Assisted Suicide and the Death Penalty: Examining Attitudes towards State Sanctioned Death

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Abstract

In this study, we test Durkheim's (1897) conceptualization of suicide as a pattern of suicidal behavior caused by sociological conditions and its effects on attitudes towards state sanctioned death through examining support for assisted suicide and the death penalty. Using secondary-data and quantitative analytical methods, we empirically examine personal attitudes towards assisted suicide for oneself and its relationship to supporting assisted suicide for medical reasons and the death penalty as a punishment for others. The primary goal of our analysis is to determine whether Durkheim's (1897) theory of suicide is a relevant theoretical model for specifying the sociological factors influencing attitudes towards state sanctioned death. Findings from our analysis indicate that the sociological factors, such as, gender and religious beliefs influence attitudes towards support for assisted suicide and the death penalty.

Keywords: suicide, death penalty, euthanasia, Durkheim, state sanctioned death

1. Introduction

In this study, we test Durkheim's theory of suicide by analyzing data collected from the Detroit Area Study, 1999: Life and Death Decision Making survey (Anspach, 1999). Using Durkheim's (1897) theory of suicide, we hypothesize that sociological variables predict support for state sanctioned death. More specifically, we hypothesize that sociological variables are consistently predictive of both support for assisted suicide and the death penalty. We believe that this study is important because governments around the globe are routinely examining the utility, ethics, and legality of state sanctioned death as a matter of shaping domestic policies and public opinion, which is then tied to public health initiatives and crime-control measures that involve the administration of terminating life.

However, there exists a significant gap in our current understanding of the sociological factors that influence and impact attitudes towards state sanctioned death and whether these factors are consistently predictive of both assisted suicide and the death penalty. It is possible, that differing sociological factors separately, but significantly, influence attitudes towards assisted suicide and the death penalty. Therefore, it is important to examine both assisted suicide and the death penalty using identical statistical models in order to compare and contrast the significance and impact of our theoretically specified sociological factors on attitudes towards state sanctioned death. Also, we believe that by examining the sociological factors associated with support for state sanctioned death we may uncover latent sociological conditions that influence public policy and

produce biased ethical reasoning when policy makers and the public evaluate the administration of state sanctioned death. By conducting research on this topic, we aim to make policy makers and the general public more aware of the underlying sociological factors that impact attitudes and decision-making towards the treatment and termination of life in both a public health and criminal justice context.

2. Durkheim's theory of suicide

Durkheim's (1897) theory of suicide is one of the first empirical tests of how aggregate sociological variables are correlated with individual-level suicidal behavior. He is heralded as a pioneer in the field of sociology for his emphasis on using statistical data to test theories on collective human behavior. Durkheim (1897) developed and empirically tested a sociological theory describing the varying societal conditions that produce four distinct forms of suicidal behavior in individuals. Durkheim taxonomically categorized the varying types of suicide as egoistic, altruistic, anomic, and fatalistic.

Of the four different types of suicide that Durkheim (1897) theorized and examined, we will be testing his theory of egoistic suicide, because of its rigorous sociological conceptualization and methodological specification. Durkheim (1897) conceptualized egoistic suicide within society as a pattern of suicidal behavior caused by excessive individualism, weakened social relationships, and diminished belief and support in the religious authorities. Durkheim (1897) argues that excessive individualism emerges when the authorities are no longer able to provide control and censorship over religious beliefs, intellectual discourse, and social-control and interaction. Durkheim (1897) theorizes that egoistic suicide is a byproduct of excessive individualism and alienation from the larger society, due to the lack of social interaction and support that was historically emphasized by religious authorities that promoted a collectivist society.

