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Attitudes of Social Workers about Rational Suicide

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Abstract

Suicide is a major public health concern. It is the tenth leading cause of death in the United States. Social workers serve as the largest group of mental health care providers, and commonly intervene with suicidal clients. Despite the high rate of suicide and social workers interface with client suicidality, there is no research on the attitudes of social workers toward rational suicide. The notion of rational suicide challenges traditional views on suicide intervention and has complex ethical implications for the social work profession. Social workers adhere to the ethical standards set forth by the NASW and rational suicide involves two of those ethical standards, client self-determination and commitment to clients. This quantitative research study examined the attitudes of 2,157 licensed clinical social workers toward rational suicide. Findings revealed that social workers broadly agree (67.1%) that individuals can make a rational decision to die by suicide. Social workers' personal characteristics (gender, age, race/ethnicity, state residency, religious affiliation and having personal thoughts of suicide) were found to predict their attitudes about rational suicide. The findings suggest that social workers' attitudes about rational suicide are related to their personal

characteristics. These findings have ethical considerations for the social work profession when intervening with suicidal persons with physical and psychological pain as well as value neutral practice.

Keywords: Rational suicide, ethics, clinical social work, physical, psychological pain

Introduction

Rational suicide involves the decision to take one's own life based upon logical decision making and personal autonomy (Werth & Holdwick, 2000, p. 513). The notion of rational suicide challenges traditional views on suicide intervention with complex ethical and ideological implications for the social work profession, one of the core values of which is to uphold the dignity and worth of each person (National Association of Social Workers [NASW], 2017). The NASW calls upon social workers to "promote clients' socially responsible self-determination" (NASW, 2017, p. 5). Consequently, social workers must respect each client's personal autonomy and right to make their own decisions. However, self-determination is limited when the client poses an imminent risk to themselves or others (NASW, 2017, pg. 7).

The historical and current aim of suicide prevention efforts are to discourage and intervene with suicidal clients (Werth, 1995). The NASW developed and maintains a code of ethics for the social work profession which stipulates practice interventions, specifically, how to intervene with suicidal clients. However, there are potentially conflicting ethical standards that can make the decision to intervene with suicidal persons a difficult undertaking. Suicide concerns social workers' views on their profession's ethical standards, client self-determination, and their commitment to client well-being. Although there is emerging research on rational suicide, at present, there is no research that has examined social workers' attitudes about rational suicide. Thus, it is important for social workers to understand rational suicide and its implications on practicing within the ethical framework established by the NASW. The purpose of this study is to examine social workers' attitudes toward rational suicide and discover their personal and professional experiences associated with their attitudes toward rational suicide.

Literature Review

Rational Suicide

Rational suicide presents a paradigm shift in the way society thinks about suicide. The notion that a person can make a personal, autonomous, and rational choice to die by suicide has significant implications for suicide prevention and intervention efforts, which traditionally aim to decrease and eliminate suicide. Understanding rational suicide requires understanding suicide prevalence and suicide prevention programs and policies in the United States.

Suicide Prevalence

Crosby et al. (2011) defines suicide as "death caused by self-directed injurious behavior with any intent to die as a result of the behavior" (p. 23) and a suicide attempt as "a non-fatal self-directed potentially injurious behavior with any intent to die as a result of the behavior" (p. 21). Suicide was the tenth leading cause of death for all ages and the second leading cause of death for those ages 10 to 24 (Hedegaard et al., 2018). The impact of suicide extends beyond completed suicides; for every completed suicide, there are 25 attempts (Drapeau &McIntosh, 2020). Hedegaard et al. (2018) reported that from 1999 through 2017, the age-adjusted suicide rate increased 33%, from 10.5 to 14.0 per 100,000 persons. Specifically, from 1999 to 2014, the suicide rate for middle-aged women, ages 45 to 64, increased by 63%, while the rate for men in the same age range rose by 43%, representing the sharpest increase for males of any age group (Hedegaard et al., 2018). Despite prevention programs and policies that have focused on decreasing and eliminating suicide, the annual suicide rate has steadily increased in the United States to 13 per 100,000 people, the highest since 1986 (Hedegaard et al., 2018).

Suicide Prevention

Over the past two decades, various stakeholders, such as government and state agencies, have attempted to create strategies and policies for suicide prevention (Sheehan, et al., 2015). Despite these efforts, suicide prevention and treatment programs continue to lack social or financial support compared to prevention and treatment efforts for other leading causes of death (Canady, 2015). Strategies and modalities have a mental health treatment-orientation that focuses on identifying risk factors and recognizing warning signs; however, suicide prevention programs within a mental health treatment model do not address the complexity of suicide. According to David-Ferdon et al. (2016), a mental health approach "only reaches small segments of the population who have identified risk factors and who can surmount treatment barriers, such as stigma and limited availability of or access to services" (p. 894). According to David-Ferdon et al. approximately 70% of suicide decedents were not receiving mental health services at the time of their death, and approximately 80% had no known history of previous suicide attempts.

