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# Ethical Decision Making of Counseling Mental Health Practitioners Working With Clients Right-To-Die Issues

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Ethical Decision Making of Counseling Mental  
Health Practitioners Working With Clients Right-to-Die Issues

A Dissertation

Submitted to the Graduate Faculty of the  
University of New Orleans  
in partial fulfillment of the  
requirements for the degree of

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in  
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By  
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## Table of Contents

List of Tables .....	vii
Abstract .....	viii
Chapter I: Introduction.....	1
Background.....	1
Importance of the Study .....	2
Key Constructs and Theoretical Framework .....	3
Purpose of the Study .....	5
Overview of Methods .....	6
Research Questions .....	6
Limitations of the Study.....	7
Delimitations of the Study .....	7
Assumptions of the Study .....	7
Definition of Terms.....	8
Chapter II: Literature Review .....	12
Case Study .....	12
Introduction.....	13
Euthanasia and Suicide .....	13
Existentialism: Life and Death.....	16
Existential concerns .....	17
Existential Therapy .....	18
Religion and Spirituality: Suicide and Euthanasia.....	19
Ethical Guidelines: Suicide and Euthanasia .....	22
Medical ethics .....	22
Mental health ethics .....	24
Counseling ethics .....	26
Ethical decision making.....	29
Laws and Public Policy: Suicide and Euthanasia .....	31
Therapeutic concerns: Suicide and Euthanasia.....	35
Rational Suicide and Depression .....	35
Families and Cultures .....	36
Counseling Process .....	38
Summary .....	40
Chapter III: Methodology .....	42
Introduction.....	42
Purpose of the Study .....	42
Instrumentation .....	42
Demographics questionnaire.....	42
Attitudes toward euthanasia scale.....	43
Ethical decision making scale revised .....	45
Pilot Study.....	48
Participants.....	49
Data Collection Procedures.....	50
Methods of Analysis .....	51

Research question one.....	52
Data analysis .....	52
Research question two .....	52
Data analysis .....	52
Research question three .....	52
Data analysis .....	53
Research question four.....	53
Data analysis .....	53
Research question four (revised) .....	53
Data analysis .....	53
Chapter IV: Results.....	54
Frequencies and Descriptive Statistics.....	54
Attitude toward euthanasia scale (ATE) frequencies and descriptives.....	60
Ethical decision making scale –revised (EDMS-R) frequencies and descriptives .....	61
Results of Research Questions.....	62
Research question one.....	63
Data analysis .....	63
Research question two .....	65
Data analysis .....	65
Research question three .....	67
Data Analysis .....	67
Research question four.....	69
Data analysis .....	69
Research question four (revised) .....	69
Data analysis .....	69
Summary of the Findings.....	70
Chapter V: Discussion .....	71
Summary of Research Findings and Related Research .....	71
Counselors’ attitudes toward euthanasia and ethical decision making levels.....	71
Counselors’ demographics related to ATE and P index scores .....	73
Counselors’ religion.....	73
Counselors’ gender .....	75
Counselors’ years in practice .....	75
Counselors’ state of residence .....	77
Implications for Counselors.....	77
Implications for Counselor Educators .....	80
Future Research .....	81
Limitations .....	82
Conclusions.....	83
References.....	85
Appendix A: Demographics Questionnaire.....	92
Appendix B: Attitudes Toward Euthanasia (ATE).....	93
Appendix C: Letter of Consent to Use ATE.....	95
Appendix D: Ethical Decision Making Scale Revised (EDMS-R, 2 Dilemmas).....	96
Appendix E: Letter of Consent to Use EDMS-R.....	98
Appendix F: Participant Request Letter to Organizations: Pilot Study .....	99

Appendix G: Pilot Study: Agreement to Participate.....100  
Appendix H: IRB Approval.....102  
Appendix I: Participant Request Letter to Organizations.....103  
Appendix J: State Counseling Organizations Agreement for Participation .....104  
Appendix K: Blurb posted to Listserve/Informed Consent .....108  
Vita.....109

## List of Tables

Table 1	Frequencies of Age .....	55
Table 2	Frequencies of Ethnicity .....	56
Table 3	Frequencies of Gender .....	57
Table 4	Frequencies of State of Residence .....	57
Table 5	Frequencies of Educational and Professional Experience .....	59
Table 6	Frequencies of Religious Affiliation.....	60
Table 7	Descriptive Statistics ATE Scores .....	60
Table 8	Frequencies of ATE Overall Scores .....	61
Table 9	Descriptive Statistics for EDMS-R P Index and Level Scores .....	62
Table 10	Frequencies for EDMS-R P Index Scores .....	62
Table 11	Multiple Regression Analysis for ATE Overall Scores by 4 Predictor Variables .....	64
Table 12	Regression Correlation Analysis for ATE Overall Scores by 4 Predictor Variables .....	64
Table 13	Regression Coefficient for ATE Overall Scores by 4 Predictor Variables .....	64
Table 14	Regression Correlations for ATE Overall Scores by 4 Predictor Variables .....	65
Table 15	Multiple Regression Analysis for P Index Scores by 4 Predictor Variables .....	66
Table 16	Regression Correlation Analysis for P Index Scores by 4 Predictor Variables .....	66
Table 17	Regression Correlation Coefficients for P Index Scores by 4 Predictor Variables .....	67
Table 18	Regression Correlation for P Index Scores by 4 Predictor Variables.....	67
Table 19	Pearson Correlations for ATE Overall Scores by EDMS-R P Index Scores.....	68
Table 20	Pearson Correlations for ATE Active Subscale Scores by EDMS-R P Index Scores .....	68
Table 21	Pearson Correlation for ATE Passive Subscale Scores by EDMS-R P Index Scores.....	68
Table 22	Box's Test of Equality of Covariance for ATE Active and Passive Subscale Scores .....	69
Table 23	MANOVA for ATE Active and Passive Subscale Scores by Years in Practice.....	70

## **Abstract**

The purpose this study was to explore the relationship between counseling mental health practitioners' attitudes toward euthanasia and their ethical decision making levels when confronted with clients facing end-of-life concerns. A review of literature indicated a series of complex ethical, moral, and societal issues surrounding clients' right-to-die issues. Because of the lack of research in the counseling field and the growing prevalence of right-to-die issues with clients who have a diagnosis of a terminal illness, more research in the counseling field is needed (Hadjistavropoulos, 1996; Winograd, 2012). Participants for the present study were recruited from six state divisions of the American Counseling Association; Alabama, Louisiana, North Dakota, Maryland, Vermont, and Utah. Two multiple regressions were conducted in addition to one correlation and one MANOVA. One multiple regression was conducted using EDMS-R as the dependent variable and one multiple regression was conducted using ATE overall score as the dependent variable. The Independent variables used were years in practice, gender, state, and religion. The dependent variables used were participant EDMS-R score and participant ATE score. Variables were chosen to examine variability accounted for in ATE and EDMS-R participant scores. Findings from this small study indicated that counselors' years in practice, gender, state, and religion accounted for more of the variability in their beliefs about euthanasia (13.5) than their ethical decision making levels (2.7). Also, counselors' religion had the greatest effect on participants' ATE overall scores and on their EDMS-R P index scores. Counselors' ATE overall scores as well as their both active and passive scores were all shown to be correlated to their P index scores with their ATE active scores exhibiting the strongest correlation and their ATE passive score exhibiting the weakest correlation. Future research suggestions include assessing counselors' religion in more depth, and focusing on the other

demographic variables in the study, as well as conducting an initial qualitative study to provide insight from individual participants as opposed to assessing a large group of participants.

**Keywords:** ethics; counseling; ethical decision making; right-to-die; end-of-life

## **Chapter I**

### **Introduction**

Working with clients facing end-of-life concerns is an issue of increasing prevalence within therapeutic relationships. End-of-life concerns involve clients attempting to hasten death via means such as euthanasia and physician assisted suicide (PAS). Euthanasia, the act of taking one's life to relieve suffering, is a point of legal, ethical, and moral contention (Harris, 2001). Related to the legal, ethical, and moral contention is PAS, when physicians aid individuals with the information or the means to take their own life (American Medical Association, 2001b). When considering alternative end-of-life decisions such as means to a hastened death, individuals may be confronted by a variety of social taboos. In the past century, Americans have developed an aversion to death as noted by many cultural commentators. Societal and cultural constraints may complicate the decision making process for terminally ill individuals who want to end their lives (Hickman, 2002). In spite of these constraints, individuals facing a terminal illness cite a variety of reasons for requesting hastened death including "intolerable pain, mind altering side effects from medications, loss of bodily functions, loss of identity, desire for autonomous control, fears about future quality of life while dying, and negative past experiences with the dying process" (Kurt & Piazza, 2012, p. 90).

### **Background**

Dr. Jack Kevorkian, a prominent figure in the euthanasia debate, brought PAS to the mainstream media with his highly publicized trial in which he was accused of aiding in the deaths of over 100 of his patients (Nicol & Wylie, 2006). Hickman (2002) stated that "The American healthcare system is designed with a focus on preserving life, not accepting and facilitating the natural process of death" (p. 252). Only five of the 50 states in the United States

allow PAS. According to Kliff (2014), Oregon was the first state to make PAS legal via the *Oregon Death with Dignity Act* in 1994. Kurt and Piazza (2012) stated that Washington followed in 2008 with the *Washington Death with Dignity Act*. In 2009, the state of Montana followed via a decision by the State Supreme Court now referred to as the *Baxter* decision, as did New Mexico via a court of appeals ruling (Kliff, 2014). Currently, the legality of PAS in Montana is on shaky ground. In April, 2013, the Montana State Senate defeated *H.B. 505*, in a vote of 27 to 23, which required prison sentences for physicians participating in PAS (Span, 2013). Most recently in May, 2013, Vermont became the fourth state to legalize PAS when Governor Pete Shumlin signed the proposed bill for legalization of PAS ([www.rt.com](http://www.rt.com)).

### **Importance of Study**

Appreciation and need are growing for the therapist's role in working with clients facing death and end-of-life issues (Kurt & Piazza, 2012). Some advocates for the welfare of clients take a position that a therapist should be involved with clients who are facing end-of-life issues regardless of a physician referral because of the possible involvement of mental health issues (Kurt & Piazza, 2012). Even with an absence of mental health issues such as depression, clients with end-of-life concerns are faced with emotions that can include grief, guilt, fear, or anger. These emotions may be intertwined within the context of the numerous relationships in their lives. A therapeutic relationship can provide clients with the needed outlet for emotional expression and facilitate clients' self-expression and acceptance of their situation (Daneker, 2006).

## **Key Constructs and Theoretical Framework**

The conceptual framework for this study was based in existential psychology with a specific emphasis on the work of Irvin Yalom and his construct of death anxiety. People deal with the fear of death at a young age by coming to terms with their death awareness and resulting defenses. Irvin Yalom (2009) identified death anxiety as a universal phenomenon and described the ways death anxiety shapes a person's internal experience. Terminal illness directly challenges defense mechanisms that an individual has created (Yalom, 2009). Manis and Bodenhorn (2006) stated that "everyone, including counselors and clients, live along a continuum of death anxiety and death awareness" (p. 198).

Verbake and Jasper (2010) found differences in support of euthanasia that were tied to religion, with Protestants having a more favorable view than Catholics. They also found that individuals who live within a religious context (i.e., participates in religious ceremonies or is a religious person) are more strongly opposed to euthanasia. Within the mental health arena, PAS has been declared a mental health issue by an overwhelming number of psychological experts (Winograd, 2012). Therapists may have professional and personal viewpoints on this subject that are at odds with each other, placing their professional ethics and personal morals in conflict (Verges, 2010).

When reviewing the American Counseling Association (ACA) *Code of Ethics* (2014), Section B.2.b. includes the statement that "counselors...have the option to maintain confidentiality" (p. 7), such as when working with clients who are considering end-of-life issues. By reviewing this code, one may gain understanding of how counselors in their professional practice perceive euthanasia and right-to-die issues and the ethical principles to which they adhere when faced with clients presenting with right-to-die concerns. This section of the code

leaves to therapists the interpretation of what is best for a client; to report requests for euthanasia in the same manner one would report a suicide statement or continue to work with a client. This section of the code does reference seeking appropriate consultation and referencing state specific laws. At this juncture, therapists are faced with the juxtaposition of client autonomy versus beneficence (Kleespies, 2004). In addition to reviewing one's professional ethical code, professional and personal examination of how therapists make meaning of their life and death is important so that therapists do not interject their own belief systems into the therapeutic relationship (Manis & Bodenhorn, 2006).

An ethical decision making model is a helpful tool to navigate complex ethical decision making processes (Verges, 2010). A variety of options exist in the counseling field for ethical decision making models and it is important to choose a model befitting of the dilemma and the therapist involved with the dilemma (Kleespies, 2004). Van Hoose and Paradise (1979) theorized an orientation model of ethical decision making based on previous moral theories such as those of Kohlberg (Dufrene & Glossoff, 2004). Van Hoose and Paradise (1979) proposed five hierarchical levels of ethical decision making specifically for counseling mental health practitioners. The following five levels comprise their model: Level 1 (punishment), Level 2 (institutional), Level 3 (societal), Level 4 (individual), and Level 5 (principle). Each level refers to the way in which counseling mental health practitioners approach their professional decisions when dealing with ethical dilemmas. Level 1 implies that decision making is evaluated based on a punishment/reward system. Level 2 refers to decision making based on the function of an agency; counseling mental health professional will make decisions based on agency rules. At level 3, counseling mental health practitioners' decisions are based heavily in societal approval and the approval of others. At level 4, counseling mental health practitioners' decisions are

focused on the individual client while maintaining adherence to laws. At level 5, counseling mental health practitioners base their decisions on their own personal principles and conscience (Dufrene & Glossoff, 2004). This model of ethical decision making and the framework that it provides was the best fit for the current study.

A need for research is illustrated by Hadjistavropoulos's (1996) call for education and discussion concerning therapists' role in client end-of-life decisions in addition to clearer cut ethical guidelines on the topic. While the American Counseling Association (ACA), American Medical Association (AMA), American Psychological Association (APA), and National Association of Social Workers (NASW) have made steps toward ethical clarification regarding end-of-life issues, education is still of utmost importance. The majority of existing research pertains to physicians and nurses working with patients regarding to right-to-die issues, which disregards therapists. Almost 15 years after Hadjistavropoulos (1996) outlined the need for research related to psychological care of end-of-life clients in a therapeutic context, Winograd (2012) wrote a similar article delineating the need for education and clarification in the area of end-of-life decisions. It is not enough to add to ethical codes within professions; research is needed on clarification and application of issues surrounding end-of-life issues with clients to assure therapists that their decisions provide a standard quality of care.

### **Purpose of the Study**

Existential psychology was used as the conceptual framework for this study to better conceptualize concerns that affect counseling mental health practitioners' attitudes and ethical decision making process when working with clients facing end-of-life issues. The purpose of the present study was to explore the relationship between counseling mental health practitioners'

attitudes toward euthanasia and their ethical decision making levels when confronted with clients facing end-of-life concerns.

### **Overview of Methods**

The best fit design used to accomplish the purpose of the study was a quantitative design using a survey method. Participants were 116 members from eight state divisions of ACA (i.e., Alabama, Colorado, Louisiana, Maryland, Tennessee, North Dakota, Utah and Vermont). Participants were emailed a link to the survey that included the following instruments: (1) Demographic Questionnaire, (2) Ethical Decision Making Scale-Revised (Dufrene & Glossoff, 2004), and (3) Attitudes Toward Euthanasia (Wasserman, Clair, & Ritchey, 2005). Results of the survey were analyzed using the following research questions.

### **Research Questions**

Research questions were investigated:

1. What amount of variance do the four independent demographic variables contribute both individually and together to counseling mental health practitioners' attitudes toward euthanasia?
2. What amount of variance do the four independent demographic variables contribute both individually and together to counseling mental health practitioners' levels of ethical decision making?
3. Are there significant relationships between counseling mental health practitioners' attitude toward euthanasia and their levels of ethical decision making?
4. Are there group difference in counseling mental health practitioners' attitudes toward euthanasia for active euthanasia versus passive euthanasia across counseling mental health practitioners' gender (male versus female)? Because of the small number of male participants,

a multiple analysis of variance (MANOVA) was not conducted for research question four.

Research question four was revised: Are there group differences in counseling mental health practitioners' attitudes toward euthanasia for active euthanasia versus passive euthanasia across counseling mental health practitioners' years in experience in practice?

### **Limitations of the Study**

Limitations involved two major areas: self-report instruments and cross-sectional design. First, as Jobe (2003) reported regarding problems with self-reporting, participants in this study may not have reported accurately due to lack of understanding of self or lack of understanding of the questions and concepts included in the two instruments. Second, although research conducted by Dufrene and Glosoff (2004), Lambie Ivea, Mullen, & Hayes (2011), and Markve (2013) confirmed that the Ethical Decision Making Scale Revised (EDMS-R, Dufrene & Glosoff, 2004) has good validity using six dilemmas, only two of the six dilemmas were used in the present study. Using only two dilemmas could have compromised the results of the study. A third limitation related to the use of the instruments in this study is that this is the first time that the EDMS-R was administered online. A fourth area of limitation is related to the cross-sectional design. Data was collected at one point in time. Participants' opinions and responses could change over time due to various factors not measured in the study.

### **Delimitations of the Study**

This study was delimited to a sample of counseling mental health professionals (Licensed Professional Counselors, Counselor Interns, Students, and Other) who were active members in their state American Counseling Association divisions. Participating states included: Alabama, Louisiana, Maryland, North Dakota, North Dakota, Utah and Vermont.

## **Assumptions of the Study**

An assumption was that participants responded honestly regarding their beliefs about euthanasia and right-to-die issues when working with clients. It was also assumed that participants had an understanding of professional ethics and that they were a representative sample of counseling mental health practitioners who work with clients facing right-to-die issues.

Additional assumptions were made about the two instruments that were used in the present study. In the past, reliability and validity for the Ethical Decision Making Scale-Revised (EDMS-R) has been tested for the entire instrument (Dufrene, & Glossoff, 2004). However, in this study only two dilemmas from the EDMS-R were chosen, which were related to the present study: religious issue, possible euthanasia, diagnosis of acquired immune deficiency syndrome (AIDS), and transfer of a client. It was assumed that the two dilemmas measured the ethical decision making level of counseling mental health practitioners who work with clients experiencing end-of-life issues. For the second instrument used in this study, it was assumed that the Attitude Toward Euthanasia (ATE) scale (Wasserman et al., 2005) assessed participants' attitudes concerning euthanasia.

## **Definition of Terms**

**Active euthanasia** is the deliberate action to hasten a patient's death by a medical professional or lay person (Wasserman et al., 2005).