Also, Durkheim (1897) theorized that a strong ideological acceptance of the government or the religious authorities is associated with collectivism. He believed that collectivist societies provide social support and social control to counter mental health issues and to prevent and address socio-demographic and public health issues, such as, unemployment, depression, dysfunctional family structures, and disease within their societies. More specifically, based on his findings (figure 2, in the appendix) Durkheim (1897) discussed how societies which have higher percentages of their citizens educated and literate are societies that also demonstrate decreased support for the religious authorities. Therefore, as a society becomes more individualistic, values increased education, and rejects authoritarian ideological and religious dogma may then facilitate and cause individuals within those societies to become increasingly self-absorbed and egoistic. The increased affluence and surplus time among members of individualistic societies causes its members to contemplate the emptiness of reality and the belief that pleasure and satisfaction can only be achieved through ceasing to exist (Durkheim, 1897). Durkheim (1897) effectively describes suicide as a public health outcome that occurs in affluent individualistic societies that reject collectivist values, authoritarian and ideological structures, and religious dogma.

Durkheim (1897) in his treatise on suicide provides numerous examples of the varying egoistic suicide rates between European nations. In figure 1 (in the appendix), Durkheim (1897)

describes the findings that the diverging suicide rates per million inhabitants in the cantons of Switzerland by religious affiliation. In figure 1 (in the appendix), Durkheim (1897) describes that individuals of the Protestant religion commit suicide at higher rates than compared to individuals of the Catholic religion. Durkheim (1897) argues that Catholic societies, compared to Protestant societies, have lower suicide rates due to the collectivistic characteristics of their society. Durkheim (1897) describes followers in societies that are predominantly Catholic as unquestioning of the religious dogma published in religious texts and that they are obedient to the moral values professed by the Catholic religious hierarchy. Durkheim (1897) observes that societies that promote strong Catholic religious beliefs have lower suicide rates because of their adherence to religious dogma, rituals, and moral values controlled by religious authorities, which serve as a protective factor against mental health issues and the explicit condemnation of suicide in the religious doctrine facilitate conformity among Catholic followers. According to Durkheim (1897), Catholic societies encourage their members to maintain strong social bonds and community involvement. The Catholic churches provides space for religious socialization and community services, which offer a communal environment that allow for deep social connections to be forged among members of the Catholic church.

3. Historical and social factors influencing support for state sanctioned death

3.1. Historical factors effecting attitudes towards state sanctioned death

State sanctioned death can be defined as artificially induced deaths that are supported and protected by the state or government through public opinion, legislation, and legal immunity (Sarat, 2001). Generally, in order for state sanctioned death to be permitted, there must exist concrete legislation which outlines the conditions and protocols under which state sanctioned death is permitted and the legal immunities for those who administer or assist in the death of members of a given society (Sarat, 2001). Historically, state sanctioned death has been justified and conducted to advance public health, criminal justice, and national security policies. However, around the globe, not all states or governments allow euthanasia, physician assisted suicide, or the death penalty because of cultural, religious, and historical influences that continue to shape and dominate the ethical and legal debate regarding the administration of state sanctioned death.

Additionally, historical atrocities, such as, the systematic elimination of millions of individuals, who were Jewish, minorities, political dissidents, or had physical disabilities and psychological handicaps in Nazi Germany, in the 1930s and 1940s, continues to offer a cautionary example of how attitudes, ethics, morality, and the legality of state sanctioned death must be continually evaluated and debated, in order to guard it against its potential for overwhelming abuse by the authorities. The unprecedented use of state sanctioned death in Nazi Germany provides contemporary societies around the world with a cautionary example of the detrimental effects that unchecked and carte blanche policies and legislation towards state sanctioned death has on the violation of basic human rights (Arendt, 1971).

3.2. Social factors influencing support for assisted suicide

There are numerous categories of assisted suicide, which include passive euthanasia, active euthanasia, and physician assisted suicide (PAS). Passive euthanasia is equated with "letting someone die (Rachel, 1975)." Withdrawing medical treatment would result in an individual's expiration. Active euthanasia involves taking the necessary steps required to commit suicide. For example, ingesting a lethal dosage of medication would be considered active euthanasia.

Physician assisted suicide is the act of suicide which occurs under the supervision of a licensed doctor. Physician assisted suicide in the United States is only provided to individuals who have a physical condition that is terminal and unable to be treated with contemporary medical treatments. The availability of assisted suicide varies across the patchwork of state laws within the United States. Individuals who wish to end their lives perhaps due to severe depression or a disturbed psychological state are often prohibited from electing physician assisted suicide. Physician assisted suicide is meant to reduce an extraordinary burden, such as, physical pain or suffering, it is not intended to merely satisfy the psychological desires of an individual. For this study, we focus on attitudes towards physician assisted death and active euthanasia.

