Acceptance of Conditional Suicide and Euthanasia among Adult Americans

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ABSTRACT: Analysis of the attitudes of a 1977 cross-sectional sample of 1,530 American adults concerning euthanasia and suicide indicates that sex, age, and education are significant variables. Males, those who are younger and those who are better educated, are more likely to approve of euthanasia and suicide when a person has an incurable disease. Religious affiliation was not an important variable, although those who were frequent church-service attenders or who were high on religiosity were highly likely to reject euthanasia and suicide.

Despite an increasing interest in the subject, the general public's attitudes toward induced death (that is, suicide and euthanasia), remain confused and often contradictory (Kluge, 1975). With discussion of abortion, suicide, and euthanasia entering the political arena, these controversies will no doubt increase in urgency. Douglas (1967), in his discussion of suicide, has conjectured that suicide is widely condemned in our society, particularly on the abstract level. Induced death, in contrast, tends to be evaluated within specific contexts, in that its acceptance or rejection is influenced by a number of situational factors (Vernon, 1970). The purpose of this paper is to focus upon the extent to which various segments of the population accept or reject suicide and euthanasia under a specific condition.

To date, few studies have adequately examined attitudes toward suicide or euthanasia (Kalish et al., 1972). The studies conducted in this area have been based on samples from restricted populations (Kalish, 1963; Kalish et al., 1972; Beswick, 1970), or are largely impressionistic (Douglas, 1967a; Speijer, 1975).

A recent study by Kalish et al. (1972), for instance, used a sample from the county of Los Angeles. They reported that one-third of the sample viewed suicide victims as mentally ill while another third at-

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tributed suicide to stress and frustration. Kalish et al. concluded that these respondents find the victim's situation, as well as the victim, equally responsible. In addition the authors found that age was negatively correlated with stress attribution and that education was positively correlated. Using the same data-set, Reynolds et al. (1975) found that ethnicity was an additionally significant variable: Japanese-Americans disapproved of suicide, blacks tended to attribute suicide to mental illenss, and whites focused on stress as the major cause of suicide.

Additional studies on suicide and euthanasia attitudes have used data from other societies which seem, in part, to contradict conclusions based on American samples. Iga and Tatai (1975) reported that the Japanese do not seem to consider suicide a social problem. Indeed, approximately one-third of their student sample believed that "suicide is good." Beswick's (1970) Australian data revealed that sex, religion and religiosity were related to acceptance of "mercy killing." Females, Catholics, and highly religious individuals were all less likely to tolerate euthanasia. Beswick (1970) found no relationship between age or education and attitudes toward euthanasia. Speijer (1975), utilizing his own impressions stated that Dutch society is tolerant of suicide and euthanasia. According to Speijer, suicide is even frequently seen as a healthy response to a bad situation.

The influence of such variables as sex, age, race and religion have also been addressed in studies on general death attitudes. Although not specifically focusing on the entities of suicide and euthanasia, it is interesting to note the general trends in this literature. With regard to sex, some studies have illustrated that females are more concerned with death than males (Hogan, 1970; Lowry, 1965). Kahana and Kahana (1972), however, found that females had a more practical orientation toward death than did males. Golburgh et al., (1967) found no differences in death attitudes between the sexes.

Some researchers (Swenson, 1961; Christ, 1961; Jeffers *et al.*, 1961) have found no significant relationship between age and fear of death. Cumming and Henry (1961), in contrast, found adolescents to be more anxious concerning the approach of death than older individuals. In general, race and socioeconomic class have not been seen as important influences on death attitudes (Golburgh et al., 1967; Vernon, 1970). Religion, however, has occasionally emerged as a significant variable (Golburgh et al., 1967).

