, such as .01, may be warranted.

Perhaps the most significant limitation of the study is that it does not answer the question of how attitudes toward suicide *directly impact* psychologists' actual clinical work. Still, the nature of the study, and the topic being explored, does not easily permit for any manner of experimental design. Therefore, the results must be interpreted cautiously as to the ultimate consequence such attitudes have on the actual professional actions of psychologists.

Clinical Implications

As noted, one important finding from the study is that rational suicide is being experienced by those in training. To assume that dealing with matters of death is challenging for seasoned professionals, psychologists-in-training likely find such an encounter particularly difficult, as has been indicated in research (Kirchberg, Neimeyer, & James, 1998). This reflects the need for the matter to be addressed in coursework such that those in training at least may be prepared to deal with the situation should it arise.

Still, given that attitudes toward rational suicide proved not to have a relationship with professional status may cause one to ponder what good training on the topic would actually do. Indeed, if personal beliefs are the impetus for either approving or disproving of the act then training supporting a particular stance may be less than effective.

Furthermore, the results highlight the importance of psychologists and psychologists-in-training reaching clinical conclusions based on their personal values, instead of arriving at a more objective basis for pursuing a particular therapeutic avenue. This only reinforces the need for both psychologists and those in training to explore the impact of their own personal values on the counseling relationship.

Directions for Future Research

Continuing to explore potential predictors is warranted given this study was only able to account for roughly 33% of the variance in attitudes toward the right to engage in rational suicide. Continued exploration of this important topic is needed so as to identify other factors contributing to attitudes toward the act.

In addition, qualitative research with individuals reporting having experienced clients engage in rational suicide seems particularly interesting. Not only that, but interviewing individuals who report having had such an experience and resulting in having their minds drastically changed on the matter would seem very helpful in shedding light on unique factors which may contribute to modification of attitudes, either becoming more supportive or becoming less supportive of this controversial act.

Concluding Remarks

The results of this study have helped to confirm the fact that rational suicide is an issue that psychologists, as well as psychologists-in-training, are experiencing in their

clinical work. Given that two of the largest predictors have to do with religious and political values, factors which are likely solidified prior to any graduate level training in therapy, the personal viewpoints of practitioners and their purported basis for arriving at particular clinical conclusions seems that much more intriguing.

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Appendix A

Psychologist Demographics Questionnaire

1. **What is your age:_____**

2. **What is your sex?**
   a. Female
   b. Male

3. **Please identify your race/ethnicity:_____**

4. **What is your current relationship status?**
   a. Single
   b. Dating
   c. Committed long-term relationship
   d. Married
   e. Divorced
   f. Separated
   g. Widowed

5. **Do you have a religious affiliation?**
   a. Yes (Please identify your affiliation below)
   b. No (Skip item 5a.)

   5a. Please identify your religious affiliation:_____

6. **Please indicate the number of times, on average, that you attend religious services in a month:_____**

7. **What degree do you possess:**
   a. PhD in Clinical Psychology
   b. PhD in Counseling Psychology
   c. PsyD
   d. Other: (Please identify: _____)

8. **Please estimate the number of years experience you have as a psychologist:_____**

9. Please estimate the number of hours you spend conducting therapy (individual, child, family, and/or couples therapy) in the average week:_____

10. Have you ever worked with a client that voiced suicidal ideation?

a. Yes
b. No

11. Please indicate the number of clients that have <u>attempted</u> suicide while you were working with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 11 THEN SKIP ITEM 11a.</u>

11a. What impact did the client suicide <u>attempt</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

12. Please indicate the number of clients that have <u>committed</u> suicide while you were working with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 12 THEN SKIP ITEM 12a.</u>

12a. What impact did the client <u>suicide</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

13. Have you ever worked with a client that voiced suicidal ideation that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

14. Have you ever worked with a client that attempted/completed suicide that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

15. Please indicate the number of family members or close friends that have <u>attempted</u> suicide during the course of your relationship with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 15 THEN SKIP ITEM 15a.</u>

15a. What impact did the suicide <u>attempt</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

16. Please indicate the number of family members or close friends that have <u>committed</u> suicide during the course of your relationship with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 16 THEN SKIP ITEM 16a.</u>

16a. What impact did the <u>suicide</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

17. Have you ever attempted suicide?

a. Yes
b. No (Please answer item 17a. below)

17a. If you have never attempted suicide, have you ever seriously considered doing so?

I have never considered suicide — I have given suicide serious consideration

1……..2……..3……..4……..5……..6……..7

Appendix B

Psychology Graduate Student Demographics Questionnaire

1. **What is your age:_____**

2. **What is your sex?**
   a. Female
   b. Male

3. **Please identify your race/ethnicity:_____**

4. **What is your current relationship status?**
   a. Single
   b. Dating
   c. Committed long-term relationship
   d. Married
   e. Divorced
   f. Separated
   g. Widowed

5. **Do you have a religious affiliation?**
   a. Yes (Please identify your affiliation below)
   b. No (Skip item 5a.)

   5a. Please identify your religious affiliation:_____

6. **Please indicate the number of times, on average, that you attend religious services in a month:_____**

7. **What type of degree program are you currently enrolled in:**
   a. Master's Degree in Counseling
   b. Master's Degree in Psychology or Psychology Related Area
   c. PhD in Clinical Psychology
   d. PhD in Counseling Psychology
   e. PsyD
   f. Other: (Please identify: _____)

8. What year are you in your academic training program (for example, 1st year master's student, 4th year doctoral student)?:_____

9. Please estimate the total number of hours you have spent conducting therapy (individual, child, family, or couples therapy) as a graduate student (count practicum hours, plus internship hours if applicable):_____

10. Have you ever worked with a client that voiced suicidal ideation?

c. Yes
d. No

11. Please indicate the number of clients that have attempted suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 11 THEN SKIP ITEM 11a.

11a. What impact did the client suicide attempt have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

12. Please indicate the number of clients that have committed suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 65 THEN SKIP ITEM 12a.

12a. What impact did the client suicide have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

13. Have you ever worked with a client that voiced suicidal ideation that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

14. Have you ever worked with a client that attempted/completed suicide that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

15. Please indicate the number of family members or close friends that have <u>attempted</u> suicide during the course of your relationship with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 15 THEN SKIP ITEM 15a.</u>

15a. What impact did the suicide <u>attempt</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

16. Please indicate the number of family members or close friends that have <u>committed</u> suicide during the course of your relationship with them:_____

<u>IF YOU INDICATED '0' FOR ITEM 16 THEN SKIP ITEM 16a.</u>

16a. What impact did the <u>suicide</u> have on your attitude toward the acceptability of suicide?

Significantly <u>Decreased</u> my Approval — No Impact — Significantly <u>Increased</u> my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

17. Have you ever attempted suicide?

a. Yes
b. No (Please answer item 17a. below)

17a. If you have never attempted suicide, have you ever seriously considered doing so?

I have never considered suicide — I have given suicide serious consideration

1……..2……..3……..4……..5……..6……..7

Appendix C

Rational Suicide Questionnaire

For the purposes of this questionnaire, rational suicide is defined as: The process by which a person who has an unremitting helpless condition, makes a free choice decision to end his/her life, and has engaged in sound decision making (based on the work of Werth and Cobia, 1995).

A) Given the above definition, do you think generally that *rational suicide* is (circle one):

Completely Unacceptable ... Completely Acceptable

-3.....-2.....-1.....0.....+1.....+2.....+3

What follows are a series of hypothetical situations. For each of the situations below the interest lies in the degree to which you believe an individual should have the right to commit suicide if he/she were in this situation. It is recognized that minimal information is being provided for each situation, thus your answer may "depend" (for example, depend on whether the individual has explored the impact of his/her death on others). However, please respond to the statements given the extent to which you think a circumstance could exist, within the provided situation, in which you think the person should have the right to commit suicide.

1. **A 40-year-old woman has been treated for severe depression for 5 years and no existing treatment has relieved her symptoms.**

Definitely should not have the right to commit suicide ... Definitely should have the right to commit suicide

1……2……3……4……5

2. **A 40-year-old woman has been diagnosed with terminal cancer.**

Definitely should not have the right to commit suicide ... Definitely should have the right to commit suicide

1……2……3……4……5

3. **A 70-year-old woman is on life support in the hospital after a car accident, and doctors predict she will not recover.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

4. **A 40-year-old woman has been quadriplegic since an injury 5 years ago.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

5. **A 40-year-old woman is on life support in the hospital after a car accident, and doctors predict she will not recover.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

6. **A 70-year-old woman has been treated for severe depression for 5 years and no existing treatment has relieved her symptoms.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

7. **A 10-year-old girl is on life support in the hospital after a car accident, and doctors predict she will not recover.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

8. **A 70-year-old woman has been diagnosed with terminal cancer.**

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

9. A 70-year-old woman has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

10. A 10-year-old girl has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

11. A 10-year-old girl has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

12. A 10-year-old girl has been severely depressed for 5 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

13. A 40-year-old man has been severely depressed for 5 years and no existing treatment has relieved his symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

14. A 40-year-old man has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

15. A 40-year-old man has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

16. A 40-year-old man is on life support in the hospital after a car accident, and doctors predict he will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

17. A 40-year-old woman has been severely depressed for 15 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

18. A 40-year-old woman has been quadriplegic since an injury 15 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

19. Consider the prior item(s) for which you feel suicide is most acceptable (if at all). If the individual(s) in the scenario(s) was/were your client, to what extent would you go to prevent him/her from committing rational suicide?

I would take no action to prevent the suicide of the client — Any means Including involuntary hospitalization

1……2……3……4……5……6……7

Appendix D

Revised 12-Item Religious Fundamentalism Scale

You will probably find that you agree with some of the statements, and disagree with others, to varying extents.

Circle the number:

-4 if you *very strongly disagree* with the statement
-3 if you *strongly disagree* with the statement
-2 if you *moderately disagree* with the statement
-1if you *slightly disagree* with the statement
0 if you feel exactly and *precisely neutral* about the statement
+1 if you *slightly agree* with the statement
+2 if you *moderately agree* with the statement
+3 if you *strongly agree* with the statement
+4 if you *very strongly agree* with the statement

1. **God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

2. **No single book of religious teachings contains all the intrinsic, fundamental truths about life.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

3. **The basic cause of evil in this world is Satan, who is still constantly and ferociously fighting against God.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

4. **It is more important to be a good person than to believe in God and the right religion.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

5. **There is a particular set of religious teachings in this world that are so true, you can't go any "deeper" because they are the basic, bedrock message that God has given humanity.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

6. **When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God: and the rest, who will not.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

7. **Scriptures may contain general truths, but they should NOT be considered completely literally true from beginning to end.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

8. **To lead the best, most meaningful life, one must belong to the one, fundamentally true religion.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

9. **"Satan" is just the name people give to their own bad impulses. There really is *no such thing* as a diabolical "Prince of Darkness" who tempts us.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

10. **Whenever science and sacred scripture conflict, *science* is probably right.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

11. The fundamentals of God's religion should never be tampered with, or compromised with others' beliefs.

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

12. *All* of the religions in the world have flaws and wrong teachings. There is *no* perfectly true, right religion.

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

Appendix E

Political Ideology Inventory

Please read each of the following statements carefully. Indicate the extent to which you agree or disagree with each statement using the scale shown below. Please think carefully before answering.

1. Abortion is wrong, because everyone, even unborn babies, has the right to life.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

2. Sex education should be taught at home by the parents, not in public schools.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

3. The government should spend less on defense and focus more on domestic needs.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

4. If drugs were decriminalized, society would degenerate.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

5. Some crimes are so despicable, they should be punishable by death.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

6. Gay people are entitled to the same constitutional rights as heterosexuals.

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

7. **Because the U.S. is a world leader, it cannot cut its defense spending position without losing its world position.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

8. **It is women's constitutional right to choose whether or not to have an abortion.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

9. **An increase in taxes is needed.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

10. **Capital punishment is not an effective deterrent.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

11. **Censorship of music and art violates people's constitutional rights.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

12. **Sex education in schools is vital, especially with the increasing concern of AIDS.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

13. **Censorship of art is justified when the artwork is deemed pornographic or obscene.**

Strongly Disagree ……-2……-1……0……+1……+2…… Strongly Agree

A) How would you rate yourself on the following scale?

Conservative Neither one or the other Liberal

1……2……3……4……5……6……7

Appendix F

Suicide Intervention Self-Efficacy Scale

Please respond to items 1 - 5 by circling the one response that best reflects your agreement with the statement.

1. **I feel that my training and professional experiences (will eventually sufficiently prepare/have sufficiently prepared) me to work with suicidal clients.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

2. **I imagine becoming uncertain of my abilities when a client talks about the possibility of harming his or her self.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

3. **I often question whether or not I have the skills and abilities to work with clients that are suicidal.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

4. **Upon learning a client is suicidal I know that I can offer optimal assistance to him or her.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

5. **Experiencing the suicide of a client in the future is not something that I worry about.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

6. **After a session with a suicidal client I can imagine myself reflecting and wondering whether I did a 'good enough' job of counseling him or her.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

7. **I feel confident in my ability to work with suicidal clients.**

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

Appendix G

Psychologist Questionnaire

1. **What is your age:_____**

2. **What is your sex?**
   a. Female
   b. Male

3. **Please identify your race/ethnicity:_____**

4. **What is your current relationship status?**
   a. Single
   b. Dating
   c. Committed long-term relationship
   d. Married
   e. Divorced
   f. Separated
   g. Widowed

5. **Do you have a religious affiliation?**
   a. Yes (Please identify your affiliation below)
   b. No (Skip item 5a.)

   5a. Please identify your religious affiliation:_____

6. **Please indicate the number of times, on average, that you attend religious services in a month:_____**

7. **What degree do you possess:**
   a. PhD in Clinical Psychology
   b. PhD in Counseling Psychology
   c. PsyD
   d. Other: (Please identify: _____)

8. **Please estimate the number of years experience you have as a psychologist:_____**

9. **Please estimate the number of hours you spend conducting therapy (individual, child, family, and/or couples therapy) in the average week:_____**

++

For items 10-21 you will probably find that you agree with some of the statements, and disagree with others, to varying extents.

Circle the number:

-4 if you *very strongly disagree* with the statement
-3 if you *strongly disagree* with the statement
-2 if you *moderately disagree* with the statement
-1if you *slightly disagree* with the statement
0 if you feel exactly and *precisely neutral* about the statement
+1 if you *slightly agree* with the statement
+2 if you *moderately agree* with the statement
+3 if you *strongly agree* with the statement
+4 if you *very strongly agree* with the statement

10. **God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

11. **No single book of religious teachings contains all the intrinsic fundamental truths about life.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

12. **The basic cause of evil in this world is Satan, who is still constantly and ferociously fighting against God.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

13. It is more important to be a good person than to believe in God and the right religion.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

14. There is a particular set of religious teachings in this world that are so true, you can't go any "deeper" because they are the basic, bedrock message that God has given humanity.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

15. When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God: and the rest, who will not.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

16. Scriptures may contain general truths, but they should NOT be considered completely literally true from beginning to end.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

17. To lead the best, most meaningful life, one must belong to the one, fundamentally true religion.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

18. "Satan" is just the name people give to their own bad impulses. There really is *no such thing* as a diabolical "Prince of Darkness" who tempts us.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

19. Whenever science and sacred scripture conflict, *science* is probably right.

Very strongly disagree — Very strongly agree

-4..……-3..……...-2..……-1..……0..……+1..……+2..……+3..……+4

20. The fundamentals of God's religion should never be tampered with, or compromised with others' beliefs.

Very strongly disagree — Very strongly agree

-4..……-3..……...-2..……-1..……0..……+1..……+2..……+3..……+4

21. *All* of the religions in the world have flaws and wrong teachings. There is *no* perfectly true, right religion.

Very strongly disagree — Very strongly agree

-4..……-3..……...-2..……-1..……0..……+1..……+2..……+3..……+4

++

For items 22-35 please read each of the following statements carefully. Indicate the extent to which you agree or disagree with each statement using the scale shown below. Please think carefully before answering.

22. Abortion is wrong, because everyone, even unborn babies, has the right to life.

Strongly Disagree — Strongly Agree

-2……-1……0……+1……+2

23. Sex education should be taught at home by the parents, not in public schools.

Strongly Disagree — Strongly Agree

-2……-1……0……+1……+2

24. The government should spend less on defense and focus more on domestic needs.

Strongly Disagree — Strongly Agree

-2……-1……0……+1……+2

25. If drugs were decriminalized, society would degenerate.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

26. Some crimes are so despicable, they should be punishable by death.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

27. Gay people are entitled to the same constitutional rights as heterosexuals.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

28. Because the U.S. is a world leader, it cannot cut its defense spending position without losing its world position.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

29. It is women's constitutional right to choose whether or not to have an abortion.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

30. An increase in taxes is needed.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

31. Capital punishment is not an effective deterrent.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

32. Censorship of music and art violates people's constitutional rights.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

33. Sex education in schools is vital, especially with the increasing concern of AIDS.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

34. Censorship of art is justified when the artwork is deemed pornographic or obscene.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

35. How would you rate yourself on the following scale?

Conservative ... Neither one or the other ... Liberal

1……2……3……4……5……6……7

++

Please respond to items 36-42 by circling the one response that best reflects your agreement with the statement.

36. I feel that my training and professional experiences (will eventually sufficiently prepare/have sufficiently prepared) me to work with suicidal clients.

Strongly disagree ... Strongly agree

-2……..….-1……..….0……..….+1……..….+2

37. I imagine becoming uncertain of my abilities when a client talks about the possibility of harming his or her self.

Strongly disagree ... Strongly agree

-2……..….-1……..….0……..….+1……..….+2

38. I often question whether or not I have the skills and abilities to work with clients that are suicidal.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

39. Upon learning a client is suicidal I know that I can offer optimal assistance to him or her.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

40. Experiencing the suicide of a client in the future is not something that I worry about.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

41. After a session with a suicidal client I can imagine myself reflecting and wondering whether I did a 'good enough' job of counseling him or her.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

42. I feel confident in my ability to work with suicidal clients.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

++

For the purposes of items 43-62, rational suicide is defined as: The process by which a person who has an unremitting helpless condition, makes a free choice decision to end his/her life, and has engaged in sound decision making (based on the work of Werth and Cobia, 1995).

43. Given the above definition, do you think generally that *rational suicide* is:

Completely Unacceptable — Completely Acceptable

-3.....-2.....-1.....0.....+1.....+2.....+3

What follows are a series of hypothetical situations. For each of the situations below the interest lies in the degree to which you believe an individual should have the right to commit suicide if he/she were in this situation. It is recognized that minimal information is being provided for each situation, thus your answer may "depend" (for example, depend on whether the individual has explored the impact of his/her death on others). However, please respond to the statements given the extent to which you think a circumstance could exist, within the provided situation, in which you think the person should have the right to commit suicide.

44. A 40-year-old woman has been treated for severe depression for 5 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

45. A 40-year-old woman has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

46. A 70-year-old woman is on life support in the hospital after a car accident, and doctors predict she will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

47. A 40-year-old woman has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

48. A 40-year-old woman is on life support in the hospital after a car accident, and doctors predict she will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

49. A 70-year-old woman has been treated for severe depression for 5 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

50. A 10-year-old girl is on life support in the hospital after a car accident, and doctors predict she will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

51. A 70-year-old woman has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

52. A 70-year-old woman has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

53. A 10-year-old girl has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

54. A 10-year-old girl has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

55. A 10-year-old girl has been severely depressed for 5 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

56. A 40-year-old man has been severely depressed for 5 years and no existing treatment has relieved his symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

57. A 40-year-old man has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

58. A 40-year-old man has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

59. A 40-year-old man is on life support in the hospital after a car accident, and doctors predict he will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

60. A 40-year-old woman has been severely depressed for 15 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

61. A 40-year-old woman has been quadriplegic since an injury 15 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

62. Consider the prior item(s) for which you feel suicide is most acceptable (if at all). If the individual(s) in the scenario(s) was/were your client, to what extent would you go to prevent him/her from committing rational suicide?