The Context of Rational Suicide

The idea of rational suicide emerged as a response to the increasing aging population, scientific advances to prolong life, and the right-to-die movement (Siegel, 1986). In addition, changes in the way people die have also lent support for rational suicide. Rogers et al. (2001) suggested the way we die has changed historically, from dying at an early age due to acute causes, to dying from chronic and worsening diseases later in life. Rational suicide can be viewed as an effort to control death in both its process and timing (Rogers et al., 2001). Rational suicide was first introduced to address the right to die by those with a terminal illness but has since expanded to other untreatable conditions, including psychological pain (Siegel, 1986); although rational suicide for both is controversial, the latter holds more stigma and shame (Werth & Holdwick, 2000). For example, making a rational decision to die by suicide when suffering from a terminal illness has

at times been considered both morally and socially acceptable, compared to wanting to die by suicide due to psychological pain (Hewitt, 2013). This fact seems likely due to psychological pain being associated with mental illness and irrationality.

Theories & Factors

There are several theories and factors that have helped shift societal perspectives on suicide and rationality: technology, the right-to-die perspective, and the legalization of assisted death (Dzeng & Pantilat, 2018). Life-changing technological advances have changed the way we live and die, such as in the case of medical advances. These technological advances have led to increased life expectancy, although longevity may prolong suffering and disease (Lee & Grube, 2017). Dzeng and Pantilat (2018) suggested these technological advances have raised concerns about the aggressive nature of medical care and the enduring suffering it can impose upon patients and their loved ones. Consequently, the assumption that life should be sustained as long as possible has raised considerable questions concerning ethics, individualism, and the dignity of the individual throughout the dying process (Banjar, 2017). These concerns have paved the way for the right-to-die movement, whose mission has been to ensure that persons can die with dignity. This movement has also led to assisted-suicide laws being enacted for terminally ill patients.

Next, the right-to-die movement was pivotal in shaping the views and beliefs associated with terminal illness in the United States (McCormick, 2011). As technology and medical treatments developed, these concerns centered on a person's quality of life versus their end of life (McCormick, 2011). Terminally ill patients' concerns include loss of autonomy and control and the fear of being a burden (Humphry & Clement, 2000); the right-to-die perspective centers on individual choice, personal decision making, and free will. The right-to-die movement has resulted in legislation to allow persons to make health care choices, such as foregoing medical treatment. The central feature of the right-to-die movement is autonomy. In 2006, the Pew

Foundation found that 84% of Americans support right-to-die laws (Pew Research Center, 2006), and in 2015, a Gallup reported that 68% of Americans support the legal right of terminally ill people to die (Gallup, 2015). This perspective underlies the concept of rational suicide. In addition to changing the way suicide is understood, the right-to-die movement also paved the way for assisted suicide laws.

A final factor is the concept of assisted suicide, which is described as - "the act of intentionally killing oneself with assistance from another person, who provides the knowledge, means, or both" (World Health Organization [WHO], 2004, p. 10). Oregon's 1994 Death by Dignity Act made it the first state to legalize assisted suicide. The law allows terminally ill adults who are likely to die within six months to obtain a prescription for lethal medication from a doctor, although they must first be able to demonstrate that they can make their own decisions (Oregon Death with Dignity Act, 2019). It should be noted that psychological pain is not mentioned in the Death by Dignity Act, and that no states include psychological pain as a condition for assisted suicide in assisted suicide legislation. As of 2020, 8 states and Washington D.C. have legalized assisted suicide for terminally ill patients.

Assisted suicide is associated with rational suicide. Both are philosophically grounded in self-determination and individual autonomy. In the United States, assisted suicide laws, together with the right-to-die movement, reinforce the importance of individual choice, personal decision making, and rationality for those with terminal illness, thereby reducing societal stigma about suicide for those individuals. Rational suicide, then, may be considered more morally and socially acceptable for those who have terminal physical illness than for those suffering from psychological pain. Psychological pain is rooted in the construct of mental illness and is aligned with stigma and labels assigned to those deemed "mentally ill" and thus, 'unfit' to choose rational suicide. It follows that suicide for people who experience psychological pain may be viewed differently than suicide for those who are suffering from a terminal physical illness. Consequently, personal autonomy regarding the decision to die by suicide has complex ethical

considerations for social work professionals who may be called upon to intervene with suicidal persons.

Significance for Social Work

Social workers serve as the largest group of mental health care providers in the United States (NASW, n.d.). Because they play a key role in providing mental health services, it is important for social workers to understand the attitudes they have about rational suicide for persons experiencing pain from terminal illness and psychological conditions. The increase in suicide prevalence is a concern for all mental health professions. Understanding suicide, specifically rational suicide, is important for research, practice, and training in the mental health field broadly and the social work profession in particular.