**Assisted suicide** is referred to as an act of assisting another in ending their life, contingent upon the latter individual wanting to do so; assistance typically comes in the form of equipment and/or drugs (Winograd, 2012)

**Death anxiety** is the fear of death (Yalom, 2009)

**End-of-life issues** is the management of the final stage of life to include the type of end-of-life care (i.e., palliative or curative), after the death and disposition of the body, memorial services and disposition of assets (Cavanaugh & Blanchard-Fields, 2010)

**Ethical dilemma** is a conflict in which choosing one moral imperative result in transgressing another, leaving a professional with two mutually exclusive choices (Winograd, 2012).

**Ethical orientation** is a model developed by Van Hoose and Paradise (1979), which includes five levels of ethical orientation on a continuum ranging from: 1) punishment, 2) institutional, 3) societal, 4) individual, and 5) principle. These levels influence the ways in which therapists make ethical decisions (Dufrene & Glosoff, 2004).

**Euthanasia** (Greek *eu*, goodly or well + *thanatos*, death) is “a deliberate intervention undertaken with the express intention of ending a life, to relieve intractable suffering” (Harris, 2001, p. 367)

**Existential psychology** is tasked with helping individuals resolve inner conflicts that arise from confrontation of one’s existence (Sharf, 2011).

**Hastened death** is a term used when an individual with a terminal illness makes a rational decision to take a self-directed action and choose when, within the final six months of life, death will occur (i.e., suicide/self-termination of life; Tucker, 2008).

**Hospice** or hospice-eligible is referred to when a patient receives a prognosis that the normal course of illness will terminate his or her life in six months or less. Care is provided in home and/or a hospice facility. Hospice care is based on the principles of palliative care (Despleder & Strickland, 2010).

**Individual orientation** is the fourth level of ethical orientation and is when an individual's decisions are made based on a client's needs while maintaining adherence to laws and avoiding transgressing the rights of other individuals (Dufrene & Glosoff, 2004).

**Institutional orientation** is the second level of ethical orientation and is when an individual's decisions are based on agency policies where one is employed (Dufrene & Glosoff, 2004).

**Morals** (n.d.) are defined as a person's personal standards of behaviors and/or beliefs about what is right and wrong (<http://dictionary.reference.com/browse/moral>).

**Palliative care** (n.d.) is care provided by a medical team with a focus on a relief from symptoms, pain, and stress with a goal of improving quality of life for the patient and loved ones. Care is focused on symptoms such as depression, pain, shortness of breath, fatigue, loss of appetite, and difficulty sleeping. Other components include close communication by helping individuals navigate the health system and providing guidance with complex treatment choices ([www.getpalliativecare.org/whatis](http://www.getpalliativecare.org/whatis)).

**Passive euthanasia** is the ending of life by deliberately withholding drugs or other life sustaining treatment (Wasserman et al., 2005).

**Physician assisted suicide (PAS)** is when a "physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" (see euthanasia; AMA, 2001).

**Principle orientation** is the fifth level of ethical orientation and is when an individual's decisions are based on principles chosen by oneself with adherence to personal ethics and conscious (Dufrene & Glosoff, 2004).

**Professional ethics** are a created universal set of standards and principles to guide a specific profession (Verges, 2010).

**Punishment orientation** is the first level of ethical orientation and is when an individual's decisions are based on adherence to rules and a belief of punishment based on good versus bad behavior (Dufrene & Glossoff, 2004).

**Religion** is an individual's beliefs, practices and behaviors that are expressed in an institutional setting or associated with a denominational affiliation, which includes attendance at a church, synagogue, or mosque; participation in public rituals; participation in public prayer; and publicly spreading religious scriptures (Richards, Hardman, & Berrett, 2005).

**Right-to-die** is defined as a person's determination that he or she, under certain circumstances, has the right to choose death (Despleder & Strickland, 2010).

**Societal orientation** is the third level of ethical orientation and is when an individual's decisions are based on approval of others and society, laws, and public opinion (Dufrene & Glossoff, 2004).

**Spirituality** is defined as "thoughts and feelings of enlightenment, vision and harmony with truth, transcendence, and oneness with God, nature or the universe" (Richards & Bergin, 2005, p. 22).

**Suicide** is an act of taking one's own life intentionally (Burgess & Hawthorne, 1998).

**Terminal illness** is a disease or illness which will terminate the course of an individual's life. Diseases such as cancer may be terminal for some but not others, according to what stage the disease is in and the physician prognosis (e.g., AIDS, cancer, heart disease, liver disease, Alzheimer's, and Parkinson's; Cavanaugh & Blanchard-Fields, 2010).

## **Chapter II**

### **Literature Review**

#### **Case Study**

Karen, a 65 year old Asian-American woman, dressed stylishly, enters a therapist's office for her first visit. She is handed a new client packet by the receptionist and as she sits down to fill out the form she begins to chat with the receptionist about her large number of grandchildren, the oldest of whom will be graduating college in six months. Karen walks back to the therapist's office, places her designer purse on the ground and perches gingerly on the couch still clutching her new client packet. The therapist apologizes for Karen's wait; Karen laughs nervously and states she has all the time in the world as she has just left her very high stress job, her husband is constantly away on business trips, and the majority of her children and grandchildren live in different states. The therapist begins to discuss the boundaries of a therapeutic relationship, including confidentiality and duty to warn. Karen listens attentively and begins to enlighten the therapist as to the reason for her visit.

Karen was diagnosed with stage 4 cancer with a poor prognosis; it was not caught until the later stages. She has been given six months or less to live by her physician and her physician has also reviewed her options with her and has recommended hospice/palliative care. Karen mentions that she moved here from another country when she was a child and her parent's culture honors dying with dignity. She states that, as she has gotten older she has become more traditional and has gone back to her parent's chosen religion, which is one that believes in reincarnation. Karen states, finally, that she has sought therapy to make peace with her life as she has decided to end her own life before the suffering from her disease becomes too great. She also states that the decision to end her life has been well thought out and her final estate planning

has been completed. She states that she is aware of the therapist duty to warn for suicide, as she has done her research. She feels her case is different, however, and acknowledges that a 72 hour suicide watch for her will do nothing other than cause unnecessary chaos within her family and cause her to go through with her end-of-life decision more quickly.

How many therapists have had a client similar to Karen enter their offices and been faced with the numerous ethical dilemmas this case presents? Therapists must be prepared for the reality that focusing on the needs of a dying client can change the therapeutic relationship and direction of counseling. More education is needed in this area as the population within the United States continues to age and life expectancy increases.

## **Introduction**

Therapists face a variety of ethical dilemmas; some of the most sensitive are those that can result in the termination of a client's life. In the traditional sense, most therapists consider this to include homicide and suicide. However, with the increased number of diagnosed terminal illnesses, the concept of euthanasia calls into question both the clients' and therapists' ethical and moral standards. Surrounding this topic the following areas will be discussed: euthanasia and suicide, existentialism, laws and public policy, therapeutic concerns, rational suicide and depression, families and cultures, and the counseling process.

## **Euthanasia and Suicide**

Euthanasia typically refers to "an easy and painless death," but in the medical field euthanasia means an "Act or method of causing death painlessly, so as to end suffering..." (Afzali, 2010, p. 83). Clients who request euthanasia are essentially requesting to end their lives. In the context of a terminal disease and counseling, when clients request to end their lives, the dynamics of the therapeutic relationship and the possible course of action therapists take may

change. Terminally ill patients may face depression, fear of physical pain or suffering, feelings of loss of control, lack of knowledge about care options, lack of communication with those around them, and lack of ability to express their wishes (Albright & Hazler, 1990; Dean, 1984). These concerns need to be assessed by therapists. Therapists also need to validate client fears and concerns and provide supportive mental health care (Albright & Hazler, 1990). Therapists should also determine at what point their supportive stance and assistance with client decision making becomes an encouragement to commit suicide (Hickman, 2002; Winograd, 2012). Providing emotional support for clients is essential for productive therapy; however, encouragement to end one's life raises more questions than answers (Dees, Vernooji-Dassen, Dekkers, & van Weel, 2010). Proponents of assisted suicide argue that "the most ethical psychotherapy treatment would focus on promoting clients' self-determination in end-of-life decision making, even if the resulting decision was to accelerate the death" (Winograd, 2012, p. 47). In contrast, opponents argue that the cessation of life for any reason other than natural causes is at odds with the concept of doing no harm and that all forms of requests for hastened death should be treated as suicidal intent (Winograd, 2012).

The ultimate controversy surrounding euthanasia, whether one is a physician, a therapist, or even a client, is the question of suicide. Suicide in most cultures and religions is considered wrong and a mortal sin (Afzali, 2010; British Broadcasting Company [BBC], 2009; Bleich, 2003). By 1963, only three states within the United States still considered suicide a crime and by 1990 only two states. Currently, suicide is not listed as a crime in 48 of the 50 states (Winograd, 2012). In comparison, euthanasia is legal only in four states (Werth & Richmond, 2008). Suicide as defined by Winograd (2012) is the act of taking one's life. In ancient literature and cultural practices, acts of suicide are described; for example, the Japanese ritual of hari-kari

which values death over dishonor and the importance of taking one's own life over living with disgrace (Burgess & Hawthorne, 1998). Alternate views of the practice of suicide also exist. Some argue that the ability to take one's life is an innate right of any human being.

The concept of rational suicide has been posed, although the definition of rationality is a constant source of debate. Dunning and Story (1991) reported that results of studies conducted on depression indicated that mildly depressed patients were more accurate and realistic in their worldviews than non-depressed patients. Illnesses such as cancer and Acquired Immune Deficiency Syndrome (AIDS) historically have been used in the argument for rational suicide (Winograd, 2012). Advocates for rational suicide often reference the painful and debilitating nature of diseases such as cancer that lead to death. According to Martin and Range (1991), debate exists that if death is inevitable due to such an illness, then individuals should be allowed to choose to end their lives before these inevitable symptoms and resulting pain occur. The antithesis to the argument for rational suicide is, of course, that it does not exist and anyone who is suicidal is mentally ill by definition (Burgess & Hawthorne, 1998). The movement for rational suicide has promoted a wider acceptance of the practice of euthanasia as reflected in the evolution of organizations such as the Hemlock Society and the Voluntary Euthanasia Society. Organizations such as these are designed to aid patients and their families in making end-of-life decisions by providing support and guidance (Martin & Range, 1991).

## **Existentialism: Life and Death**

Born from the tenets set out by existential philosophy, existentialism is tasked with helping individuals resolve inner conflicts that arise from confrontation of one's existence (Sharf, 2011). In the 19<sup>th</sup> century, philosophers such as Kierkegaard and Nietzsche popularized this style of thinking. Kierkegaard placed a heavy emphasis on individuals' desire to be eternal, whereas Nietzsche emphasized the importance of irrational aspects of human nature that should not be repressed. Authors such as Dostoyevsky and Camus brought these themes into their plays and novels (Sharf, 2011). Existential psychology places an emphasis on the importance of the past and the future with the goal of understanding self in the present. The goal of existential therapy is to "set clients free" (Schneider & Krug, 2010, p. 9). Freedom manifests itself as the ability to exercise choice within natural and self-imposed limits, which are set forth by society, such as language and cultural norms. All freedoms have inherent limitations. Making a choice for one option implies the giving up of the other option (Schneider & Krug, 2010). Natural limits are considered things over which one has no control; for example, death, age and birth.

In the case of clients choosing to end their lives, they are giving up life for the alternative; death. Clients seeking to end their lives push the natural limit of death as a constant and the social limit of culture, which include the set of social norms and mores that surround the concept of suicide. To an existential practitioner, death is a given (Schneider & Krug, 2010; Yalom, 2009). It is a natural limit that at some point will juxtapose itself to an individual's freedom. However, the added implications of ending one's life intentionally change the context in which death is viewed. From an existentialist's perspective, suicidal ideation is treated as a lack of balance in an individual's self-concept and can be alleviated through movement towards an authentic self (Sharf, 2011).

**Existential concerns.** Irvin Yalom (1980) described existential concerns by means of four givens of human existence: freedom, death, meaningless, and isolation. He believed that one confronts the quality and make -up of life through confrontation of these four givens. Each of the four givens arouses internal conflicts. Confrontation of death arouses urgency, intensity, and seriousness, whereas isolation arouses a confrontation with an individual's needs and their opposites. Solitude is confronted simultaneously with isolation. Life is comprised of one's relationship to these four givens. One's quality of life depends on the extent to which one is willing to explore, integrate and coexist with these givens and the internal conflicts that they arouse (Schneider & Krug, 2010).

Greening (1992) elaborated on Yalom's (1980) work when he suggested that paradoxical dialects exist for each of the givens. One is challenged to respond to each paradox in three ways: 1) overemphasis on the positive, 2) overemphasis on the negative, or 3) transcendence of the dialect. Clients in the process of wishing for or requesting help for their own death confront all four givens as they confront their mortality. Assuming terminal illness is the reason behind the decision to end one's life, an existential counselor helps clients navigate the meaning of their life; what life has meant in the past and what life means now. If clients are terminally ill, they are confronted with the loss of meaning in their life as they are no longer able to do for others or engage with others, which can result in a state of isolation. Clients can also be confronted with the loss of certain functional capacities (i.e., mental and physical). As a disease progresses, clients are inevitably in a position of relying on others for their basic needs and eventually lose all self-controlled freedoms resulting in death. They are left with the choice to end their life on their own terms or the prospect of uncertainty. Existentialists define that uncertainty as how and when the normal course of an illness will end one's life (Schneider & Krug, 2010).

**Existential therapy.** The task of an existential counselor is to view clients as holistic beings regarding their past/present and unconscious/conscious (Schneider & Krug, 2010). Typically, counselors working with clients presenting with end-of-life issues ask about a client's self-concept and where disease fits into a client's concept of self. If clients are depressed, counselors view clients as seeking to end their life due to a sense of meaninglessness. Conscious and unconscious thought processes are examined, such as fear of the course of an illness and/or fear of becoming a burden to others. Another concern viewed by existential therapists is clients' ability to accept responsibility for their role in their problems (Sharf, 2011). Therapists might consider if clients are taking ownership and responsibility for the decision to end their life, or are basing their decision on some great injustice (e.g., disease) that has been done to them. It is possible that clients' decisions could be a result of feelings of being let down by life or feeling let down by someone they perceived as their rescuer (e.g., physician/medical science). Feelings of being let down and a lack of perceived responsibility could lead clients to lash out in anger (Sharf, 2011). The ultimate concern for existential therapists is how clients cope with their awareness of life and living (Schneider & Krug, 2010).

When working with terminally ill clients, death anxiety is interwoven throughout therapeutic sessions. Yalom (2009) referred to death anxiety as "the mother of all religion" and he argued that "it is the most pervasive conflict or anxiety in life" (p. 5). Death anxiety is defined as fear of death and can manifest in many forms brought on by an event, such as being diagnosed with a terminal illness or a subconscious fear, such as getting a face lift for one's 60<sup>th</sup> birthday to combat the fear of getting older and nearer death (Yalom, 2009). For clients requesting assistance with a hastened death, existential therapists may review clients' request in terms of death anxiety by evaluating whether such a request is coming from a fear that has been

brought on by a recent event. Or, therapists can explore with clients their reactions and help clients make peace with their death anxiety as part of becoming a congruent self. An exploration of client perceived death anxiety and attaining peace would be accomplished through a process of evaluating clients' lived experience (Schneider & Krug, 2010).

If determined that a client's request for death is based in depression, existential counselors can aid the client in developing a congruent authentic self-concept in relation to the world. Existential therapists view clients as needing to accept responsibility for their circumstances and to exert freedom of choice within the context of limitations (Schneider & Krug, 2010; Yalom 2009). At this stage in therapy, clients forego thoughts of suicide for a more meaningful concept of life. Alternatively, if the right variables are present (i.e., terminal illness, appropriate legal backing, professional ethical guidelines, and absence of depression), therapists' attempts at aiding clients in developing an authentic self-concept could move clients closer towards their request for a hastened end-of-life. In such a scenario, a request for hastened death happens as a result of clients moving away from meaninglessness and isolation towards a congruent self-concept. The same responsibility and freedom of choice are present in this scenario; however, they are enacted in a different way (Scharf, 2011; Yalom, 1980). To facilitate clients becoming self-congruent in an existential context, therapists may incorporate the concept of death anxiety, a frequent concern of clients.

### **Religion and Spirituality: Suicide and Euthanasia**

Religious and existential concerns are linked, especially with regard to the concept of death anxiety and the preoccupation with what happens in the time after death (Yalom, 2009). Many religions claim that individuals have a soul and experience an afterlife; this is tied to the existential concern of death anxiety (Yalom, 2009). In many religious contexts, individuals'

good works and deeds are seen as a path to a better afterlife, whereas suicide is seen as going against the basic tenets of religious teachings (Afzali, 2010; BBC, 2009; Blicch, 2003).

Ingrained religious teachings and principles can weigh heavily on the minds of clients as well as clinicians when considering end-of-life decisions.

An overwhelming number of Americans claim a connection with some type of religion. Eight of ten Americans claim an allegiance to a specific religion and nine of ten Americans say they believe in God or a universal spirit. Over half of these individuals reported that they believe their religion is very important to them (Pew Forum, 2008). Americans also believe in a variety of religions, each with their own set of traditions and beliefs. In many settings, the terms religion and spirituality are used interchangeably and both have variations in their definitions according to where one places them on a continuum (Cornish, Wade, & Post, 2012).

Richards and Bergin (2005) defined spirituality as “thoughts and feelings of enlightenment, vision and harmony with truth, transcendence, and oneness with God, nature or the universe” (p. 22). Spirituality also can include personal experiences such as feeling compassion, hope, and love; feeling inspiration; being honest and congruent; and feeling a sense of meaning in life. Religion as defined by Richards et al. (2009) is individuals’ beliefs, practices and behaviors that are expressed in an institutional setting or ways individuals associate with a denominational affiliation. Practicing religion includes attendance at a church, synagogue, or mosque; participation in public rituals and prayers; and publicly spreading religious scriptures. Religion and spirituality fall along a continuum according to which practices and beliefs an individual prescribes. An individual may be both spiritual and religious falling along the previously mentioned continuum (Cornish et al., 2012; Richards & Bergin, 2005).

Currently, in most cultures suicide is seen as a moral disgrace and a mortal sin (Alfanzi, 2010; BBC, 2009; Bleich, 2003). In today's society, suicide typically is associated with the moral dilemmas of religious practice. Religious views of suicide currently overlap with religious views of euthanasia, creating what could be a very complex moral dilemma for terminally ill patients considering euthanasia (Alfanzi, 2010; BBC 2009; Bleich, 2003). In part, because euthanasia has yet to be distinguished from suicide, many traditional religious teachings are opposed to euthanasia. For instance, in Islamic ethics, based on the Muslim faith, dignity is a concept of utmost importance. Human dignity is akin to spiritual perfection, but may also be attributed to the physical body and as such, any act against one's physical body, including murder and suicide, is opposed to the concept of dignity (Afzali, 2010).