I would take no action to prevent the suicide of the client — Any means Including involuntary hospitalization

1……2……3……4……5……6……7

++

63. Have you ever worked with a client that voiced suicidal ideation?

e. Yes
f. No

64. Please indicate the number of clients that have attempted suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 64 THEN SKIP ITEM 64a.

64a. What impact did the client suicide attempt have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

65. Please indicate the number of clients that have committed suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 65 THEN SKIP ITEM 65a.

65a. What impact did the client suicide have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

66. Have you ever worked with a client that voiced suicidal ideation that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

67. Have you ever worked with a client that attempted/completed suicide that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

68. Please indicate the number of family members or close friends that have attempted suicide during the course of your relationship with them:_____

IF YOU INDICATED '0' FOR ITEM 68 THEN SKIP ITEM 68a.

68a. What impact did the suicide attempt have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

69. Please indicate the number of family members or close friends that have committed suicide during the course of your relationship with them:_____

IF YOU INDICATED '0' FOR ITEM 69 THEN SKIP ITEM 69a.

69a. What impact did the suicide have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

70. Have you ever attempted suicide?

a. Yes
b. No (Please answer item 70a. below)

70a. If you have never attempted suicide, have you ever seriously considered doing so?

I have never considered suicide — I have given suicide serious consideration

1……..2……..3……..4……..5……..6……..7

Appendix H

Psychology Graduate Student Questionnaire

1. **What is your age:_____**

2. **What is your sex?**
   a. Female
   b. Male

3. **Please identify your race/ethnicity:_____**

4. **What is your current relationship status?**
   a. Single
   b. Dating
   c. Committed long-term relationship
   d. Married
   e. Divorced
   f. Separated
   g. Widowed

5. **Do you have a religious affiliation?**
   a. Yes (Please identify your affiliation below)
   b. No (Skip item 5a.)

   5a. Please identify your religious affiliation:_____

6. **Please indicate the number of times, on average, that you attend religious services in a month:_____**

7. **What type of degree program are you currently enrolled in:**
   a. Master's Degree in Counseling
   b. Master's Degree in Psychology or Psychology Related Area
   c. PhD in Clinical Psychology
   d. PhD in Counseling Psychology
   e. PsyD
   f. Other: (Please identify: _____)

8. **What year are you in your academic training program (for example, 1st year master's student, 4th year doctoral student)?:_____**

9. **Please estimate the total number of hours you have spent conducting therapy (individual, child, family, or couples therapy) as a graduate student (count practicum hours, plus internship hours if applicable):_____**

++

For items 10-21 you will probably find that you agree with some of the statements, and disagree with others, to varying extents.

Circle the number:

-4 if you *very strongly disagree* with the statement
-3 if you *strongly disagree* with the statement
-2 if you *moderately disagree* with the statement
-1if you *slightly disagree* with the statement
0 if you feel exactly and *precisely neutral* about the statement
+1 if you *slightly agree* with the statement
+2 if you *moderately agree* with the statement
+3 if you *strongly agree* with the statement
+4 if you *very strongly agree* with the statement

10. **God has given humanity a complete, unfailing guide to happiness and salvation, which must be totally followed.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

11. **No single book of religious teachings contains all the intrinsic fundamental truths about life.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

12. **The basic cause of evil in this world is Satan, who is still constantly and ferociously fighting against God.**

Very strongly disagree — Very strongly agree

-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

13. It is more important to be a good person than to believe in God and the right religion.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

14. There is a particular set of religious teachings in this world that are so true, you can't go any "deeper" because they are the basic, bedrock message that God has given humanity.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

15. When you get right down to it, there are basically only two kinds of people in the world: the Righteous, who will be rewarded by God: and the rest, who will not.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

16. Scriptures may contain general truths, but they should NOT be considered completely literally true from beginning to end.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

17. To lead the best, most meaningful life, one must belong to the one, fundamentally true religion.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

18. "Satan" is just the name people give to their own bad impulses. There really is *no such thing* as a diabolical "Prince of Darkness" who tempts us.

Very strongly Very strongly
disagree agree
-4..……-3..……..-2..……-1..……0..……+1..……+2..……+3..……+4

19. Whenever science and sacred scripture conflict, *science* is probably right.

Very strongly disagree — Very strongly agree

-4..……-3..……...-2..……-1..……0..……+1..……+2..……+3..……+4

20. The fundamentals of God's religion should never be tampered with, or compromised with others' beliefs.

Very strongly disagree — Very strongly agree

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21. *All* of the religions in the world have flaws and wrong teachings. There is *no* perfectly true, right religion.

Very strongly disagree — Very strongly agree

-4..……-3..……...-2..……-1..……0..……+1..……+2..……+3..……+4

++

For items 22-35 please read each of the following statements carefully. Indicate the extent to which you agree or disagree with each statement using the scale shown below. Please think carefully before answering.

22. Abortion is wrong, because everyone, even unborn babies, has the right to life.

Strongly Disagree — Strongly Agree

-2……-1……0……+1……+2

23. Sex education should be taught at home by the parents, not in public schools.

Strongly Disagree — Strongly Agree

-2……-1……0……+1……+2

24. The government should spend less on defense and focus more on domestic needs.

Strongly Disagree — Strongly Agree

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25. If drugs were decriminalized, society would degenerate.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

26. Some crimes are so despicable, they should be punishable by death.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

27. Gay people are entitled to the same constitutional rights as heterosexuals.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

28. Because the U.S. is a world leader, it cannot cut its defense spending position without losing its world position.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

29. It is women's constitutional right to choose whether or not to have an abortion.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

30. An increase in taxes is needed.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

31. Capital punishment is not an effective deterrent.

Strongly Disagree -2……-1……0……+1……+2 Strongly Agree

32. Censorship of music and art violates people's constitutional rights.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

33. Sex education in schools is vital, especially with the increasing concern of AIDS.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

34. Censorship of art is justified when the artwork is deemed pornographic or obscene.

Strongly Disagree ... Strongly Agree

-2……-1……0……+1……+2

35. How would you rate yourself on the following scale?

Conservative ... Neither one or the other ... Liberal

1……2……3……4……5……6……7

++

Please respond to items 36-42 by circling the one response that best reflects your agreement with the statement.

36. I feel that my training and professional experiences (will eventually sufficiently prepare/have sufficiently prepared) me to work with suicidal clients.

Strongly disagree ... Strongly agree

-2……..….-1……..….0……..….+1……..….+2

37. I imagine becoming uncertain of my abilities when a client talks about the possibility of harming his or her self.

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38. I often question whether or not I have the skills and abilities to work with clients that are suicidal.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

39. Upon learning a client is suicidal I know that I can offer optimal assistance to him or her.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

40. Experiencing the suicide of a client in the future is not something that I worry about.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

41. After a session with a suicidal client I can imagine myself reflecting and wondering whether I did a 'good enough' job of counseling him or her.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

42. I feel confident in my ability to work with suicidal clients.

Strongly disagree — Strongly agree

-2……..….-1……..….0……..….+1……..….+2

++

For the purposes of items 43-62, rational suicide is defined as: The process by which a person who has an unremitting helpless condition, makes a free choice decision to end his/her life, and has engaged in sound decision making (based on the work of Werth and Cobia, 1995).

43. Given the above definition, do you think generally that *rational suicide* is:

Completely Unacceptable — Completely Acceptable

-3.....-2.....-1.....0.....+1.....+2.....+3

What follows are a series of hypothetical situations. For each of the situations below the interest lies in the degree to which you believe an individual should have the right to commit suicide if he/she were in this situation. It is recognized that minimal information is being provided for each situation, thus your answer may "depend" (for example, depend on whether the individual has explored the impact of his/her death on others). However, please respond to the statements given the extent to which you think a circumstance could exist, within the provided situation, in which you think the person should have the right to commit suicide.

44. A 40-year-old woman has been treated for severe depression for 5 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

45. A 40-year-old woman has been diagnosed with terminal cancer.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

46. A 70-year-old woman is on life support in the hospital after a car accident, and doctors predict she will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

47. A 40-year-old woman has been quadriplegic since an injury 5 years ago.

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50. A 10-year-old girl is on life support in the hospital after a car accident, and doctors predict she will not recover.

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1……2……3……4……5

58. A 40-year-old man has been quadriplegic since an injury 5 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

59. A 40-year-old man is on life support in the hospital after a car accident, and doctors predict he will not recover.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

60. A 40-year-old woman has been severely depressed for 15 years and no existing treatment has relieved her symptoms.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

61. A 40-year-old woman has been quadriplegic since an injury 15 years ago.

Definitely should not have the right to commit suicide — Definitely should have the right to commit suicide

1……2……3……4……5

62. Consider the prior item(s) for which you feel suicide is most acceptable (if at all). If the individual(s) in the scenario(s) was/were your client, to what extent would you go to prevent him/her from committing rational suicide?

I would take no action to prevent the suicide of the client — Any means Including involuntary hospitalization

1……2……3……4……5……6……7

++

63. Have you ever worked with a client that voiced suicidal ideation?

g. Yes
h. No

64. Please indicate the number of clients that have attempted suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 64 THEN SKIP ITEM 64a.

64a. What impact did the client suicide attempt have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

65. Please indicate the number of clients that have committed suicide while you were working with them:_____

IF YOU INDICATED '0' FOR ITEM 65 THEN SKIP ITEM 65a.

65a. What impact did the client suicide have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

66. Have you ever worked with a client that voiced suicidal ideation that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

67. Have you ever worked with a client that attempted/completed suicide that you considered to be *rational* in their desire to end their life?

a. Yes
b. No

68. Please indicate the number of family members or close friends that have attempted suicide during the course of your relationship with them:_____

IF YOU INDICATED '0' FOR ITEM 68 THEN SKIP ITEM 68a.

68a. What impact did the suicide attempt have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

69. Please indicate the number of family members or close friends that have committed suicide during the course of your relationship with them:_____

IF YOU INDICATED '0' FOR ITEM 69 THEN SKIP ITEM 69a.

69a. What impact did the suicide have on your attitude toward the acceptability of suicide?

Significantly Decreased my Approval — No Impact — Significantly Increased my Approval

-3……..-2……..-1……..0……..+1……..+2……..+3

70. Have you ever attempted suicide?

a. Yes
b. No (Please answer item 70a. below)

70a. If you have never attempted suicide, have you ever seriously considered doing so?

I have never considered suicide — I have given suicide serious consideration

1……..2……..3……..4……..5……..6……..7

Appendix I

Institutional Review Board Approved Information Sheet

INFORMATION SHEET FOR CONSENT TO PARTICIPATE IN A RESEARCH STUDY

My name is Marty Kennedy, and I am a Doctoral Candidate in the Counseling Psychology Program in the Department of Educational Psychology at the University of Oklahoma. I am requesting that you volunteer to participate in a research study titled Psychologists and Psychologists-in-Training: Predictors of Attitudes toward Suicide. You were selected as a possible participant because of your status as either a Member or Graduate Student Affiliate of the Association for Psychological Science, with a U.S. address, and a designated major field of 'clinical' psychology. Please read this information sheet and contact me to ask any questions that you may have before agreeing to take part in this study.

Purpose of the Research Study: The purpose of this study is to explore potential predictors of attitudes toward suicide among psychologists and psychologists-in-training.

Procedures: If you agree to be in this study you will be asked to complete the enclosed survey instrument. It is anticipated that completing the survey instrument should take approximately 20 minutes. Once it is completed it is requested that you mail the survey instrument back to the Principal Investigator in the accompanying stamped and self-addressed envelope.

Risks and Benefits of Being in the Study: The study has the risk of probing for sensitive or personal information including beliefs about the acceptability of suicide, professional and personal experience with suicide, participants' own history of suicidal thoughts and behavior, and attitudes toward controversial social topics such as abortion. This study has the potential benefit of participants gaining increased insight into their own personal attitudes toward suicide in the context of clinical work.

Compensation: You will not be compensated for your time and participation in this study.

Voluntary Nature of the Study: Participation in this study is voluntary. Your decision whether or not to participate will not result in penalty or loss of benefits to which you are otherwise entitled. If you decide to participate, you are free not to answer any question or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled.

Length of Participation: It is anticipated that participation will take approximately 20 minutes.

Confidentiality: The records of this study will be kept private. In published reports, there will be no information included that will make it possible to identify you as a research participant. Research records will be stored securely. All data will be locked in the Principal Investigator's Faculty Sponsor's campus office when not in use. All records listing participant names and addresses created for the purpose of making mailing labels will be destroyed promptly after all mailing is complete. There will be no links on any of the research materials that will allow the Principal Investigator to identify who completed any particular survey instrument. Only approved researchers will have access to the records.

Contacts and Questions: If you have concerns or complaints about the research, the researcher conducting this study can be contacted at (405) 325-2914, or by email at

mgkennedy@ou.edu. The researcher's Faculty Sponsor can be contacted at (405) 325-8442 or by email at rockey@ou.edu. In the event of a research-related injury, contact the researcher. You are encouraged to contact the researcher if you have any questions. If you have any questions, concerns, or complaints about the research and wish to talk to someone other than the individuals on the research team, or if you cannot reach the research team, you may contact the University of Oklahoma – Norman Campus Institutional Review Board (OU-NC IRB) at (405) 325-8110 or irb@ou.edu.

Please keep this information sheet for your records. By completing and returning this questionnaire, I am agreeing to participate in this study.

Appendix J

Participation Reminder

Prospective Participant,

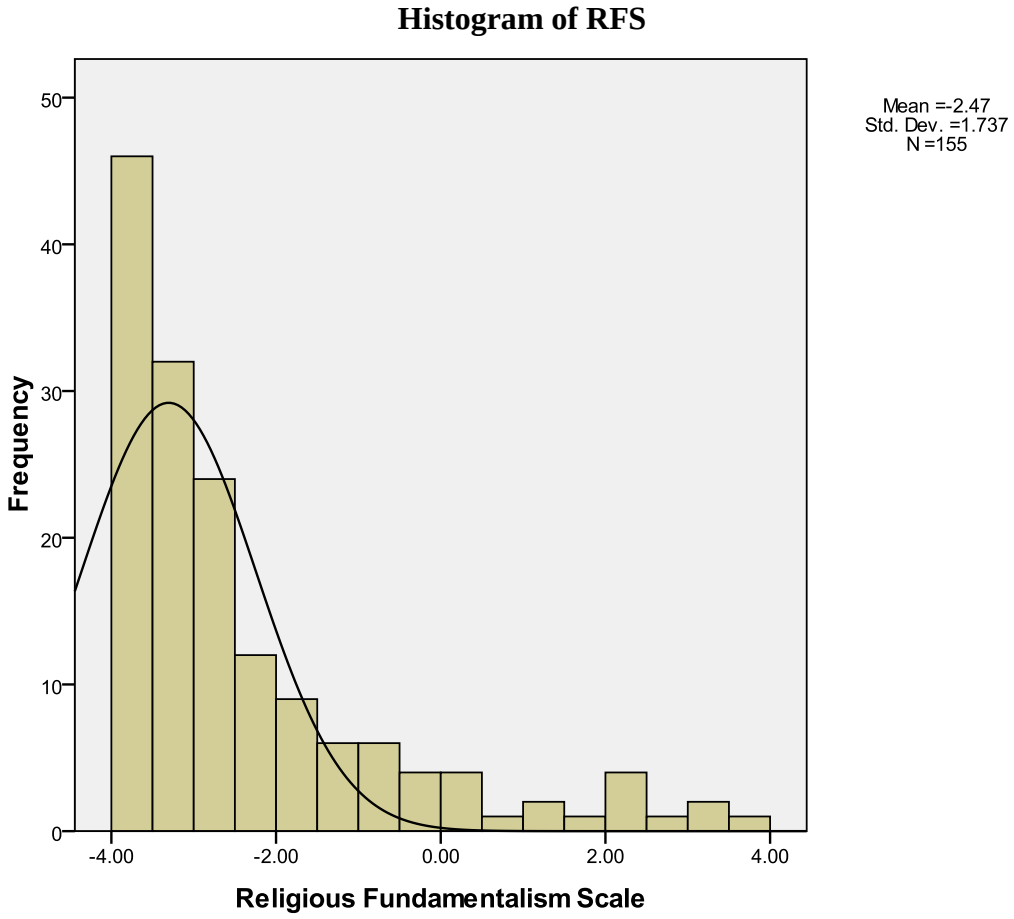
Roughly one week ago you should have received a request to volunteer to participate in a research study entitled: Psychologists and Psychologists-in-Training: Predictors of Attitudes toward Suicide.

This letter is meant to serve as a reminder to consider participating in the study if you have not already made a decision on whether or not to do so. If you have already completed and returned the survey instrument then please disregard this letter.

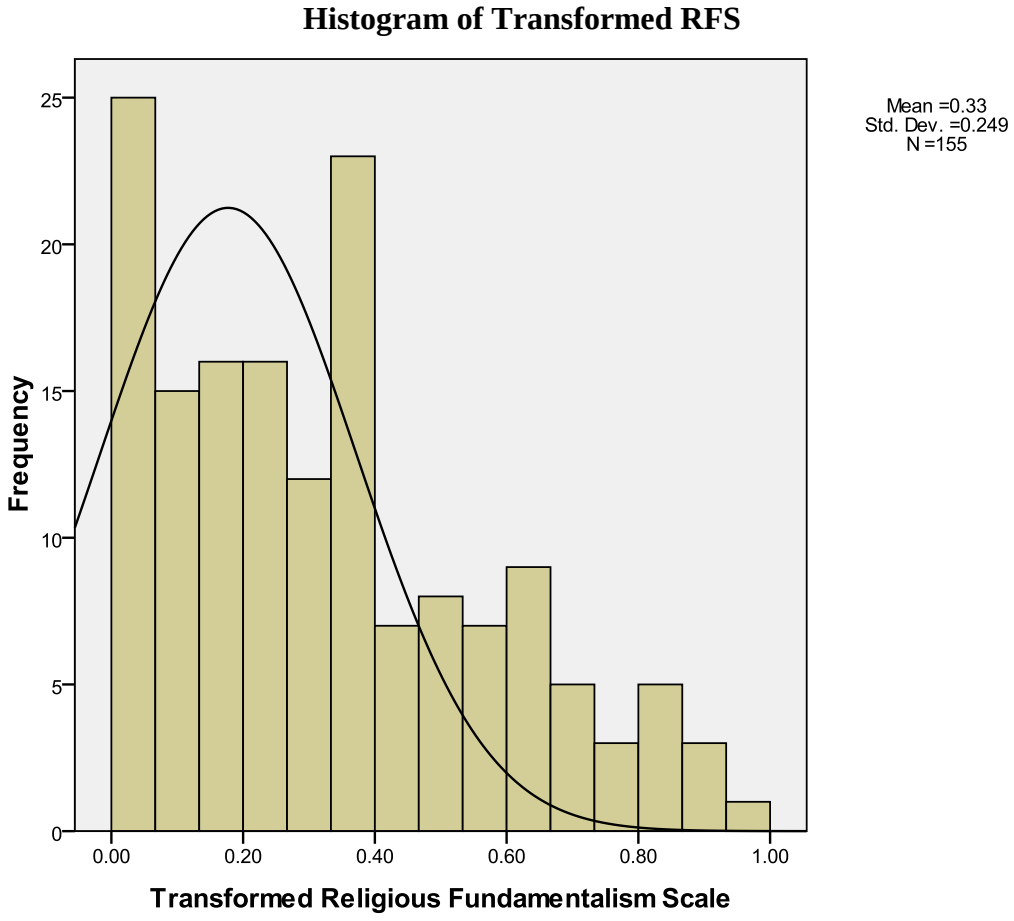
Should you have any questions regarding the research you can contact the researcher conducting this study at (405) 325-2914, or by email at mgkennedy@ou.edu. The researcher's Faculty Sponsor can be contacted at (405) 325-8442 or by email at rockey@ou.edu.