Previous research conducted by Emanuel et al. (2000) on attitudes toward euthanasia and physician assisted suicide (PAS) found that 60.2% of terminally ill patients supported euthanasia and PAS. Additionally, 32.7% of the terminally ill patients supported euthanasia for terminally ill patients who did not suffer from pain but felt that they were a burden. Emanuel et al. (2000) also found that 58.7% of caregivers supported euthanasia for terminally ill individuals with pain and only 29.1% of caregivers supported euthanasia for individuals who felt that they were a burden (p. 2463).

Emanuel et al. (2000) conducted a multivariate analysis of significantly ill patients and found that patients who were highly religious and African American were significantly less likely to support euthanasia or PAS. However, patient attitudes towards euthanasia and PAS were not related to age, income, length of illness, or physical activity (Emanuel et al., 2000). Emanuel et al. (2000) found that Catholics, who felt tranquil or serene, and who received home care were less likely to support euthanasia and PAS (Emanuel et al., 2000).

Emanuel et al. (2000) also collected data from caregivers of deceased patients and found that individuals who reported that caring for patients was interfering with their personal lives were significantly more likely to support euthanasia or PAS. However, Emanuel et al. (2000) also found that caregivers with strong religious orientations, were African American, and had strong social support networks were significantly less likely to support euthanasia or PAS.

Johansen et al. (2005) conducted a research study on the varying attitudes held by cancer patients with a short life expectancy who are seeking euthanasia or PAS. They explored and described individual wishes for euthanasia and their predictive attitudes and sought to understand the psychological processes and how it impacts attitudes towards euthanasia. Johansen et al. (2005) found that wishes for euthanasia were based on future oriented fears, hypothetical or conditioned responses to pain, fluctuating worries about the quality of life, and ambivalent worries about the lack of hope for survival. According to Johansen et al. (2005) future oriented fears of pain shaped their respondents' outlook towards electing euthanasia. The prospect of future pain created worries

and anxieties that prompted necessity for a quick solution, such as, death in order to avoid pain (Johansen et al., 2005). The researchers quote an interviewee who states "it is the pain that I am most afraid of, because I don't want to live with pain. My only hope is to have no pain" (Johansen et al., 2005). The experience of pain was positively correlated with an individual's decision to elect euthanasia. The researchers quoted a patient that stated "[when the pain is alleviated] then I want to live a little bit longer (Johansen et al., 2005, p. 457)." The researchers found that the desire to elect euthanasia was not constant and fluctuated with the subjective experience of pain.

Johansen et al. (2005) states that because of the irreversible nature of euthanasia and physician assisted suicide it is important for physicians, policy makers, healthcare workers, and patients to understand the ambivalent nature of wishes and attitudes towards euthanasia. Johansen et al. (2005) discuss how attitude theory provides an explanatory framework for understanding the complexity of opinions and attitudes an individual has for an issue, such as, physician assisted suicide or the death penalty. Johansen et al. (2005) argue that the predictive power of attitudes is limited as a result of conflicting and strong emotions. Relationships with loved ones, will to live, and hopes for the future serve to counter an individual's desire from considering euthanasia (Johansen et al., 2005). The researchers state that:

> Several psychological dimensions fluctuate as death approaches:
> fluctuations between hope/despair, certainty/uncertainty and will
> to live/with to die (Johansen, 2005, p. 458).

3.3. Social factors effecting support for the death penalty

When examining attitudes towards the death penalty as an effective crime control policy, Tyler and Weber (1982) found that political and social beliefs were the strongest predictors of support for the death penalty. The influence of political and social beliefs on the death penalty remains strong, even when controlling for perceptions on the effectiveness of the punishment. Therefore, ideology and socialization patterns were strong predictors of attitudes towards the death penalty, rather than an individuals' logical consideration of the effectiveness of the death penalty as a deterrent. Young (1992) found that individuals who were white, male, and have fundamentalist beliefs and devotional practices were more likely to support the death penalty. Findings from both studies, demonstrate that sociological factors tied to race, religiosity, and political orientation explain a significant percentage of the variation in support for the death penalty.