People who die by suicide often see human service workers within weeks before they die (Jacobson, et al., 2012). Social workers intervene with suicidal patients in various settings and in different roles. Therefore, it is critical that burgeoning social workers are educated and trained in their undergraduate and graduate programs on suicide, risk assessments, and interventions. Education is particularly relevant given that one-third of social workers will experience a client death by suicide over the course of their career (Jacobson et al., 2012). When addressing suicide, education is a key area to inform social work practice.

Rational suicide is also an ethical consideration for the social work profession. In human services professions, the moral, ethical, and legal response to suicide has been prevention (Werth, 1995). Most professional organizations (social workers, counselors, psychologists, physicians, and nurses) have ethical codes detailing standards that govern service delivery. Professional codes stipulate that the proper response to suicidal clients is to try to discourage them from attempting suicide and, if that fails, to intervene (Mayo, 1998). Social workers deal with complex ethical issues and commonly intervene with individuals who are suicidal (Mishna et al., 2002). According to Misha (2002), ethical decision making is based on being able to

discern when an individual can make an informed decision and when they lack this ability. The complexity exists in an individual's right to choose suicide and the social worker's responsibility to prevent it. Self-determination is a value and an ethic within the social work profession; however, social workers also adhere to the value of client commitment and well-being, which underscores safety from harm. In adhering to this value, social workers intervene with suicidal clients and work to prevent and preserve life. The conflict between respecting client self-determination and having a professional commitment to client well-being presents an ethical conundrum for social workers who take into consideration the concept of rational suicide. Thus, this study poses the following research questions: RQ1: What are social workers' attitudes about rational suicide? RQ2: What is the relationship between social workers' professional experiences and their attitudes about rational suicide? RQ3: What is the relationship between social workers' personal characteristics and their attitudes about rational suicide?

Methodology

Research Design

This is a quantitative research study that used the Qualtrics online survey platform to collect data. The researcher used a descriptive correlational design to examine the association between social workers' attitudes on rational suicide, and their professional experiences and personal characteristics.

Sampling

To establish a baseline understanding of social workers' attitudes about rational suicide, the researcher surveyed social workers directly. The list of clinical social workers licensed by state licensing boards in Arkansas, Florida, Nebraska, New York, Oregon, Rhode Island, Utah, Wisconsin, and Wyoming comprised the sampling frame. These nine states were selected

because their licensing boards were able to provide email addresses for clinical social workers. The sampling frame included 56,975 licensed social workers across all nine states. The final convenience sample (n = 29,021) included all clinical social workers from each state who met criteria to participate in the study. Each participant had to have a minimum of a master's degree in social work, an active clinical social work license, and valid email address.

Procedures

This is a quantitative exploratory study that examined social workers' attitudes about rational suicide by using a survey administered to licensed clinical social workers across nine states: Arkansas, Florida, Nebraska, New York, Oregon, Rhode Island, Utah, Wisconsin, and Wyoming. The information from this study provides a baseline understanding of social workers' attitudes toward rational suicide and identifies personal and professional characteristics associated with these attitudes.

Items in this survey focused on social workers' attitudes about rational suicide. The survey also included items related to the social workers' personal characteristics and professional experiences related to suicide. This study received IRB Approval and each participant was presented with an informed consent form prior to answering the first question on the survey. Participants were unable to access the survey without first reviewing the consent form and indicating voluntary consent. Both the recruitment letter and consent form explained the limits of confidentiality and respect for participants' privacy.

Instrumentation

The survey (Appendix A) consists of three sections: attitudes toward rational suicide, personal characteristics, and professional experiences. The survey included closed-ended Likert-type questions pertaining to demographic and personal data. Demographic and personal characteristics included: state residency, age, gender, years of experience, race and ethnicity,

religious affiliation, and primary practice area. Professional experiences were related to past experiences with clients who attempted or completed suicide, personal thoughts about suicide, and past experiences with family members or friends who thought about or completed suicide with five categorical response choices to assess respondents' views on rational suicide.

Variables

The variables were conceptualized and operationalized based on the research questions and from information in existing literature on rational suicide. Several research studies have examined health care professionals' attitudes about rational suicide. Researchers have also examined characteristics associated with attitudes about rational suicide, such as gender, race, religious affiliation, occupation, professional setting, and years of experience (Rogers et al., 2001; Werth & Liddle, 1994; Westefeld et al., 2004). For data analysis purposes, all variables were at the nominal level.