Sincerely,
Marty Kennedy
Doctoral Candidate
Counseling Psychology Program
University of Oklahoma

Appendix K

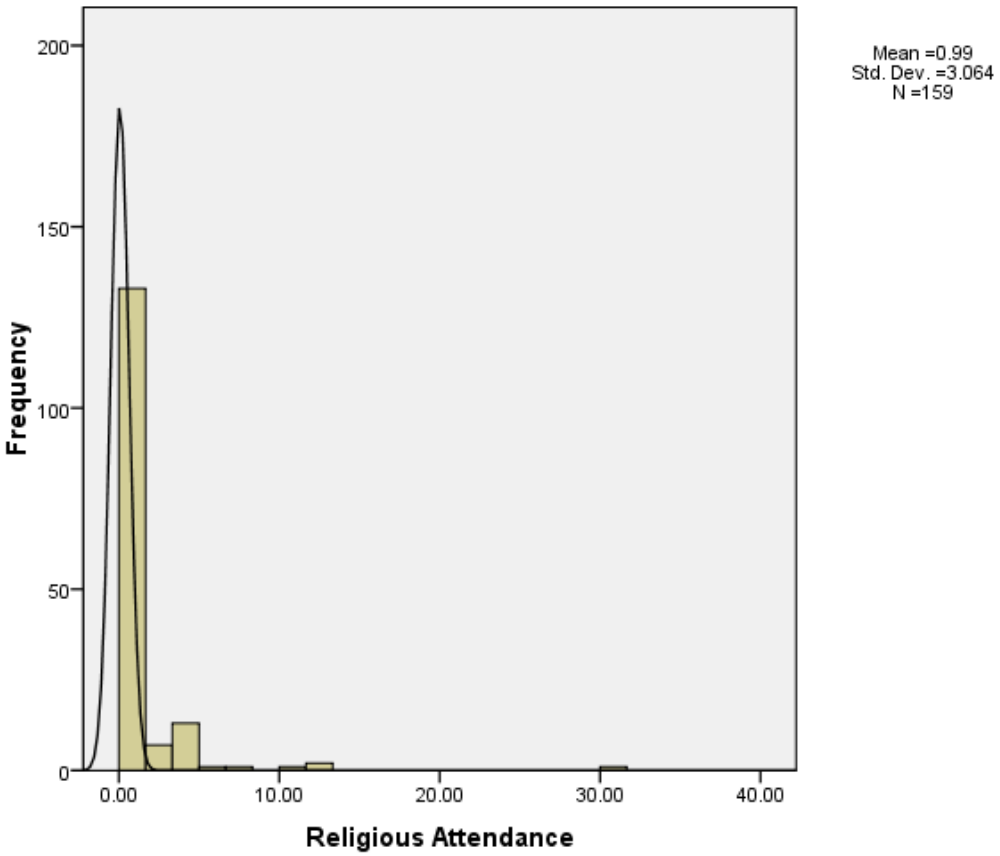

Histogram of RFS
Mean =-2.47
Std. Dev. =1.737
N =155
Frequency
50
40
30
20
10
0
-4.00
-2.00
0.00
2.00
4.00
Religious Fundamentalism Scale

Appendix L

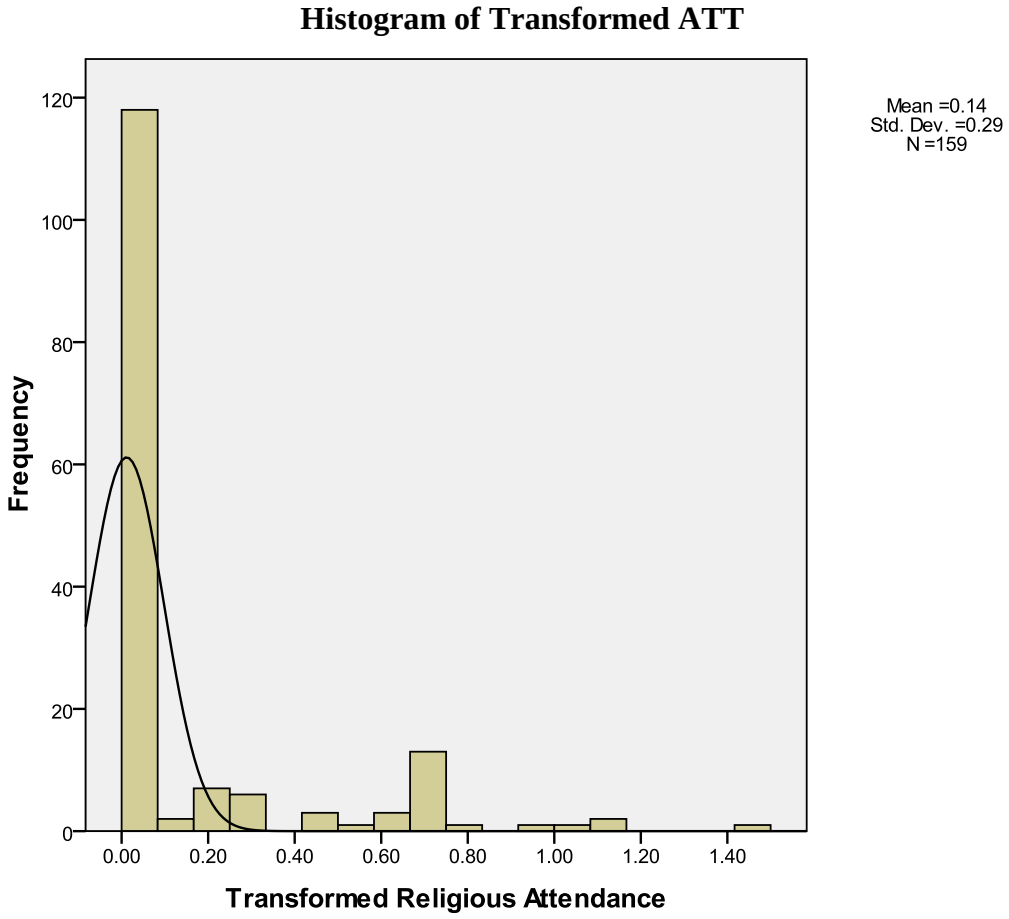

Histogram of Transformed RFS
Mean =0.33
Std. Dev. =0.249
N =155
Frequency
25
20
15
10
5
0
0.00
0.20
0.40
0.60
0.80
1.00
Transformed Religious Fundamentalism Scale

Appendix M

Histogram of ATT



Appendix N


Histogram of Transformed ATT
Mean =0.14
Std. Dev. =0.29
N =159
Frequency
120
100
80
60
40
20
0
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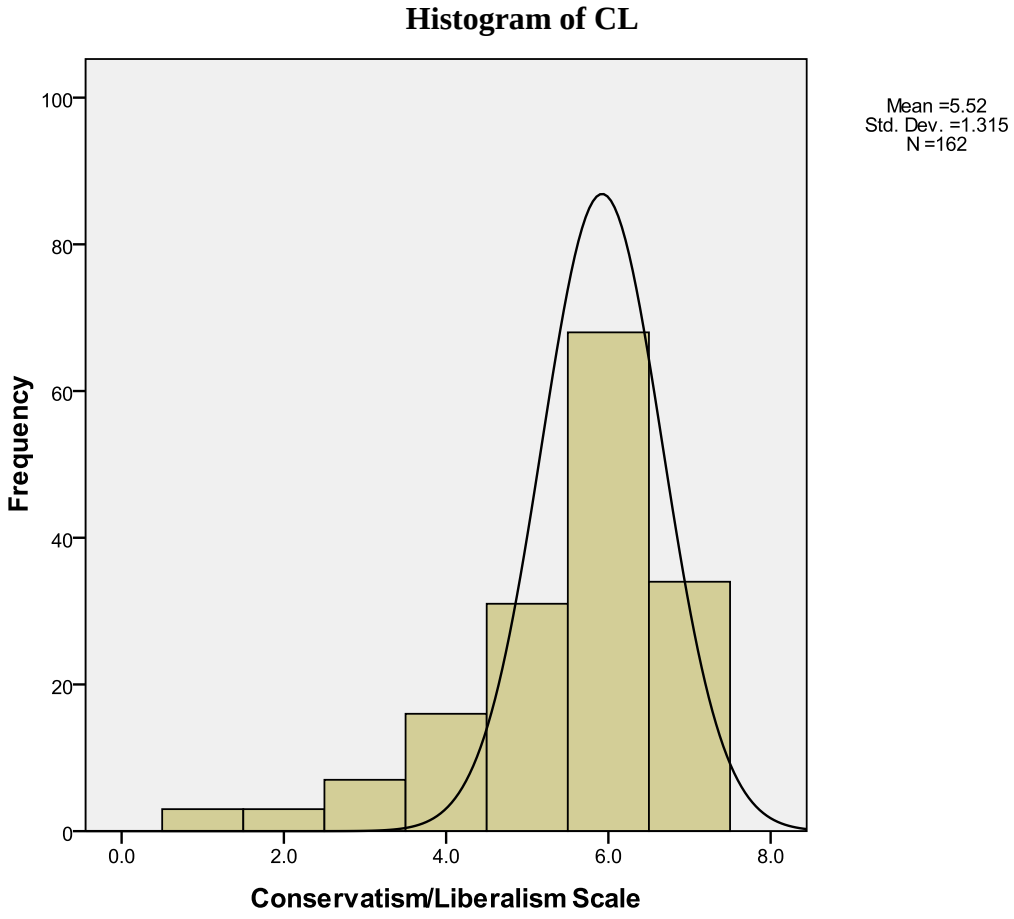
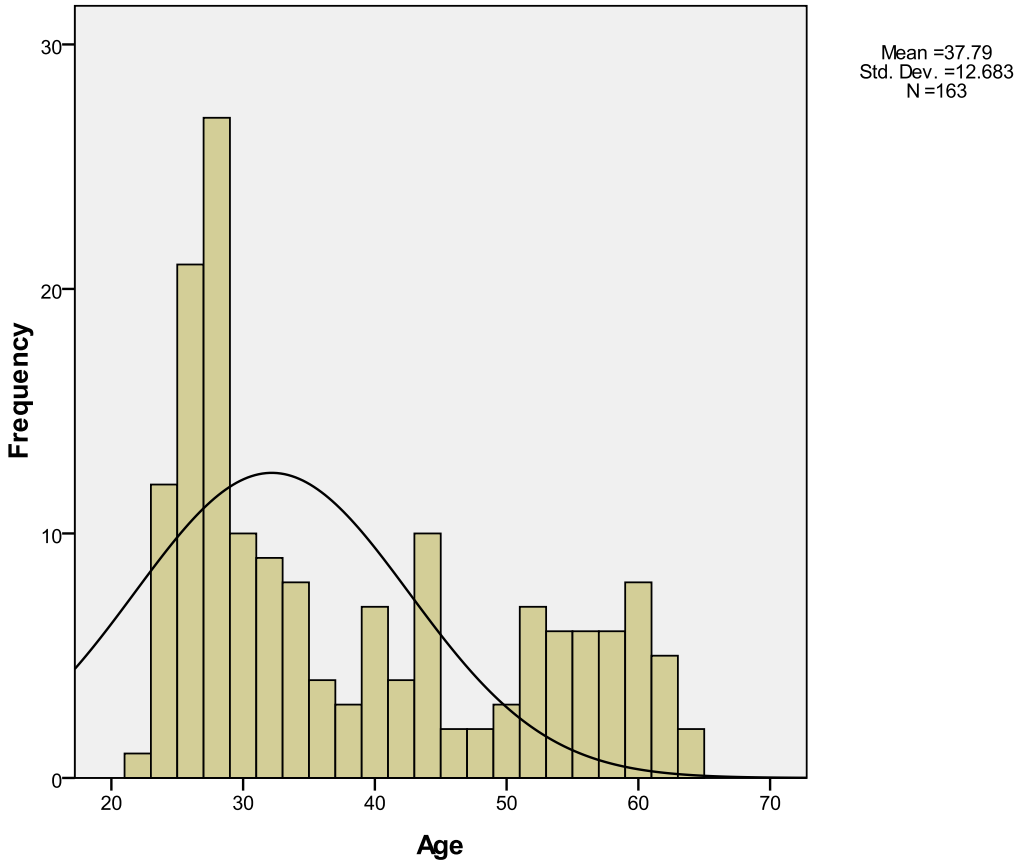
0.20
0.40
0.60
0.80
1.00
1.20
1.40
Transformed Religious Attendance

Appendix O


Histogram of CL
Mean =5.52
Std. Dev. =1.315
N =162
Frequency
100
80
60
40
20
0
0.0
2.0
4.0
6.0
8.0
Conservatism/Liberalism Scale

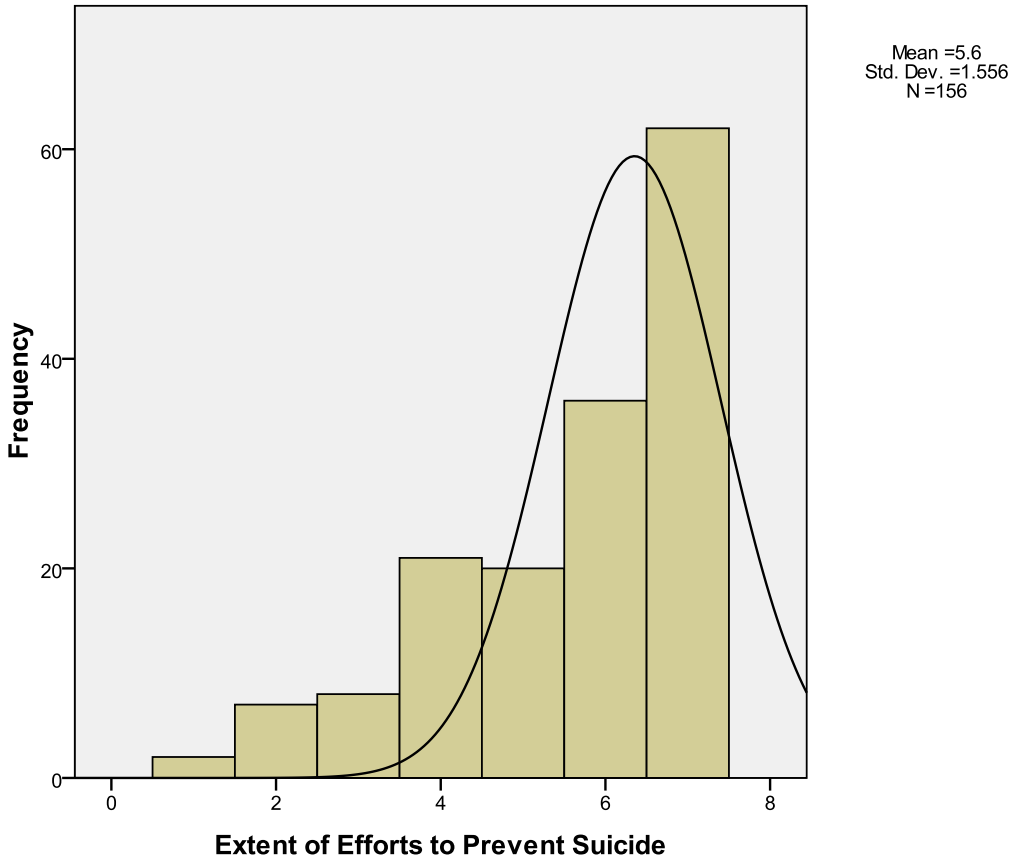
Appendix P

Histogram of AG



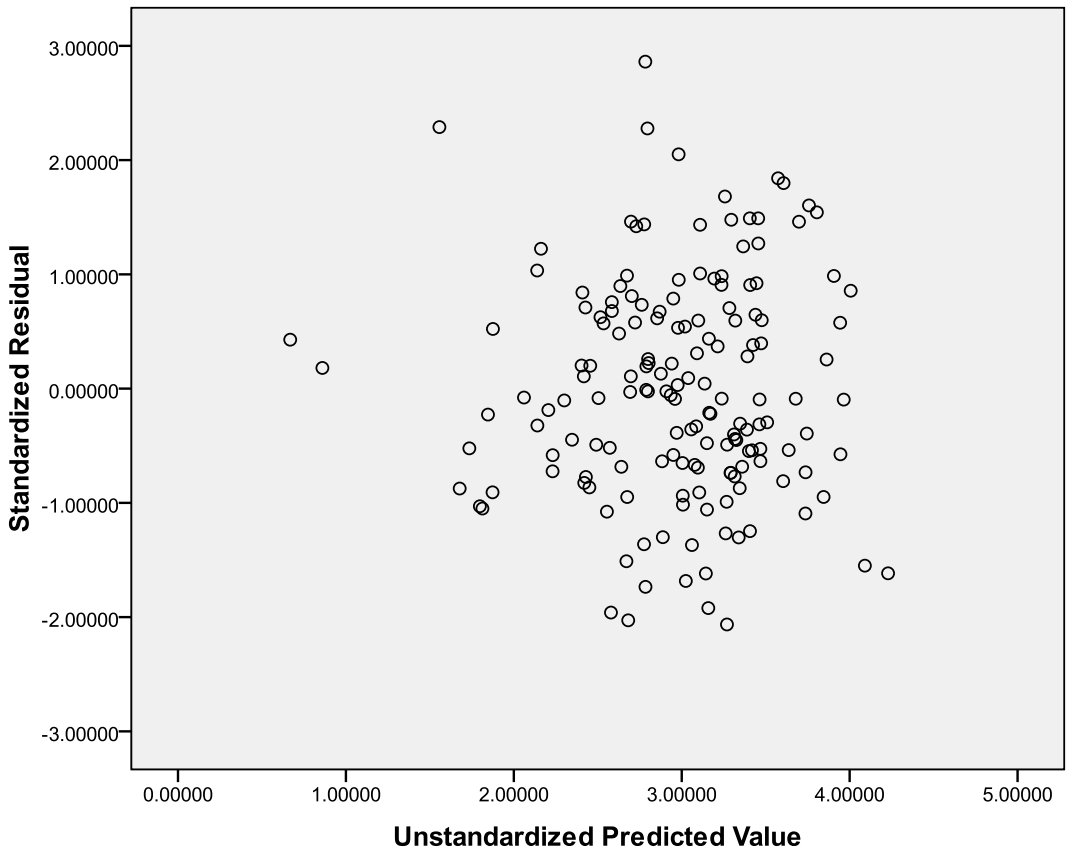
Appendix Q

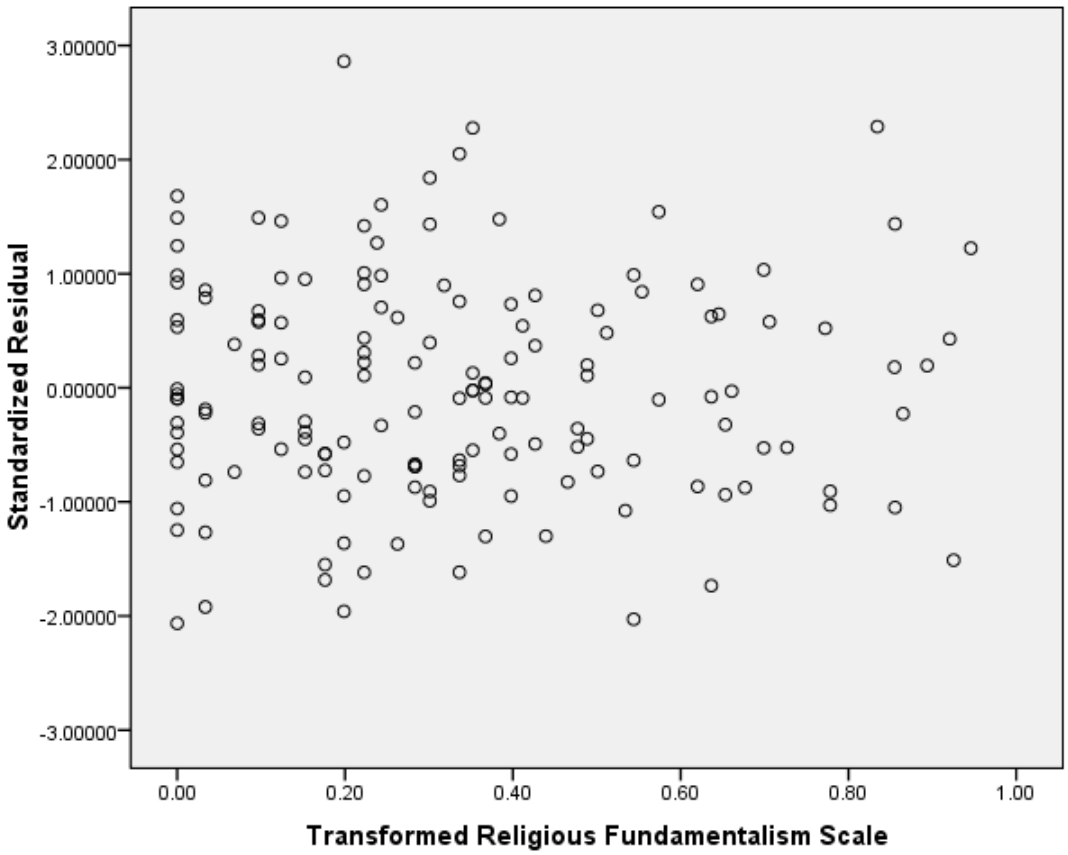
Histogram of PRE



Appendix R

Scatterplots of Standardized Residuals and Unstandardized Predicted Values/ Individual Predictors