In the Muslim faith, euthanasia is considered suicide and Islamic law does not leave room for a bad act based on good intentions. According to Afzali (2010), euthanasia is considered out of step with religion and is looked upon in a negative light. Similarly, in many Christian sects, euthanasia is negatively perceived because human beings are valued, made in God's image, and all life should be given and taken away by God (BBC, 2009). Jewish doctrine stands against euthanasia, as it views euthanasia as suicide. Jewish tradition holds that life as well as death are both involuntary and both occur against one's will, therefore taking one's own life in any context would go against a basic religious principle (Bleich, 2003). Conversely, Buddhists hold a different view of euthanasia. The Dalai Lama, Tibetan head of state and spiritual leader, has been quoted in interviews as stating that he believes that while all life is precious, euthanasia should be judged on a case by case basis and is not always at odds with religious principles (Presse, 1996).

Therapists may work with clients who express entirely different definitions of spirituality from their therapists. Also, a discrepancy may exist between the religious beliefs of clients and therapists. It is easy to see why counselors must be very aware of value-based judgments and possible implications of imposing their own value set in counseling sessions when religion and/or spirituality is the topic (Cornish et al., 2012). The ACA *Code of Ethics* (2014) addresses religion in Standard C.5 which stipulates, “Counselors do not condone or engage in discrimination based on age, culture, disability, ethnicity, race, religion/spirituality, gender, gender identity, sexual orientation, marital status/partnership, language preference, socioeconomic status, or any basis proscribed by law.” Avoiding the topic of religion or spirituality entirely is done at the risk of negating a very large part of clients’ experiences or worldviews. Finding a proper balance is recommended when discussing religion and spirituality with clients (Cornish et al., 2012). Richards, Bartz, and O’Grady (2009) identified two levels of religious and spiritual integration appropriate for the counseling process, allowing counselors to address religion and spirituality in a manner in which counselors feel is appropriate. The two levels are based on counselor involvement and in their basic form are considered, to be involved and not involved. These interventions exist on a continuum of therapist and client involvement from less involved such as client filling out a questionnaire, to more involved such as open discussion in therapeutic sessions (Richards et al., 2009).

### **Ethical Guidelines: Suicide and Euthanasia**

**Medical ethics.** Professional concerns regarding ethics and legal repercussions are of great importance when considering client right-to-die issues. To gain a comprehensive picture about right-to-die issues; physicians and nurses historically are most closely associated with patients’ right-to-die issues (Cavanaugh & Blanchard-Fields, 2010). Physicians’ roles are

different than those of therapists. In addition to providing patients with terminal prognoses, physicians also have the capabilities to end patients' lives (Winograd, 2012). Physicians take the Hippocratic Oath, pledging to treat their patients ethically and to take every possible measure to do no harm (Cavanaugh & Blanchard-Fields, 2010). The American Medical Association (AMA) *Code of Medical Ethics* (2001a) addresses end-of-life care in *Opinion 2.037, Medical Futility in End of Life Care* in that if "prolonging patients' lives become futile, it is a physician's responsibility to move towards comfort measures for patients' end-of-life issues" (para 1). In the *Code of Medical Ethics*, a suggestion is provided that each medical institution adopt a medical futility policy that includes a seven-step decision making process, written by the AMA. However, AMA suggestions address comfort measures only, not requests to end life prematurely. In the AMA *Code of Medical Ethics, Opinion 2.211 – Physician Assisted Suicide (PAS)* is outlined including a definition for PAS; "physician facilitates a patient's death by providing the necessary means and/or information to enable the patient to perform the life-ending act" (para 1). *Opinion 2.21* – states that "permitting physicians to engage in euthanasia would ultimately cause more harm than good is fundamentally incompatible with the physician's role as healer, would be difficult or impossible to control, and would pose serious societal risks" (para 1).

A physician known for his controversial stance on end-of-life decisions; Dr. Jack Kevorkian, known as "Dr. Death," was sentenced to prison for 10 to 20 years. He served eight years on a second degree murder conviction for his claim that he assisted 130 patients by using PAS. Dr. Kevorkian's story illustrates the numerous professional repercussions that one must consider when working with patients who want to end their lives (Nicol & Wylie, 2006). Nurses are put in similar predicaments as physicians when reviewing ethical standards and end-of-life

decisions with patients, which can sometimes be complicated by the fact that nurses are the professionals on the frontlines carrying out physician orders. Ethical guidelines for nurses propose both care based and principle based approaches that appear to be at odds with each other (Hewitt & Edwards, 2006). Care based approaches are those that put patient care first and principle based approaches put professional ethical decision making first. The two approaches could result in different courses of action that rest heavily on patient autonomy. The overarching standard of any medical profession is to act in the best interest of patients, which can be translated to the counseling profession as well (Hewitt & Edwards, 2006).

**Mental health ethics.** Looking at other professionals' ethical codes in the mental health field can be helpful when considering ethical dilemmas. In the American Psychological Association (APA, 2002) *Ethics Code*, Principle A: Beneficence and Non-maleficence and Principle E: Respect for Peoples Rights and Dignity are relevant to the topic of end-of-life client concerns. Principle A enlists psychologists to “strive to benefit those with whom they work and take care to do no harm” (p. 3). APA's principles align with AMA's principles. Further, APA's (2002) Principle E prescribes respect to individual dignity and rights to confidentiality, privacy, and self-determination. Limits to confidentiality are provided in Standard 4.02, which states that psychologists should discuss with clients situations that might call for a breach of confidentiality and Standard 4.05, which reads that confidentiality should be breached when required by law and that when breaching confidentiality protection of clients or others from harm should be considered.

Psychologists trying to work within the framework of Principle A and Principle E may find themselves considering two alternate courses of action. Principle E explores the possibility of a psychologist engaging in a right-to-die conversation with a terminally ill client with respect

for client dignity, privacy and self-determination. Principle A explores the alternative, the psychologist's obligation to do no harm to the client (Winograd, 2012). Alternatively, could the client be harmed more by ignoring his or her request for death and insisting that the client live out the course of a disease? A psychologist asking this question treads dangerously into the territory of personal beliefs which also are outlined in Principle E, and should be omitted from clinical practice as much as possible (Winograd, 2012). In 2000, APA convened a working Group on Assisted Suicide and End-of-Life Decisions. This group issued a report offering two resolutions, one on end-of-life decisions and one on assisted suicide. In 2001, both of these resolutions were accepted by the APA Council of Representatives. Both resolutions acknowledged the important role psychologists play in client end-of-life decision making and asserted that psychologists could provide counseling and assessment, and were not required to prevent clients from following through when hastening their own death in the case of being terminally ill (Werth & Richmond, 2008).

The National Association for Social Workers (NASW) was the first association of mental health to address their role in hastened end-of-life decision making. In 1994, a statement was issued titled, "Client Self-Determination and End-of-Life Situations" (NASW, 2008). The statement's focus was that social workers could aid in client decisions for a hastened death in the case of a terminal illness. The NASW statement did not specifically outline whether breaking confidentiality was optional or required because in such situations clients were engaging in self harm (Werth & Richmond, 2008).

Similar to the APA *Code of Ethics*, issues relating to right-to-die clients are not specifically addressed in the ethics code for social workers. NASW's *Code of Ethics* has multiple sections applicable to the context of terminally ill clients. The Preamble (Workers,

2008) includes the goal of social workers is to “enhance human wellbeing and help meet the basic needs of all people...” (preamble). Additionally, the values of service, dignity and the worth of people and social justice are addressed in the NASW’s *Code of Ethics*; each value accompanied by an ethical principle. In *Code* (1.02), Self Determination states that, “Social workers respect and promote the right of clients to self-determination and assist clients in their efforts to identify and clarify their goals may limit clients’ right to self-determination when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others” (Workers, 2008, para. 1.02). *Code* (1.07), Privacy and Confidentiality, places restrictions similar to those of the APA and ACA requiring social workers to report, in certain instances including harm to self. NASW’s *Code of Ethics* (2008) does not provide further clarification when working with terminally ill clients and right-to-die issues.

**Counseling ethics.** The American Counseling Association (ACA) *Code of Ethics* (2014) addresses confidentiality and reporting in a fashion similar to APA and NASW codes. In ACA’s *Code of Ethics*, Standard B.2.a., Serious and Foreseeable Harm and Legal Requirements, “the general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm” (p. 7). The Danger and Legal Requirements section of the ACA *Code* can be directly related to a client’s decision to commit suicide. In the case of terminally ill clients, a few additional elements should be considered (Werth & Richards, 2008). Is it technically suicide if terminally ill clients do not take medications to prolong their life? What are the ethical implications if clients who have been given an agonizing three months to live decide it is better to die and plan to commit suicide (i.e., consider quality of life)? With regard to the last question, the

professional concepts of autonomy, non-maleficence and beneficence should be also reviewed. Counselors immediately reporting suicidal ideation in the context of end-of-life decision making could be directly opposing clients' autonomy and the ethical principles of beneficence and non-maleficence. In such cases, immediate reporting of suicidal ideation is not in the best interest of clients and may do more harm than good (Werth & Richmond, 2008).

Counselors are faced with the juxtaposed ethical principles of protecting clients from harm and encouraging client autonomy. Client autonomy is protected in ACA's *Code of Ethics* (2014) Standard A.1.a. Primary Responsibility, "the primary responsibility of counselors is to respect the dignity and promote the welfare of clients" (p. 4). Concerning end-of-life decisions, the Primary Responsibility Standard asserts that competent persons should have the right to make personal choices concerning right to refuse medication and other life sustaining issues (Kleespies, 2004). Alternatively, Standard B.2.a addresses counselors' responsibility to report to the proper authorities if clients are in danger of harm. The juxtaposition of the two standards (A.1a. and B.2.a.) creates an ethical dilemma for counselors. With such a dilemma, choosing one ethical standard transgresses another standard when viewing them in terms of clients who have expressed the need or desire for euthanasia to terminate their life, leaving counselors with two mutually exclusive choices (Winograd, 2012). In the most recent version of the *ACA Code of Ethics* (2014), standard B.2.a. now includes the statement, "Additional considerations apply when addressing end-of-life issues" (p. 7). While this statement brings to light a concern for end-of-life issues, it gives no alternate direction on how to the counselor should precede and decisions are still left to counselors best judgment. Here, clients' rights for autonomy are in contradiction with non-maleficence and beneficence. Kleespies (2004) suggested an alternate view of the conflict between autonomy and beneficence by viewing these as opposing concepts,

“beneficence provides the primary goal of healthcare, while autonomy places moral limits... on the professionals’ efforts to pursue this goal” (p. 30-31).

Also, when dealing with such a dilemma professional ethics and personal morals may conflict. At this juncture, it is important for counselors to review personal values (Albright & Hazler, 1990). Professional ethics are defined as a created universal set of standards and principles to guide a specific profession (Verges, 2010). Personal morals refer to a person’s personal standards of behavior and/or beliefs about what is right and wrong (<http://dictionary.reference.com/browse/moral>). Differentiating between ethics and morals is important when faced with parsing out the details of an ethical dilemma. In ACA’s *Code of Ethics*, Standard A.4.b. Personal Values states, “Counselors are aware of their own values, attitudes, beliefs, and behaviors and avoid imposing values that are inconsistent with counseling goals. Counselors respect the diversity of clients, trainees, and research participants” (p. 5). Counselors’ personal biases should be reviewed in the context of patients’ decision making. Werth and Richard (2008) questioned whether counselors’ perceptions of clients as hopeless is due to counselors’ personal biases.

ACA directly addresses clients’ right-to-die in the 2014 ethical standards. In the ACA (2014) *Code of Ethics*, Standard B.2.b. Confidentiality Regarding End-of-Life Decisions, “Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation after seeking consultation or supervision from the appropriate professional and legal parties” (p. 7). Standard I.1.addresses Standards and the Law. Standard I.1. provides information in the following areas: I.1.a Knowledge, I.1.b. Ethical Decision Making, and Standard I.1.c. Conflicts between Ethics and Laws. Section I.1.a.

provides information regarding counselor knowledge, “Counselors know and understand the *ACA Code of Ethics* and other applicable ethics codes from professional organizations or certification and licensure bodies of which they are members...(p.19).”Section I.1.b addresses ethical decision making, “When counselors are faced with an ethical dilemma, they use and document, as appropriate, an ethical decision making model that may include, but is not limited to, consultation; consideration of relevant ethical standards, principles, and laws; generation of potential courses of action; deliberation of risks and benefits; and selection of an objective decision based on the circumstances and welfare of all involved” (p. 19). Section I.1.c. provides information addressing the juxtaposition between law and professional ethics than can arise, “If ethical responsibilities conflict with the law, regulations, and/or other governing legal authority, counselors make known their commitment to the *ACA Code of Ethics* and take steps to resolve the conflict. If the conflict cannot be resolved using this approach, counselors, acting in the best interest of the client, may adhere to the requirements of the law, regulations, and/or other governing legal authority” (p. 19).

**Ethical decision making.** Determining the appropriate course of action to take is difficult when presented with an ethical dilemma. Choosing an ethical decision making model aids counselors in articulating the need for an ethical judgment to be made and later reaching a proactive decision in the appropriate context (Verges, 2010). A variety of ethical decision making models are available from which to choose. Verges (2010) proposed integrating contextual issues into the ethical decision making process. Focusing on the context allows counselors to make proactive decisions instead of reactive decisions. The right course of action is not necessarily determined by the final outcome, but more so by the steps that lead to the decision.

In the field of counseling, research has yielded predominant ethical decision making models from which to choose. The rational model focuses on principle ethics. An example of one such model was developed by Forester-Miller and Davis (1995), “A Practitioners Guide to Ethical Decision Making” used in conjunction with the *ACA Code of Ethics*. Forester-Miller and Davis’s model addresses the principles inherent in the counseling profession which include beneficence, autonomy, justice, fidelity, and non-maleficence. In their model, the five principles are seen as the absolute against which counselors can structure their decision making process and gain resolution. Models such as Forester-Miller and Davis are based on choosing one option over another through rational evaluation (Garcia, Cartwright, Winston, & Borzuchowska, 2003). Another type of model proposed is a virtue ethics model. Virtue ethics is defined as “who one is, what one ought to become, and what form of action will bring one from the present to the future” (Freeman, 2000, p. 90). Virtue ethics models are based on the virtue traits of counselors. Freeman (2000) stated that counselors using this model must discern what is perceived as virtuous and good before a decision about what is right can be reached. A third model developed by Cottone (2001) proposes a social constructivism perspective that blends the psychological with the sociological. Cottone’s (2001) model is based on the notion that decisions are influenced externally and are made based on interaction with others. A fourth model, collaborative, was proposed by Davis (1997). The collaborative model uses a relational approach based on cooperation and inclusion, using a four step process that ends in a decision mutually beneficial to all parties based on group goals and expectations. A fifth and feminist model of ethical decision making, based on the feminist principle of power equality between counselors and clients, takes into account the emotional–intuitive responses of both therapeutic parties. This model also takes into account the social context and assesses for details such as the

location of counselors and their values, beliefs, as well as factors such as gender, race and sexual proclivity of the involved parties (Hill, Glaser, & Harden, 1998).

Additionally, Van Hoose and Paradise (1979) proposed a framework for ethical decision making influenced by moral development. Within this framework, a professional decides whether or not an action is ethically wrong along a continuum of levels of ethical orientation consisting of the following five hierarchical levels: 1) punishment, 2) institutional, 3) societal, 4) individual, and 5) principle (Dufrene & Glosoff, 2004). Each level refers to the context in which individuals place their decision making abilities. Punishment orientation, the first level of ethical orientation, is when an individual's decisions are based on adherence to rules and a belief in punishment based on good versus bad behavior. Institutional orientation, the second level, is when an individual's decisions are based on agency policies where one is employed. Societal orientation, the third level, is when an individual's decisions are based on approval of others and society, laws, and public opinion. Individual orientation, the fourth level, is when an individual's decisions are made based on clients' needs while maintaining adherence to laws and avoiding transgressing the rights of other individuals. Finally, principle orientation is the fifth level and is when an individual's decisions are based on principles chosen by oneself with adherence to personal ethics and conscience (Dufrene & Glosoff, 2004).

### **Laws and Public Policy: Suicide and Euthanasia**

For counselors making ethical decisions it is important to review professional codes in addition to considering state laws and court cases regarding professional practice (Hadjistavropoulos, 1996). The legality of euthanasia is currently in the forefront of many legal debates; however, suicide is not listed as a crime in 48 of the 50 states in the U.S. (Winograd, 2012). The five states in which PAS is legal are Oregon, Washington, Montana, New Mexico,

and Vermont. PAS was made legal in Oregon via *The Oregon Death with Dignity Act* which was published in the Oregon Revised Statutes (1994). Washington then passed *The Washington Death with Dignity Act* in 2008 (Kurt & Piazza, 2012). Montana currently upholds the legality of PAS via the 2009 *Baxter v. Montana* court case ruling (Kurt & Piazza, 2012). Similar to Montana, in 2009, New Mexico via a court of appeals ruling now upholds the legality of PAS in that state (Kliff, 2014). Vermont, the most recent state to pass legislation regarding PAS, passed in bill *H.B. 505* in 2013 upholding the legality of PAS in that state (Kliff, 2014). Montana and New Mexico's policies are based on precedent set by specific cases whereas Oregon and Washington passed their laws through ballot referendums. Euthanasia is not considered a federal crime, but is regulated by individual state laws (Werth & Richmond, 2008). Vermont was the third (the other two being Oregon and Washington) state to pass a law permitting physicians to prescribe lethal doses of medication to the terminally ill who request such measures. Vermont was the first state to pass a euthanasia law through the state legislature. Their bill passed the house with a vote of 65 to 75 and was awaiting approval from Governor Pete Shumlin who signed it in April, 2013 ([www.rt.com](http://www.rt.com)). The Vermont law provides certain safeguards to prevent abuse, including the following: 1) a patient must make two verbal requests and one written request, 2) a patient must be deemed capable of decision making, and 3) a patient must be fully aware of all aspects of his or her diagnosis. In addition to these safeguards provided by Vermont, physicians are required to file extensive records on each case (Liptak, 2013).

In 1994, Oregon legalized PAS (Kliff, 2014). PAS in Oregon represents .12% of deaths annually (Dees et al., 2010). Winograd (2012) referenced *Gonzales v Oregon* 368 F. 3d 1118 from 2004 that affirmed *546 U.S. 243* in 2006, which upheld the guidelines for PAS as follows: 1) a physician must prescribe the medication; 2) the medication must be self-administered; 3) the

prognosis must be for a life span of six months or less; 4) the person must be a resident of Oregon; 5) a written request for prescription and two oral requests from the patient must occur; and 6) a written confirmation by a doctor that the act is voluntary and informed must be provided. The reason so few states allow PAS is because suicide is declared a mental health issue by an overwhelming number of psychological experts and euthanasia is still largely associated with suicide (Winograd, 2012). The lack of distinction between euthanasia and suicide creates a legal problem for mental health therapists as many lawsuits have been filed in the past for failure to prevent suicide (Winograd, 2012).