Data Collection & Sample Demographics

Surveys were randomly assigned to participants in each state to ensure that the surveys distributed were proportional to the sample size within and across states. Surveys were distributed in early October of 2018; participants were sent a link to the survey via email. The email included an introductory letter and participants were removed from future emailing if the email address was determined to be incorrect through automatically generated email rejections. The survey instrument was active from October 14, 2018, through December 14, 2018. The final sample consisted of two thousand three hundred fifty-seven participants; of that number, 2,157 were valid responses.

Results

Data was analyzed through the use of the statistical analytical software SPSS.

Sample Demographics

The survey included several questions on personal characteristics. Respondents' personal characteristics included information on their state residency, gender, age, years of experience, race and ethnicity, religious affiliation, and practice area. Complete demographic and descriptive data can be found in Table 1.

Characteristics	*N*	%
State Residency		
Arkansas	617	28.6
Florida	105	4.9
Nebraska	7	0.3
New York	568	26.3
Oregon	119	5.5
Rhode Island	84	3.9
Utah	317	14.7
Wisconsin	110	5.1
Wyoming	72	3.3
Missing	158	7.3
Gender		
Male	449	20.8
Female	1588	73.6
Transgender male	3	0.1
Gender variant	6	0.3
Other	3	0.1
Prefer not to answer	19	0.9
Missing	89	4.1
Age		
18-24 years old	1	< 0.1
25-34 years old	201	9.3
35-44 years old	397	18.4
45-54 years old	439	20.4
55-64 years old	540	25.0
65-74 years old	394	18.3

75 years or older	82	3.8
Prefer not to answer	14	0.6
Missing	89	4.1
Years of Experience		
Less than 1 year	0	< 0.1
1-5 years	126	5.8
6-10 years	295	13.7
11-15 years	280	13
16-20 years	277	12.8
21-25 years	257	11.9
26-30 years	302	14
31-35 years	207	9.6
36-40 years	137	6.4
More than 40 years	183	8.5
Missing	93	4.3
Race and Ethnicity		
Non-Hispanic White or Euro- American	1720	79.7
Black, Afro-Caribbean, or African American	96	4.5
Latino or Hispanic American	98	4.5
East Asian or Asian American	19	0.9
South Asian or Indian American	3	0.1
Middle Eastern or Arab American	9	0.4
Native American or Alaskan Native	30	1.4
Other	38	1.8
Prefer not to answer	55	2.5
Missing	89	4.1
Religious Affiliation		
Buddhist	62	2.9
Catholic	253	11.7
Evangelical	58	2.7
Hindu	4	0.2
Jehovah's Witness	1	< 0.1
Jewish	236	10.9
Mormon	139	6.4
Muslim	1	< 0.1

Orthodox Christian	14	0.6
Unaffiliated	610	28.3
Other	363	16.8
Prefer not to answer	86	4.0
Missing	90	4.2
Practice Area		
Children	66	3.1
Gerontology	25	1.2
Medical	145	6.7
Mental Health	866	40.1
Child Welfare	59	2.7
Aging	127	5.9
Addiction	312	14.5
Intellectual disabilities	108	5.0
Other area not listed	351	16.3
Prefer not to answer	0	< 0.1
Missing	98	4.5

Table 1: Participant Demographics (n=2157)

Research questions one investigates social workers' attitudes about rational suicide. In order to answer this questions, descriptive statistics were used to summarize responses to survey item one to answer this research question. Participants were presented with the statement: "*An individual can make a rational decision to die by suicide*." Almost half of the respondents agreed (43.2%, n = 932) or strongly agreed (23.9%, n = 515) with this statement. The remaining respondents were split between being undecided (14.1%, n = 305), disagreeing (10.7%, n = 230), or strongly disagreeing (8.1%, n = 175).

Research question two investigates the relationship between social workers' professional experiences and their attitudes about rational suicide. To answer this research question, a multinomial logistic regression was run to predict social workers' attitudes about rational suicide based on their professional experiences (*i.e., having a client that attempted suicide; having a client die by suicide; having one's own thoughts of suicide; having a friend, family member, or loved one attempt suicide; and having a friend, family member, or loved one*

die by suicide). Then, separate regressions for each professional experience variables was run.

A recoded variable, which combined three final response choices strongly agree/agree, undecided and strongly disagree/disagree, was entered into the model. There was a statistically significant relationship between attitudes about rational suicide and social workers' personal thoughts of suicide ($x2(2) = 15.77$, $p < .01$). The McFadden, Cox-Snell, and Nagelkerke pseudo-R2 values were .005, .008, and .010, respectively. Social workers who reported having had their own thoughts of suicide were 1.5 times as likely as social workers who had not had thoughts of suicide to strongly agree/agree that individuals can make a rational decision to die by suicide than they were to strongly disagree/disagree (OR = 1.55, Wald F = 13.36, $p < .01$). No other statistically significant results were found for the remaining statements.