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1.00000
0.00000
-1.00000
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-3.00000
Standardized Residual
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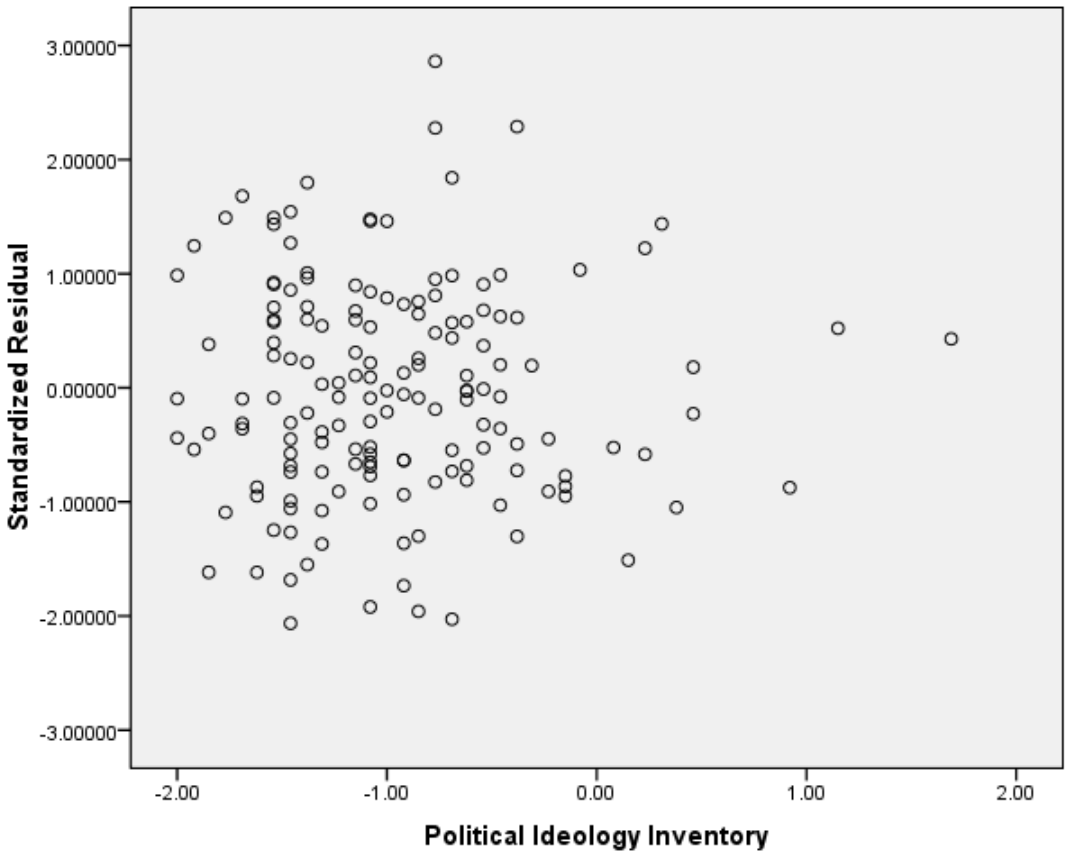
0.20
0.40
0.60
0.80
1.00
Transformed Religious Fundamentalism Scale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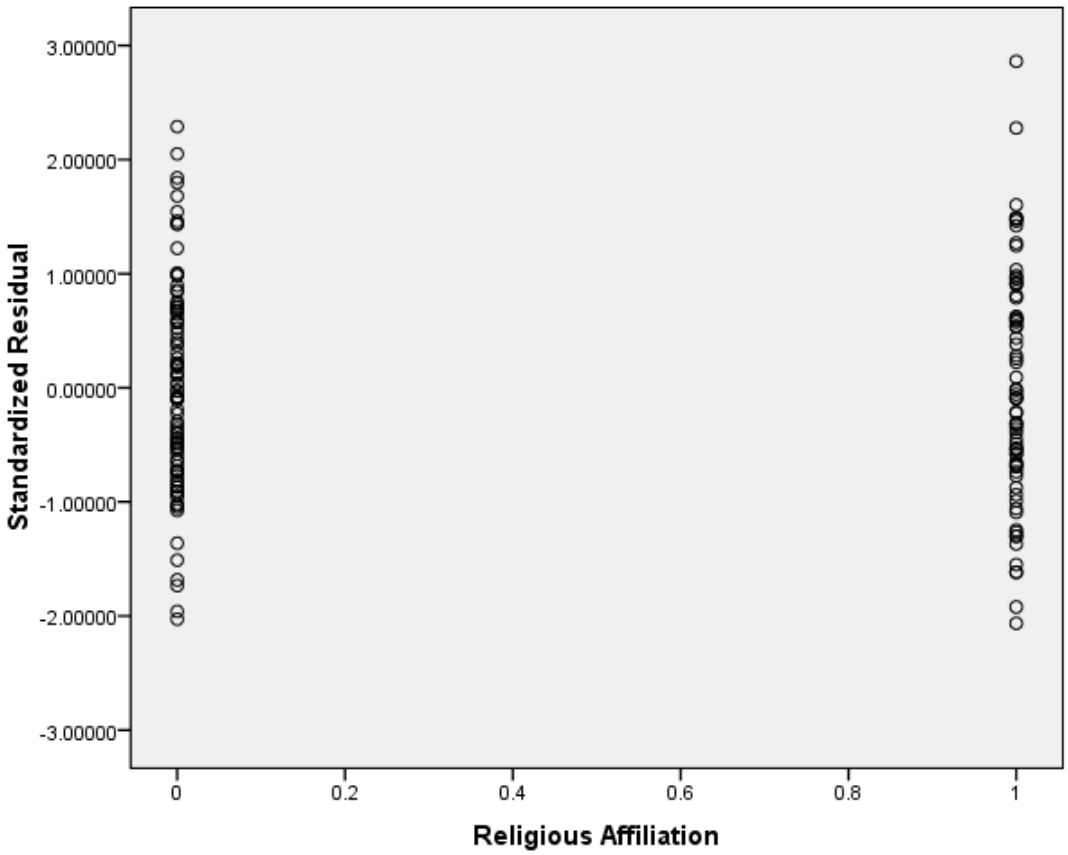
1.00000
0.00000
-1.00000
-2.00000
-3.00000
Standardized Residual
-2.00
-1.00
0.00
1.00
2.00
Political Ideology Inventory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2.00000
1.00000
0.00000
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Standardized Residual
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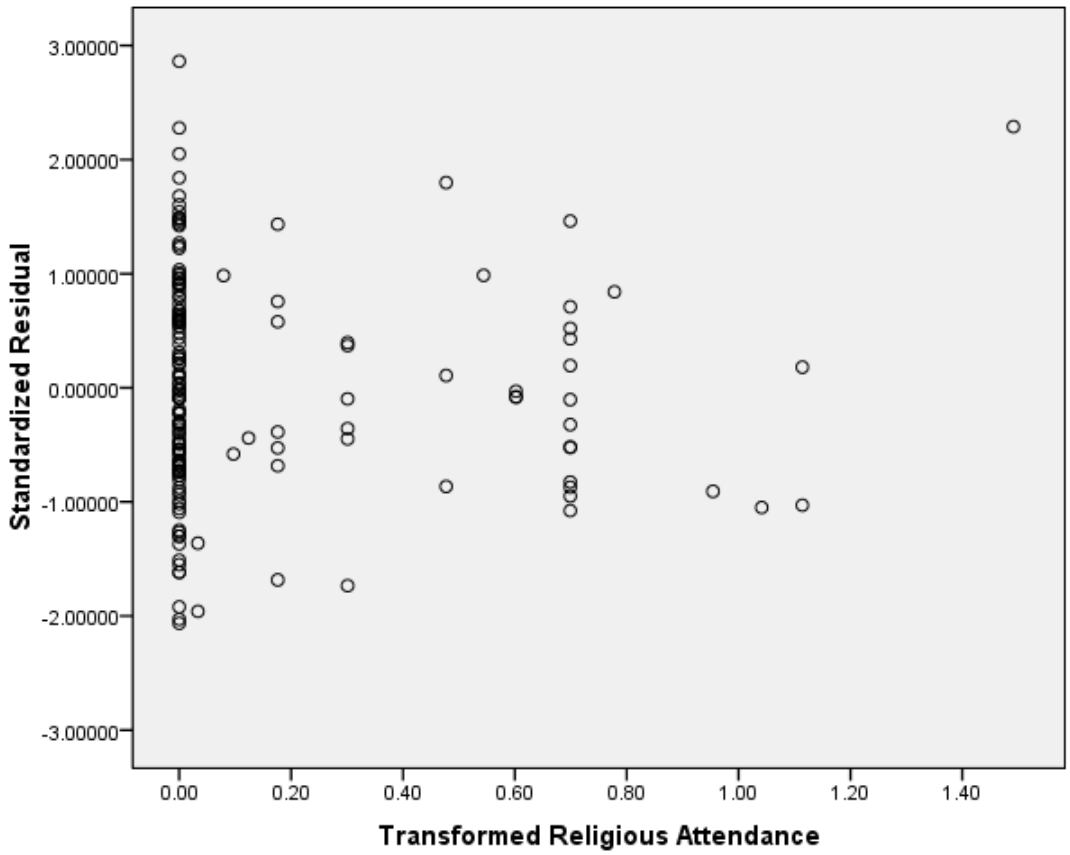
0.2
0.4
0.6
0.8
1
Religious Affiliation


Standardized Residual
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0.00000
-1.00000
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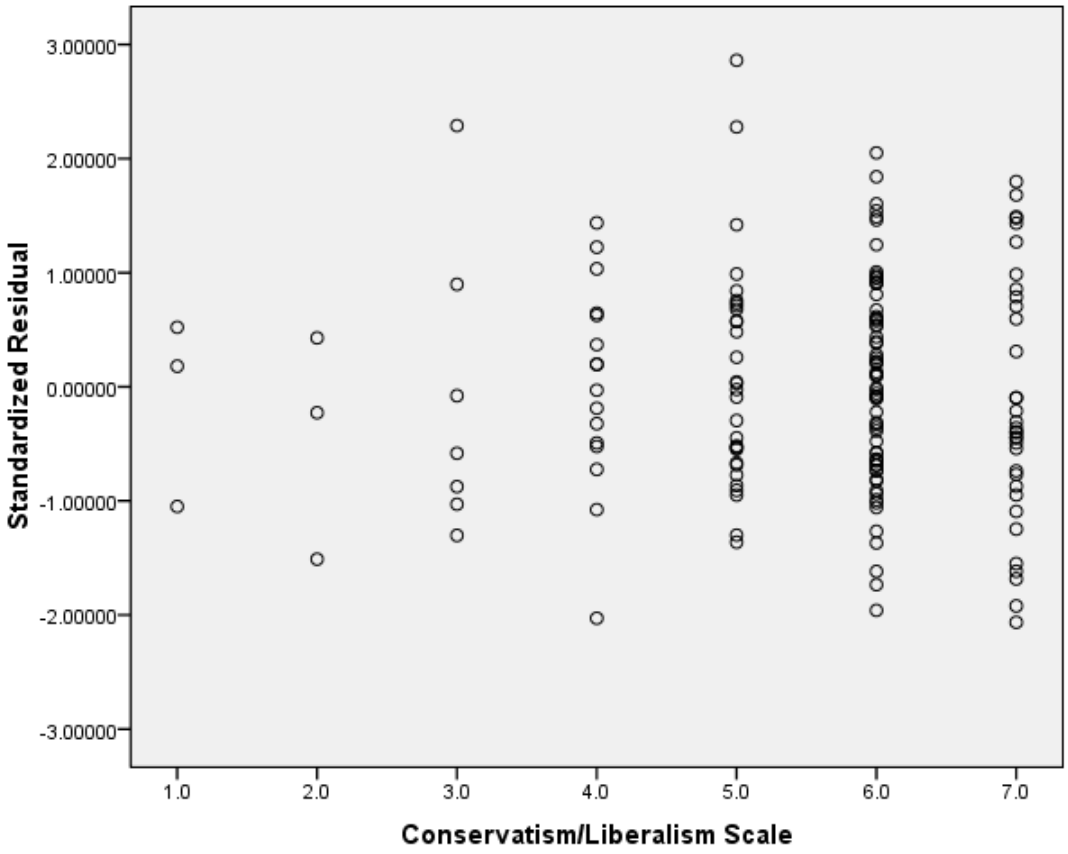
0.00
0.20
0.40
0.60
0.80
1.00
1.20
1.40
Transformed Religious Attendance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Standardized Residual
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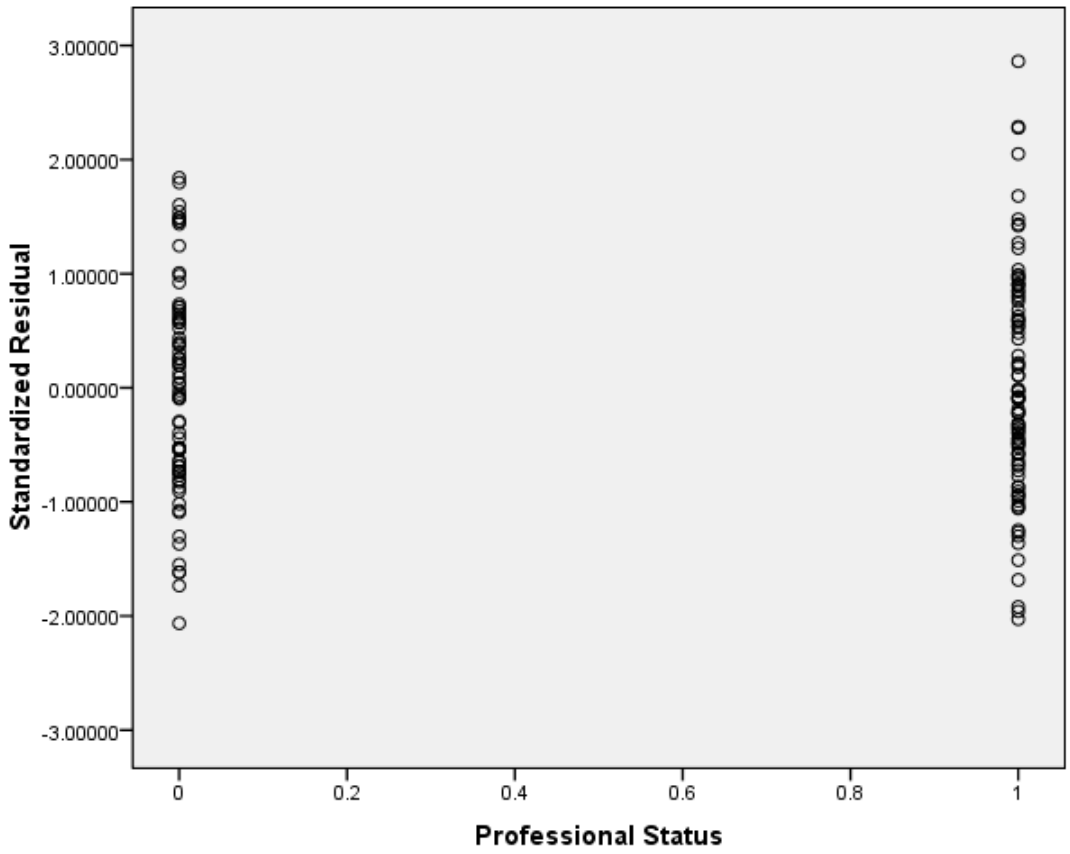
3.0
4.0
5.0
6.0
7.0
Conservatism/Liberalism Scale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2.00000
1.00000
0.00000
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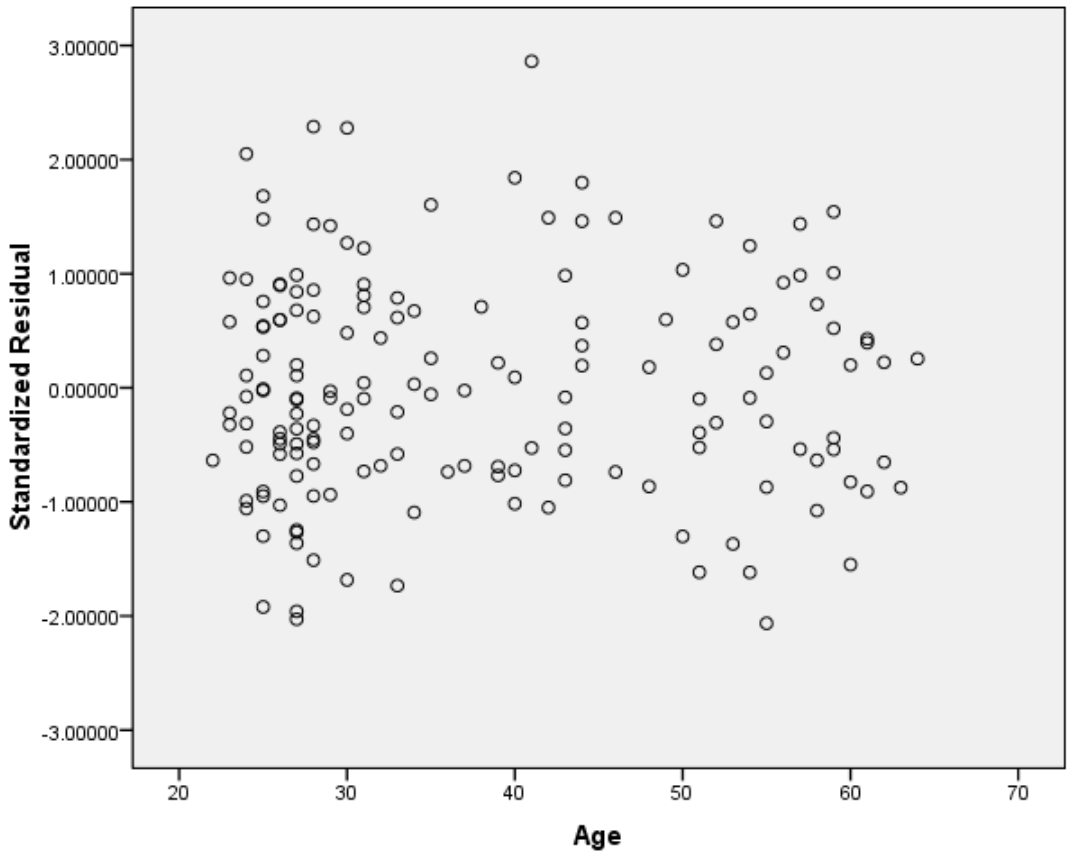
Standardized Residual
0
0.2
0.4
0.6
0.8
1
Professional Status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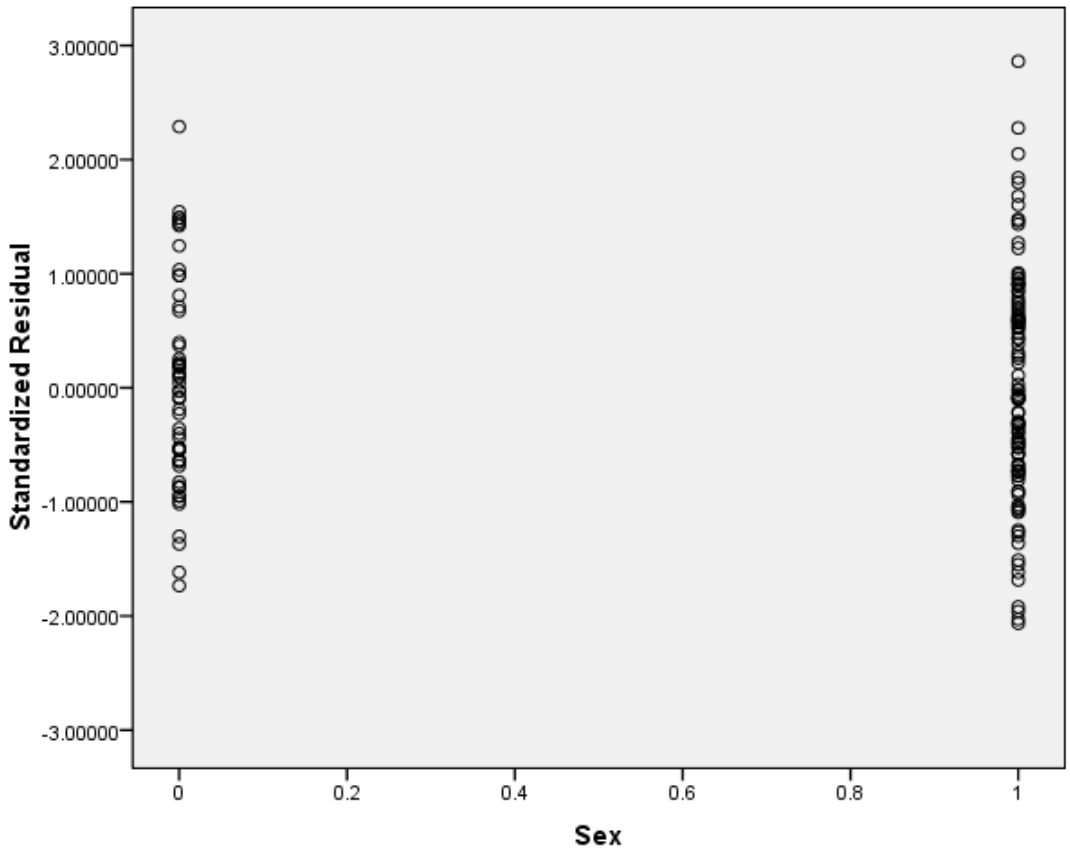
Standardized Residual
20
30
40
50
60
70
Age