Data Analysis and Discussion

The data for the present study are derived from the 1977 General

Social Survey, conducted yearly by the National Opinion Research, University of Chicago. This survey is based upon a full-probability sample of households in the continental United States. The sampling design first selected a sample of metropolitan and non-metropolitan counties, grouped according to size within the nine census regions, as determined by the 1970 census. Each size stratum was also ranked by geographic and racial characteristics, and include most of the major cities of the continental United States. The second stage procedure selected census block groups or enumerated districts as established by the U.S. census. Before final selection, these census tracts were stratified by geographic location, income, and racial distribution. Random lists of households from each of these sampling points were then distributed to the interviewers. This should result in a representative sample of households in America, consisting of 1530 respondents, of which 176 are blacks and 1339 are white. (See Davis *et al.*, 1977 for further details regarding the sampling design and the items utilized to obtain the data).

Our preliminary analysis of the data indicated that the public's acceptance of both suicide and euthanasia was highly conditional and limited to certain segments of the population. Some of this variation is associated with race, in that blacks are less likely to approve of suicide when an individual has an incurable disease than are whites (blacks, 21 percent; whites, 42 percent). On the other hand, both whites and blacks are equally likely to disapprove of suicide when an individual has dishonored his or her family (blacks, 96 percent; whites, 92 percent) or because of bankruptcy (blacks, 94 percent; whites, 93 percent).

Since there is an overwhelming disapproval of suicide for non-health reasons, we have omitted this aspect in the present analysis. We, instead, focus on the extent of acceptance/rejection of suicide as a response to poor health. We have also limited our analysis to the responses of whites only, as the number of black respondents is too small for reliable analysis.

Two attitudinal questions are analyzed. The first deals with the individual's attitude toward euthanasia:

> "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?"
> The question on suicide is:
> "Do you think a person has a right to end his or her life if this person has an incurable disease?"

Although the questions are similar in that both ask about the validation of induced death when a person has an incurable disease, response

levels to the two questions are quite different. Table 1 indicates that euthanasia is more acceptable (62 percent) to the general white public than is suicide (39 percent). It would seem that euthanasia is an act or decision involving more than the terminally ill person himself. In this case, the death of the individual is more a collective act, in that the le-

Table 1. ATTITUDE TOWARD EUTHANASIA AND SUICIDE BY SELECTED SOCIOECONOMIC VARIABLES

	Acceptance Of Euthanasia[1]			Acceptance Of Suicide[2]		
	Yes	No	Total (n)	Yes	No	Total (n)
Total Population	62%	38	(1438)	39%	61	(1461)
Whites	66%	34	(1274)	42%	58	(1291)
Blacks	39%	61	(164)	21%	79	(170)
Chi Square (Sig.):	42.19 (.001)			25.24 (.001)		
Gamma:	.50			.45		
Sex[3]						
Male	71%	29	(593)	45%	55	(595)
Female	61%	39	(681)	38%	62	(696)
Chi Square (Sig.):	13.67 (.001)			6.48 (.01)		
Gamma:	.22			.15		
Age[3]						
20-29 Years	79%	21	(277)	57%	43	(282)
30-64 Years	63%	37	(781)	38%	62	(786)
65 + Years	55%	45	(187)	30%	70	(195)
Chi Square (Sig.):	33.62 (.001)			44.19 (.001)		
Gamma:	.31			.33		
Education[3]						
0-8 Years	56%	44	(206)	27%	73	(211)
9-12 Years	66%	34	(675)	39%	61	(683)
13 + Years	70%	30	(389)	54%	46	(393)
Chi Square (Sig.):	10.85 (.004)			43.90 (.001)		
Gamma:	-.15			-.32		
Religion[3]						
Protestants	64%	36	(807)	39%	61	(811)
Catholics	63%	37	(339)	36%	64	(350)
Jews	76%	24	(33)	71%	29	(34)
Chi Square (Sig.):	2.09 (.35)			15.29 (.001)		
Gamma:	-.02			-.02		

1 The question asked was: "When a person has a disease that cannot be cured, do you think doctors should be allowed by law to end the patient's life by some painless means if the patient and his family request it?"

2 The question was" "Do you think a person has a right to end his or her own life if this person has an incurable disease?"

3 Whites only

gal system, doctors, and family members are involved. Suicide, in contrast, appears to deal with death involving the decision and action of only one person. This would suggest that a primary concensus of the general public is that the decision to die should not be made in isolation. The emphasis is on a social perspective rather than an isolated one.