Research question three investigates the relationship between social workers' personal characteristics and their attitudes about rational suicide. To answer this question, multinomial logistic regression was used to examine social workers' personal characteristics and their attitudes about rational suicide. The independent variables (*state residency, gender, age, years of experience, race and ethnicity, religious affiliation, and practice area*) were entered into separate models. Results for the relationship between each independent variable and the dependent variable are reported below.

State Residency

Recoded variables for state with the response choices South (included Arkansas and Florida); Midwest (included Nebraska and Wisconsin); Northeast (included New York and Rhode Island); and West (included Oregon, Utah, and Wyoming) were entered into the model. The majority of respondents in each geographic grouping agreed or strongly agreed that individuals could make a rational decision to die by suicide. A statistically significant relationship between social workers' state residency and their attitudes about rational suicide ($x2(6) = 24.68$, $p <.01$). The McFadden, Cox-Snell and Nagelkerke pseudo-R2 values were .007, 0.12 and .015, respectively. Social

workers in the Northeast region were 1.8 times as likely (OR = 1.87, Wald F = 15.86, $p < .01$) as social workers in the West region to strongly agree/agree that individuals can make a rational decision to die by suicide than to strongly disagree/disagree. Social workers in the South were 1.4 times as likely (OR = 1.44, Wald F = 6.01, $p < .01$) as social workers in the West region to strongly agree/agree that individuals can make a rational decision to die by suicide than to strongly disagree/disagree.

Gender

The recoded gender variables with the response choices male, female, other (including transgender female, transgender male, gender variant/non-conforming, and not listed), and prefer not to answer were entered into the model. The majority of respondents in each gender group agreed or strongly agreed that individuals could make a rational decision to die by suicide. A statistically significant relationship between social workers' gender and their attitudes about rational suicide ($x2(6) = 16.54$, $p = .011$). The McFadden, Cox-Snell and Nagelkerke pseudo-$R2$ values were .005, .008 and .010, respectively. Male social workers were about half as likely as female social workers to be undecided in their response to the statement that individuals can make a rational decision to die by suicide compared to strongly disagreeing/disagreeing (OR = 0.48, Wald F = 13.23, $p < .01$).

Age

The recoded age variables with response choices young adult (18-44 years of age), middle-age adult (45-64 years of age), and older adult (65 years of age and up), were entered into the model. The majority of respondents in each age group agreed or strongly agreed that individuals could make a rational decision to die by suicide. There was a statistically significant relationship between social workers' age and their attitudes about rational suicide ($x2(4) = 23.78$, $p <.01$). The McFadden, Cox-Snell and Nagelkerke pseudo-$R2$ values were .007, .012 and .014, respectively. Young adult social workers (18-44 years) were less likely as older adult social workers (65 years and older) to strongly agree/agree that individuals can make a rational decision to die by suicide than strongly disagree/disagree (OR = 0.70, Wald F = 4.50, $p = .034$).

Social workers in the young adult category (18 and 44 years of age) were 1.7 times as likely as older adult social workers (65 years of age and up) to be undecided that individuals can make a rational decision to die by suicide than to strongly disagree/disagree (OR = 1.70, Wald F = 5.09, p = .024).

Years of Experience

The majority of respondents in each experience group agreed or strongly agreed that individuals could make a rational decision to die by suicide. Multinomial logistic regression results indicated that social workers' years of experience did not have a statistically significant relationship to their attitudes about rational suicide.

Race and Ethnicity

The recoded race/ethnicity variables with response choices White, non-White (*included Black, Afro-Caribbean, or African American, Latino or Hispanic American, East Asian or Asian American, South Asian, or Indian American, Middle Eastern or Arab American, Native American or Alaskan Native, other, and prefer not to answer*) were entered into the model. The majority of respondents in each race/ethnicity group agreed or strongly agreed that individuals could make a rational decision to die by suicide. A statistically significant relationship between social workers' race and ethnicity and their attitudes about rational suicide (x2(6) = 24.70, p <.01). The McFadden, Cox-Snell and Nagelkerke pseudo-R2 values were .007, .012 and .015, respectively. White social workers were 1.7 times as likely as non-White social workers to strongly agree/agree that individuals can make a rational decision to die by suicide than to strongly disagree/disagree (OR = 1.79, Wald F = 12.46, p < .01).