Standardized Residual
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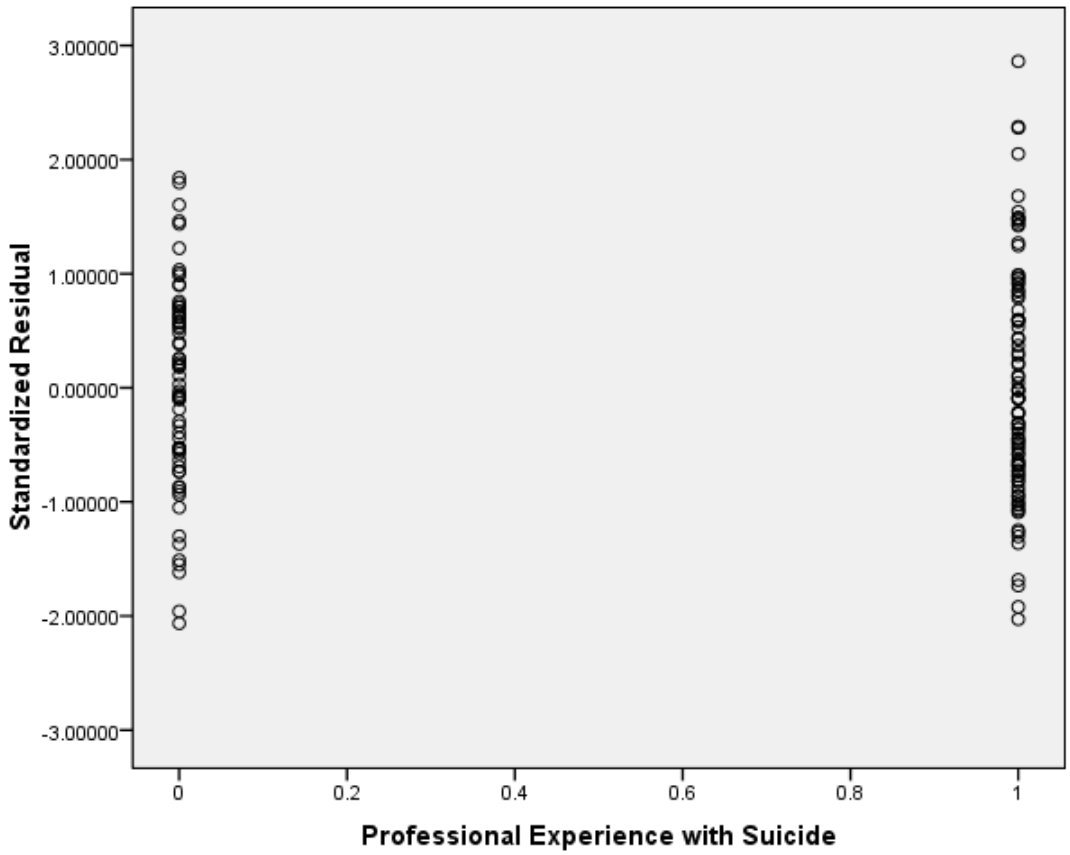
0
0.2
0.4
0.6
0.8
1
Sex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1.00000
0.00000
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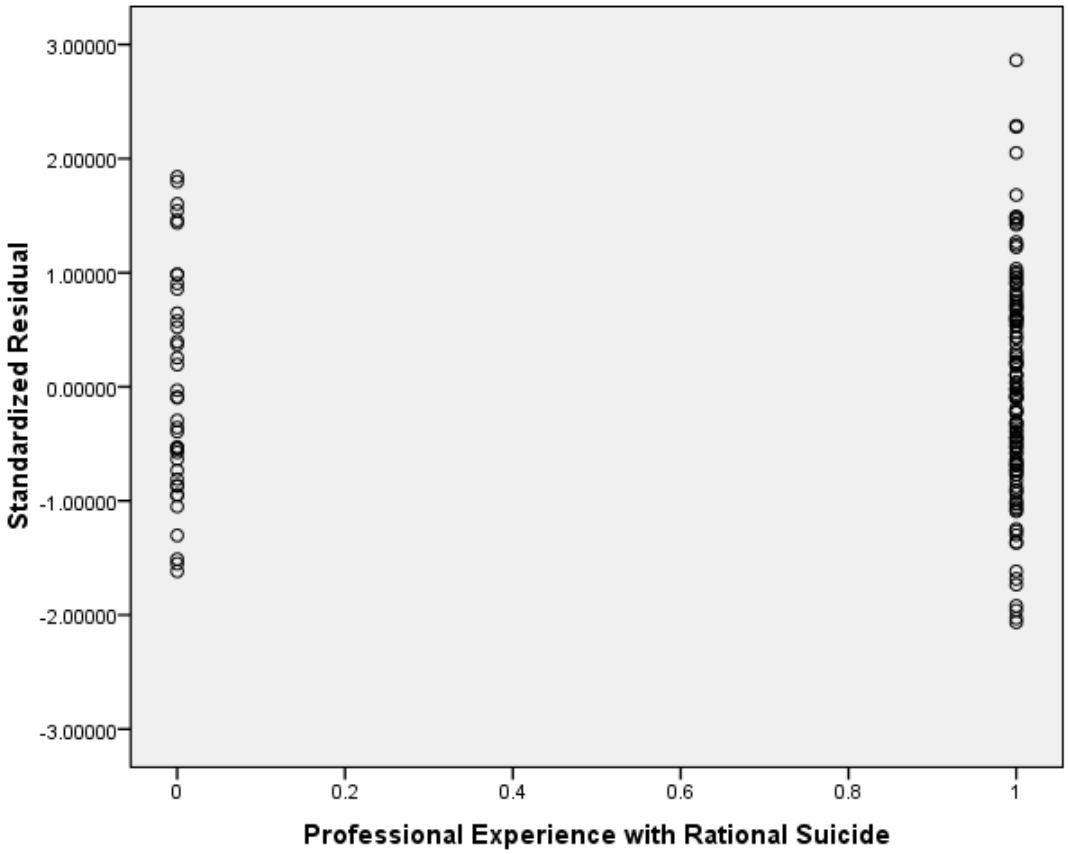
Standardized Residual
0
0.2
0.4
0.6
0.8
1
Professional Experience with Suicide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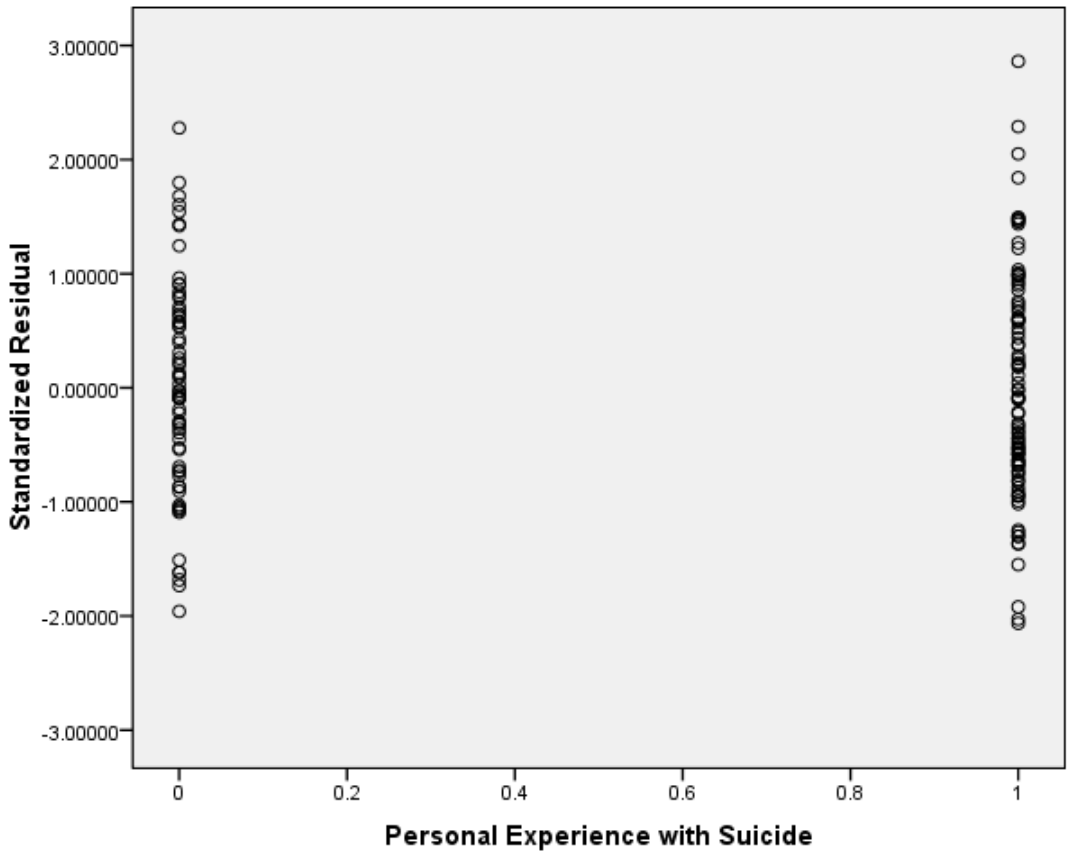
1.00000
0.00000
-1.00000
-2.00000
-3.00000
Standardized Residual
0
0.2
0.4
0.6
0.8
1
Professional Experience with Rational Suicide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0.00000
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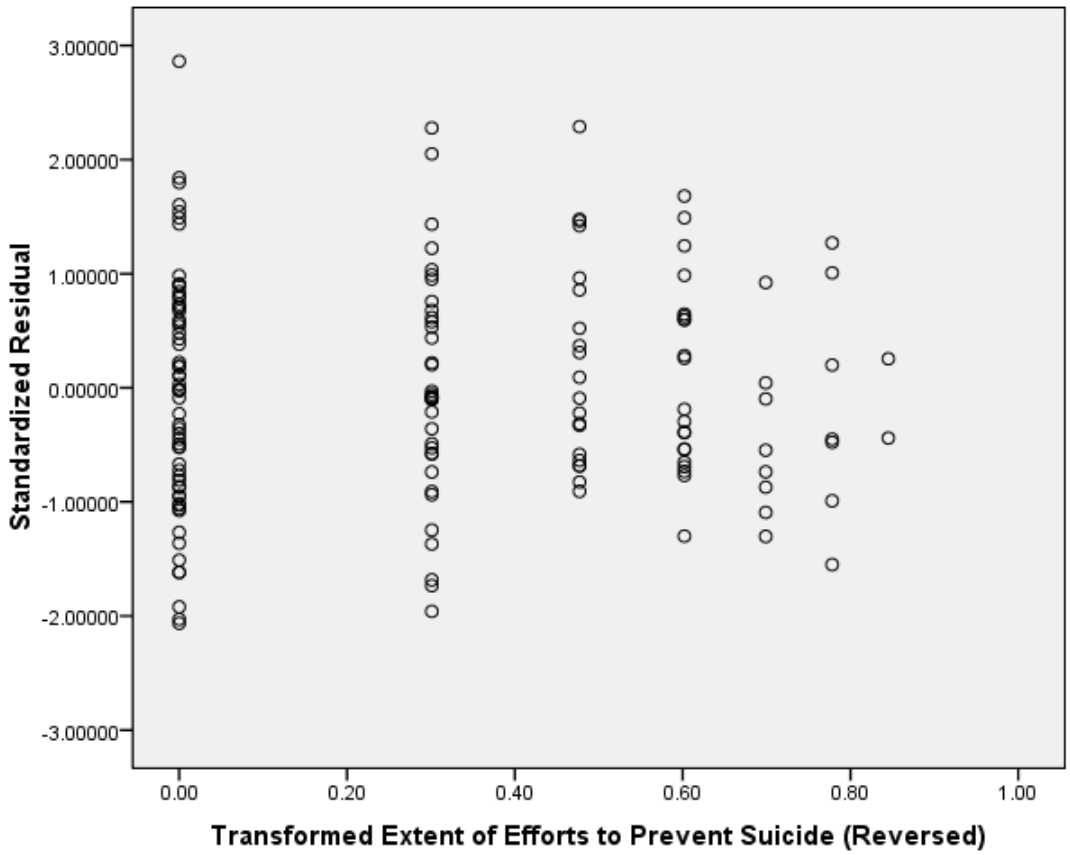
Standardized Residual
0
0.2
0.4
0.6
0.8
1
Personal Experience with Suicide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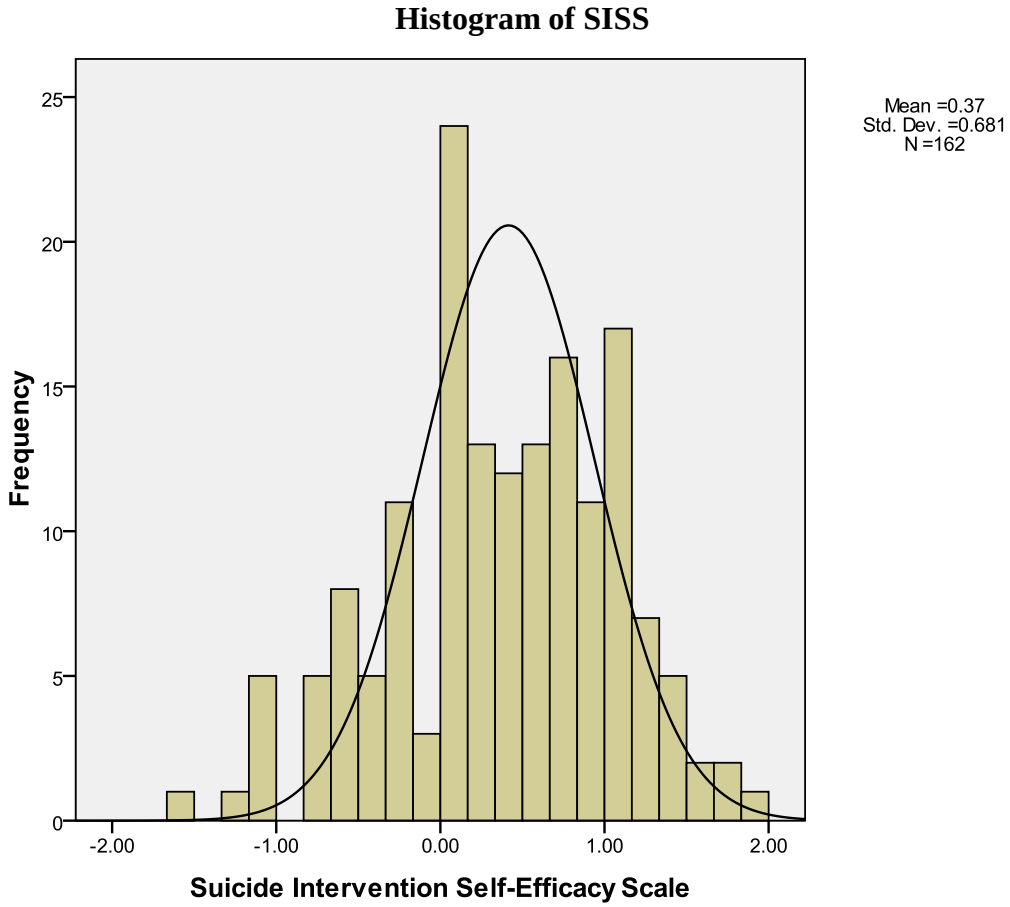
-2.00000
-3.00000
Standardized Residual
0.00
0.20
0.40
0.60
0.80
1.00
Transformed Extent of Efforts to Prevent Suicide (Reversed)

Appendix S


Histogram of SISS
Mean =0.37
Std. Dev. =0.681
N =162
Frequency
25
20
15
10
5
0
-2.00
-1.00
0.00
1.00
2.00
Suicide Intervention Self-Efficacy Scale

Appendix T

Prospectus

Marty Kennedy
Attitudes toward Suicide and Counselor Development
University of Oklahoma

Introduction

Paul Tillich (1952) argues that the anxiety of death "is most basic, most universal, and inescapable...even arguments for the immortality of the soul...do not have the power to convince existentially" (p. 42). First, he feels there is a primal, preverbal anxiety connected with the disappearance of the outside world and the self. Secondly, he explains that, especially in individualistic societies, there is an anxiety concerning "the threat" of nonbeing to man's needed self-affirmation, that is the possibility of not realizing one's unique potentials, which appears to be absolute in death (p. 44).