Tyler and Weber (1982) make the assumption that liberalism, authoritarianism, and dogmatism are shaped early in the life of an individual and remain static throughout the life course. Therefore, individual preferences and support for the death penalty may be the product of psychological, sociological, and developmental factors that passively influence emotional and attitudinal support for retributive punishment schemes, rather than a rational choice or logical reasoning based framework that forces individuals to actively assess and examine the quantitative effectiveness of deterrent options provided by the state to reduce violent crime.

4. Research questions

In this study, we ask three research questions related to support for state sanctioned death that we specify using Durkheim's theory of egoistic suicide. In our first research question, we examine whether socio-demographic characteristics, education and employment characteristics, political orientation, and religious orientation variables are predictors of *personal attitudes towards assisted suicide for oneself*?

In our second research question, we examine whether socio-demographic characteristics, education and employment characteristics, political orientation, religious orientation, and *attitudes towards assisted suicide for oneself* are predictors of support for assisted suicide for other individuals?

Finally, in our third research question, we examine whether socio-demographic characteristics, education and employment characteristics, political orientation, religious orientation, and *attitudes towards assisted suicide for oneself* are predictors of support for the death penalty as a punishment for other individuals?

4.1. Hypotheses

For our first research question, we hypothesize that religious orientation will be the strongest predictor of attitudes towards assisted suicide for oneself. Based on Durkheim's (1873) results and theoretical specification of suicide rates, we hypothesize that those survey respondents who self-identify as Catholic and indicate having strong religious beliefs will be less likely to support assisted suicide for oneself. For our second research question, we hypothesize that those survey respondents, who strongly support assisted suicide for oneself, will have an increased probability of supporting assisted suicide for others in a medical context. For our final research question, we hypothesize that those survey respondents, who support assisted suicide for oneself, support the death penalty as a punishment for others.

5. Methods

5.1. Data

Anspach (1999) conducted the Detroit Area Study: Life and Death Decision Making survey and collected respondent data (N=1109) from three counties in Detroit, Michigan. The data that was collected from respondents included information on demographics, personal health, satisfaction with health care, attitudes towards assisted suicide policies, and life and death decision making (Anspach, 1999). In this study, we are conducting a secondary data analysis of the Detroit Area Study (Anspach, 1999), because we are interested in examining attitudes towards assisted suicide using predictor variables related to socio-demographic characteristics, education and employment characteristics, political orientation, and religious orientation characteristics. In this study, we will be constructing a factor score for measuring *personal attitudes towards support for assisted suicide for oneself*. The outcome variables that we will be analyzing in this study are related to support for assisted suicide and the death penalty for others.

5.2. Participants

The data for this study was collected by Anspach (1999) from Michigan residents, who were 18 years and older in the tri-county area of Wayne, Oakland, and Macomb. Anspach (1999) collected data from households using face-to-face interviews, web surveys, and mailed surveys.

5.3. Predictor variables

5.3.1. Socio-demographic characteristic variables

The socio-demographic characteristic variables that we operationalize include the age, gender, race, and relationship status of respondents. The age variable is continuously coded, ratio data, that is measuring the length of time that respondents' have been alive for in units of years. Gender is a dichotomously coded, nominal variable, that is a measure of the self-reported gender orientation of the respondents, which is coded as *male* = 1 and *female* = 2. Race is a nominal variable that is a measure of the self-reported race orientation of the respondents, which is coded as *white* = 1, *black* = 2, and *other* = 3. Relationship status is a nominal variable that is a measure of whether respondents are married or in a relationship, which is coded as *married or in a relationship* = 1 or *single* = 2.

5.3.2. Education and employment characteristic variables

The education and employment characteristic variables include the level of education, employment status, and annual salary range. The level of education variable is a dichotomously coded, nominal variable, that is a measure of the respondents' level of educational attainment, which is coded as *high school education or less* = 1 and *at least some college education or more* = 2. Employment status is a dichotomously coded, nominal variable, that is a measure of the self-reported employment status of respondents, which is coded as *employed* = 1 and *unemployed* = 2. Annual salary is an ordinal variable that is a measure of the self-reported annual salary of the respondents, which is coded as *$29,999 or less* = 1, *$30,000 to $49,999* = 2, *$50,000 to $74,999* = 3, and *$75,000 or more* = 4.