Religious Affiliation

The recoded religious affiliation variables with response choices unaffiliated, affiliated (*included Buddhist, Catholic, Evangelical, Protestant, Hindu, Jehovah's Witness, Jewish, Mormon, Muslim, Orthodox Christian, other and prefer not to answer*) were entered into the model. Attitudes about rational suicide varied by religious affiliation. The majority of respondents without a religious affiliation or those affiliated with the Buddhist, Protestant, Hindu,

Jehovah Witness, Jewish, and Orthodox Christian religions agreed or strongly agreed that individuals can make a rational choice to die by suicide. Conversely, the majority of respondents who reported being affiliated with the Catholic, Evangelical, or Mormon religions disagreed or strongly disagreed that individuals can make a rational choice to die by suicide. A statistically significant relationship between social workers' religious affiliation and their attitudes about rational suicide ($X2(4) = 56.73$ $p < .01$). The McFadden, Cox-Snell and Nagelkerke pseudo-R2 values were .016, .027 and .033, respectively. Specifically, social workers who had no religious affiliation were 2.7 times as likely to strongly agree/agree that individuals can make a rational decision to die by suicide than strongly disagree/disagree, compare to social workers who were affiliated (OR = 2.76, Wald F = 43.25, $p < .01$). Additionally, social workers who had no religious affiliation were twice as likely to be undecided that an individual can make a rational decision to die by suicide than strongly disagree/disagree than social workers who had a religious affiliation (OR = 2.04, Wald F = 13.16, $p = .01$).

Practice Area

The recoded practice area variables with response choices *children (including children, child welfare and intellectual disabilities), aging (including gerontology, medical and aging), other (including other and prefer not to answer), and mental health (including mental health and addiction)* were entered into the model. The majority of respondents in each practice area agreed or strongly agreed that individuals could make a rational choice to die by suicide. There was no statistically significant relationship between social workers' practice area and their attitudes about rational suicide.

Discussion

The findings from this study suggest social workers broadly agree with the notion of rational suicide. Social workers' personal characteristics (gender, age, race/ethnicity, state residency, religious affiliation, and personal thoughts of suicide) were associated with attitudes about rational suicide.

Professional experiences (having had a client attempt suicide or having had a client die by suicide) were not associated with attitudes about rational suicide.

First, the results of the first research question, "*What are social workers' attitudes about rational suicide*" indicate that over half of the respondents strongly agreed/agreed (67.1%) that individuals can make a rational decision to die by suicide. This finding is similar to other research studies that found mental health practitioners agreed with the notion of rational suicide (Rogers et al., 2001; Werth & Corbia, 1995; Werth & Liddle, 1994; Westefeld et al., 2004). It should be noted that although this finding is similar to previous research studies on attitudes about rational suicide, previous studies examined different populations, used different sampling methods, and employed different statistical analyses than were used in the present study. For example, Rogers et al. (2001) studied counselors and used ANOVAs to examine seven-point ordinal scale responses, while Westefeld et al. (2004) studied psychologists, nurses, and state legislators and used ANOVAs to analyze five-point ordinal scale responses. Werth and Liddle (1994) studied psychotherapists and used ANOVAs to analyze responses to semantic differential scale responses.

This finding also suggests that respondents' attitudes may parallel society's views on the right to die. Proponents of the right-to-die movement have advocated for laws to support autonomy in decision making regarding death. The right-to-die movement, along with organizations that support it, maintains that individuals have a right to make decisions about the timing and circumstances of their death (McCormick, 2011). According to McCormick (2011), support for right-to-die laws has grown since the inception of the right-to-die movement in the 1970s, with the majority of Americans supporting an individual's right to die. For example, in 2006, The Pew Research Center surveyed 1,500 Americans and reported that 84% of Americans supported right to die laws (Pew Research Center, 2006), and in 2015, Gallop reported that 68% of Americans support the legal right of terminally ill people to die (Gallup, 2015). This finding could suggest the influence of the right-to-die movement on respondents' attitudes. Another possibility is

that respondents were influenced by their code of ethics and adherence to the NASW value of client self-determination. Self-determination refers to the "capacity and right of individuals to affect the course of their lives" (Weick & Pope, 1988, p. 10). This finding suggests that social workers' adherence to the value of self-determination may be perceived as being consistent with their view that an individual can make a rational decision to die by suicide. Although it is possible that the right-to-die movement may have influenced some respondents, it is possible that it is the NASW Code of Ethics and the value of self-determination that influenced respondents' views on rational suicide. There is a reciprocal relationship between social workers and the NASW Code of Ethics. Social workers influence the creation of the Code of Ethics as well as adhere and uphold the ethics.

Results of the second research questions, "*What is the relationship between social workers' professional experiences and their attitudes about rational suicide*" were not statistically significant. Specifically, response choices for having had a client attempt suicide and having had a client die by suicide were not statistically significantly related to respondents' attitudes about rational suicide. This finding is in keeping with findings from previous research studies, which did not find a relationship between respondents having had a client attempt suicide or having had a client die by suicide (Rogers et al., 2001; Werth & Liddle, 1994).