For Tillich, as well as other existentialists, such as Hiedigger, Sartre, and Camus, the question is, do we exhibit courage to be when faced with threats to our self-affirmation. Through *Hamlet*, Shakespeare wonders, "to be or not to be, that it the question." When counselors are directly confronted with primal terror of obliteration when one of their clients commits suicide they are potentially in a position where the defenses to their own mortality are weakened. They may attempt to deny this core inner conflict or they may wrestle at the deepest level with this ultimate concern, but either way there is no escape from death.

Counselors enter their profession with the deeply rooted conviction that their goal of facilitating persons to greater psychological health matters. They are taught from the beginning that the instillation of hope in their clients is paramount to healing. When clients despair so much that they choose to terminate all their potentialities, it is no wonder that many counselors are shaken to their cores.

It is this existential issue of suicide and its relationship to counselor development that this study looks in the face. It is hoped that this research will continue to explore

what we may too frequently attempt to avoid. Considering whether one should live or die has a way of exposing trivialities and reassessing potentialities.

The current dearth of literature on counselors and their attitudes toward suicide leaves much room for research on this important topic. While attitudes toward suicide have been investigated under various circumstances and across various mental health professions, no studies have looked directly at such attitudes in their potential relationship with level of counselor development.

Statement of the Problem

Suicide comes from a combination of the Latin words *sui* which means 'of oneself' and *cidium* which means 'to kill' (Hewitt & Edwards, 2006). De Leo, Burgis, Bertolote, Kerkhof & Bille-Brahe (2006) stated that while most everyone has an understanding of the term 'suicide' many do not recognize the actual complexity in creating a proper distinction of the behavior. The researchers subsequently offered what they considered a comprehensive definition. "Suicide is an act with fatal outcome, which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes" (p. 12).

Suicide was listed as the 11th leading cause of death in the United States in 2005, with over 32,000 individuals taking their lives that year. Also important to recognize is the number of individuals treated for self-injurious behavior that same year, which was close to 400,000. Furthermore, the incidence of suicide has been on the rise. The age-adjusted suicide rate for U.S. adults rose from 10.5 to 10.9 per 100,000 individuals between 1999 and 2005 (Kung, Hoyert, Xu, & Murphy, 2005).

Attitudes toward suicide, and death in general, have been explored as well, based on a host of different variables such as religious affiliation and gender (Dattell & Neimeyer, 1990; Holcomb, Neimeyer, & Moore, 1993; Sadowski, Davis, & Loftus-Vergari, 1979-80; Siegrist, 1996; Smyth & MacLachlan, 2005; Stack & Wasserman, 1992; Stack, Wasserman, & Kposowa, 1994).

In addition, a number of studies have looked at the issue of suicide and death as it relates specifically to attitudes and feelings of various mental health professionals (Kirchberg, Neimeyer, & James, 1998; Light, 1976; Neimeyer & Dingemans, 1980-81; Neimeyer & Neimeyer, 1984; Neimeyer & Hartley, 1986; Neimeyer, Fortner, & Melby, 2001; Swain & Domino, 1985; Terry, Bivens, & Neimeyer, 1995). Much of the data suggests complexity with respect to death and suicide and how feelings and attitudes toward these constructs can affect mental health practitioners.

Indeed, many pieces of research exist that have pointed to the deleterious effects, both professional and personal, of suicide, as experienced by mental health professionals (Brown, 1987; Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989; Foster & McAdams, 1999; Goldstein & Buongiorno, 1984; Kleespies, 1993; Kleespies, Smith, & Becker, 1990; Knox, Burkard, Jackson, Schaak, & Hess, 2006; Menninger, 1991; Ruskin, Sakinofsky, Bagby, Dickens, & Sousa, 2004).

Furthermore, it has been noted that opinions on the topic of death are believed to be quite idiosyncratic (Neimeyer, Bagley, & Moore, 1986; Neimeyer & Moore, 1989). Attitudes specific to suicide are also believed to be complicated, encompassing much more than simple approval or disapproval of the act. The increasing attention that

rational suicide is receiving is at least one catalyst for the public thinking more complexly about suicide (Ingram & Ellis, 1992).

Significance of the Study

Being able to gauge differences in attitudes toward suicide based on level of development has several different implications. Most notably, differences in attitude could prove to be specifically affected by level of training, and subsequently by level of counselor development. This could inform decisions with respect to which level of counselor is most equipped to deal effectively with suicidal clients. Such information could perhaps begin to address how to remediate potential blind spots that counselors-in-training may have.

Another benefit of this study is that it could link specific attitudes with relatively finite periods of development, and indicate the presence of subtle changes in counselors over time based on the amount of training and subsequent development. Another byproduct could be further support for a model of counselor development that addresses the differences in attitude toward suicide based on development.

In addition, it appears that no piece of research to the author's knowledge exists that explores suicide in relationship to counselor development. While research that explores the difference between graduate students and professionals in the mental health field does exist, the difficulty is that no studies make extensive efforts to distinguish among the level of training of the participants beyond a simple classification of *professional-in-training* versus *professional*.

In addition, previous measures of opinions toward suicide may have been somewhat faulty in that they lacked a degree of psychometric integrity. A study that

explores opinions toward suicide with more sound tools is consequently valuable. The study could pave the way for stronger research on the topic of suicide as well as further support for new and modified inventories.

Review of the Literature

General Attitudes Regarding Death and Suicide

Research has looked at the role of locus of control as it pertains to death anxiety (Sadowski et al., 1979-80). The researchers used the Death Anxiety Scale (DAS) and the Reid-Ware Three Factor Locus of Control Scale as instruments in their particular study. One finding was that middle-aged participants tended to have less death anxiety than younger participants. In addition, it was suggested that "death anxiety reflects more of a concern over an inability to determine one's own behavior rather than beliefs about whether or not events in the environment occur as a consequence of one's behavior" (p. 209).

Common attitudes regarding death and the intricacies of the issue have also been investigated (Neimeyer et al., 1986). They noted the error in assuming that death anxiety is a function of either positive or negative emotion to death. Instead, using the Death Attitude Repertory Test (DART) it was hypothesized that death anxiety may have a correlation with some manner of philosophy of life and death, and may in fact be quite multidimensional, although it was cautioned that the hypothesis required further verification. Still, it is clear that at this time, researchers were beginning to look more closely at the fear of death, realizing that perhaps it was a much broader construct than originally theorized.

Neimeyer and Moore (1989) explored different tests used in establishing death anxiety. They noted the likelihood that various tests perhaps measured an array of dimensions, thus calling for methods capable of observing those *idiosyncratic* attitudes toward death that each of us creates in an effort to get a broader picture of the construct.

In 1990, Dattell and Neimeyer explored the specific differences in death anxiety between men and women. The authors used the Death Anxiety Scale (DAS), which is believed to be an emotional measure of death fear, and the Threat Index (TI), which is believed to be a more cognitive measure of death fear; the Marlow-Crowne Social Desirability Scale was also used to control for socially desirable responses to the instruments. The researchers found that the sexes differed on the DAS considerably, but not on the TI, as suspected; women scored higher than men on the former instrument, which again, is thought to tap more into affect, indicating greater anxiety when it comes to death.

Narrative based responses of the feelings of college students regarding death have yielded significant results over several variables (Holcomb et al., 1993). Women viewed death more in terms of negative emotions, having greater personal impact, and wrote of an afterlife more frequently than did men. Also of interest was the fact that those in poor health viewed death as less purposeful than those in good health. Those that previously experienced suicidal ideation or attempted suicide saw death as having "low impact" (p. 315). Also, those without a general philosophy of death were more likely to see the end of life as lacking a purpose.

Overall, views toward suicide were investigated by Ingram and Ellis (1992) via a literature review where it was found that attitudes appear to be mixed. However, it was

speculated that increasing acceptance of individual rights being embraced by some has "served to move societal attitudes away from a simple dichotomy of good or bad" (p. 41). As suicide continues to become a more complicated matter, perhaps more and more differing and idiosyncratic attitudes will perhaps emerge, which was consistent with the opinion of Neimeyer and Moore in 1989.

Smyth and MacLachlan (2005) found that women are more likely to find matters related to the factors of Death (the loss of an important person in one's life) and Nurturing Bonds (suffering abuse or losing a parent) to be more reasonable for committing suicide than men. It was also found overall that women were more accepting of suicide, based on higher overall scores across all four factors than men, which the authors noted was in conflict with extant research which suggests than men are believed to be more amenable to the act of suicide.

Attitudes toward Suicide in Relation to Spirituality

Regarding the impact of religion on suicide, in a study by Stack and Wasserman (1992), it was found that those individuals involved in "Conservative churches, churches with a high tension between their teachings and those of the greater societal culture, non-ecumenical churches, and churches with a Presbyterian polity all tend to exhibit reduced suicide ideology" (p. 464). The authors used responses to the acceptance of suicide under varying conditions as a gauge of overall thoughts on the acceptability of suicide. The strength of social support from the particular forms of churches identified was seen as the impetus behind the particular disapproving attitudes toward suicide.

Suicide as it relates to religion has also been explored in the context of feminism. Stack et al. (1994) tested two different models via LISREL, including the aforementioned

variables, based on survey data from a few thousand individuals. The researchers measured religiosity based on church attendance; individuals responded to a scale ranging from 0-8, spanning "never" to "several times a week" (p. 113). This same gauge of church attendance was one manner of establishing religiosity in the previously mentioned study by Stack and Wasserman (1992). Results suggested that "religiosity shapes the probability of feminist beliefs and these, in turn, condition the nature of suicide ideology" (p. 110). The article suggests the strength of religious identification as a determinant in views toward suicide.

It should be noted that other researchers have explored religiosity as it relates to specific denomination. Roof and McKinney (1987) (as cited in Burdette, Hill, & Moulton, 2005) have reported the benefit of categorization based on the following realms: conservative Protestants, moderate Protestants, liberal Protestants, Catholics, other faiths, and those not affiliated with any churches. Each group has certain characteristics commonly associated with it; furthermore, the first three groups are broken down into subgroups (e.g. moderate Protestants consist of Lutherans and Methodists). Conservative Protestants are said to be supportive of fundamentalist beliefs; moderate Protestants are thought to be integrated to a greater degree into society, thus possessing more moderate attitudes; liberal protestants are more accepting of varying political and social beliefs than the other protestant groups; Catholics are thought to be conservative, although the impact of the denomination on political views of its members is thought to be weaker than that of conservative Protestants.

In a 1996 study, Siegrist found that among a group of Germans between the ages of 15 and 30, that Catholics were the least supportive of suicide, followed by Protestants,

then followed by those with no religious affiliation. It was also noted that frequent churchgoers were less supportive of suicide than those than attended infrequently. Another interesting finding was that the suicide of an acquaintance decreased approval of suicide if the participant was involved in church, yet approval of suicide increased if one had an acquaintance engage in the act and the participant attended church infrequently.

Attitudes toward Suicide from Various Helping Professions

Research from various professions dealing with the matter of suicide and subsequent attitudes has also been conducted (Swain & Domino, 1985). Results of a study of family practice physicians, psychiatrists, psychologists, psychiatric nurses and aides, social workers, crisis line workers, and clergy, revealed significant differences between the groups as judged by the SOQ. Perhaps not surprisingly, clergy were least accepting of suicide as an option. Interestingly, social workers were the only group to fall within the "agree" range in terms of acceptability of suicide. Differences between physicians and psychologists showed that the former tended to view suicidal acts as a means of manipulating others. Still, those with personal experience of losing others to suicide were more accepting of the so-called "self-destructive drive" accounting for suicidal acts (p. 465). Also, it was observed that such individuals are better able to detect signs of suicide lethality. Another important finding was that those with a background in psychology, versus medical or theological training, were better able to feel empathy regarding suicide. Perhaps the most compelling concept to be shared by the authors is that "attitudes toward suicide are complex and ought not to be considered from a simplistic positive/negative viewpoint" (p. 463). The researchers made use of the SOQ and the Recognition of Suicide Lethality (RSL) scale in the study.

Mental Health Professionals and Feelings on Death and Suicide

In 1976, Light noted the complications inherent in treating a suicidal client. He hypothesized that perhaps the reason behind fear of death and suicide among mental health professionals has to do with the "professional stigma against suicide" (p. 64). He further questioned the ensuing interactions between the suicidal client so desperately in need of extensive support, and the reactions of the therapist concerned with having a suicide on their record. The author drew upon the degree to which proper suicide intervention exists and to what degree a therapist's own beliefs may diminish their level of effectiveness.

Neimeyer and Dingemans (1980-81) studied death anxiety among a group of 54 suicide intervention workers. The results of the study suggested that perhaps suicide intervention workers have a higher degree of death anxiety than a control group, as assessed by the Collett-Lester Fear of Death Scale (CL), the TI, the Lester Fear of Death Scale (FDS), and the DAS. Still, it was noted that the data suggested that the groups did not differ in their concerns for the death or the dying of other individuals. The authors questioned, though, whether the occupation of the suicide interventionists caused them to be more comfortable with being open about death, which then caused their greater degree of openness about their death anxiety. The researchers even questioned the degree to which perhaps a curvilinear relationship with respect to death anxiety might exist.

Neimeyer and Neimeyer (1984) chose to investigate the role that death anxiety plays in the suicide counselor. The researchers administered the Suicide Intervention Response Inventory (SIRI) and DAS to 109 participants. The results showed that counselors perhaps have less anxiety than do non-counselors; however, it was mentioned

that this information was in conflict with others studies. Also noted was the fact that having high death anxiety did not necessarily correlate with a decrease in ability to offer appropriate counseling to suicidal clients, although it was suggested that in vivo research would be needed to verify such.

Indeed, the SIRI, used in the previously mentioned study, as well as others, was investigated by Neimeyer and Hartley (1986). It was determined that the test perhaps measured several different constructs as a part of effective counseling of the suicidal client. These included "Elaboration of the Complaint, Exploration of Suicidality, Involvement, and Reflection of Negative Feelings" (p. 442). However, the researchers did note that some of the loadings were rather weak, and that the study did consist of only novice counselors. Still, it is intriguing that the second factor involves the willingness to examine potential suicidal ideation, a factor that could potentially be difficult for counselors-in-training to deal with, yet very much critical to the process of offering effective therapy to such clients.

In a study of 71 death counselors, with an average of just over 14 years experience, it was found that such providers show greater empathy toward scenarios involving death than they do toward scenarios that do not involve death. Further, it was found that increased level of education was associated with more empathetic response to death related situations, but that overall death attitudes did not appear to alter the degree of effectiveness of responses to such clients. Interestingly though, it was found that those counselors that dealt primarily with clients bringing up matters related to death were less likely to be appropriately empathetic to situations not involving death. The average level of education by those in the study was a master's degree in mental health. Degree of

empathy was calculated in response to the Counselor Response Form (CRF), which provided various counseling related vignettes (Terry et al., 1995).

Kirchberg et al. (1998) investigated the responses of neophyte counselors to situations involving death. Their results indicated that when faced with situations involving death versus some other serious concern commonly addressed in counseling, such counselors were significantly more distressed when dealing with the issue of mortality. The study also suggested that such distress was associated with "high death fear" (p. 115). In addition, the study reflected the notion that there could indeed be a "saturation point" for counselors that are inundated with "vivid death stimuli" (p. 115). The study utilized the Multidimensional Fear of Death Scale (MFODS) to measure fear of death on the part of the counselors, and also made use of the TI which was used to assess the degree to which an event significantly affects one's "core identity constructs" (p. 105). These measures were included as a means of assessing overall fear of death prior to having counselors in training view different counseling vignettes, some involving death and others not.

Neimeyer et al. (2001) reported on the paucity of research regarding suicide and counseling skills:

> Although the relationship between death anxiety and suicide intervention skills has received some attention, little research has been focused on the relationship between attitudes specifically toward suicide and suicide intervention skills. Even less attention has been paid to the effects of personal history of suicidal behaviors on the part of the interventionist and suicide counseling skill. (p. 72)

It is evident from this statement that counselors' experiences and attitudes about suicide must be examined as it relates to their ability to work effectively with clients presenting with such critical scenarios. It is further noted that there is no research that points to the

effects that personal suicidal ideation or attempts on behalf of a counselor may have on their actual ability to work with such clients (Neimeyer et al., 2001).

The aforementioned researchers showed that those counselors with a more accepting attitude toward suicide showed more inappropriate responses to suicidal clients than did counselors who firmly believed that suicide is wrong (Neimeyer et al., 2001). It further showed that personal history of suicidality, which can have negative effects on one's ability to counsel suicidal individuals (as judged by the SIRI), perhaps cannot be overcome by professional training. The authors noted that this suggests that individuals "currently dealing with their own suicidal tendencies may not respond optimally" to suicidal clients (p. 80). Also, it was found that counselors that are able to maintain composure and are clear in their attitude against suicide are more likely to offer effective counseling to their clients. And given the fact that variables contributing to variance in the study all related to personal attitudes and experiences involving suicide, it was hypothesized that appropriate response to suicide is "a unique skill, one that is distinctively linked to the interventionist's history with and reactions to situations involving life-threatening behavior" (p. 80). Packets supplied to the 131 subjects included the Death Attitude Profile – Revised (DAP-R), the Suicidal Behaviors Questionnaire (SBQ), the SOQ, and the SIRI.

Prevalence and Impact of Suicide on Mental Health Professionals

In terms of the response that practicing mental health professionals have to client suicide, a good amount of research has been collected. Goldstein and Buongiorno (1984) pointed out that psychotherapists must accept the reality that they may work with a client that decides to commit suicide. The authors interviewed fellow professionals that had

lost a patient through suicide. They reported that responses included "shock, disbelief, anger, guilt, self-blame, and loneliness" as reactions to the suicide (p. 394). It was noted that suppression of the matter was soon to follow. Those that were interviewed tended to remember incidences of client suicide very clearly, and ultimately allowed the psychotherapist to respond more appropriately to suicidal clients after finally getting over the matter. Another factor that was attributed to the loss of a client was that psychotherapists were allowed to address their "grandiose rescue fantasies" and faulty "sense of security" in dealing with client suicide (p. 398). The authors emphasized the importance of allowing the psychotherapist to discuss the loss of clients to suicide, and ensuring training programs encourage "explicit exploration of suicidal issues, including the patient's responsibility for suicidal behavior" (p. 398).