5.3.3. Political orientation variables

For examining political orientation we examine a political views variable. Political views is a nominal variable that is a measure of the respondents' political and ideological orientation, which is coded as *liberal* = 1, *conservative* = 2, *moderate* = 3, and *no political preference* = 4.

5.3.4. Religious orientation variables

The religious orientation variables we examine include religious preference and religious importance. Religious preference is a nominal variable that is a measure of the respondents' self-reported identification with a major religion, which is coded as *Protestant* = 1, *Catholic* = 2, and *other* = 3. Religious importance is an ordinal variable that is a measure of the respondents' self-reported perceptions of the importance of their religious beliefs, which is coded as *not at all* = 1, *somewhat important* = 2, *pretty important* = 3, and *very important* = 4.

5.3.5. Personal attitudes towards assisted suicide for oneself factor score

We combine five different self-report variables related to support for assisted suicide for oneself, measured using a Likert scale (table 1, in appendix). Using the factor analysis program in SPSS v22, we create a single factor measuring *personal attitudes towards assisted suicide for oneself*. The output from the factor analysis indicates that one component explains 74.65 percent of the total variation in those five items as a linear combination. Using the Scree-Plot we observe that only one component sets itself apart from the others in terms of efficiently explaining a high degree of variation across the multiple items. In table 1, in the appendix, we observe that all of the variables load relatively high on the scale (0.870 to 0.916). The Cronbach's Alpha statistic for the scale reliability is 0.914, indicating that our factor has strong internal consistency and unidimensionality. A higher factor score indicates increased support for assisted suicide for oneself.

5.4. Outcome variables for support for assisted suicide and death penalty

We examine the respondents' support for assisted suicide for others in a medical context using five different outcome measures with varying scenarios regarding conditions under which respondents would support assisted suicide. All outcome variables are dichotomously coded, nominal variables, that are coded as *yes, supports removing life support* = 1 and *no, does not support removing life support* = 2. The five outcome variables include removing life support for the following conditions: (1) man in a coma, (2) woman with a heart attack, (3) woman in a coma, (4) man diagnosed with AIDS, and (5) a baby born with a genetic disorder. We will be examining the respondents' support for the death penalty for others in a criminal justice context using one outcome measures, which is coded as *yes, approves of the death penalty* = 1 and *no, does not approve of the death penalty* = 2.

5.5. Analysis plan

In this study, we will be conducting descriptive statistics that demonstrate aggregate percentages and means for predictor and outcome variables. Next, we will conduct mean comparisons of the factor score for *personal attitudes towards assisted suicide for oneself* on all predictor and outcome variables using Independent Sample *t*-tests and One-Way ANOVA statistical tests. We will report means, standard deviations, and *p*-values. Results from marginal and statistically significant differences will be discussed. Results from our exploratory bivariate analysis will allow us to specify our multivariate models. In the final part of our analysis, we will conduct a series of multivariate analyses using both multiple regression and logistic regression approaches to examine our theoretically specified models of support for assisted suicide and the death penalty for others.