Baron et al. (1996) joined as a group from the fields of law, medicine, economics, and philosophy to propose a legal model to act and regulate PAS to be used in all 50 states. These researchers stated a need for the model because a significant but undocumented number of individuals commit suicide with the aid of a physician every year in states where PAS is not currently legal. Currently, physicians wishing to aid patients in end-of-life decisions risk legal prosecution for manslaughter, jail time, and loss of their medical license. The statute proposed by Baron et al. includes specific procedural requirements to provide physicians protection and prevent mistaken decisions. Proposed statutes for an overarching model to regulate euthanasia nationwide include: 1) the physician's assistance is limited to making the substance available, 2) the patient's illness is terminal and is causing intractable and unbearable suffering, and 3) the patient's decision to hasten death is due to an illness (Baron et al., 1996). Although some of these provisions are included in the laws passed by Montana, Washington, Vermont and Washington, many states chose to ignore these suggestions.

The issue of legality of PAS and euthanasia is a debate in most developed countries with aspects very similar to the debate in the United States. Australia allowed euthanasia briefly

under the *Rights of the Terminally Ill Act* in 1995, but later repealed the decision (Global Euthanasia Laws, 2011). Columbia now allows voluntary euthanasia after a 1997 Supreme Court case (Global Euthanasia Laws, 2011). Dees et al. (2010) stated that the United Kingdom, France, China, New Zealand and Luxembourg all have had important legal cases surrounding the legality of end-of-life decisions to include euthanasia and PAS and are all in different stages of the debate

The Netherlands and Switzerland have developed educational tools, standards, and protocols for end-of-life care. Also, the Netherlands developed suicide clinics, both mobile clinics and stationary facility clinics to aid patients in PAS and euthanasia. Although these clinics are still shrouded in controversy, their ethical standards are of interest to review. De Jong said, “The criteria are that there must be a reoccurring voluntary request. “There must be an unbearable and hopeless suffering, no alternatives anymore, and there must also be a second opinion doctor, who says yes, this doctor is fulfilling the criteria... and then the euthanasia or assisted suicide can be done” (as cited in Brumfield, 2012, para. 17). For consideration, The *Universal Declaration of Human Rights* (1947) published by the United Nations in *Article 22* states that “Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality” (para. 22). Personality development and dignity by extension could include the right-to-die with dignity as chosen by a specific individual.

In countries where PAS is legal, mental competency exams are used to determine the clients’ state of mind (Liptak, 2013). Mental competency exams are designed to test a patient’s

“ability to communicate choice, factual understanding of the issues, appreciation of one’s situation and consequence, and ability to rationally manipulate information” (Stewart, Peisah, & Draper, 2011, p. 35). These exams are used for a variety of medical procedures in the United States, have been adapted for use in various countries where assisted suicide is legal and are used in assisted suicide clinics. A survey of Oregon psychiatrists showed that 4% of psychiatrists were confident, 43% were somewhat confident, and 51% were not confident that they could determine if a patient’s request for assisted suicide was based on sound judgment or brought on by a preexisting mental disorder, such as depression, within the context of one evaluative session (Ganzini, Leong, Fenn, Silva & Weinstock, 2000). The lack of confidence evidenced by psychiatrists illuminates the need for general assessment tools and interventions that can be used when therapists are working with clients considering end-of-life decisions. If a mental health clinician is not confident of the rational reasoning of a patient to make an end-of-life decision then that could affect the patient’s quality and type of mental health care as well as weigh in on a clinician’s ethical decision making (Werth & Richmond, 2008).

### **Therapeutic Concerns: Suicide and Euthanasia**

Suicide has long been seen as a mental health issue linked by many professionals to depression as well as other mental health disorders. The emotional and mental state of terminally ill clients seeking counseling is of utmost concern to the therapeutic process. Symptomology of suicide includes feelings of hopelessness and despair, which are also associated by many with terminally ill patients (Winograd, 2012). However, some terminally ill patients are ready to make peace with their life narratives and are not hopeless.

**Rational suicide and depression.** Werth and Richards (2008) argued that rushing to the option of hospitalization for a terminally ill client discussing euthanasia, based on traditional

suicide protocol, would be based more on moral beliefs than ethical obligations and could damage the therapeutic relationship. In 1974, researchers using retrospective diagnosis (i.e., looking at patient records after death) found that in 93 out of 100 completed suicides, participants were suffering from mental illness, mainly depression (Barraclough, Bunch & Nelson, 1974). However, not all researchers agree that there is always a link between suicide and depression (Brietbart, 1990; Werth & Richmond, 2008). To look at one terminal illness specifically, Brietbart (1990) reported studies showed that 25% of cancer patients develop depression at some point in their illness; 6% of those meet the criteria for major depression. However, research also suggested that only 10% of terminally ill patients request a hastened end to life; meaning not all of those who are terminally ill and depressed seek to hasten death. Regarding rational suicide, Winograd (2012) questioned whether clients are of rational mind to make an end-of-life decision or whether the decision is being made by clients with an altered mental state caused by depression or other mental illness.

**Families and cultures.** Family dynamics and cultural concerns are also important when considering end-of-life care. When working with terminally ill clients, the family may be more involved in clients' care and decision making than is typical for other clients. Terminally ill clients may have concerns of being a prolonged burden to their family and may also experience difficulty separating their own concerns and wishes from those of concerned family members (Lapine et al., 2011). Prochard et al. (2001), in a review of the literature, found that previous studies suggested that as many as two thirds of family members visiting patients in hospital intensive care units suffer from symptoms of depression and/or anxiety. These symptoms most likely do not disappear when families are caring for terminally ill patients at home. In fact, symptoms may even be exacerbated due to stress of current care giving and pre-grief thoughts of

what the home will be like once terminally ill patients are gone. Family communication styles and preferences could affect therapists' confidentiality when family members approach them with concerns. It is important that therapists and clients thoroughly discuss confidentiality and disclosure as part of the therapeutic relationship, especially with regard to end-of-life concerns and client illnesses. In some cases, it may be beneficial for family members to attend therapy sessions; however, in other cases it may be counterproductive to client autonomy (Prochard et al., 2001).

Clients' culture and race also influence their decision making processes. Cultures can define how clients make meaning out of their illness and suffering (Kagawa-Singer & Blackhall, 2001). In the United States, the possibility of a cross-cultural misunderstanding is increased by the variety of cultures and races that make up the country. In many places, the formerly dominant European-American (White) culture is no longer a majority (Kagawa-Singer & Blackhall, 2001). Werth and Richmond (2008) cited potential challenges as being "the history of discrimination in this country, the lack of trust in the healthcare system, religious beliefs, and a focus on interpersonal relationships as opposed to independent decision making" (p. 198). Individuals from non-Western backgrounds may have a different approach when it comes to healthcare. Patients may request that their families are given their diagnosis and make their decisions for them. However, when family members receive such information in lieu of patients receiving the information to relieve the burden for dying clients, it also withholds important information from clients about their diagnosis and alleviates their ability of informed decision making. Cultures with a communal rather than individualistic background may also take a more active role in dying persons' care to the extent that families may stay in the hospital providing care and bringing food (Lapine et al., 2001). A history of discrimination and race relations also

effects patient decision making. In a study of elderly African Americans in North Carolina, researchers found that these patients were three times as likely as Whites to want more treatment. This statistic did not vary based on education level (Morrison, Zayas, Mulvihill, Baskin, & Meier, 1998). Results of a similar study found that 37% of African American patients requested CPR when terminally ill, as opposed to only 16% of White patients (McKinley, Garrett, Evans, & Danis, 1996). Results such as these have been attributed to overall mistrust of the healthcare system by African Americans and a belief that they were being treated differently (Kagawa-Singer & Blackhall, 2001).

Given that cures for life threatening diseases such as cancer, heart disease, Alzheimer's, Parkinson's or other diseases have not been discovered, it is likely that the number of clients who come to counseling to make peace with end-of-life decisions will increase. Statistics in 2000 showed an increase in elderly terminally ill individuals, with 12% of the population over the age of 65. Statistics showed a 10.2% increase from 1992 to 2002 with the elderly population increasing (Meyers, 2007). A 38% increase was seen in the 45 to 65 age bracket. As the baby boomer generation ages and reaches the 65+ bracket in the next decade more information is needed on working with an aging population who will experience a terminal illness (Myers, 2007).

**Counseling process.** When working with clients faced with end-of-life decisions, counselors should first assess and then treat depression if it exists before progressing to further treatment and counseling techniques (Albright & Hazler, 1990). Possible topics to consider when working with terminally ill clients who request hastened death are “within what personal, legal, religious, and moral framework does the client exist... what are the client's philosophic and religious beliefs that they use to make meaning out of life... what type of support system is

available to the client... how hopeless is the situation surrounding the illness... and is there a system of referral in place for the client should the counselor be unable or unwilling to handle the situation” (Albright & Hazler, 1990, p. 186).

After assessing clients’ mental status, determining what amount of information clients have been given regarding their terminal illness and possible alternatives for decision making is beneficial (Lapine et al., 2001). When looking at client end-of-life decisions it is important to consider the point of view of physicians because many end-of-life decisions are made with the aid of a multi-faceted healthcare team. Physicians’ point of view can greatly influence the level of knowledge clients have regarding their illness and their end-of-life decisions. Physicians’ personal preferences, perspectives on culture, perspectives on hospice care, and communication and training experiences are all factors that influence physicians’ communication with patients about end-of-life decisions (Yapp, 2012). Counselors may encounter clients seeking therapy for end-of-life decisions who already have personal biases or preconceived notions based on information received from physicians (Lapine et al., 2011).

Much research has been conducted on counseling terminally ill clients in regard to comfort measures at the end-of-life; however, little research has been conducted regarding therapeutic techniques used with clients choosing options such as euthanasia or PAS. Researchers who looked at short-term life review in terminally ill cancer patients found significantly greater improvement with regard to hopelessness and depression in those who engaged in short term life review compared with those who did not (Ando, Morita, Akechi, & Okamoto, 2010). One of the most prevalent therapeutic suggestions found in the literature is narrative therapy or life review. Narrative therapy provides clients with an outlet to review, examine and evaluate where they have been and where they want to go and possibly set future

short term goals that aid in coming to terms with their lives and impending deaths (Pickrel, 1989).

The ability to identify past achievements and positive events in life may aid in increased client self-esteem and self-awareness (Kalish, 1981). Counselors' use of interventions, such as narrative therapy, that focus on identifying past life achievements may be particularly helpful with aging individuals. Some suggested activities to use with clients include oral history, interview, family tree, autobiography, life line of significant events, and peaks and valleys of significant events both positive and negative (Pickrel, 1989). These activities allow clients to take advantage of both introspection and creative processes to not only review their lives but create their stories and possibly even rewrite and/or take ownership of some of the unpleasant pieces. Creating a narrative or life story can also be used with family activities. Activities such as looking at family pictures, corresponding with other family members, having family or friend reunions, or taking a pilgrimage back to a special place can be used. Questions that can be used while engaging clients in these activities are, "I always wanted to... or ... If I had three wishes..." (Pickrel, 1989, p. 131). Choosing therapeutic techniques to engage in when working with terminally ill clients is one of the most important steps of counselors' preparation (Albright & Hazler, 1995). The therapeutic challenge is to offer support and encouragement and at the same time allow clients the flexibility to be creative and move at their own pace (Dean, 1984).

### **Summary**

With the increased number of diagnosed terminal illnesses, euthanasia is an issue that will become more prevalent in health care. Concerns that can impact terminally ill patients include feelings of depression, fear of physical pain or suffering, feelings of loss of control, lack of knowledge about care options, lack of communication with others, and lack of ability to

express their wishes. Therapists play a role in assessing and aiding clients in working on their concerns and needs. Therapists must also take into consideration the ultimate controversy surrounding euthanasia: the question of suicide. Suicide in most cultures and religions is considered wrong and a mortal sin. Debate exists that if death is inevitable due to such an illness, then individuals should be allowed to choose to end their lives before these inevitable symptoms and resulting pain occur, through the use of rational suicide. The antithesis to the argument for rational suicide is, of course, that it does not exist and anyone who is suicidal is mentally ill by definition. As clients face the thought of ending their lives, they also face many existential concerns which can cause internal conflicts. Typically, counselors working with clients presenting with end-of-life issues ask what clients' self-concept is and where does disease fit into their concept of self. Professional ethical codes and state laws are two of the first to consider. If therapists choose to work with clients with end-of-life issues, euthanasia and other end-of-life concerns can arise including issues with family of origin, cultures and religion.

## **Chapter III**

### **Methodology**

#### **Introduction**

This chapter includes the purpose of the study, a description of the participants, and a description of the instruments used in the study: the Demographic Questionnaire, the Wasserman's Attitudes Toward Euthanasia Scale (ATE; Wasserman et al., 2005), and the Ethical Decision Making Scale-Revised (EDMS-R; Dufrene & Glosoff, 2004). A small pilot study that was conducted is described in the fourth section. The three final sections include the data collection procedures, methods for data analysis and research questions.

#### **Purpose of the Study**

The purpose of this study was to explore counseling mental health practitioners' attitudes toward euthanasia and their ethical decision making levels when confronted with clients facing end-of-life concerns. A review of literature indicated a series of complex ethical, moral, and societal issues surrounding clients' right-to-die issues. Inherent in therapists' decisions to work with clients who are faced with right-to-die issues are ethical and legal dilemmas and issues related to clients' cultures and families (Winograd, 2012). Because of the lack of research in the counseling field and the growing prevalence of right-to-die issues with clients who have a diagnosis of a terminal illness, more research in the counseling field is needed (Hadjistavropoulos, 1996; Winograd, 2012).

#### **Instrumentation**

**Demographic questionnaire.** Demographic information was obtained from participants via a self-report Demographic Questionnaire (see Appendix A). Of the eight questions included in the Demographic Questionnaire, questions 1 through 4 asked participants to provide their age,

race (i.e., Caucasian, African-American, Pacific Islander, Native American, Hispanic, Asian, and Other), gender (i.e., Male, Female), and state of residence. For question 5, participants were asked to indicate their professional license(s) which included: Licensed Professional Counselor (LPC), Counselor Intern, Student, Other. For question 6, participants were asked to indicate their highest level of schooling; bachelor's degree, master's degree, or doctoral degree.

For question 7A, participants were asked to indicate the number of years in professional practice (i.e., less than 6 months, 6 months to 1 year or 1 year through 15+ years). For question 7B, participants were asked to indicate their number of years in hospice work. For question 8, participants were asked to indicate their level of familiarity with their professional ethical code(s) using a Likert scale from 1 = *Not Very Well* to 5 = *Very Well*. For question 9, participants were asked to indicate their affiliation with the following: Christian, Buddhist, Hindu, Muslim, Jewish, Pagan, Spiritual, and Other.

**Attitudes toward euthanasia (ATE).** The ATE is a self-report measure of attitudes toward euthanasia (Wasserman et al., 2005; see Appendix B). The ATE consists of 10 items, each of which is ranked on a Likert scale (i.e., 1 = *Strongly Disagree*, 2 = *Disagree*, 3 = *Undecided*, 4 = *Agree*, and 5 = *Strongly Agree*). Within the 10 items, six concepts that include both passive and active means of euthanasia, severe pain, no recovery, autonomy, and doctor authority are measured. Each question measures either one or three of these concepts, with most of the items assessing at least three concepts. All questions except item 6 and item 9 assess for either agreement with active or passive euthanasia. Question 6 assesses for no recovery only and item 9 assesses for severe pain only. Every question, other than 6 and 9, assesses for three concepts which include either an active or passive euthanasia component. Questions 1, 4, 7, and 10 assess for agreement with passive euthanasia and questions 2, 5, 3, and 8 assess for active

euthanasia. Question 6 and 9 are reverse coded items to check for participant response set bias. For example, for question 1, “If a patient in severe pain requests it, a doctor should remove life support and allow the patient to die” includes the concepts of severe pain, patient request, and passive euthanasia. An overall score for the ATE is calculated by adding each participant Likert score for each item across all ten items, for an overall participant score ranging from 0 to 50. The ATE was pre-tested in two separate instances in several university introductory to sociology classes in the southeastern region of the United States ( $n = 47$ ,  $n = 176$ ; Wasserman et al., 2005). In the first pre-test, the internal consistency was .914 with item to scale correlations ranging from .578 to .821 ( $n = 47$ ). For the second pre-test, a Cronbach’s alpha of .87 with item to scale correlations ranging from .578 to .821 ( $n = 176$ ) was reported. The researchers believed the ATE indicated both reliability and validity based on their data. Aghababaei, Farahani, and Hatami (2011) used the ATE in their comparison using the Euthanasia Attitude scale (EAS) and obtained a Cronbach’s alpha of .90. When compared, the two scales demonstrated a 17.5% difference in mean scores for participants’ acceptance or opposition to euthanasia. Aghababaei, et al. (2011) proffered that the difference in participants’ scores on the two scales was due to the presence or absence of the word euthanasia. The ATE does not contain the word euthanasia, whereas the EAS does contain the word euthanasia. Aghababaei (2013) conducted further studies using the ATE at the University of Tehran and found no significant differences in participants’ attitudes toward active versus passive euthanasia. In the same study, the ATE correlated negatively with religiosity. Aghababaei and Wasserman (2013) conducted further research on the psychometric properties of the ATE, which showed high internal reliability and consistency, with a Cronbach’s alpha at .90. Descriptive statistics showed men were more supportive of euthanasia than women; however, further t tests showed the difference was not significant. Religiosity

variables were shown to significantly predict ATE in university students when controlling for other variables. For the present study, permission to use the ATE was obtained via email communication from Jason Wasserman (see Appendix C).

**Ethical decision making scale-revised.** The EMDS-R consists of six ethical dilemmas that assess an individual's ethical orientation level (Dufrene & Glosoff, 2004; see Appendix D). Each dilemma consists of three sections. Section A presents a varied number of courses of action related to each of the six dilemmas; participants choose an action. Section B includes 12 items that participants rate on a scale of 1 to 5 from *Very Important* to *Very Unimportant*. Section C asks participants to rank order the four most important items of the 12 items from section B from *Most Important* to *Least Important*. The item stems in each section are based on Van Hoose and Paradise's (1979) five hierarchal levels of ethical orientation in order of complexity as follows: punishment, institutional, societal, individual, and principle (Dufrene & Glosoff, 2004). Permission to use the EDMS-R was obtained via email communication from Dr. Roxane L. Dufrene (see Appendix E).