In speaking of practicing psychologists, research has been done on their probability of experiencing suicide in their professional life, as well as those variables that appear to correlate highly with the event (Chemtob et al., 1989). Results indicated that 28% of psychologists experienced the death of a client. It was noted that therapist characteristics including age, gender, and theoretical orientation did not correlate with an increased risk of having a client commit suicide. However, among other variables, work setting and the type of patient treated, did correlate with suicide, with those working in psychiatric hospitals and with clients with affective, schizophrenic, and substances abuse disorders experiencing higher rates of suicide. It was also concluded that patient suicide "has a consistently strong impact on most mental health professionals" (p. 299).

In an earlier study of 365 psychologists, it was found that 22% had experienced the death of a client by suicide, and that the chance of experiencing a second suicide

thereafter was 39% (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988). Further it was found that there was no significant difference in terms of age of the practitioner, years in the field, or gender among those experiencing client suicide. It was also noted that as level of education increased, the likelihood of having a client commit suicide decreased; still, it was reported that such findings may not be conclusive as the results did not take into account the type of work setting the individuals worked in, which likely contributed to experience of suicide of a client.

Menninger (1991) found through a survey of psychotherapists that 39% had experienced the death of a client by suicide, and that only 11.8% of those surveyed at the particular conference had never treated a client that committed or attempted suicide. Further, the therapists identified the noxious aftereffects of the loss. Negative affect, as well as doubts about one's competency, were common feelings following the suicide of a client. Perhaps most striking about the study is that roughly 2/3 of those therapists that experienced suicide subsequently modified the manner in which they worked with clients, with changes including more serious consideration upon mention of suicide ideation and increased vigilance. Menninger further noted that the very fist step in coping should be acceptance that one will likely experience the suicide of a client, and that such a realization should be imparted upon trainees during residency.

Jobes and Berman (1991) wrote of the dangers associated with client suicide, as it pertains to malpractice. It was noted that "some therapists may overtly or covertly wish to avoid these potentially troublesome patients" in speaking of those clients that are suicidal (p. 92). They countered this notion by then mentioning that coming across such situations is common, and that practitioners must accept the fact that they will very likely

be working with such individuals, whom they additionally point out, can be amenable to psychotherapy. The authors went on to cite various steps in dealing with a suicidal client, and commented on the fact that clinical judgment may be incorrect at times, but that neglecting to actually assess for suicide risk is inexcusable. They further stressed the importance, among others, of "competence through appropriate and adequate professional training" (p. 94).

General Training Issues in Responding to Suicidal Clients

Researchers have commented on the need for further training on the issue of client suicide in different programs (Kleespies, 1993). It is offered that although one incident, in this case suicide, cannot likely significantly alter the course of one's professional life, that the event can be the catalyst for a "powerful emotional reaction and, at times, a professional crisis" (p. 478). Given the dangers associated with a trainee losing a client to suicide, preparing for the likelihood of such a possibility is in the best interest of those in graduate programs as it may allow for resources to be prepared in advance, if and when the situation might occur. The author specifically noted the benefit of having training programs prime students for the practically inevitable experience of patient suicidal ideation, and more importantly, patient suicide.

In a study conducted by Bongar and Harmatz (1991) it was reported that only 40% of clinical psychology programs surveyed offered formal training in suicide, noted as surprising given the seriousness of the issue. Indeed, this was consistent with an earlier study where it was found that of 92 clinical psychology programs, only 43% offered formal training in the study of suicide (Bongar & Harmatz, 1989). This study further noted that with an average of 12 faculty members per program, only 2 were likely

to have had specialty training in managing suicidal clients, and that of the faculty members, roughly 10% were likely to have experienced a suicidal client. The authors noted that the confidence of students in working with suicidal individuals could likely be bolstered if their training programs sought to include increased study of this phenomenon in coursework.

Dexter-Mazza and Freeman (2003) investigated the degree of training in matters related to suicide occurring in psychology programs. First, it was noted that of 238 participants who were all pre-doctoral interns, roughly 5% had experienced the death of a client by suicide; over 99% had worked with a suicidal client. Furthermore, it was noted that only about half of the participants indicated that their school offered formal training in working with suicidal clients. Formal training was defined as seminars, workshops, and courses.

It was noted by Werth (2002), with the emergence of the importance of end-of-life issues, the American Psychological Association (APA) realized the value of addressing the role that counselors can play in such scenarios. Werth cites that the APA Working Group on Assisted Suicide and End-of-Life Decisions (2000) has urged that end-of-life issues be made a part of the curriculum for both undergraduate and graduate students in psychology courses. He noted that the APA further advocated for faculty members to come to their own conclusions in their stance on death, personally as well as professionally.

Ellis and Dickey (1998) found that 75% of psychology internship sites offered some manner of training on the issue of dealing with suicidal clients, mostly in the form of supervision. Still, among the 247 sites, only 30% reported that there were specific

instructions on post-suicide procedures outlined in any training manual. Further, following the suicide of a client, only 8% required mandatory counseling on the part of the trainee, although 43% of the programs recommended such therapy. The authors brought up the additional complication of some supervisors being hesitant to discuss the death of a client during supervision, due to potential legal ramifications. It was observed that such inaction is to the detriment of the trainee trying to cope with the loss of a client by suicide. The importance of having procedures in place to assist the individual in dealing with the death of a client, given the obvious potential harmful ramifications, was emphasized.

Mental Health Professionals-in-Training and Response to Suicide

In a study of 54 pre-doctoral interns in clinical psychology, 16.7% reported having had a client commit suicide while in training (Kleespies et al., 1990). Of those surveyed, 18.5% had a client make a suicide attempt. It was noted that there was no significant difference in age or years of training between those that experienced a suicide attempt and those that did not experience a suicide or suicide attempt; however, those that did experience a completed suicide had significantly fewer years of training than the rest of the group. And of those that had a client commit suicide, several initial feelings were noted including shock, shame or guilt, fear, and feelings of incompetence. Those who experienced a client attempt suicide also experienced the same emotions, but were less likely to experience any guilt.

Interestingly, 75% of those that lost a client to suicide reported that it had a significantly positive effect on their professional life, as it made them more cautious in working with suicidal clients in the future. It should also be noted that three of the

participants that experienced the loss of a client reported they did anticipatory work on the issue of losing a client, but following the actual event, such education had minimal benefits (Kleespies et al., 1990).

Also, based on scores from the Impact of Event Scale (IES) that each individual completed, it was determined that no significant difference was found between the responses of those whose clients completed, and those whose clients only attempted suicide. This led the researchers to point out that both actions, suicide and suicide attempt, on the part of a client, can have serious repercussions for the counselor. However, it was noted that the small number of participants, as well as the deficiencies in the IES, along with other factors, should make one cautious in viewing this relationship. Still the authors argued that there is a need for an "immediate supportive response to the student to prevent traumatization and minimize isolation" as well as to create a "safe forum that will allow the student to express his or her feelings in the wake of a suicide" (Kleespies et al., 1990, p. 262).

Response to Suicide Training

Richards and Range (2001) found that among beginning psychology graduate students, advanced graduate students, practicing psychologists, and nursing graduate students, all were correctly able to identify when a subject in a vignette was contemplating suicide. However, the group did differ in ability to offer what were deemed correct therapeutic responses as measured by the Suicide Intervention Response Inventory-II (SIRI-II). Indeed, the researchers here made use of the revision to the original SIRI. Neimeyer and Bonnelle (1997) changed the original SIRI to include a 7-point Likert scale, as opposed to a dichotomous "yes" or "no" scale. The authors found

that the changes to the 25-item self-administered inventory resulted in greater internal consistency and test-retest reliability, while maintaining the construct validity of the measure, and perhaps most importantly, diminishing the ceiling effect that had been associated with the instrument and its difficulty in discriminating between counselors of varying competencies.

Still, Neimeyer and Pfeiffer (1994) noted that "no single method can stand alone in the assessment of suicide intervention processes or outcomes" (p. 154). Here, the authors point to the variety of variables that combine to produce effective suicide intervention training, including the manner of skills that can be assessed by the SIRI.

In another study, it was observed how training can help individuals outside of mental health professions. Davidson and Range (1999) offered a one-hour seminar on suicide prevention to a group of relatively young teachers. Their results, as indicated by the degree of difference in post- and pre-seminar scores, showed that teachers became more responsive to instances of suicide threat in their students. Perhaps most importantly, the authors reasoned that the increase in potentially confronting a student about their perceived threat to his or her self was the result of having experienced training in how to do so, which was thought to raise the teachers' level of overall comfort in addressing suicide, something that counselors-in-training might find difficult for us to do.

Still, in a much earlier study it was found that there was no relationship between knowledge of suicidal factors and ability to offer appropriate responses to a suicidal individual (Inman, Bascue, Kahn, & Shaw, 1984). The researchers in this study used scores on the Lethality Scale (LS) and the SIRI as measurements; participants included students studying nursing.

Mental Health Professionals-in-Training and Suicide of a Client

Dexter-Mazza and Freeman (2003) surprisingly found that 238 pre-doctoral psychology interns gave themselves an average rating of 4.92 (on a scale of 1 – 7, with 7 being the highest) in their ability to work effectively with suicidal clients, causing the authors to wonder if such students do not present a sense of false confidence regarding their ability to work with suicidal clients.

In research completed by Kirchberg and Neimeyer (1991) graduate students in counseling were asked to rate 15 different counseling scenarios, five relating to death, in terms of their level of comfort with the presenting issues. It was clearly noted that issues involving death were far more troubling for these counseling students to deal with than issues such as rape, incest, and other forms of abuse. However, the study failed to show that discomfort to situations involving death were related to high scores on the TI (short form), which is intended to measure "threat implied in a respondent's view of personal death" (p. 605). The lack of relationship between the variable and fear of counseling scenarios related to death and scores on the TI (short form) was perhaps the result of the limited range in the scores on the former, with nearly all students reporting death situations as creating the most discomfort for them. Still, the researchers were able to clarify the fear associated with death in the counseling situation, including a scenario involving suicidal ideation.

Foster and McAdams (1999) noted that students are likely to feel as though they are a personal and professional failure if unable to anticipate and prevent client suicide. Indeed, losing a client to suicide is an experience that is "powerfully shocking and disturbing" (Brown, 1987, p. 106). The author reported that 21% of a survey of staff at

Cambridge Hospital had experienced a patient suicide during their training. Brown (1987) cautioned that trainees that lose a client to suicide are likely to feel that they have failed in their duties. However, an important factor from the experience is learning one's limitations. Brown also mentioned that support from one's program can be a critical factor in how a student deals with the experience of a suicidal client.

In speaking of the clinician in training, Kleespies, Penk, and Forsyth (1993) reported that "a positive or negative resolution to such a crisis will determine whether it personally or professionally increases or restricts development" (p. 293). They used the Impact of Events Scale (IES) to measure intrusive thoughts or memories and the avoidance of them and a significant linear relationship between the degree reached and experience with suicide, specifically ideation, attempt, and completion. It is interesting to consider that of the 282 participants, 40% either experienced a suicide attempt or completion while in training.

Ruskin et al (2004) found that roughly half of a sample of psychiatrists experienced the suicide of a client. It was noted that 60% of those experiencing client suicide did so by the end of their first postgraduate year. Perhaps it should come as no surprise that 25% of the sample reported that the experience "had a profound and enduring effect on them throughout their careers as physicians" (p. 109). Perhaps most surprisingly, 1/3 of the respondents experienced suicide in family or friends, yet this did not affect their scores on the acute stress disorder, chances of having had PTSD, scores on the IES, or the chances they would experience the suicide of a patient.

In a recent qualitative study of 13 pre-licensure psychologists that experienced a patient suicide while under supervision, several important findings were addressed. One

was that the respondents reported that their relationships with the clients prior to the suicides were "tenuous" and that there tended to be a strong focus on the presenting problems rather than the therapeutic relationship (Knox et al., p. 551). It was also noted that the respondents experienced anger and sadness, and questioned their ability to work effectively with clients following the event. Also, the participants reported being more thorough in future lethality assessments of their clients.

Inventories of Attitude toward Suicide

Smyth and MacLachlan (2004) reported that the SOQ is one of the most widely used measures of opinion toward suicide. In addition, Anderson (2007) also noted the SOQ as being "the most prominent tool to measure suicide, since its inception in 1980" (p. 13). In contrast, the Trinity Inventory of Precursors to Suicide (TIPS) is a much newer measure and was subsequently created as a tool to look at *specific instances* under which suicide is acceptable, versus whether or not the act is acceptable in general (Smyth & MacLachlan, 2004).

Suicide Opinion Questionnaire

The SOQ was created as a means of gauging the opinions of individuals toward suicide (Domino, Moore, Westlake, & Gibson, 1982). The authors noted that at the time of its creation, there were measures to assess attitudes regarding death, but nothing related to suicide, itself. It has been used in a *multitude* of studies including those designed to explore the opinions of suicide on the part of medical staff working with children and adolescents that engage in self-harm (Anderson & Standen, 2007), German and United States Nationals (Domino & Groth, 1997), Chinese and American adults as it relates to conservatism (Domino, Lin, & Chang, 1995), Canadian and American college

students (Domino & Leenaars, 1989), Singaporean and Australian college students (Domino, Niles, and Raj, 1993-1994), Italian and American physicians (Domino & Perronne, 1993), HIV/AIDS patients (Domino & Shen, 1996-97), Japanese and American medical students (Domino & Takahashi, 1991), suicide attempters, contemplators, and non-attempters (Limbacher & Domino, 1985-86), and a host of other groups and populations.

The measurement was created from an initial set of over 3000 questions following a review of literature on the topic. This original set was trimmed down to 138 total items following the removal of extraneous questions and the assessment of judges comprised partly of crisis counselors and psychologists. After giving the assessment to a group of 96 college students the test was again trimmed to a total of 100 items which all had test-retest reliabilities of .68 or higher (Domino et al., 1982).

The questions are meant to reflect both the subject's attitudes toward suicide, as well as his or her overall knowledge of the topic. Participants taking the inventory are asked to respond honestly and openly to statements, with both positive and negative loadings, by choosing a response from "strongly agree" to "strongly disagree" on a 5-point Likert scale (Domino et al., 1982).

The creators of the study later tested the 100-item inventory with a sample of 285 adults, followed by a factor analysis. Results pointed to 15 different factors, all with loadings above the arbitrarily designated cut-off of .30. The authors argued at the time that the findings "suggest that attitudes toward suicide are a rather complex phenomenon that requires a more sophisticated approach that simply a positive vs. negative analysis" (Domino et al., 1982, p. 261).

Among the 15 factors identified, Acceptability and Normality, and Mental and Moral Illness, with 16 and 13 items respectively, were the largest factors. The authors concluded their seminal piece arguing for the utility of the instrument and the idiosyncrasies of attitudes toward suicide.

One of the first uses of the SOQ (prior to the Domino et al., 1982, publication) was to assess whether or not attitudes toward suicide could be modified via learning more information on the topic. Domino (1980) noted that a prior factor analysis of the instrument provided for five separate factors. These factors, in order of most variance provided for, included: Normality of Suicide, Motivational Aspects, Religious-Moral Aspects, Demographic Dimensions, and Risk. A follow-up found significant differences in the first four factors between the pretest, and the posttest administered 10 months later. The training on the topic of suicide included pertinent reading materials, as well as contact with suicide interventionists and individuals that had attempted suicide. The author noted the training was meant to be "both academic and experiential" (p. 240).

Other research found support for a 15-factor model after factor analysis, as well (Swain & Domino, 1985). The authors explored the difference in attitudes on the SOQ, as well a measure of knowledge of suicide, based on professions. Social workers, psychiatrists, psychologists, crisis workers, nurses, physicians, and members of the clergy were included. Again, Acceptability was noted as the factor accounting for the most variance, taking up 9.8%.

Later, admitting a great deal of variation with respect to results from factor analyses, the researchers explored a clinically derived 8-factor model for the SOQ (Domino, MacGregor, & Hannah, 1988-89). This was done as "some of the fifteen

factorially derived scales seem to be clinically convoluted, that is, composed of items that do not appear to fit together at an intuitive or content level; other factor scales contain too few items" (p. 353). A combination of psychologists, psychiatrists, and one social worker, all very familiar with work with suicide, assisted in grouping existing SOQ questions according to meaningful categories. From an initial 14 factors, the number was reduced to eight after collaboration by judges, followed by internal consistency and reliability analyses based on randomly selected previously completed SOQs.

However, Rogers and DeShon (1992) argued against the eight-factor model after a *confirmatory* factor analysis failed to support the model in question. A subsequent *exploratory* factor analysis yielded "confusing" results that also failed to support the eight-factor model of the SOQ (p. 433). The authors advocated for a revision of the instrument as their analysis showed that many of the items did not correlate highly with the scales to which they belonged.

In 1995 Rogers and DeShon again explored the SOQ. They investigated a five-factor model the two had proposed in their earlier research on the instrument. The five factors included Acceptability, Perceived Factual Knowledge, Social Disintegration, Personal Defect, and Emotional Perturbation. The researchers concluded that the cross-validation study revealed "moderate support for the integrity of the five-factor model of the SOQ" (p. 309). The researchers called for additional research using the five-factor model, but also urged for the development of additional questions that could potentially load on the scales, as well as to attempt use with samples not comprised mainly of students.

Domino (1996) responded to criticism of the reliability of the instrument. The author provided analyses of the instrument from eight separate studies, including six that were conducted with minority populations. He concluded the article stating, "Despite the variability in samples and in the length of the test-retest intervals, these coefficients indicate substantial test-retest reliability" (p. 1010).

In another study, researchers chose to look at certain *a priori themes* from the SOQ:

> (a) Is there stigma attached to suicide? (b) Conversely, is suicide perceived as a normal behavior? (c) Do people have the right to die? (d) Are there circumstances that make suicide more or less acceptable? (e) Is suicide perceived as a "cry for help"? (f) Are suicide attempters perceived as mentally ill? (g) Is suicidal behavior judged in a religious context? (h) What are seen as the antecedents of suicide? (i) Is suicide perceived to be an impulsive act? (j) How common are suicide ideation and suicide attempts? (Domino & Leenaars, 1995, p. 493)

The researchers explored the attitudes of English-speaking Canadians and found they were "quite complex" (p. 498). They went on to further note, "There are modal responses reflecting substantial unanimity. Yet the mean is more diversity than agreement" (p. 498). For example, items related to the acceptability of suicide yielded diverse responses. One particular statement related to whether suicide is appropriate for someone with an incurable illness found that 31% agreed, 33% disagreed, and 36% were uncertain on the matter.

Domino, Su, and Shen (2000) further explored the use of the SOQ and commented on the instrument's use to that point. The authors acknowledged variability in terms of factors derived through factor analysis over several studies, and pointed to the fact that Acceptability tends to be the largest factor across the board. Using two samples, one from the U.S. and one from Taiwan, the researchers compared the five-factor model,

which they referred to as the SOQ-F, and the eight-factor clinically derived model known as SOQ-C. The findings inclined the researchers to suggest safety in the use of the inventory in cultures outside of the U.S. In addition, the researchers pointed to the SOQ-F scales having greater overlap with one another than the SOQ-C scales.

At least one other instrument is being used to assess the attitudes of individuals toward suicide. The Attitudes Toward Suicide (ATTS) was created in an effort to gauge public opinion on the phenomenon (Renberg & Jacobbson, 2003). The instrument, which has roughly 20 items, has run into similar problems in terms of factor analysis. The authors noted that one potential problem is that "the instrument is measuring a too broad area of attitudes toward suicide" (p. 10). They further noted the possibility of adding more items to hopefully load on the already established factors, or to decrease the overall level of factors in an effort to trim down the overall focus of the instrument, as it was too wide at the time.