Attitudes toward suicide do not appear to have changed in recent years. Such attitudinal stability can be measured by comparing the present data to that derived from a question with similar wording asked of a national sample by Gallup in 1975. The proportion of respondents accepting suicide when an individual has an incurable disease was the same in 1975 (65 percent) as in the 1977 data (Roper Public Opinion Research Center, 1975).

Table 1 further indicates that, in addition to race, the variables of sex, age, and education are also associated with acceptance of euthanasia and suicide. Males are more likely to support the notion of suicide and euthanasia than are females. Those who are younger or who are better educated are also more accepting. A similar pattern has been found with attitudes toward other moral and religious issues (Argyle and Beit-Hallahmi, 1975).

There is one exception to the summary above, in that educational level, while an important consideration, is only important under certain conditions. For males, increased education is associated with more positive attitudes toward euthanasia. By contrast, education is

Table 2. RELIGIOUS INTENSITY AND ATTITUDE TOWARD EUTHANASIA AND SUICIDE[1]

	Acceptance Of Euthanasia[2]			Acceptance Of Suicide[2]		
Religious Intensity[3]	Yes	No	Total (n)	Yes	No	Total (n)
Strong	47%	53	(455)	26%	74	(469)
Weak	75%	25	(718)	47%	53	(719)
Chi Square (Sig.):	89.59 (.001)			52.71 (.001)		
Gamma	-.53			-.43		

1 Whites only

2 See Table 1 for wording of the questions

3 The question asked was: "Would you consider yourself a strong (Protestant, Catholic, etc.) or a not very strong (Protestant, Catholic, etc.)?"

Table 3. ATTITUDE TOWARD SUICIDE AND EUTHANASIA BY FREQUENCY OF CHURCH ATTENDANCE AND SEX[1]

	Acceptance Of Euthanasia[2]			Acceptance Of Suicide[2]		
	[Males Only]					
Freq. of Church Attendance[3]	Yes	No	Total (n)	Yes	No	Total (n)
Seldom	82%	18	(163)	60%	40	(162)
Occasionally	77%	23	(187)	53%	47	(181)
Regularly	70%	30	(80)	44%	56	(81)
Very Regularly	52%	48	(160)	23%	78	(167)
Chi Square (Sig.):	41.38 (.001)			52.57 (.001)		
Gamma:	.40			.41		
	[Females Only]					
Freq. of Church Attendance[3]	Yes	No	Total (n)	Yes	No	Total (n)
Seldom	80%	20	(137)	53%	47	(141)
Occasionally	71%	29	(161)	52%	48	(164)
Regularly	62%	38	(110)	39%	61	(111)
Very Regularly	45%	55	(273)	23%	77	(280)
Chi Square (Sig.):	57.64 (.001)			55.57 (.001)		
Gamma:	.45			.41		

1 Whites only

2 See Table 1 for wording of questions

3 The question asked was: "How often do you attend religious services? (Seldom = Never, Less than once a year; Occasionally = About once a year, Several times a year, Several times a year; Regularly = About once a month; 2-3 times a month; Very regularly = Nearly every week, Every week, Several times a week.

significant among females only for attitudes toward suicide. More educated white females are highest (51 percent) in accepting suicide. Education among females is not, however, statistically associated with attitudes toward euthanasia.

In examining religion, Protestants and Catholics do not appear to differ in their evaluation of euthanasia. By contrast, the relationship between suicide and religion is statistically significant. The differences in proportions of those accepting suicide is not great, however, and is due more to the large sub-sample sizes than a large absolute difference. We conclude that religious affiliation is not especially predictive of attitudes toward either euthanasia or suicide.

Religiosity, however, proves to be an important indicator of attitudes toward suicide or euthanasia. This corresponds with an earlier study by Nelson (1977), who has suggested that attitudes toward suicide are more related to the degree of religiosity rather than religious affiliation *per se.* Tables 2 and 3 present data related to this finding. Those respondents who define their faith as "strong" are much more likely to reject the notions of both euthanasia and suicide. This finding supports those of Glock and Stark (1965), Demerath (1965), and Davidson (1972), who have found that religious preference or affiliation has less impact upon beliefs and attitudes than does the person's degree of religious commitment, based on either one's involving a religious group or one's feelings of religious identification (cf. McIntosh *et al.,* 1979). Of the males, for example, 80 percent of those who seldom attend church services accept the idea of euthanasia. Only half (52 percent) of the males who regularly attend church services accepted euthanasia.