The first version of the EDMS was revised due to weakness in the construction of the scale. Dufrene (2000) reviewed the EDMS in three phases for validity and reliability. Initially, content and construct validity was established for the EDMS-R with a panel of expert judges. Next, a sample of 102 master's and doctoral students in various mental health fields was tested with the EDMS-R, with a retest in three weeks ( $r = .64$ ). Additionally, a second sample of 578 master's and doctoral level students was used to examine criterion validity (Dufrene & Glosoff, 2004). Spearman correlations were completed for each of the six dilemmas based on dilemma ratings and rankings. Consistency ratings and rankings for dilemmas 1, 2, 3, and 5 fell in the following ranges: Dilemma 1, .12 to .60; Dilemma 2, .05 to .48; Dilemma 3, .16 to .60, and

Dilemma 5, .17 to .52 (Dufrene & Glosoff, 2004). Cronbach's alpha was .90. A factor analysis indicated eight factors, with 28.4% explained total variance. Differences in ethical decision making levels were found for students' educational level (i.e., doctoral level, master's level pre-internship, and master's internship). Doctoral level students scored significantly higher in ethical decision making than master's pre-internship students as indicated by post hoc analysis (Dufrene & Glosoff, 2004).

Lambie et al. (2011) used the EDMS-R with a correlation study and found that the EDMS-R did not have a statistically significant relationship with age or gender for school counselors. They asserted that the EDMR-S is "the only instrument found that was designed to measure the ethical decision making of counseling professionals" (p. 236). Markve (2013) studied differences in rehabilitation counselors' ethical decision making. He stated, that "... the EDMS-R remains a useful tool for educators and researchers interested in ethical decision-making in counseling" (p. 103). Further analysis done by Markve (2013) suggested multiple items on the EDMS-R were valid for use in detecting differences, with regard to ethical decision making, in the population for his study.

Dufrene and Glosoff (2004) described the scoring system for the EDMS-R that included two types of scores; level scores (i.e., ethical orientation level) and principle scores (P index).

Each dilemma has four ranks equaling 10 points to distribute among the five orientation levels. The points for each dilemma were totaled across the six dilemmas for each of the five orientation levels, for a total of 60 points. For example, if a Level 3 (societal) item was ranked in the first place (4 points) and another Level 3 item was ranked in the fourth place (1 point) on the first dilemma, followed by a Level 3 item on the next dilemma that was ranked in the second place (3 points), then the Level 3 points would be  $4 + 1 + 3$ . If

no other Level 3 items were ranked at a Level 3 for any of the other dilemmas, a participant's Level 3 (societal) score would equal 8.

Next, a participant's P index score was calculated by summing the scores of Level 5 (principle) items across the six dilemmas and dividing by the base total of 60 points converted to a proportion (.60). Each dilemma has at least two principle items except for Dilemma 2, which has three principle items. There are 7 possible points (4 + 3) for principle items within each dilemma except for Dilemma 2, which has 9 possible points (4 + 3 + 2). There is a possible total of 44 points for principle items across the six dilemmas. Thus, P index scores range from 0 to 73 (i.e.,  $44/.60 = 73$ ). An example of a Level 5 (principle) score is as follows: If a Level 5 item was ranked in the first place (4 points) and another Level 5 item was ranked in the fourth place (1 point) on the first dilemma, followed by a Level 5 item on the next dilemma ranked in the first place (4 points) and another Level 5 item ranked in the third place (2 points) on the third dilemma, then the Level 5 points would be 4 + 1 + 4 + 2. If no other Level 5 items were ranked for any of the other dilemmas, a participant's Level 5 score would equal 11. The P index score would be 18.3 (i.e., Level 5 score;  $11/.60 = 18.3$ ). P index scores are interpreted as the degree to which a participant thinks principled considerations are important in making ethical decisions. P index scores are used to compare mean group differences (p. 5-6).

For the present study, two dilemmas (dilemmas 2 and 3) from the EDMS-R were used. Dilemma 2 is about a client's possible euthanasia, and dilemma 3 involves a client's diagnosis of AIDS and the possibility of suicide. Level scores and P index scores were totaled for each participant. Level scores are based on participant rankings of importance of items for each of the two dilemmas for a total of 20 possible points. For level score calculation, 4 points are assigned to

the most important item, 3 points are assigned to the second most important item, 2 points are assigned to the third most important item, and 1 point is assigned to the least important item. P index scores were totaled by finding the sum of each participant's level 5 score and dividing it by the base total for two dilemmas of 20 which was converted to .20. Dilemma 2 has three principle items for a total of 9 points and dilemma 3 has two principle items for a total of 7 points. The sum of principle items for both dilemmas total 16 points. Thus, P index scores can range from 0 to 80 (i.e.,  $16/.20 = 80$ ).

### **Pilot Study**

The proposed study was to include a participant sample from a national hospice corporation with offices in 30 states; however, the research request for the present study was not approved. Subsequently, state hospice associations in each of the 50 states were contacted individually by email to request participants (see Appendix F). Only four of the 50 state hospice associations (i.e., New York, Oregon, Texas and Iowa) agreed to individually send the research request to their members (see Appendix G). From those states, 13 participants responded and completed the survey instruments. These responses were used as a pilot study for feedback on the instruments. The largest percentage of demographics from the 13 participants included the following: 81% were White, 81% were females, 50% identified as Christian, 41% were from Texas, 90% had a master's degree, 40% had 11 to 15 years in experience, 50% had 2 to 5 years hospice experience, and 60% felt they were very familiar with their specific ethical codes. Participant results on the Attitudes Toward Euthanasia Scale (ATE) were overall *agree* or *strongly agree* with the perspective of ending life in times of the patient's consent and a patient experiencing severe pain. Participants *disagreed* when physician involvement is paramount as in instances where a physician makes the decision for a patient. When reviewing the results from

participant responses on the EDMS-R, participants responded that the concern that takes precedent was reporting to the proper authorities and consulting with colleagues in both the ethical dilemmas. Results from the pilot study did not indicate any changes that should be made to the survey.

Because of the very small number of responses from the four state hospice organizations, an alternate means of collecting a larger sample size was explored. The population was changed to counselors registered with the 50 state counseling associations. Based on this change, two questions were changed on the demographic questionnaire. Question 5 was changed to include only Licensed Professional Counselors, Counselor Interns, or Other. The verbiage for question 7B was changed to request specific experience with end-of-life concerns as opposed to hospice specific experience.

### **Participants**

A sample was obtained by requesting participation from each state American Counseling Association division. Of the 50 states, eight state associations agreed to send the survey to the members of their association: Alabama, Colorado, Louisiana, Maryland, North Dakota, Tennessee Utah, and Vermont. Of those eight states; participants were obtained from the following six: Alabama, Louisiana, Maryland, North Dakota, Utah, and Vermont. Participant criteria for inclusion were: Licensed Professional Counselor, Counselor Intern, and Other. The sample size was estimated using G\*Power, a statistical analysis program which estimates a sample needed based on type of statistical analysis used. Four methods of statistical analysis were used: descriptive statistics, correlation, multiple regression and a multiple analysis of variance (MANOVA). The determined sample size G\*Power for each of the statistical methods was  $N = 74$  for the correlation,  $N = 114$  for the multiple regression,  $N =$  for the MANOVA (Faul,

Erdfelder, Lang, & Buchner, 2007). Each sample size was calculated with a significance level of .05 and a confidence interval of .95. The total sample size collected was 180. Of those 180, the number that completed the entire survey was 116 participants for a 64.44% completion rate.

### **Data Collection Procedures**

The University of New Orleans (UNO) Internal Review Board (IRB) approval was obtained on April 22, 2014 for the present study (see Appendix H). Minimal risks were anticipated to participants. Participants who experienced unpleasant thoughts related to personal experiences with clients, family members, or loved ones who were terminally ill were advised to seek personal counseling. Informed consent was obtained from all participants. Participants' privacy and confidentiality were upheld according to current IRB standards.

The state counseling association for each of the 50 states was individually contacted via email (see Appendix I). Of the 50 states, eight state associations (i.e., Alabama, Colorado, Louisiana, Maryland, North Dakota, Tennessee, Utah, and Vermont) agreed to send a participant request to their members, yielding a 6.25% return rate ( $50/8 = 6.25$ ) (see Appendix J). An email blurb containing a brief description of the survey and a link to the survey was sent to each of the eight states to share the information with their members (see Appendix K). Of the eight states, five sent the research request via their listserv (i.e., Louisiana, Alabama, Tennessee, Utah, and Maryland). The remaining three states posted the request via the following methods: Vermont posted the request to a page on their organization's website, North Dakota posted the request in their online newsletter, and Colorado posted the request to their organization's LinkedIn (social media) page. Of those eight states; participants responded from the following six states: Alabama, Louisiana, Maryland, North Dakota, Utah, and Vermont. Informed consent was

gained from all participants via online contact and the voluntary nature of the study was stressed to all participants (see Appendix K).

### **Methods of Analysis**

The five independent variables in this study included age, gender, state of residence, number of years in practice, and religious and spiritual preference. Religion and spirituality have been noted as having an effect on individuals' views of euthanasia and can effect individuals' perceptions of suicide (Yalom, 2009; Winograd, 2012). Wasserman et al. (2005) found that individuals scoring high on spirituality tended to score low on support for euthanasia.

Two dependent variables was used to measure participants' scores on the ATE (Wasserman et al., 2005; see Appendix B) and on the EDMS-R (Dufrene & Glossoff, 2004; see Appendix D). The ATE has been used in multiple studies to assess attitude towards euthanasia (Wasserman et al., 2005; Aghababaei et al., 2011). The EDMS-R has been used to assess level of ethical orientation, which includes the following five levels: punishment, institutional, societal, individual, and principle.

Statistical analyses used to analyze the data included descriptive statistics, correlations, logistic regression and a multiple analysis of variance (MANOVA). Data were collected and coded into IBM SPSS Statistics version 19.0. Missing information and outliers were identified in the data set. Cases with any missing data were eliminated from data analysis; 64 cases contained missing data. To minimize the chance of Type I error, an alpha level of .05 was used for all analysis. A Levene's test of homogeneity of variance was performed for all variables a-priori for the MANOVA. The Levene's test was not significant, indicating no violation of the assumption of homogeneity of variance for all of the comparisons. Tests of Kurtosis were conducted for the dependent variables used in the multiple regression; ATE overall score (1.13),

ATE active score (-.51), ATE passive score (.41), and the P index (-.815). The participants' ATE active scores and P index scores had flatter distributions due to negative kurtosis statistic and the ATE overall score and ATE passive score had peaked distributions due to positive kurtosis.

## **Research Questions**

Four research questions were investigated:

**Research question one.** What amount of variance do the four independent demographic variables (i.e., gender, state of residence, number of years in practice, and religious affiliation) contribute both individually and together in counseling mental health practitioners' attitudes toward euthanasia as measured by the ATE?

**Data analysis.** A multiple regression analysis was used to measure the amount of variance of the four independent variables to counseling mental health practitioners' ATE scores.

**Research question two.** What amount of variance do the four independent demographic variables (i.e., gender, state of residence, number of years in practice, and religious affiliation) contribute both individually and together in counseling mental health practitioners' levels of ethical decision making as measured by the EDMS-R?

**Data analysis.** A multiple regression analysis was used to measure the amount of variance in the four independent variables to counseling mental health practitioners' ethical decision making levels.

**Research question three.** Are there significant relationships between counseling mental health practitioners' attitude toward euthanasia (ATE scores) and their ethical decision making level (EDMS-R P index scores)?

**Data analysis.** A Pearson's r correlation coefficient was used to measure the relationship of counseling mental health practitioners' attitude toward euthanasia (ATE scores) and their ethical decision making level (EDMS-R scores).

**Research question four.** Are there group differences in counseling mental health practitioners' attitudes toward euthanasia for active euthanasia versus passive euthanasia across counseling mental health practitioners' gender (male versus female)?

**Data analysis.** Because of the small number of males a multiple analysis of variance (MANOVA) was not conducted for research questions four.

**Research question four revised.** Are there group differences in mental health practitioners' attitudes toward euthanasia for active euthanasia versus passive euthanasia across counseling mental health practitioners' experience in years in practice?

**Data analysis.** A multiple analysis of variance (MANOVA) was used for counseling mental health practitioners' attitudes toward active euthanasia and passive euthanasia (ATE scores) and their years in practice.

## Chapter IV

### Results

The purpose this study was to explore the relationship between counseling mental health practitioners' attitudes toward euthanasia and their ethical decision making levels when confronted with clients facing end-of-life concerns. In this chapter, frequencies of participants' demographics are provided and descriptive statistics are delineated on the ATE and EDMS-R. Also, the results of the research questions are provided.

#### Frequencies and Descriptive Statistics

The 116 participants' ages ranged from 21 to 69, with an average age of approximately 43 years old ( $M = 42.64$ ,  $SD = 12.66$ ; see Table 1). The highest percentage of participants were 30, 32, 36, 39, and 43 ( $n = 6$ , 5.2 %) and the second highest percentage had ages of 29, 34, and 54 ( $n = 5$ , 4.3%). Ages 27, 31, 37, 40, 45, 56, 60, and 67 were reported by four participants each (3.4%). Age 61 was reported by three participants (2.9%). Ages of 23, 28, 33, 35, 38, 44, 48, 52, 57, and 63 were reported by two participants each (1.7%). Ages of 21, 24, 26, 42, 46, 49, 50, 51, 53, 55, 59, 62, 64, 65, 68, and 69 were reported by one participant each (0.9 %).

Table 1

*Frequencies of Age (N = 116)*

Age	<i>f</i>	%
21	1	.9
23	2	1.7
24	1	.9
26	1	.9
27	4	3.4
28	2	1.7
29	5	4.3
30	6	5.2
31	4	3.4
32	6	5.2
33	2	1.7
34	5	4.3
35	2	1.7
36	6	5.2
37	4	3.4
38	2	1.7
39	6	5.2
40	4	3.4
42	1	.9
43	6	5.2
44	2	1.7
45	4	3.4
46	1	.9
48	2	1.7
49	1	.9
50	1	.9
51	1	.9
52	2	1.7
53	1	.9
54	5	4.3
55	1	.9

56	4	3.4
57	2	1.7
59	1	.9
60	4	3.4
61	3	2.6
62	1	.9
63	2	1.7
64	1	.9
65	1	.9
67	4	3.4
68	1	.9
69	1	.9

The most prevalent race reported by participants was White ( $n = 83, 71.6\%$ , see Table 2). The second most common ethnicity was Black or African-American ( $n = 28, 24.1\%$ ), followed by Multiple Races ( $n = 4, 3.4\%$ ), followed by American Indian or Alaskan Native ( $n = 1, 0.9\%$ ), followed by Asian and Native Hawaiian or Pacific Islander ( $n = 0, 0.0\%$ ).

Table 2

*Frequencies of Ethnicity (N=116)*

Ethnicity	<i>f</i>	%
White	83	71.6
Black/African American	28	24.1
Multiple Races	4	3.4
American Indian /Alaskan Native	1	.9

A total of 101 participants (87.1%) were female and 15 were male (12.9%, see Table 3)

Table 3

*Frequencies of Gender (N=116)*

Gender	<i>f</i>	%
Male	15	12.9
Female	101	87.1

The most prevalent state of residence/practice reported by participants was Louisiana ( $n = 45, 38.8\%$ ; see Table 4). The second most prevalent state was Alabama ( $n = 33, 33 \%$ ), followed by Maryland ( $n = 24, 20.7 \%$ ), Vermont ( $n = 8, 6.9 \%$ ), Utah ( $n = 5, 4.3 \%$ ), and North Dakota ( $n = 1, .9\%$ ).

Table 4

*Frequencies of State of Residence (N=116)*

State of Residence	<i>f</i>	%
Utah	5	4.3
Louisiana	45	38.8
Maryland	24	20.7
Alabama	33	28.4
Vermont	8	6.9
North Dakota	1	.9

*Note:* States with no responses were not included.

The most prevalent level of education reported by participants was Master's degree ( $n = 82, 70.7\%$ ; see Table 5). The second most prevalent was Doctoral degree ( $n = 14, 12.1\%$ ), then Bachelor's degree ( $n = 11, 9.5\%$ ), and Other ( $n = 9, 7.8\%$ ).

The most prevalent license reported by participants was Licensed Professional Counselor ( $n = 77, 66.4\%$ ; see Table 5). The second most prevalent type of license held was student ( $n = 16, 13.8\%$ ), then Counselor Intern ( $n = 13, 11.2\%$ ), and Other ( $n = 10, 8.6\%$ ).

The most prevalent response by participants for years in practice was 2 to 5 years ( $n = 30, 25.9\%$ ; see Table 5). The second most prevalent years of practice was 15+ years ( $n = 23, 19.8\%$ ), then 11 to 15 years ( $n = 20, 17.2\%$ ), 6 to 10 years ( $n = 18, 15.5\%$ ), less than 6 months ( $n = 17, 14.7\%$ ), and 6 months to 1 year ( $n = 8, 6.9\%$ ).

The most prevalent number of years with specific end-of-life client experience by participants was less than 6 months ( $n = 70, 60.3\%$ ; see Table 5). The second most prevalent number of years reported was 2 to 5 years ( $n = 17, 14.7\%$ ), then 15+ years ( $n = 10, 8.6\%$ ), 6 months to 1 year ( $n = 9, 7.8\%$ ), 6 to 10 years ( $n = 5, 4.35\%$ ), and 11 years to 15 years ( $n = 5, 4.3\%$ ).

The most prevalent level of familiarity with professional ethical codes reported by participants was 4 ( $n = 48, 41.4\%$ ; see Table 5). The second most prevalent response was 5 ( $n = 33, 28.4\%$ ), then 1 and 2 ( $n = 8, 6.9\%$ ).

Table 5

*Frequencies of Educational and Professional Experience (N=116)*

	<i>f</i>	<i>%</i>
<b>Level of Education</b>		
Master's	82	70.7
Doctoral	14	12.1
Bachelor's	11	9.5
Other	9	7.8
<b>License Held</b>		
Licensed Professional Counselor	77	66.4
Student	16	13.8
Counselor Intern	13	11.2
Other	10	8.6
<b>Years in Practice</b>		
< 6 months	17	14.7
6 months to 1 year	8	6.9
2 to 5 years	30	25.9
6 to 10 years	18	15.5
11 to 15 years	20	17.2
> 15 years	23	19.8
<b>End-of-Life Experience</b>		
< 6 months	70	60.3
6 months to 1 year	9	7.8
2 to 5 years	17	14.7
6 to 10 years	5	4.3
11 to 15 years	5	4.3
> 15 years	10	8.6
<b>Familiarity with Professional Ethical Codes</b>		
1- <i>Not very familiar</i>	8	6.9
2	8	6.9
3	19	16.4
4	48	41.4
5 - <i>Very familiar</i>	33	28.4

The most prevalent religious affiliation reported by participants was Christian ( $n = 82$ , 70.7%; see Table 5). The second most prevalent reported religious affiliation was Spiritual ( $n = 16$ , 13.8%), then Buddhist ( $n = 11$ , 9.5%), Judaism ( $n = 4$ , 3.4%), and Other ( $n = 3$ , 2.6%).