In similar fashion, the SOQ has been culled through a series of statistical procedures. Anderson (2007) provided strong, critical insights into the psychometric properties of the instrument. "Further use of any of the prior SOQ models from the literature in not recommended" (p. 107). The author came to this conclusion after four different models failed to find fit following confirmatory factor analyses.

Indeed, it was noted that only two sound factors resulted from a subsequent exploratory factor analysis: Perceived Suicide Knowledge, and Acceptability. Together the two components comprised 25 of the original 100 SOQ items, and amounted for a combined 15.33% of the total variance. "The Perceived Suicide Knowledge factor from the study had an acceptable internal consistency reliability ($\alpha = .81$)" (p. 108). It was

noted that this factor did not have any correlation with Acceptability or with any of the other measures in the study, including indicators of spirituality or life satisfaction. "The Acceptability factor, containing 12 items, had acceptable internal consistency reliability ($\alpha = .77$) and exhibited construct validity" (p. 109). The author also found that Acceptability of suicide was not related to any personal experience with the matter, which was in contradiction to other studies.

Anderson (2007) noted the need for research to be conducted to investigate the utility of the two aforementioned factors:

> Moreover, additional research is needed to determine whether the factors could be administered as independent scales. For example, the Perceived Suicide Knowledge factor could be used to assess the outcome of preventative educational programs through the use of a pre/post test design. On the other hand, the Acceptability factor could be used to assess attitudes toward suicide, leading to the development of preventative educational programs. Research should also focus on developing construct validity evidence for the two factors that emerged in this study. (p. 114)

It would seem then that the SOQ as a whole is lacking in integrity. Still, there are valuable components that could be used in developing a specific inventory investigating perceived acceptability of suicide.

Additional complaints about the SOQ include the fact that versions have been translated into languages for use with other cultures without much regard for the nuanced process of translation (Smyth & MacLachlan, 2004). It has also been noted that the SOQ tends to use outdated (Anderson, 2007), or somewhat pejorative language with respect to suicide (Smyth & MacLachlan, 2004). Also, it has been suggested that the 100-item SOQ is simply too long, noting that its overall utility could be compromised by its excessive length (Smyth & MacLachlan, 2005).

Trinity Inventory of Precursors to Suicide

The TIPS was created based on information from the literature on suicide, specifically as it relates to risk factors. It was found that "(a) interpersonal difficulty, (b) illness, (c) familial disruption and (d) loss" are the four "predisposing" factors associated with suicide (p. 85). The original inventory included 25 items and was tested on a population of 100 undergraduate students in psychology in Ireland, with an average age of 21. Factor analyses ultimately revealed the existence of four factors that comprised 69.75% of the variance, across 12 items. Each of the factors had an alpha of above .7, indicating internal validity.

The current TIPS is thus a 12-item tool with four scales: Role Status, Physical Limitations, Nurturing Bonds, and Death. Smyth and MacLachlan (2005) had decided to create the TIPS, another scale measuring attitudes toward suicide, for a specific reason: "The value of asking, "Is suicide an understandable or fitting act generally?" is, we believe, limited. A more fruitful avenue, we propose, lies in the question "when is suicide understandable?"" (p. 335). Indeed, the inventory focuses on *specific instances* under which suicide is possible, rather than simply whether suicide is acceptable generally speaking. It was created in an effort to look specifically at the "contextual" factors surrounding suicide (Smyth & MacLachlan, 2005, p. 344).

Counselor Development

In 1981, Stoltenberg noted the need for *developmental* models of training progress for counselors. Later, by way of the Supervisee's Level Questionnaire (SLQ) support for his particular model was found (McNeill, Stoltenberg, & Pierce, 1985). Individuals were classified into groups of beginning, intermediate, and advanced levels based on

experience with counseling, supervision, and education. Results indicated that those with more overall experience showed greater levels of autonomy and also greater levels of self-awareness.

Reising and Daniels (1983) reported on *Hogan's* model of development as one that includes a difficult process of overcoming anxiety and other obstacles to eventually reach a point where the counselor has a better understanding of himself and his clients, and is thus able to work more competently and independently. The authors explored the Counseling Development Questionnaire (CDQ) to establish the extent to which Hogan's model of development was consistent with responses from the instrument. "It appears that anxiety, dependence, and skills focus give way to independence and self-confidence, as trainees grow into professional psychologists" (p. 239). The authors compared scores from the CDQ among pre-master's level, masters, advanced masters, and doctoral-level counselors. Results showed that pre-master's level counselors were significantly more anxious than master's level counselors, although they did not differ much on other constructs. Doctoral level counselors needed less validation from supervisors than the other groups, and were more independent than the other groups.

McNeill, Stoltenberg, and Romans (1992) explored the use of the Supervisee Levels Questionnaire-Revised (SLQ-R) with counselors of various levels of training. The results supported construct validity for the instrument based on its ability to discriminate between varying levels of trainees. The authors established groups not on the basis of practicum status, but rather in relation to "semester of previous counseling and supervision experience, as well as years of graduate education" (p. 506). The result was a study with *beginning trainees* (one semester of supervision and counseling

experience and one-two years of graduate education), *intermediate trainees* (two-four semesters of counseling and supervision and three years of graduate studies), and *advanced trainees* (five or more semesters of supervision and counseling and four or more years of graduate studies). Results of the study showed little differentiation between the beginning and intermediate groups, but difference between the latter two groups and the advanced group.

Earlier research by Blocher (1983) explored the idea that it is actually the development of increasingly complex schemas to understand human behavior that is of importance to the counselor-in-training. Stoltenberg, McNeill, and Delworth (1998) have also supported this particular stance within the Integrated Developmental Model (IDM). Emphasized is the idea that beginning counselors tend to view relatively complex ideas of counseling as being rather simplistic. This is based on the fact that counselors "evaluate much of the information provided in early course work against their personal experience" (p. 34). The idea is that counselors in training will have very limited schemas when initially beginning therapeutic work with clients, and information that conflicts with their experience of the world will be much more difficult to integrate into their notions of how the process of therapy works.

Stoltenberg, McNeill, and Delworth (1998) supported three levels of counselor development. Autonomy is a theme that is prevalent across the levels. Counselors at Level 1 have a high need for support and validation from their supervisor. Those at Level 2 experience a conflict between requiring dependency yet still desiring autonomy. At Level 3, individuals display a move toward autonomy and a confidence in abilities.

Another facet of counselor development is Awareness. Counselors functioning at Level 1 tend to have a focus on themselves, yet tend not to have a great deal of self-awareness. In Level 2, counselors are beginning to have an appreciation of others' perception of the world. At Level 3 the counselor is able to focus even further on the client and actually demonstrate their understanding and empathy.

The third component of interest in the three levels of counselor development is Motivation. At Level 1, Motivation is high, yet accompanied with a great deal of anxiety. At Level 2 there is a shaky sense of confidence. Level 3 finds counselors still having some doubts about the process of counseling and their own abilities, yet, having the overall confidence to be effective.

Such a developmental model of counselor growth has not gone without criticism. Holloway (1987) argued that counselor training need not be based on a finite model of development, questioning the extent to which the process simply involves the acquisition of new skill sets, for example. Stoltenberg and Delworth (1988) responded to Holloway in commenting on the importance of development as a *metaphor*. They also noted there is overlap and difficulty establishing clear boundaries between levels.

Summary of Literature Review

Current research clearly suggests that suicide is something that mental health professionals should be prepared for, as well as something that can have significant ramifications on their personal and professional lives. Gender has been found not to be a predictor of having a client experience suicide, but has been found to show differences with respect to views toward death. Also, religious views appear to impact opinions on suicide, with those adhering to orthodox Christian religions showing a stronger slant

toward opposition to suicide. Education appears to have an impact on feelings toward death and suicide, with counselors earlier in training being more intimidated by issues related to death, and having less empathetic responses. Differences as they relate to the topic of suicide are also present across mental health professions, and are arguably complex.

One of the primary instruments used to gauge opinions toward suicide over the past several years has been the SOQ. It has been used in a variety of different studies despite researchers pointing out its psychometric flaws. Still, the factor of Acceptability often represents one of the strongest elements following factor analyses. Indeed, Anderson (2007) found that Acceptability has been one of only two factors from the SOQ to have credible psychometric integrity. In contrast, the TIPS is a relatively new tool that looks not just at whether suicide is acceptable, but attempts to look at the specifics contexts under which the act is appropriate.

In terms of counselor development, the IDM suggests that counselors operate differently on three different constructs, including: Autonomy, Awareness, and Motivation. Across the three different levels there is a range of functioning, with more advanced therapists operating in a manner that permits greater capabilities as it relates to the three aforementioned constructs.

Research Questions

This study will attempt to answer the following questions:

1) Do differences exist among beginning/intermediate doctoral students in psychology, advanced graduate students in psychology, and professional psychologists in terms of their attitudes toward suicide?

2) Does personal experience with suicide combine with development level to impact views on suicide?

3) Do the three groups differ with respect to specific scores on the SOQ and the TIPS?

4) Does gender relate to scores on the TIPS and SOQ?

Method

Participants

Participants will include students that are members of doctoral programs in professional psychology, as well as practicing psychologists. The students will be divided into two groups based on amount of training completed. Those students having completed 1-4 semesters of practicum work will be included in the beginning/intermediate trainee group (Group 1), while students with 5 or more semesters of practicum work (but that have not yet graduated) will be classified as part of the advanced trainee group (Group 2). The professional psychologist group (group 3) will consist of individuals that have graduated and have been working for at least one year as a psychologist with a primary work activity of providing therapy.

Measures

Demographic Information. Several pieces of information will be requested from each participant. This information will include: gender, race, age, religious affiliation, religious service attendance, experience having worked with suicidal clients, and having personally experienced suicide (Appendix A).

Level of Training. Information about educational experiences will be assessed. In addition it will also be important to establish any specific training in suicide awareness

or intervention. Information on concurrent or previous work in the mental health field will be assessed in consideration of those participants having worked in the mental health field prior to beginning work on a doctorate. It will also be important to learn about any specific training or coursework related to suicide that participants might have had (Appendix A).

Procedure

Student participants will come from various schools in the Southwest and Midwest regions of the United States. Students will be contacted through their graduate training program; the researcher will contact several different schools to seek permission to distribute packets to students via faculty members. Professional psychologist participants will come from Oklahoma. A random selection of psychologists practicing in Oklahoma will be sent packets to complete.

The packets will include the Demographic Questionnaire (which includes demographic and training questions), the SOQ, and the TIPS. Potential student participants will receive packets to complete as provided by staff persons working in the graduate program in question. Each packet will include a stamped envelope with the researcher's school address in which participants can place completed surveys to return to the researcher. Potential participants in the psychologist group will also each be provided with a survey and a stamped and addressed envelope in which to return the completed survey.

Participants will be asked to complete the survey as honestly as possible, and will be reminded it is completely anonymous. They will be told that it should take no longer than 15 minutes to finish the survey, and that they should complete it in one sitting.

Demographic Questionnaire. Each participant will be asked to complete the Demographic Questionnaire (Appendix A). This will assess a number of variables including gender, religious affiliation, training experience, and personal experience with suicide.

Suicide Opinion Questionnaire. Each participant will be asked to complete a portion of the original SOQ (Appendix B). This will be the tool by which the participants' overall attitudes toward the acceptability of suicide will be assessed. Specifically, the 12-item Acceptability scale will measure general attitudes with respect to whether or not suicide is permissible (Anderson, 2007).

Trinity Inventory of Precursors to Suicide. Each participant will also complete the 12-item TIPS (Appendix C). This will be another tool used to gauge participants' attitudes; this inventory will be used to specifically explore situations and circumstances under which suicide is seen as acceptable or understandable.

Data Analysis

A multivariate analysis of covariance (MANCOVA) will be performed on the data. The independent variable will be level of counselor development. The dependent variables will consist of the SOQ and the TIPS. The covariate will be participant age, as some research has shown that older individuals can have more accepting attitudes toward suicide (Segal, Mincic, Coolidge, & O'Riley, 2004).

While it may be assumed that there is a good deal of overlap between the SOQ and the TIPS, as both measure opinions toward suicide, the latter measures attitudes under contextual situations. It will be interesting to find whether the combination of a measurement that provides for instances of specific suicidal action might provide for

greater overall variability across the groups than the SOQ alone. It is reasonable to suspect that participants will be able to provide general disapproval or approval of suicide, but may perhaps become somewhat more supportive of or more in opposition to suicide when provided with specific scenarios. It will also be interesting to explore differences between the two instruments, and which one better accounts for differences across the groups.

Hypothesis 1: A significant overall multivariate effect will be present. The two dependent measures (the SOQ and the TIPS) will account for significant variation across the independent variable (level of counselor development).

Hypothesis 2: Following a significant overall multivariate affect, it is suspected that Group 3 (professional psychologists) will show more approval of suicide than Group 2 (advanced trainees), which will in turn show more approval of suicide than Group 1 (beginning/intermediate trainees).

Hypothesis 3: Following a 2 X 2 factorial MANCOVA, there will be a significant interaction between group level and experience with suicide for those participants in Group 1. (beginning/intermediate trainees).

Hypothesis 4: Women will have significantly different scores on the TIPS than men, and will be more approving of suicide, but not on the SOQ.

Hypothesis 5: Given the fact that Level 1 counselors struggle with attempting to achieve Autonomy, they may have a larger proportion of "uncertain" responses on the SOQ. Specifically, it is suspected that Group 1 will have more undecided responses than Group 2 or Group 3.

In addition, it may be beneficial to complete a confirmatory factor analysis on the TIPS to find out whether or not items are loading on factors as they were in previous research by Smyth & MacLachlan (2005). It might also be interesting to perform a confirmatory factor analysis on the SOQ. The resulting data could be contrasted with Anderson's (2007) run down of which questions contribute most to the Acceptability scale. Standard post hoc analyses will also be completed.

It is often common in the social sciences to hope to find a medium effect size. Also, power of .80 is generally considered a reasonable level. To achieve a medium effect size of .25, with an alpha level of .05, and a power level of .80, there must be 52 subjects per group (Stevens, 1999). Therefore, a total of 156 subjects will be needed for the study. With 12 items on the TIPS, as well as the SOQ, there will be more than a 10:1 ratio of subjects to items suggesting enough participants to complete a confirmatory analysis on both of the inventories.

Limitations of the Study

One limitation stems from the nature of the participants. Those that take part will represent a convenience sample of sorts, and many will be included via the snowball effect. Several of the participants will likely include individuals that are known by the researcher. In addition, the study may not be generalizable beyond the scope of the geographical region from which it is expected that most of the participants will come.

Another limitation related to the sample is that the data will be cross-sectional. To be able to review the progress of counselors over time and changes in their opinions toward suicide would certainly provide for stronger evidence of any obtained results. Still, such a technique is not feasible given the constraints of time and resources.

Also, the fact that the SOQ has been criticized for having a rather nebulous middle rating is another cause for concern. While the SOQ has been used in dozens of studies, the "undecided" option that falls in the middle of its 5-point Likert scale, has been criticized as it does not necessarily reflect a clear opinion. Rather, choosing such an option might instead indicate confusion with respect to the item, rather than reflecting a participant's view falling somewhere between "agree" and "disagree" (Anderson, 2007).

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Appendix A

Demographic Questionnaire

Please indicate your current age:

1) Age:_____

Please circle the appropriate response for each question:

2) Gender:
   a. Female
   b. Male

3) Race:
   a. African/African American
   b. Asian/Asian American
   c. Caucasian/European American
   d. Latino/Latino American
   e. Native American
   f. Other: (Please identify:_____)

4) Religious Affiliation:
   a. Buddhist
   b. Catholic
   c. Episcopalian
   d. Evangelical
   e. Jew
   f. Lutheran
   g. Methodist
   h. Mormon
   i. Other: (Please identify:_____)
   j. Pentecostal
   k. Not affiliated with any denomination
   l. Presbyterian
   m. Southern Baptist

5) **How often do you currently attend religious services?**
   a. 0 = Never
   b. 1
   c. 2
   d. 3
   e. 4
   f. 5
   g. 6
   h. 7
   i. 8 = Several times a week

6) **Have you ever personally ever experienced suicidal ideation?**
   a. Yes
   b. No

7) **Have you ever personally experienced the death of a close friend/relative/significant other through suicide?**
   a. Yes
   b. No

8) **Highest level of education you have completed:**
   a. Bachelor's degree
   b. Master's degree
   c. Doctoral degree

9) **Describe your current educational status:**
   a. Current doctoral student
   b. Psychologist

10) **Describe the type of training program you are currently enrolled in, or the type you graduate from if you already have your degree:**
   a. Doctoral Level Counseling Psychology
   b. Doctoral Level Clinical Psychology
   c. Doctorate of Psychology (PsyD)

11) **Have you ever worked with a suicidal client (as a primary therapist or a co-therapist)?**
   a. Yes
   b. No

12) Have you ever had a client <u>attempt</u> suicide?

a. Yes
b. No

13) Have you ever had a client <u>commit</u> suicide?

a. Yes
b. No

14) Describe any specific training that you have had on working with suicidal clients (<u>YOU MAY CIRCLE MORE THAN ONE RESPONSE</u>):

a. Attended a seminar(s) specifically related to working with suicide clients
b. Attended a conference(s) specifically related to working with suicidal clients
c. Completed course(s) specifically related to working with suicidal clients
d. Worked in a position offering services to suicidal clients (e.g., crisis line telephone counselor)

<u>QUESTIONS 15 AND 16 ARE FOR CURRENT STUDENTS ONLY:</u>

15) How many semesters of *<u>doctoral</u>*** practicum work have you completed?**

a. 1-4
b. 5 or more

16) Have you completed or are you currently completing an internship in professional psychology?

a. Yes
b. No

Appendix B

Suicide Opinion Questionnaire: Acceptability Scale

Suicide Opinion Questionnaire (SOQ) items loading on Factor 2: Acceptability (Anderson, 2007).

This is not a test but a survey of your opinions; there are no right or wrong answers, only your honest opinion counts.

For each item indicate whether you:
A = Strongly Agree
B = Agree
C = Undecided
D = Disagree
E = Strongly Disagree

1. People with incurable diseases should be allowed to commit suicide in a dignified manner.

2. Suicide is an acceptable means to end an incurable illness.

3. Suicide is acceptable for aged and infirm persons.

4. There may be situations where the only reasonable resolution is suicide.

5. People should be prevented from committing suicide since most are not acting rationally at the time.*

6. Suicide is normal behavior.

7. Sometimes suicide is the only escape from life's problems.

8. If someone wants to commit suicide, it is their business and we should not interfere.
9. Suicide goes against the laws of God and/or of nature.*

10. We should have "suicide clinics" where people who want to die could do so in a painless and private manner.

11. Some people are better off dead.

12. People do not have the right to take their own lives.*

**Indicates item will be reverse scored*

Appendix C

Trinity Inventory of Precursors to Suicide

Trinity Inventory of Precursors to Suicide (TIPS) (Smyth and MacLachlan, 2005).

As the suicide rate continues to increase, we are being forced to think of possible reasons people feel that suicide is the only option open to them. Below are various reasons that have been given to explain suicide in specific circumstances. Whatever your personal views on suicide, please think of each item in turn and indicate by circling whether it is a poor reason, good reason, etc., in that particular situation for someone to take their own life.

1 = very poor reason
2
3
4
5 = very good reason

1. Not being able to get a girlfriend/boyfriend

2. Becoming unemployed

3. Having no money

4. Breast cancer in a 30 year-old woman

5. Being diagnosed with AIDS

6. Finding out you can't have children

7. Suffering sexual abuse as a child

8. Death of a parent

9. Suffering emotional abuse in a relationship

10. Wanting to be with a loved one who has died

11. Death of a spouse/lover

12. Death of a close friend