Respondents having had their own thoughts about suicide did have a statistically significant relationship to their attitudes about rational suicide. Almost half (47%) of respondents who participated in the present study reported having had thoughts of suicide, and respondents who had thoughts of suicide were 1.5 times more likely to strongly agree/agree that individuals can make a rational decision to die by suicide than strongly disagree/disagree. This finding indicates that personally experiencing suicidal thoughts may influence a respondent's view on rational suicide. Notably, this finding contradicts previous research that did not find a statistically significant relationship between personal thoughts of suicide and attitude toward rational suicide (Rogers et al., 2001; Werth & Liddle, 1994). There is no clear explanation for this difference, but it may be that the different findings are

due to the different populations under investigation. Also, as already noted, the previous studies used different response scales and statistical analyses. This discrepancy suggests the need for further research to examine how personal experiences affect attitudes about rational suicide in a larger sample of social workers, as well as studies that compare social workers' attitudes with those held by other helping professionals (i.e., counselors, psychotherapists, physicians, nurses, etc.).

Finally, results of research question three, "*What is the relationship between social workers' personal characteristics and their attitudes about rational suicide*" yielded several statistically significant relationships. Specifically, results posit statistically significant relationships between respondents' state residency, gender, age, race and ethnicity, and religious affiliation and their attitudes about rational suicide; the effect size for each of the variables (state residency, gender, age, race, and ethnicity) was small, but large for religious affiliation.

State Residency

Respondents in the Northeast region (New York and Rhode Island) and South region (Arkansas and Florida) were more likely than respondents in the West region (Oregon, Utah, and Wyoming) to strongly agree/agree that individuals can make a rational decision to die by suicide than to strongly disagree/disagree. This finding may be explained by the fact that the West region, specifically the Mountain West region, has the highest suicide rates for men and women, across all racial groups, and ages, compared to other regions (Pepper, 2017). The high rates of suicide in the West region may have influenced respondents to be less likely to agree that individuals can make a rational decision to die by suicide.

Gender

In contrast with other research studies that did not find a relationship between gender and attitude toward rational suicide (Rogers et al., 2001; Werth & Liddle, 1994; Westefeld et al., 2004) this research study found females were more likely than males to be undecided whether individuals can

make a rational choice to die by suicide. Again, inconsistency with previous research may be due to methodological differences. This research finding suggests a need to further examine the relationship between gender and attitudes about rational suicide in a larger sample of social workers, as well as the relationship between the type of profession and attitudes about rational suicide.

Age

Young adult social workers (18-44 years) were less likely than older adult social workers (65 years and older) to agree that individuals can make a rational decision to die by suicide. This finding suggests that a respondent's age may influence their acceptance of a client's right to autonomy in relation to suicide. It was interesting that age had a statistically significant relationship to attitudes about rational suicide, while years of practice experience, which is discussed later, did not. It was presumed that age and years of experience would be comparable; yet, age does not necessarily equate to more years of experience, as social workers can enter the field at any age. Because there has been no other research that has examined the relationship between age and attitudes about rational suicide, this finding indicates there is a need to further examine the influence of age on attitudes about rational suicide.

Race and Ethnicity

Race and ethnicity were statistically significantly related to respondents' attitudes about rational suicide, with White respondents more likely than non-White respondents to agree that individuals can make a rational choice to die by suicide. This finding contradicts Rogers et al.'s (2001) findings that counselor race was not related to attitudes about rational suicide. Rogers et al.'s (2001) study, although with a smaller sample, had a majority of White respondents, similar to this research study. Again, methodological differences between studies may account for this divergence. This finding suggests a need to examine further the relationship between race and ethnicity

and attitudes about rational suicide in a more representative sample of social workers than was used in this study.

Religious Affiliation

This research study found a statistically significant relationship between religious affiliation and attitudes about rational suicide, where non-affiliated respondents were more likely to agree that an individual can make a rational choice to die by suicide, compared to respondents with a religious affiliation. This finding is consistent with other studies that found religious affiliation to be associated with attitudes toward rational suicide (Rogers et al., 2001; Werth & Liddle, 1994; Westefeld et al., 2004). Religious doctrines traditionally preach against suicide (Hsieh, 2017), which may explain why unaffiliated respondents were more likely to agree that individuals can make a rational decision to die by suicide than were affiliated social workers.

Years of Experience and Practice Area

The number of years of experience as a social worker and the type of practice area did not have statistically significant relationships with respondents' attitudes about rational suicide. This result is in keeping with previous research that did not find an association between attitudes about rational suicide and practice area (Rogers et al., 2001; Werth and Liddle, 1994) or years of experience (Rogers et al., 2001; Westefeld et al., 2004). Overall, this finding suggests that personal characteristics influence attitudes about rational suicide; attitudes are complex and are shaped by a variety of factors (Moyle et al., 2010).