Table 6

*Frequencies of Religious Affiliation (N=116)*

	<i>f</i>	<i>%</i>
Christian	82	70.7
Spiritual	16	13.8
Buddhist	11	9.5
Jewish	4	3.4
Other	3	2.6

**Attitudes Toward Euthanasia (ATE) Descriptives and Frequencies**

The mean score for participants' overall ATE scores was 30.74 and the standard deviation was 5.55 (see Table 7). For participants' ATE active subscale scores the mean scores were 11.46 and the standard deviation was 3.95. For participants' ATE passive subscale scores the mean was 13.10 and the standard deviation was 3.33. For overall ATE scores, the most prevalent was 32 ( $n = 15$ , 12.9%; see Table 8). The second most prevalent score was 30 ( $n = 11$ , 9.5%); then 28 and 34 ( $n = 10$ , 8.6%); 33 and 31 ( $n = 8$ , 6.9%); 27 ( $n = 6$ , 5.2%); 26, 29, 36, and 38 ( $n = 5$ , 4.3%), 25 ( $n = 4$ , 3.4%); 22 and 39 ( $n = 3$ , 2.6%); 18, 21, 23, 24, 37, and 42 ( $n = 2$ , 1.7%); and 15, 19, 35, 41, 44, and 50 ( $n = 1$ , 0.9%).

Table 7

*Descriptive Statistics ATE Scores (N=116)*

	Mean ( <i>SD</i> )
Overall Scores	30.74 (5.55)
Active Scores	11.46 (3.95)
Passive Scores	13.10 (3.33)

Table 8

*Frequencies of ATE Overall Scores (N=116)*

	<i>f</i>	<i>%</i>
15.00	1	.9
18.00	2	1.7
19.00	1	.9
21.00	2	1.7
22.00	3	2.6
23.00	2	1.7
24.00	2	1.7
25.00	4	3.4
26.00	5	4.3
27.00	6	5.2
28.00	10	8.6
29.00	5	4.3
30.00	11	9.5
31.00	8	6.9
32.00	15	12.9
33.00	8	6.9
34.00	10	8.6
35.00	1	.9
36.00	5	4.3
37.00	2	1.7
38.00	5	4.3
39.00	3	2.6
41.00	1	.9
42.00	2	1.7
44.00	1	.9
50.00	1	.9

**Ethical Decision Making Scale Revised (EDMS-R) Descriptives and Frequencies**

Participants' P index mean score was 21.81 and the standard deviation was 13.31 (see Table 9). Participants' mean score for Level 1 was 1.42 with a standard deviation of 2.04 (see

Table 9). The mean for Level 2 was 2.53 with a standard deviation of 2.93; the mean for Level 3 was 5.25 with a standard deviation of 5.00; the mean for Level 4 was 5.57 with a standard deviation of 2.87; and the mean for Level 5 was 4.36 with a standard deviation of 2.66. The most prevalent P index score was 15 ( $n = 20, 17.2\%$ ); 25 ( $n = 14, 12.1\%$ ); 20 and 5 ( $n = 13, 11.2\%$ ); 35 ( $n = 12, 10.3\%$ ); 10, 30, and 40; ( $n = 10, 8.6\%$ ); 0 ( $n = 7, 6.0\%$ ); 50 ( $n = 4, 3.4\%$ ); and 45 ( $n = 3, 2.6\%$ ; see Table 10).

Table 9

*Descriptive Statistics for EDMS-R P Index and Level Scores (N =116)*

	Mean (SD)
P index	21.81 (13.31)
Level 1	1.42 (2.04)
Level 2	2.53 (2.93)
Level 3	5.25 (5.00)
Level 4	5.57 (2.87)
Level 5	4.36 (2.66)

Table 10

*Frequencies for EDMS-R P Index Scores (N=116)*

	<i>f</i>	%
0.00	7	6.0
5.00	13	11.2
10.00	10	8.6
15.00	20	17.2
20.00	13	11.2
25.00	14	12.1
30.00	10	8.6
35.00	12	10.3
40.00	10	8.6
45.00	3	2.6
50.00	4	3.4

## Results of Research Questions

**Research question one.** What amount of variance do the four independent demographic variables (i.e., gender, state of residence, number of years in practice, and religious affiliation) contribute both individually and together in counseling mental health practitioners' attitudes toward euthanasia as measured by the ATE overall score?

**Data analysis.** A multiple regression analysis was conducted to examine the relationship between participants' overall scores on the ATE and the four potential predictors. The multiple regression model with all four predictors indicated  $R = .368$ ,  $R^2 = .135$  and a standard error of 5.25 with a significant relationship at .003 (see Tables 11 and 12). A strong positive correlation (.368) was found between the four variables and participants' ATE scores, with 13.5% of the variance explained. As indicated in Table 13; years in practice, religion, and gender had positive regression weights (i.e., .25, 1.90, 1.34, respectively) and a negative regression weight (-.81) was found for state. Of the four variables, religion was significant (.000); whereas gender (.39), state (.08), and years in practice (.42) were not significant (see Table 13). Overall, results indicated that when controlling for the other three variables, participants' gender accounted for more of the variance in participants' ATE overall scores. Similarly, participants' religion accounted for more of the variance in participants' ATE overall scores and was significant.

Pearson's correlations for ATE overall scores results indicated a weak negative relationship with gender (-.02); a negligible relationship with state (-.10); a weak positive relationship with years in practice (.06); and a strong positive relationship with religion (.33). Religion was the only variable that had a significant relationship (.000). Pearson's  $r$  (n.d.) interpretation statistics were based on the following indicators for the  $r$  value: " $r = +.70$  or higher - very strong positive relationship,  $+.40$  to  $+.69$  - strong positive relationship,  $+.30$  to  $+.39$  -

moderate positive relationship, +.20 to +.29 - weak positive relationship, +.01 to +.19 - no or negligible relationship, -.01 to -.19 - no or negligible relationship, -.20 to -.29 - weak negative relationship, -.30 to -.39 - moderate negative relationship, -.40 to -.69 - strong negative relationship, -.70 or higher - Very strong negative relationship”

(<http://faculty.quinnipiac.edu/libarts/polsci/Statistics.html>).

Table 11

*Multiple Regression Analysis for ATE Overall Scores by 4 Predictor Variables (N = 116)*

Model	R	R Square	Adjusted R Square	Standard Error of Estimate
1	.368 <sup>a</sup>	.135	.104	5.25452

Table 12

*Regression Correlation Analysis for ATE Overall Scores by 4 Predictor Variables (N = 116)*

	Sum of Squares	df	Mean Square	F	Significance
Regression	479.537	4	119.884	4.342	.003 <sup>b</sup>
Residual	3064.705	111	27.610		
Total	3544.241	115			

Table 13

*Regression Coefficients for ATE Overall Scores by 4 Predictor Variables (N = 116)*

Model	Unstandardized Coefficients		Standardized Coefficients		t	Significance
	B	Standard Error	Beta			
(Constant)	26.682	3.709			7.194	.000
Gender	1.336	1.546	.081		.864	.389
State	-.806	.459	-.160		-1.755	.082
Religion	1.900	.487	.358		3.900	.000*
Years in Practice	.253	.311	.076		.815	.417

$p < .01$

Table 14

*Pearson Correlations for ATE Overall Scores by 4 Predictor Variables (N = 116)*

	ATE Overall Score	State	Years in Practice	Religion	Gender
ATE Overall Score	1.000	-.101	.058	.325	-.023
State	-.101	1.000	.210	.127	-.033
Years in Practice	.058	.210	1.000	.101	-.248
Religion	.325	.127	.101	1.000	-.251
Gender	-.023	-.033	-.248	-.251	1.000
Significance (1-tailed)					
ATE Overall Score	.	.141	.267	.000	.405
State	.141	.	.012	.088	.364
Years in Practice	.267	.012	.	.141	.004
Religion	.000*	.088	.141	.	.003
Gender	.405	.364	.004	.003	.

$p < .01$

**Research question two.** What amount of variance do the four independent demographic variables (i.e., gender, state of residence, number of years in practice, and religious affiliation) contribute both individually and together in counseling mental health practitioners' levels of ethical decision making as measured by the EDMS-R (i.e., P index)?

**Data analysis.** A multiple regression analysis was conducted to examine the relationship between participants' P index scores on the EDMS-R and the four predictor variables. The multiple regression model with all four predictors (i.e., state, gender, religion, and years in practice) indicated  $R = .166$ ,  $R^2 = .027$ , and a standard error of 13.40, and no significance (.54, see Tables 15 and 16). A weak positive correlation (.17) was indicated between the four predictor variables and 2.7% of the variance is explained by the four independent variables. Years in practice (.86), religion (1.62), and gender (3.62) had positive regression weights, with no significance, and state had a negative weight (i.e., .28, .19, .36, -.18, respectively; see Table 17). Overall, results indicated that when controlling for the other three variables, participants'

gender accounted for more of the variance in participants' P index scores. However, the differences in relationship were minimal due to the fact that, combined, these four variables only accounted for 2.7% of variance in participants' P index scores.

Using Pearson's correlations, results indicated weak positive correlations for participants' P index scores for all four variables: gender = .03, years in practice = .01, state = .02, and religion = .11, with no significant results (i.e.,  $p = .36, .16, .41, .11$ , respectively; see Table 18).

Table 15

*Multiple Regression Analysis for P Index Scores by 4 Predictor Variables (N = 116)*

Model	R	R Square	Adjusted R Square	Standard Error of Estimate
1	.166 <sup>a</sup>	.027	-.008	13.35984

Table 16

*Regression Correlation Analysis for P index Scores by 4 Predictor Variables (N = 116)*

Model	Sum of Squares	df	Mean Square	F	Significance
Regression	557.945	4	139.486	.781	.540 <sup>b</sup>
Residual	19811.882	111	178.485		
Total	20369.828	115			

Table 17

*Regression Correlation Coefficients for P index scores by 4 Predictor Variables (N = 116)*

Model	Unstandardized Coefficients		Standardized Coefficients	t	Significance
	B	Standard Error	Beta		
(Constant)	9.794	9.430		1.039	.301
Religion	1.621	1.238	.128	1.309	.193
Gender	3.616	3.931	.092	.920	.360
Years in Practice	.860	.790	.108	1.089	.279
State	-.178	1.168	-.015	-.152	.879

Table 18

*Pearson Correlations for P Index Scores by 4 Predictor Variables (N = 116)*

	P Index Score	Religion	Gender	Years in Practice	State
P index Score	1.000	.113	.033	.095	.021
Religion	.113	1.000	-.251	.101	.127
Gender	.033	-.251	1.000	-.248	-.033
Years in Practice	.095	.101	-.248	1.000	.210
State	.021	.127	-.033	.210	1.000
Significance (1-tailed)					
P index Score	.	.113	.362	.156	.411
Religion	.113	.	.003	.141	.088
Gender	.362	.003	.	.004	.364
Years in Practice	.156	.141	.004	.	.012
State	.411	.088	.364	.012	.

**Research question three.** Are there significant relationships between counseling mental health practitioners' attitudes toward euthanasia (ATE overall scores, active scores, and passive scores) and their levels of ethical decision making (EDMS-R scores, P index Scores)?

**Data analysis.** Pearson correlations were conducted for participants' ATE scores and P index scores. A moderate significant positive correlation was indicated between participants' ATE overall scores and their P index scores ( $r = .352, p = .000$ ; see Table 19) based on the indicators for r values as noted previously

(<http://faculty.quinnipiac.edu/libarts/polsci/Statistics.html>). A strong positive significant relationship was indicated between participants' ATE active scores and their P index scores  $r = .413, p = .000$ ; see Table 20). A weak significant positive relationship was indicated between participants' ATE passive scores and their P index scores ( $r = .262, p = .004$ ; see Table 21).

Results indicated that participants who had high P index scores (i.e., ethical levels) had the strongest relationship with participants' high ATE active scores (i.e., agreed more strongly with the concept of active euthanasia than passive euthanasia), followed by participants with

high ATE overall scores, and participants with ATE passive scores (i.e., agreed more strongly with the concept of passive euthanasia).

Table 19

*Pearson Correlations for ATE Overall Scores and EDMS-R P Index Scores (N = 116)*

		P Index Scores
ATE Overall Score	Pearson Correlation	.352**
	Significance (2-tailed)	.000
	N	116

Table 20

*Pearson Correlations for ATE Active Subscale Scores by EDMS-R P Index Scores (N = 116)*

		P Index Scores
ATE Active Score	Pearson Correlation	.413**
	Significance (2-tailed)	.000
	N	116

Table 21

*Pearson Correlations for ATE Passive Scores and P Index Scores (N = 116)*

		P Index Score
ATE Passive Score	Pearson Correlation	.262**
	Significance (2-tailed)	.004
	N	116

**Research question four.** Are there group differences in counseling mental health practitioners' attitudes toward euthanasia for active euthanasia versus passive euthanasia across counseling mental health practitioners' experience in years in practice?

**Data analysis.** Because of the small number of male responses and the small number participants in each group of ethnicity, a multiple analysis of variance (MANOVA) was not conducted for research question four.

**Research question four revised.** Are there group differences in counseling mental health practitioners' attitudes toward euthanasia for active versus passive euthanasia across counseling mental health practitioners' experience in years in practice?

**Data analysis.** A Box's test of equality of variance yielded a non-significant result (.34), meeting the requirement to proceed with MANOVA analysis (see Table 22). Also, a Levene's test yielded a non-significant result for participants' ATE passive scores (.41) and ATE active scores (.19): indicating no violation of the assumption of homogeneity of variance. Because not enough participants' responses for each group of years in practice experience were indicated, the groups were collapsed into two groups; less than 6 months to 5 years in practice experience, and 6 years to 15+ years in practice experience. A Pillai's Trace indicated  $F = 1.35$  with a non-significance of .26 indicating no differences were found between participants' ATE active and passive scores for years in practice with a partial eta square of 2.3% and observed power at .29 (see Table 23). Pillai's Trace was used because it is the most robust to violations.

Table 22

*Box's Test of Equality of Covariance for ATE Active and Passive Scores (N = 116)*

Box's M	F	df1	df2	Significance
3.409	1.115	3	3592221.094	.342

Table 23

*MANOVA for ATE Active and Passive Scores by Years in Practice Experience (N = 116)*

		Value	F	df	Error df	Significance	Partial Eta Square	Power
Intercept	PT	.942	925.394 <sup>b</sup>	2.00	113.00	.000	.942	1.00
	WL	.058	925.394 <sup>b</sup>	2.00	113.00	.000	.942	1.00
	HT	16.379	925.394 <sup>b</sup>	2.00	113.00	.000	.942	1.00
	RLR	16.379	925.394 <sup>b</sup>	2.00	113.00	.000	.942	1.00
Years in Practice	PT	.023	1.353 <sup>b</sup>	2.00	113.00	.263	.023	.287
	WL	.977	1.353 <sup>b</sup>	2.00	113.00	.263	.023	.287
	HT	.024	1.353 <sup>b</sup>	2.00	113.00	.263	.023	.287
	RLR	.024	1.353 <sup>b</sup>	2.00	113.00	.263	.023	.287

*Note:* PT = Pillai's Trace, WL = Wilks' Lambda, HT = Hotelling's Trace, RLR = Roy's Largest Root

### Summary of Findings

This chapter provided the demographic descriptive statistics for the sample, who had a mean age of 42.64. The majority of participants were White females with a master's degree in counseling. Participants' years in practice varied; the top three groups were 2 to 5 years (25.9%), 15 + years (19.8%), and 6 to 10 years (15.5%). Gender, religion, years in practice and state were shown to be adequate predictors of participants' ATE scores; however, they accounted for only a small portion of variance in scores. All four variables accounted for more of the effect on participants' ATE scores (13.3%) than on their P index scores (2.7%). Of all of the variables, religion was shown to be of most significance for both ATE scores and P index scores. A moderate positive correlation was indicated between participants' ATE overall scores and P index scores. Also, participants' ATE active scores and P index scores had a strong positive correlation; this relationship had the most significance of any of the three measures of

participants' ATE scores related to their P index scores. ATE passive and P index scores had the weakest relationship of the three correlations.

## **Chapter V**

### **Discussion**

Minimal research has been done in the past 20 years concerning the area of end-of-life issues within the counseling profession. The present study assessed counseling mental health professionals' ethical levels using the EDMS-R as well as counselors' attitudes toward euthanasia using the ATE. Demographic factors that included state, number of years in practice, gender, and religious affiliation were analyzed for their influence on counselors' ethical decision making levels and attitudes toward euthanasia when working with clients who have end-of-life concerns.

In this chapter, results for the research questions are reviewed as they relate to previous research. Implications for counselors and counselor educators are also discussed. Additionally, limitations are outlined and conclusions are summarized.

#### **Summary of Research Findings and Related Research**

##### **Counselors' Attitudes Toward Euthanasia and Ethical Decision Making Levels**

The purpose of this study was to explore the relationship between counselors' attitudes toward euthanasia and their ethical decision making levels when confronted with clients facing end-of-life concerns. After the initial development of the ATE, Wasserman et al. (2005) suggested further research was needed to assess active and passive ATE scores. The authors suggested that research should focus on parsing out the differences between individuals' belief about passive euthanasia, which is the ending of a patient's life by deliberately withholding drugs or other life sustaining treatment and active euthanasia which is the deliberate action to hasten a patient's death by a medical professional or lay person (Wasserman et al., 2005). Wasserman et al. (2005) also stated that, "past research has failed to find empirical evidence for

the distinction between active and passive, our scale finds higher levels of support for passive euthanasia” (p. 236). In their study, they found that participants scored higher on passive ATE items than on active euthanasia items. In the present study, the assessment of active and passive ATE scores of counselors were analyzed in relation to their P index scores. Results indicated a strong positive correlation between counselors’ ATE active scores and P index scores. With counselors’ ATE passive scores and their P index scores a weak positive correlation was indicated, and with counselors’ ATE active scores and P index scores a strong positive correlation was indicated. Counselors’ mean active ATE score (11.46) was lower than their mean passive ATE score (13.10); which is in accordance with Wasserman et al.’s (2005) findings. These results suggest that counselors’ ethical decision making levels at Van Hoose and Paradise’s (1979) principle level were more accepting of active euthanasia than counselors who identified at the lower levels of ethical decision making (i.e., institutional or societal).