Secular subjective attitudes may be significant in addition to the importance of the respondents' level of religiosity. Tables 4 and 5 examine some of these aspects, correlating the degree of acceptance/rejection of euthanasia and suicide in terms of the respondents' perceptions of their health and satisfaction with family life.

Table 4. ATTITUDE TOWARD EUTHANASIA AND SUICIDE BY RESPONDENT'S PERCEPTION OF HEALTH AND SEX[1]

	Acceptance of Euthanasia[2]			Acceptance of Suicide[2]		
	[Males Only]					
Condition of Health	Yes	No	Total (n)	Yes	No	Total(n)
Good	73%	27	(439)	49%	51	(439)
Poor	66%	34	(154)	35%	65	(156)
Chi Square (Sig):	2.43 (.12)			9.30 (.002)		
Gamma:	.16			.29		
	[Females Only]					
Condition of Health	Yes	Not	Total (n)	Yes	No	Total (n)
Good	61%	39	(507)	40%	60	(517)
Poor	62%	38	(173)	34%	66	(178)
Chi Square (Sig):	.04 (.83)			1.86 (.17)		
Gamma:	-.03			.13		

1 For Whites Only

2 See Table 1 for Wording of Questions

Table 5. ATTITUDE TOWARD EUTHANASIA AND SUICIDE BY SATISFACTION WITH FAMILY-LIFE, CONTROLLING FOR SEX.[1]

	Acceptance Of Euthanasia[2]			Acceptance Of Suicide[2]		
	[Males Only]					
Satisfaction With Family-Life	Yes	No	Total (n)	Yes	No	Total (n)
High	70%	30	(438)	43%	57	(439)
Low	73%	27	(152)	52%	48	(153)
Chi Square (Sig.):	0.28 (.60)			3.21 (.07)		
Gamma:	-.05			0.17		
	[Females Only]					
Satisfaction With Family-Life	Yes	No	Total (n)	Yes	No	Total (n)
High	59%	41	(525)	36%	64	(537)
Low	68%	32	(154)	47%	53	(157)
Chi Square (Sig.):	3.41 (.065)			6.18 (.01)		
Gamma:	-.18			-.23		

1 Whites Only

2 See Table 1 for wording of questions

The perception of one's health appears to be a factor only under certain conditions. For both males and females, perception of being either in good or ill health is not statistically associated with acceptance or rejection of euthanasia. Although the euthanasia question involved the act of euthanasia when a person was terminally ill, males and females who defined their health as "not good" are not more likely to accept euthanasia than those who perceived their health as good. Males who perceived their health as "not good" however, were more likely to accept the notion of suicide. While perception of health is a factor for suicide among males, it is not a factor among females.

Table 5 introduces the topic of satisfaction with family life. Attitudes toward euthanasia and evaluation of family life are slightly associated for females but not for males. Females who perceived their family lives to be low in satisfaction were more likely to accept the euthanasia proposal than women who perceived their family lives to be more satisfactory.

Conclusion

In examining attitudes toward suicide and euthanasia, degree of religiosity, age and education are seen as important associational variables. With regard to sex, males seem slightly more accepting of both euthanasia and suicide. This coincides with earlier studies in which females express more concern about death (Hogan, 1970; Lowry, 1965).

Females were more likely to accept euthanasia and suicide when family life was perceived as unsatisfactory. Males, while not influenced by family life, were more likely to approve of suicide when their health was perceived as "not good."

In addition to the socioeconomic variables that have been examined here, a closer analysis of both the objective and subjective variables which are associated with attitudes toward conditional euthanasia and suicide is suggested in future research. The need to examine these issues more closely is heightened as they are brought to the forefront in terms of their moral, religious, medical and legal ramifications.

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