Limitations

There were several limitations to this research study that may have influenced the findings. First, there is limited research on attitudes toward rational suicide, and there has been no research that has examined the

attitudes of social workers toward rational suicide. Another limitation is self-selection bias given this was an online survey which runs the risk of using samples that are overrepresented or underrepresented, which may bias the findings (Bhole & Hanna, 2017). In addition, there is always the chance of social desirability and the drawbacks of the use of a convenience sample. Finally, it should be noted that although the overall size of the total sample was large, the response rate was rather low. The response rate (n = 2,157) was 7.43%.

Implications for the Social Work Profession

The findings of this study have several implications for social work practice, policy, research, and education.

Implications for Social Work Practice

Because there is some evidence that personal characteristics can predict social workers' attitudes about rational suicide, this study has implications for social work practice. There is a need for social workers to examine their attitudes about rational suicide and the congruence between their attitudes and the NASW Code of Ethics. Social workers develop a professional identity in a process called professional socialization (Valutis & Rubin, 2016). This process occurs when social workers incorporate the values and ethics of the social work profession in their practice. CSWE reinforces this development in social work education by stating "social workers recognize personal values and the distinction between personal values and professional values" (CSWE, 2015, p. 7). The findings suggest that social workers' values and attitudes must be examined to determine their acceptability in social work practice. The social work profession allows for diverse beliefs, but personal values cannot comprise the NASW's core ideology (Osteen, 2011). Personal values toward rational suicide or physical and psychological pain should not interfere with the mission and intent of the NASW values and ethics.

Implications for Social Work Education

The findings from this research study suggest several things for social work education. First, there is a need for suicide training in social work education. The percentage of social workers in this research study who responded they either had a client attempt suicide (75%), or a client die by suicide (38.5%) suggest a need to train social workers on suicide. Suicide education is minimal in social work programs (Almeida, et al., 2017; Ruth et al., 2012), and no study has examined rational suicide education in social work programs. This lack of formalized training may contribute to student social workers having anxiety about working with suicidal clients (Ruth et al., 2012). The findings from this research suggest there is a continued need to examine and advocate for suicide education in social work undergraduate and graduate programs.

Lastly, the findings suggest there is a continued need for clinical social workers to engage in on-going training and education on suicide and ethical decision-making. All 50 states require continuing education for social work licensure, but they differ in what constitutes required content area (Kurzman, 2016). Therefore, not all states require suicide education training or ethics as a requirement for social work licensure. The findings from this study suggest a uniform approach to continuing education for social work licensure to include suicide education, rational suicide, and ethics training.

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Appendix A: Survey Instrument

Section I: Attitude toward rational suicide.

Rational suicide is defined as the taking of one's own life based upon logical decision making and personal autonomy (Werth & Holdwick, 2000, p. 513).

1) An individual can make a rational decision to die by suicide.

- Strongly disagree
- Disagree
- Undecided
- Agree
- Strongly agree

Section II: Personal characteristics.

1) What state do you live?

- Arkansas
- Florida
- Nebraska
- New York
- Oregon
- Rhode Island
- Utah
- Wisconsin
- Wyoming
- Prefer not to answer

2) Gender

- Female
- Male
- Transgender female
- Transgender male
- Gender variant/non-conforming
- Not listed ______________________
- Prefer not to answer

3) Age

- 18-24 years old
- 25-34 years old
- 35-44 years old
- 45-54 years old
- 55-64 years old
- 65-74 years old
- 75 years or older
- Prefer not to answer

4) Years of Experience

- Less than 1 year
- 1-5 years
- 6-10 years
- 11-15 years
- 16-20 years
- 21-25 years
- 26-30 years
- 31-35 years
- 36-40 years
- More than 40 years
- Prefer not to answer

5) Race and Ethnicity (select all that above)

- Non-Hispanic White or Euro-American
- Black, Afro-Caribbean, or African American
- Latino or Hispanic American
- East Asian or Asian American
- South Asian or Indian American
- Middle Eastern or Arab American
- Native American or Alaskan Native
- Other ___________________________
- Prefer not to answer

6) Religious affiliation

- Buddhist
- Catholic
- Evangelical
- Protestant
- Hindu
- Jehovah's Witness
- Jewish
- Mormon
- Muslim
- Orthodox Christian
- Unaffiliated
- Other ________________________________
- Prefer not to answer

7) Current Practice Area (select all that apply)

- Children
- Gerontology
- Medical
- Mental health
- Child welfare
- Aging
- Addiction
- Intellectual disabilities
- Other _______________________________
- Prefer not to answer

Section III: Professional experiences.

1) Have you ever had a client attempt suicide?

- Yes
- No
- Prefer not to answer

2) Have you ever had a client die by suicide?
- Yes
- No
- Prefer not to answer

3) Have you ever had thoughts of suicide?
- Yes
- No
- Prefer not to answer

4) Have you ever had a friend, family member or loved one attempt suicide?
- Yes
- No
- Prefer not to answer

5) Have you ever had a friend, family member or loved one die by suicide?
- Yes
- No
- Prefer not to answer