Additional findings in the present study indicated that counselors’ ATE overall scores and P index scores were moderately correlated in a positive direction. This suggests that as counselors’ level of ethical decision making increases toward the principle level their principles and personal ethics are in agreement with the concept of euthanasia, both active and passive. Wasserman et al. (2005) discussed the belief that much of past public opinion concerning physician assisted suicide has been based on its legality and policies determined by the American Medical Association (AMA). Using Van Hoose and Paradise’s (1979) model of levels of ethical orientation as a framework, physician assisted suicide which is derived from state laws and AMA policies suggest a societal level of ethical orientation in which an individual’s decisions are based on approval of others and society, laws, and public opinion. Results from the present

study supported counselors' higher level of ethical decision making was tied to agreement with euthanasia.

### **Counselors' Demographics Related to ATE and P index Scores**

Counselors' results for each of the ATE and P index scores were analyzed with the four independent variables (i.e., gender, religion, state of residence, and years in practice). Overall for all four variables, 13.5% of the variance was accounted for by counselors' ATE scores; whereas only 2.7% of the variance was accounted for by counselors' EDMS-R P index scores.

***Counselors' religion.*** Overall, in the present study the largest number of counselors identified as Christian (70.7%). Of the four variables studied, religion was shown to have more of a relationship with both counselors' ATE overall scores and P index scores. Religion was the only variable of the four previously mentioned variables (i.e., gender, religion, state, and years in practice) that had a predictive effect on counselors' ethical decision making levels. Counselors identifying as Christian had a less significant relationship to ATE overall and P index scores than counselors identifying with other religious categories such as Judaism, Other, and Spiritual.

An overwhelming portion of the American population currently claims some type of religion or spirituality; eight of ten Americans identify with some type of religious affiliation and nine of ten Americans say they believe in God or a universal spirit (Pew Forum, 2008). This is important to current research because a majority of religions contain ingrained religious teachings that describe suicide as a moral disgrace (Afzali, 2010; BBC, 2009; Blicch, 2003). In many religious contexts, individuals' good works and deeds are seen as a path to a better afterlife, whereas suicide is seen as going against the basic tenets of religious teaching (Afzali, 2010; BBC, 2009; Blicch, 2003). Although, according to Presse (1996), the Dalai said that while suicide is wrong, euthanasia should be judged on a case by case basis. Some would consider his

perspective as a liberal stance when compared to views from other religions' beliefs about euthanasia and suicide. The results of the present study, which indicated the importance that counselors give to religion, and knowing that most clients will come to therapy with a religious base, suggest that religion is something that should be addressed when working with clients who have end-of-life concerns.

Cornish et al (2012) suggested that counselors should attend to their own religion in an effort to combat personal biases or conflicts that may arise within counseling sessions with clients. The current study indicated that religion was a variable with the strongest relationship to both counselors' ATE overall scores and P index scores. This supports Cornish et al (2012) suggestion that attending to religion is important to all counselors within their scope of practice. Cornish et al. (2012) proposed that clients will come to therapy with various religious beliefs, which may be in discrepancy with the religious beliefs of therapists. The *ACA Code of Ethics* (2014) addresses religion in Standard C.5 which stipulates, "Counselors do not condone or engage in discrimination based on "... religion/spirituality ..." (para. C.5). Avoiding the topic of religion or spirituality is done at the risk of negating a very large part of clients' experiences or worldviews. Two levels of spiritual integration appropriate for the counseling process were recommended by Richards et al. (2009), which are based in counselor involvement: involved, and not involved, existing on a continuum of therapist and client engagement. Their perspective suggests that when counselors make ethical decisions while working with clients with end-of-life concerns, at least in regards to the present study, counselors should consider their own religious and spiritual beliefs as well as their clients' religious and spiritual beliefs.

***Counselors' gender.*** In the current study, the majority of participants were female counselors (87.1%). For the variable of gender, the predictive effect was minimal, when looking

at ATE overall scores, although limited counselors identifying as males had a stronger relationship to being more in agreement with a majority of the concepts associated with euthanasia (i.e., severe pain, active versus passive euthanasia, doctor involvement) than female counselors. Regarding ethical decision making levels, counselors' gender had minimal to no relationship to their highest ethical decision making level (i.e., P index scores). Similarly, in a study on ethical decision making with school counselors, Lambie et al. (2011) did not find a relationship between ethical decision making and gender of school counselors.

*Counselors' years in practice.* In the initial analysis using all levels of years in practice, counselors' years in practice varied across the levels, with the highest number of counselors reporting 15+ years in experience and the lowest number of counselors reporting 6 months to 1 year experience. Counselors identifying with having more years in practice showed a minimal relationship, between ATE overall scores and P index scores with no significance. After the initial analysis across all levels of years in practice, counselors' years in practice were analyzed with only two groups: less than 6 months to 5 years (combined 47.5%), and 6 years to 15 + years (52.5%). Albright and Hazler (1990) previously suggested that the longer therapists spend working with certain issues such as client fear of loss of control and/or fear of physical pain due to complications stemming from terminal illness, the more familiar and comfortable they become with addressing these issues in counseling sessions. In this study, no differences were found across the two groups of counselors' years in practice for their ATE active or passive scores.

When working with clients with end-of-life issues, client autonomy can be complicated when mental health practitioners make ethical decisions based on their professional ethics codes. According to Hewitt and Edwards (2006), the overarching standard of any medical profession is to act in the best interest of patients. Counseling mental health professionals working with

clients who have end-of-life concerns may be confronted with the question of whether a request for euthanasia is a statement of suicidal intent or is a request separate from the traditional professional regulations and reporting policies tied to suicidal ideation. Werth and Richmond (2008) referenced a belief that counselors immediately reporting suicidal ideation in the context of end-of-life decision making could be directly opposing clients' autonomy and the ethical principles of beneficence and non-maleficence.

The juxtaposed ethical principles of protecting clients from harm and encouraging client autonomy exist for counselors when confronting clients with end-of-life concerns. Client autonomy is protected in *ACA Code of Ethics* (2014) Standard A.1.a. Primary Responsibility. However, in Standard B.2. counselors have a responsibility to report to the proper authorities if clients are in danger of harm. Standard A.4.b. Personal Values addresses counselors maintaining awareness of personal values. Additionally, clients' right-to-die issues are addressed in the new 2014 Standard B.2.b. Confidentiality Regarding End-of-Life Decisions. Standard I.1., Standards and the Law, provides further information on legal requirements and ethical decision making. Consulting ethics codes is of paramount importance to all counseling mental health professionals regardless of years in practice. It is also important for counseling professionals to constantly check any updates or changes made to professional ethical codes as those may dictate certain decisions made within one's scope of practice. In the present study, counselors' years in practice did not have a significant relationship with ATE overall scores or P index scores, which possibly was indicated because of professional familiarity with ethics codes.

***Counselors' state of residence.*** In the present study, a majority of counselors came from the southeast region of the United States, with over half from Alabama and Louisiana. Counselors from North Dakota, Vermont and Alabama scores were less related to ATE overall

scores and P index scores than counselors' scores from Utah, Louisiana, and Maryland.

Counselors' state of residence did not have a significant relationship with either ATE overall scores or P index scores, with a negative weight in both cases.

Currently, euthanasia (to include PAS) is not considered a federal crime. However, it is regulated by individual state laws (Werth & Richmond, 2008). Vermont was the only state in the sample of this study to have a law related to physician assisted suicide. In 2013, Vermont passed bill *H.B. 505* to legalize PAS in that state (Kliff, 2014). Oregon, Washington, Montana and New Mexico are the other 4 of the 50 states where physician assisted suicide is legal ([www.rt.com](http://www.rt.com)). States that allow PAS have varying laws. An example of a state law is in Vermont where the law upholds the guidelines for PAS and provides the following safeguards to prevent abuse: 1) a patient must make two verbal requests and one written request, 2) a patient must be deemed capable of decision making, and 3) a patient must be fully aware of all aspects of his or her diagnosis (Kliff, 2014). Interestingly, in the current study, scores of counselors who were from Vermont were less related to P index score and ATE scores than counselors from states such as North Dakota and Maryland.

### **Implications for Counselors**

As previously discussed, the ACA (2014) *Code of Ethics* specifically addresses right-to-die issues in Standard B.2.b., Confidentiality Regarding End-of-Life Decisions. Reviewing the *Code of Ethics* as well as state laws and keeping abreast of changes is paramount for counselors. Also, specific to this study reviewing Standard B.2.a, Serious and Foreseeable Harm and Legal Requirements; and Standard A.1.a, Primary Responsibility would be of benefit to counselors. It is important for counselors to know the ethics code and how each standard relates, as Standard B.2.b. directly refers to confidentiality related to clients with end-of-life issues. Standard I.1

provides further guidance regarding Standards and the Law if counselors do not feel confident to make an informed decision on their own when working with clients with end-of-life concerns. Currently, the default decision per ACA's standards is to report a suicide if an informed decision is unattainable by a counseling professional.

Vermont (2013) was the most recent state to legalize PAS and Oregon was the first state to legalize PAS in 1998; three other states have some sort of policy or precedent in place legalizing PAS ([www.rt.com](http://www.rt.com)). In the future, other states could join these two states in changing laws. Constantly staying abreast of state laws and professional practices can be a benefit to counseling mental health professionals. Also, important for counselors is to have a clear understanding of the terminology related to end-of-life issues such as active and passive euthanasia and suicide. Counseling practices and procedures could drastically change and include all of the issues related to euthanasia and suicide depending on state laws at the time. Also, counseling mental health professionals could advocate to change laws in their individual state laws to broaden counselors' scope of practice when it comes to working with clients with end-of-life issues.

Having an ethical decision making model in place such as Van Hoose and Paradise (1979) or Forester-Miller and Davis (1995) is a step in the right direction. Choosing an ethical decision making model aids counselors in articulating the need for an ethical judgment to be made and later reaching a proactive decision in the appropriate context (Verges, 2010). All counseling mental health professionals need an ethical decision making model, but it becomes especially helpful when facing multifaceted situations such as end-of-life concerns that incorporate personal and professional layers of legal, ethical, religious, and moral complications. Ethical decision making models can aid counseling mental health professional in parsing out the

details of an ethical dilemma and coming to a professional decision with which they are comfortable with concerning end-of-life issues. Consulting an ethical decision making model such as Van Hoose and Paradise's may also aid counseling mental health professionals in becoming familiar with the level of professional ethical orientation that they function within (i.e., punishment or principle). This knowledge can be helpful to counselors when deciding whether or not to engage with clients or refer clients to other counselors who specialize in that practice area.

In alignment with keeping a close watch on professional ethics and knowing when to refer, becoming familiar with a process of assessment and treatment for end-of-life clients is needed and important (Albright & Hazler, 1990). Currently, 12.9%, or one in every eight Americans is over the age of 65 and individuals over the age of 65 have the highest prevalence of terminal illness (U.S. Department of Health and Human Services, 2015). These statistics suggest that the prevalence of counselors encountering a client facing end-of-life issues will only increase. Counselors should be aware of these statistics and seek the appropriate education to be able to effectively engage with and assess clients dealing with end-of-life concerns.

### **Implications for Counselor Educators**

Because there is so little research currently available concerning the topic of the present study, it is important for counseling students to be trained, or at least exposed, to end-of-life client issues and all of the related topics. This means that counselor educators should be knowledgeable in this area of study as well. Death and Dying courses are not currently required in CACREP (2009) standards for counselor training programs, but it could be beneficial for counselor educators to educate students about these client concerns in existing courses or have a specific course on death and dying.

Additionally, elderly and terminally ill populations can be subject to discrimination and stereotyping (U.S. Department of Health and Human Services, 2015). Also, clients' culture influences their decision making processes in many areas. As noted by Kagawa-Singer and Blackhall (2001), cultures can define how clients make meaning out of their illness and suffering. As such, education regarding these populations and the issues they face could possibly be incorporated into a multicultural counseling course. In addition to multicultural education, education pertaining to client religious preferences and attending to personal religion and how that affects professional practice is of benefit to counseling mental health professionals. In the current study, identifying as Buddhist did not demonstrate the strongest relationship to higher levels of counselors' ethical decision making although the Dalai Lama is the only religious leader to make a statement differentiating euthanasia as separate from suicide (Presse, 1996). Counselors' identifying as Jewish had the strongest relationship to ethical decision making at a principle level. When looking at these relationships of religion and ethical decision making, it stands to reason that religion should be strongly considered when considering training programs for mental health practitioners working with clients with end-of-life issues.

The Council for Accreditation of Counseling and Related Programs (CACREP, 2009) standards address several areas related to clients with end-of-life issues and related topics. Section II addresses Professional Identity, with Section II.2.a-f. specifically addressing social and cultural identity and a focus on advocacy, promoting understanding, and related theories. Section II.3. focuses on human growth and development with Section II.3.h. specifically focusing on lifespan development. These are two sections that are important to counselor competency training. These sections could be strengthened by adding an area on counselor training in end-of-life issues that clients are facing and the specific set of concerns associated

with their care. Section II.7. focuses on assessment. An assumption is often made that terminally ill individuals at the end-of-life are depressed; however, statistics show that only 10% of individuals at end-of-life request a hastened death (Winograd, 2012). Training counselors in assessment on how to work with end-of-life issues with clients who are terminally ill is important. Also, the need for an assessment tool that specifically addresses end-of-life concerns to distinguish depression, suicidal ideation, and request for PAS is evident.

### **Future Research**

This study leaves room for a variety of research studies to follow. Currently little to no research exists in the field of counseling on end-of-life issues when counselors work with clients. A need for research in this field was expressed by Hadjistavropoulos in a 1996 article and followed up more recently by Werth and Richmond in 2008. Given that a large sample size was difficult to obtain in the present study, it is suggested that future research be qualitative and focus on specific individual perspectives. A phenomenological qualitative study that focuses on the individual counselor's perspective who works with clients who are experiencing end-of-life issues would be useful in further research, and could provide in-depth thoughts and perceptions regarding how it is to work in the field.

When the research in the counseling field grows and more information is available on counselors' beliefs about euthanasia, further quantitative studies would be beneficial. If possible, obtaining a larger representative sample from each of the 50 states would provide a clearer picture of counselors' perspectives regarding euthanasia and how counselors are practicing with clients. This would also possibly provide a stronger link with the demographics (e.g., religion, state, and gender) that play a role in counselors' decision making when working

with clients, as this current study found a weak positive correlation with the demographics analyzed.

In addition, research specific to states with Death with Dignity Acts in place would provide insight into protocols as well as differences in state laws and ethics. For example, Oregon's website provides samples of paperwork and protocols (Oregon Health Authority, 2015). Several demographics in the present study showed a correlation with ATE and EDMS-R scores; thus, further research could be conducted using other demographic data such as religion and correlate those demographics to participants' ATE and EDMS-R scores. A final suggested area of future research would be a multicultural look at practices within the United States and countries abroad where set protocols are established and facilities have been designated for individuals to be assessed and complete the process of euthanasia (Liptak, 2013).

### **Limitations**

This study had a number of possible limitations, most of which were related to data collection. The initial sample group Gentiva Hospice declined to participate before the study began. The second proposed sample group consisted of individual state hospice and palliative care associations from the 50 states. A minimal number of these organizations replied to the initial inquiry and after months only 13 participants were obtained, which was used as a pilot study. The final data for the study were collected from a third attempt in which state ACA organizations from all 50 states were contacted. The entire process took eight months and overall 112 individual organizations were contacted. The sample used in this research was obtained by contacting each of the 50 states' individual state ACA organizations. Eight state organizations responded in the affirmative.

Limitations were also related to self-reporting. It is possible that participants may not have responded accurately due to lack of understanding of self or lack of understanding of the questions and concepts included in the two instruments used in the present study (Jobe, 2003).

Several limitations were related to the use of the EDMS-R in new ways. Results obtained in this study were derived from the use of only two of the six original EDMS-R dilemmas. Research conducted by Dufrene and Glosoff (2004), Lambie et al. (2011), and Markve (2013) all confirmed that the EDMS-R has good validity using six dilemmas; however, the use of two dilemmas has not been validated. Also, this was the first time that the EDMS-R was administered online as opposed to in person. A final limitation was the cross-sectional design of the study. Data collected were at one point in time. Participants' opinions and responses could change over time due to various factors not measured in the current study.

### **Conclusions**

Results of the present study support the conclusion that further research needs to be conducted in the area of professional counseling competencies regarding client end-of-life issues. Results also support a link between counselors' identified religion and level of ethical decision making as well as their attitudes toward the concept of euthanasia. Religion had the strongest significance for both counselors' attitudes toward euthanasia and their ethical decision making levels. Overall, all four variables analyzed (i.e., religion, years in practice, state, and gender) were shown to be stronger predictors of counselors' attitudes toward euthanasia than their ethical decision making levels, suggesting a stronger link with these four variables to counselors' attitudes toward euthanasia than their ethical decision making levels. Additionally, counselors who scored higher on their agreement with the concepts of active euthanasia had the highest correlation to counselors' ethical decision making levels.

The present study highlights several important areas for counselors and counselor educators to consider when working with clients with end-of life issues. This study also draws attention to a need for increased research and a focus on ethical decision making models for therapists in this specific area of client care. Currently, the media is bringing cases such as Brittney Maynard to light in which individuals are seeking out states such as Oregon so that they can take control of their terminal illness and end their lives in a way they feel is acceptable (Kliff, 2014). Instances such as this, and the media's attention, highlight the need for future research in this area.

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## Appendix A

### Demographic Questionnaire

Please respond to each of the following items:

1. Age: [Drop down tab for every state]
2. Race: African-American  
Asian  
Caucasian  
Hispanic  
Native American  
Pacific Islander  
Other
3. Gender: Male  
Female
4. State of Residence: [Drop down tab for every state]
5. Indicate your license(s): Counselor Intern  
Licensed Professional Counselor (LPC)  
Student  
Other
6. Indicate your highest level of education: Bachelor's degree  
Master's degree  
Doctoral degree
7. A. Years in Practice [Drop down tab for every year starting at less than 6 months, 6 months to 1 year and 1 year through 15+ years]  
  
B. Indicate your experience with working with clients facing end of life issues. [Drop down menu in years]
8. Indicate your level of familiarity with your professional ethical code(s) using the Likert scale provided.  
  

<i>Not Very Well</i>					<i>Very Well</i>
1	2	3	4	5	
9. Indicate your affiliation with any of the below listed items: Buddhist  
Christian  
Hindu  
Islam  
Judaism  
Pagan  
Spiritual  
Other \_\_\_\_\_

## Appendix B

### Attitude Toward Euthanasia (ATE)

For the items listed below, please indicate the degree to which you agree or disagree with the statement ranging from: 1) *Strongly Disagree* to 5) *Strongly Agree*.

SP = severe pain, NR = no recovery, PR = patient requests, DA = doctor's authority, ACTIVE = active euthanasia, PASSIVE = passive euthanasia.

**b** Indicates items that need to be reverse coded.

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

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

<i>Strongly Disagree</i>	<i>Disagree</i>	<i>Undecided</i>	<i>Agree</i>	<i>Strongly Agree</i>
1	2	3	4	5

## Appendix C

### Letter of Consent to Use ATE

**Source: Gmail communication**  
**Attitude Toward Euthanasia (ATE)**

Inbox x



Jason Wasserman<fleshban@gmail.com> Jul 12

to me

Sure. Feel free. There has been additional validation work done on it in a cross-cultural sense by an Iranian academic named Naser Aghababaei. He explored the factor structure of our ATE scale and the EAS scale by Tordella and Neutens (1978). You may want to look at that one too since Naser's work suggests that both are useful in different contexts.

Jason Adam Wasserman  
Department of Bioethics  
Kansas City University of Medicine and Biosciences

[\(816\) 654-7235](tel:(816)654-7235)  
[jwasserman@kcumb.edu](mailto:jwasserman@kcumb.edu)

**Appendix D**

**EDMS-R Dilemma 2**

*Pat has been working with an elderly man who is very sick. His doctors all agree he has very little time left to live. He is in terrible pain. The client tells Pat that he cannot afford to continue to pay his healthcare bills. He admits that he is planning to commit suicide, and explains exactly how he intends to do it. He has even discussed the plan with his wife. He has given up hope, and finds no purpose in continuing to live.*

**A.** What should Pat do? Select one response.

- 1. Respect the man's confidentiality.
- 2. Report to the appropriate authorities.
- 3. Speak with the wife.
- 4. Hospitalize the man immediately as suicidal.
- 5. Help the man with financial burden (insurance/ social service).
- 6. Consult with colleague(s).
- 7. Cannot determine.

**B.** Based on the following scale, please rate the importance of each issue in making your decision. Remember, for this section you may rate more than one item at a specific level of importance.

<i>Very Important</i>	<i>Important</i>	<i>Somewhat Important</i>	<i>Unimportant</i>	<i>Very</i>
<i>Unimportant</i>				
1	2	3	4	5

1 2 3 4 5

- 1. That Pat is obligated to contact the Suicide Prevention Center; it can deal with the client's disturbances.
- 2. That Pat will lose her job if she recommended that the client be hospitalized.
- 3. The importance of the law concerning imminent danger.
- 4. Whether Pat should call the medical clinic that the client is attending.
- 5. That society's expectation is to protect and save lives.
- 6. That the medical bills should be taken care of by society then people wouldn't have to worry.
- 7. That society can allow suicides and still protect the lives of individuals who want to live.
- 8. Whether the client has the right to die with dignity.
- 9. Whether the Federal Supreme Courts' ruling gives latitude regarding suicide.
- 10. That the couple has a right to make decisions about their own lives.
- 11. That the client's concerns and desire to commit suicide should be discussed during counseling.
- 12. Whether society accepts that suicide is a viable option for any member of society.

**C.** Now, please rank only four of the above listed reasons from most important (1) to least important (4). You can use each ranking number only once. If there are more than four reasons, please choose only the most important four.

	1	2	3	4	5	6	7	8	9	10	11	12
Most important item	<input type="radio"/>											
Second most important	<input type="radio"/>											
Third most important	<input type="radio"/>											
Fourth most important	<input type="radio"/>											

**Appendix D**

**EDMS-R Dilemma 3**

*Pat is working with a young college woman who reveals that she has AIDS. She has confided that Pat is the only person who has not judged her during this period, and that without this support she is not certain she would have the will to live. During this period, she has felt very alone, and has been attempting to find solace in sexual relations. However, she has not been practicing safe sex with her numerous partners. Pat believes that if confidentiality is broken, she will attempt suicide.*

**A.** What should Pat do? Select one response.

- 1. Respect woman's confidentiality.
- 2. Alert health authorities.
- 3. Warn partners.
- 4. Hospitalize woman.
- 5. Insist on safe sex practices.
- 6. Consult with colleague(s).
- 7. Cannot determine.

**B.** Based on the following scale, please **rate** the importance of each issue in making your decision. Remember, for this section you may rate more than one item at a specific level of importance.

<i>Very Important</i>	<i>Important</i>	<i>Somewhat Important</i>	<i>Unimportant</i>	<i>Very</i>
<i>Unimportant</i>				
1	2	3	4	5

1 2 3 4 5

- 1. Whether Pat will get in trouble if she doesn't report this situation.
- 2. Whether Pat should call the AIDS center.
- 3. That someone in the medical society will report Pat if she doesn't protect her client's numerous partners.
- 4. That there is a legal issue of imminent danger.
- 5. That the college the student is attending has guidelines for confidentiality of AIDS client.
- 6. Whether society has a right to know and protect life.
- 7. Whether there is a value of death so that society could learn from investigating this illness.
- 8. Whether the client has a right to privacy.
- 9. That AIDS is one of the most devastating diseases and the value of individual differences is not of importance in such a case.
- 10. That if Pat breaks confidentiality her client will lose faith in the counseling relationship.
- 11. The personal safety of the young woman.
- 12. What values are going to be considered as the most important for determining the rights of any member of society.

**C.** Now, please **rank** only **four** of the above listed reasons from most important (1) to least important (4). You can use each ranking number only **once**. If there are more than four reasons, please choose only the most important four.

	1	2	3	4	5	6	7	8	9	10	11	12
Most important item	<input type="radio"/>											
Second most important	<input type="radio"/>											
Third most important	<input type="radio"/>											
Fourth most important	<input type="radio"/>											

## Appendix E

### Letter of Consent to Use EDMS-R

Roxane Dufrene <rdufren1@uno.edu>

Thu 12/12/2013 6:19 PM

**To:**

**Amanda Elise Johns;**

...

2 attachments

[74 KBPreview](#)

[57 KBPreview](#)

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Elise

You have permission to use the 4 dilemmas from the EDMS-R. You will need to agree that you will give me a copy of your data as part of the agreement. You can just email me saying you will provide a copy of your data in excel.

I've attached one version with all 6 dilemmas and one version with all 6 dilemmas with the answers. Of course you want to use the one with the answers with your participants. I will let you do the cutting and deleting to eliminate the 2 dilemmas you are not going to use.

Dr. Dufrene

## Appendix F

### Participant Request Letter to Organizations: Pilot Study

INSERT NAME HERE:

I am a counseling student pursuing a doctoral degree at the University of New Orleans and working under the supervision of Dr. Roxane L. Dufrene in the College of Education. The title of my dissertation is *Ethical Competencies of Therapists Working with Clients with Right-to-Die Issues*. I am in need of mental health professionals to participate in my online study and am hoping that your organization would be willing to assist me.

The purpose of my study will be to explore the relationship between practitioners' attitudes toward client end-of-life concerns and their ethical decision making levels when confronted with clients facing end-of-life concerns. Because of the lack of research in the counseling field and the growing prevalence of right-to-die issues with clients who have a diagnosis of a terminal illness, more research in the counseling field is needed. The survey takes about 30 minutes and participation is voluntary. No funding was received for this research nor is the research currently under review for future funding. Identifying information will be protected throughout the study and individual results will not be disclosed in the findings. All results will be stored in a password protected file via Survey Monkey©. Hopefully, the result will aid in a better understanding of therapists role in client end-of-life decision making.

If it is possible for your organization to participate, please let me know what would be the proper steps to follow to recruit participants. I can email my survey link and participant request letter directly to you if you would like to post it to a listserve, or if you prefer to provide an email contact list of members then I can email my participation request letter and survey link directly to each member.

If there are further questions or details that you need, please do not hesitate to contact me. I am hoping to hear from you and look forward to corresponding with you further about this matter.

Sincerely,

Elise Johns, LPC, NCC, M.S.  
[aejohns@uno.edu](mailto:aejohns@uno.edu)  
706.713.6910  
Doctoral Candidate  
University of New Orleans

## Appendix G

### Pilot Study: Agreement to Participate

Amanda,  
The Nebraska Hospice and Palliative Care Association would be willing to put an article in our weekly e-newsletter about your research project if you provide further details.

*Jennifer*

*jennifer eurek | vice president of regulations and guidance | vice president of hospice and palliative care*

#### **nebraska health care association**

nebraska nursing facility association  
nebraska assisted living association  
nebraska hospice and palliative care association  
licensed practical nurse association of nebraska  
nebraska health care learning center  
nebraska health care foundation

When I receive the link and instructions, I hope, I will add to my e-bulletin and send to my database. joie

Joie Glenn RN MBA CAE  
Executive Director  
New Mexico Association for Home and Hospice Care  
Serving the Home Care & Hospice Community  
505-889-4556  
505-889-4928 (fax)  
505-228-0127 ( cell)  
joieg@nmahc.org  
[www.nmahc.org](http://www.nmahc.org)  
<http://twitter.com/nmahhc>

Hi Amanda,  
We received your request to have some of our staff to voluntarily participate in your survey. I am assuming that your research proposal has gone through the IRB.  
Please send me the link for the survey monkey. I will forward to some of our staff who are willing to do the survey.  
JP

Rev.JP Sabbithi, D.Min, BCC  
Director of Counseling Services  
T 808.791-8003  
C 808.780.5452  
[www.hospicehawaii.org](http://www.hospicehawaii.org)

Amanda - Thank you for your note requesting assistance in your research. As you likely know, Oregon was the first state in the United States to pass a Death With Dignity statute. We would be willing to invite hospices in Oregon to participate in your research - with one important change.

Oregon - and no state in the United States has "euthanasia". We have Death With Dignity, Physician Aid in Dying or other similar options. This is more than semantics. Euthanasia is when someone other than the person gives medication to hasten death. It may be a physician. This practice is not allowed in the United States. Under Oregon's statute and in other states, the person who wishes to hasten their death must ingest the medication themselves. This is a significant difference. Oregon's Death With Dignity is not euthanasia.

Several European countries do allow euthanasia. The United Kingdom is considering the issue now. But, euthanasia is not what is legal in Oregon or elsewhere in the US.

You may not have understood that there is a difference between euthanasia and Death With Dignity. Or perhaps you were seeking a single term to reference Death With Dignity which is called many different things. However, the Oregon Hospice Association could not advocate for hospices in our state to our participate in your research if the topic is referenced as "euthanasia". If your survey referenced "Death With Dignity" or "Physician Aid in Dying", we would be able to offer our support.

If you want to discuss this with me, you can reach me on 541.490.9073. I wish you the best in your efforts.

Best,

DJ

Deborah Whiting Jaques  
CEO  
Oregon Hospice Association  
Office: 503.228.2104  
Fax: 503.222.4907  
Cell: 541.490.9073  
812 SW Tenth Avenue, Suite 204  
Portland, Oregon 97205

## Appendix H

### IRB Approval University of New Orleans

*University Committee for the Protection  
of Human Subjects in Research  
University of New Orleans*

---

*Campus Correspondence*

Principal Investigator: Roxane L. Dufrene

Co-Investigator: Amanda Johns

Date: April 22, 2014

Protocol Title: "Ethical Competencies of Therapist Working with Clients' Right-to-Die Issues"

IRB#: 10Apr14

The IRB has deemed that the research and procedures described in this protocol application are exempt from federal regulations under 45 CFR 46.101category 2, due to the fact that the information obtained is not recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects.

Exempt protocols do not have an expiration date; however, if there are any changes made to this protocol that may cause it to be no longer exempt from CFR 46, the IRB requires another standard application from the investigator(s) which should provide the same information that is in this application with changes that may have changed the exempt status.

If an adverse, unforeseen event occurs (e.g., physical, social, or emotional harm), you are required to inform the IRB as soon as possible after the event.

Best wishes on your project.

Sincerely,

Robert D. Laird, Ph.D., Chair

UNO Committee for the Protection of Human Subjects in Research

## Appendix I

### Participant Request Letter to Organizations

INSERT NAME HERE:

I am a counseling student pursuing a doctoral degree at the University of New Orleans and working under the supervision of Dr. Roxane L. Dufrene in the College of Education. The title of my dissertation is *Ethical Competencies of Therapists Working with Clients with Right-to-Die Issues*. I am in need of mental health professionals to participate in my online study and am hoping that your organization would be willing to assist me.

The purpose of my study will be to explore the relationship between practitioners' attitudes toward client end-of-life concerns and their ethical decision making levels when confronted with clients facing end-of-life concerns. Because of the lack of research in the counseling field and the growing prevalence of right-to-die issues with clients who have a diagnosis of a terminal illness, more research in the counseling field is needed. The survey takes about 30 minutes and participation is voluntary. No funding was received for this research nor is the research currently under review for future funding. Identifying information will be protected throughout the study and individual results will not be disclosed in the findings. All results will be stored in a password protected file via Survey Monkey©. Hopefully, the result will aid in a better understanding of therapists role in client end-of-life decision making.

If it is possible for your organization to participate, please let me know what would be the proper steps to follow to recruit participants. I can email my survey link and participant request letter directly to you if you would like to post it to a listserve, or if you prefer to provide an email contact list of members then I can email my participation request letter and survey link directly to each member.

If there are further questions or details that you need, please do not hesitate to contact me. I am hoping to hear from you and look forward to corresponding with you further about this matter.

Sincerely,

Elise Johns, LPC, NCC, M.S.  
[aejohns@uno.edu](mailto:aejohns@uno.edu)  
706.713.6910  
Doctoral Candidate  
University of New Orleans

## Appendix J

### State Counseling Organizations Agreement for Participation

#### COLORADO

Hi Amanda,

We are still in process of figuring out the best way to assist Doctoral Candidates such as yourself. We want to support your important research and still respect the inboxes of our membership.

In the meantime, we encourage you to visit our LinkedIn webpage (link below in my e-signature) and post there to our most active members.

If you feel so inclined, let us know how this works for you.

Best wishes,  
Kristyn

**Kristyn Roe, MS, LPC** *CCA Admin/Web Manager*  
Direct (303) 991 3828 ext 101 | Fax (303) 991 3827

#### Colorado Counseling Association

7450 W. 52<sup>nd</sup> Ave. Ste M244, Arvada, CO 80002

[coloradocounselingassociation.org](http://coloradocounselingassociation.org) | [Become a fan on Facebook](#) | [Follow us on LinkedIn](#)

#### ALABAMA

We try to help students in these situations. We do not provide our database info to anyone though. We do have a listserv with about 2500 counselors on it- all types; I cannot specify exactly who will get info. If you would like for us to mail out your message we would be open to that, assuming the info once reviewed is appropriate. You need to formulate the message you want to go out exactly as you want it sent. It needs to be in body of your email message so that all I have to do is forward it. I will not edit nor will I send it out if it is not ready to go. Also, I need a copy of your IRC approval.

Hope this helps!  
Chip

#### VERMONT

Hi Amanda,

I will send this request out to my listserve in the next day or two. Sorry for the delay. I hope this is not too late for your research....

Caryn

**MARYLAND**

Emily Lamoreau <elamoreau@me.com>

Mon 10/27/2014 9:16 AM

Inbox

To: Amanda Elise Johns;

Cc: Marybeth Marybeth <marybethaheather@gmail.com>;

Inbox

You replied on 10/27/2014 11:12 AM.

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Action Items

Hi Amanda,

We love to support Counseling research! Please send us your participant request letter and a link to the survey and we will pass it along to our members.

Happy Researching!

Emily Lamoreau

MCA Public Relations

**NORTH DAKOTA**

Marcia Foss <marcia.foss@vcsu.edu>

Mon 10/27/2014 7:54 AM

Inbox

To: Amanda Elise Johns;

Inbox

You replied on 11/4/2014 11:27 AM.

Get more apps

Action Items

The first step would be for you to complete a Graduate Student Research Request which you can find on our web page – [www.ndcounseling.org](http://www.ndcounseling.org).

After I receive that, you could submit an article for our Newsletter which I would need by Nov. 15<sup>th</sup> at the latest.

Let me know if you have any questions.

Marcia Foss

NDCA Executive Director

**UTAH**

CESNET-L is a unmoderated listserv concerning counselor ed. & supervision <CESNET-L@LISTSERV.KENT.EDU>

Lashauna Dean <lashauna.dean.nganga@GMAIL.COM>

Ken Roach <kendroach@gmail.com>

Mon 11/17/2014 5:58 PM

To: Amanda Elise Johns;

Flag for follow up.

You replied on 11/18/2014 9:37 AM.

Are you still looking for participants. If so, I'll send out the info about your study. Sorry for the delay.

Ken Roach for UMHCA

“Overcoming poverty is not a task of charity, it is an act of justice. Like slavery and apartheid, poverty is not natural. It is man-made and it can be overcome and eradicated by the actions of human beings.” -- Nelson Mandela

## **LOUISIANA**

Ms Johns

LCA is more than willing to help graduate students in securing participants in their research.

However, for those students who live in Louisiana they must be member of LCA

LA is willing to share an invitation to the members though our blast email newsletter. If you refer to email them yourself there is a cost for the list of email addresses.

Diane Austin

LCA Executive Director

## **TENNESSEE**

Lisa Henderson <lisa@comprehensivehealthcenters.com>

Tue 11/4/2014 12:10 PM

Inbox

To:Amanda Elise Johns;

C Holden <tcamembership@gmail.com>;

Inbox

Flag for follow up.

You replied on 11/4/2014 12:54 PM.

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Action Items

Hi Elise & Cherrie,

We will go ahead and send out the survey to our membership. Since this is something that directly impacts Mental Health Counselors, we've determined that we can participate. Elise, if you would please send Cherrie the link, then Cherrie, if you would please send it to TMHCA membership we'll be all set. We'll send it out once.

Thanks to both of you,

Lisa

## Appendix K

### Blurb Posted to Listserve/ Informed Consent

To whom it may concern:

I am a counselor pursuing a doctoral degree at the University of New Orleans. I am requesting your voluntary participation in my dissertation research. The title of my dissertation is

*Ethical Competencies of Therapists Working with Clients With Right-to-Die Issues*. The purpose of the present study will be to explore practitioners' attitudes toward ethical decision making levels when confronted with clients facing end-of-life concerns as well as their familiarity with the topic. Hopefully, the result will aid in a better understanding of therapist role in client end-of-life decision making. Study results could be used to gain insight into needed therapist education. The questionnaires should take about 30 minutes to complete online. Informed consent is included in the survey link.

The link to the survey is listed below:

<https://www.surveymonkey.com/s/3GJP3CZ>

## VITA

Amanda Elise Johns is originally from Columbus, Georgia. Elise graduated from the University of Georgia in 2006 where she majored in Psychology. She graduated from Troy University in 2009 with a Master's of Science in Counseling Psychology and from the University of New Orleans in August 2015 with a Doctorate of Philosophy in Counselor Education. Elise is currently working as a counselor in a private practice setting in New Orleans, Louisiana. She is a Nationally Certified Counselor and a Licensed Professional Counselor registered with the Louisiana Board of Examiners.