6. Results

6.1. Descriptive statistics

Table 1 Predictor Variable Descriptive Statistics

Variable (Groupings)	n (%)	M (SD)	Missing n (%)
N	1109 (100)	-	0 (0)
Predictor variables **Social demographic characteristics**			
Age	1075 (97)	53.3 (17.0)	34 (3)
Gender			
Male	479 (43)	-	24 (2)
Female	606 (55)	-	-
Race			
White	892 (80)	-	30 (3)
Black	135(12)	-	-
Other	52 (5)	-	-
Relationship status			
Married / In a relationship	545 (49)	-	34 (3)
Single	530 (48)	-	-
Education and employment characteristics Level of education			
High school diploma or less	362 (33)	-	189 (17)
Some college or more	558 (50)	-	-
Employment status			
Employed	651 (59)	-	55 (5)
Not employed	403 (36)	-	-
Annual income			
$29,999 or less	290 (26)	-	181(16)
$30,000 to $49,999	219 (20)	-	-
$50,000 to $74,999	188(17)	-	-
$75,000 or more	231 (21)	-	-
Political orientation Political views			
Liberal	179 (16)	-	257 (23)
Conservative	298 (27)	-	-
Moderate	346 (31)	-	-
No political preference	29 (3)	-	-
Religious orientation Religious preference			
Protestant	369 (33)	-	88 (8)
Catholic	406 (37)	-	-
Other	246 (22)	-	-
Importance of religion			
Not at all	83 (8)	-	60 (5)
Somewhat important	278 (25)	-	-
Pretty important	233 (21)	-	-
Very important	455 (41)	-	-

Table 2 Outcome variable descriptive statistics

Outcome Variables	n (%)	M (SD)	Missing n (%)
Personal attitudes towards assisted suicide for oneself			
Factor score	773 (70)	0 (1)	336 (30)
Support for assisted suicide for others			
Support for removing life support for man in a coma	995 (90)	-	114 (10)
Yes, supports removing life support	912 (82)	-	-
Support for removing life support for woman with heart attack	940 (85)	-	169 (15)
Yes, supports removing life support	814(73)	-	-
Support for removing life support for woman in a coma	888 (80)	-	221 (20)
Yes, supports removing life support	556 (50)	-	-
Support for removing life support for man diagnosed with AIDS	910 (82)	-	199 (18)
Yes, supports removing life support	139(13)	-	-
Support for removing life support for baby born with genetic disorder	888 (80)	-	221 (20)
Yes, supports removing life support	473 (43)	-	-
Support for the death penalty	**951 (86)**	**-**	**158 (14)**
Yes, approves of the death penalty	691 (62)	-	-

Our summary of the descriptive statistics for outcome variables, in table 2, indicate that for assisted suicide in a medical context: 82% support removing life support for man in a coma, 73% support removing life support for woman with a heart attack, 50% support removing life support for woman in a coma, 13% support removing life support for a man diagnosed with AIDS, and 43% support removing life support for a baby born with genetic disorder. Our summary of the descriptive statistics for outcome variables, in table 2, indicate that 62% support the death penalty in a criminal justice context.

6.2. Bivariate analysis

Table 3 Mean Differences on Personal Attitudes Towards Assisted Suicide for Oneself Factor Score using Predictor Variables

Variable (Groupings)	n	M (SD)	p
Social demographic characteristics Gender			
Male	371	0.10 (0.97)	0.006**
Female	391	-0.10 (1.01)	
Race			
White	627	0.11 (0.98)	< 0.001***
Black	95	-0.52 (0.93)	
Other	34	-0.38 (0.87)	
Relationship status			
Married / In a relationship	410	0.09 (0.97)	0.007**
Single	344	-0.10 (1.01)	
Education and employment characteristics Level of education			
High school diploma or less	224	-0.08 (1.06)	0.143
Some college or more	416	0.04 (0.96)	
Employment status			
Employed	504	0.07 (0.99)	0.003
Not employed	242	-0.15 (0.98)	

Annual income			
$29,999 or less	184	-0.27 (1.02)	< 0.001***
$30,000 to $49,999	168	0.07 (0.93)	
$50,000 to $74,999	143	0.26 (1.00)	
$75,000 or more	188	0.16 (0.94)	
Political orientation Political views			
Liberal	139	0.31 (0.95)	< 0.001***
Conservative	219	-0.31 (0.96)	
Moderate	241	0.1 (0.92)	
No political preference	25	-0.2 (0.78)	
Religious orientation Religious preference			
Protestant	264	0.02 (0.97)	0.108
Catholic	276	-0.12 (0.97)	
Other	190	0.06 (1.06)	
Importance of religion			
Not at all	69	0.74 (0.72)	< 0.001***
Somewhat important	208	0.48 (0.78)	
Pretty important	166	0.06 (0.84)	
Very important	305	-0.56 (0.97)	

+*p* < 0.10
* *p* < 0.05
** *p* < 0.01
*** *p* < 0.001

In this section, we are reporting our bivariate analyses results using the Pearson's r test, Independent Sample *t*-test, and One Way ANOVA test results. We examine mean differences among predictor variables on the factor score for *personal attitudes towards assisted suicide for oneself*. Pearson's r test reveals that there is a statistically significant negative correlational relationship between the *age of survey respondents* and their *personal attitudes towards assisted suicide for oneself*; r = -0.129, n = 757, *p* < 0.001.

Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between in the gender variable for *males* (*M* = 0.10, *SD* = 0.97) and *females* (*M* = -0.10, *SD* = 1.01); *t*(760) = 2.756, *p* < 0.01. Using an Independent Samples *t*-test, we found that there was a statistically significant mean difference in the relationship status variable between those who are *married or in a relationship* (*M* = 0.09, *SD* = 0.97) and those who are *single* (*M* = -0.10, *SD*= 1.01); *t*(752) = 2.684, *p* < 0.01. Using an Independent Samples *t*-test, we found that there was no statistically significant mean difference in the education status variable between those who have a *high school education or less* (*M* = -0.08, *SD* = 1.06) and those who have *some college education or more* (*M*= -0.04, *SD* = 0.96); *t*(638) = -1.510, *p* > 0.10. Using an Independent Samples *t*-test, we found that there was a statistically significant mean difference in the employment status variable between those who are *employed* (*M* = -0.07, *SD* = 0.99) and those who are *unemployed* (*M* = -0.15, *SD* = 0.98); *t*(744) = -2.958, *p* < 0.01.

Using a One-Way ANOVA test results in table 3, we found that there was a statistically significant mean difference in the race variable between *Whites* (*M* = 0.11, *SD* = 0.98), *Blacks* (*M* = -0.52, *SD* = 0.93), and *other race* (*M* = -0.38, *SD* = 0.87); *F*(2, 753) = 19.750, *p* < 0.001. Using a

One-Way ANOVA test, we found that there was a statistically significant mean difference in the annual salary variable between *$29,999 or less* (*M* = -0.27, *SD* = 1.02), *$30,000 to $49,999* (*M* = 0.07, *SD* = 0.93), *$50,000 to $74,999* (*M* = 0.26, *SD* = 0.99), and *$75,000 or more* (*M* = 0.16, *SD* = 0.94); *F*(3, 679) = 9.902, *p* < 0.001. Using a One-Way ANOVA test, we found that there was a statistically significant mean difference in the political orientation variable between *liberals* (*M* = 0.31, *SD* = 0.95), *conservatives* (*M* = -0.31, *SD* = 0.96), *moderates* (*M* = 0.10, *SD* = 0.92), and those with *no political preference* (*M* = -0.20, *SD* = 0.78); *F*(3, 620) = 14.530, *p* < 0.001. Using a One-Way ANOVA test, we found that there was a statistically significant mean difference in perceptions of religious importance between *not all important* (*M* = 0.73, *SD* = -0.72), *somewhat important* (*M* = 0.48, *SD* = 0.78), *pretty important* (*M* = 0.06, *SD* = 0.84), and *very important* (*M* = -0.56, *SD* = 0.97); *F*(3, 744) = 80.776, *p* < 0.001.

Table 4 Mean Differences on Personal Attitudes Towards Assisted Suicide for Oneself Factor Score using Medical Scenarios for Assisted Suicide for Others Outcome Variables

	n	*M (SD)*	*n*	*M (SD)*	*P*
	Disapprove of assisted suicide		**Approve of assisted suicide**		
Man in coma from stroke	61	-0.81 (0.96)	659	0.15 (0.94)	< 0.001***
Woman has a heart attack	99	-0.76 (0.91)	593	0.21 (0.92)	< 0.001***
Woman in a coma	264	-0.38 (0.97)	399	0.31 (0.90)	< 0.001***
Man diagnosed with AIDS	99	0.21 (0.96)	579	-0.05 (1.00)	0.017*
Baby born with genetic disorder	315	-0.33 (0.96)	355	0.33 (0.91)	< 0.001***

+*p* < 0.10
* *p* < 0.05
** *p* < 0.01
*** *p* < 0.001

Table 5 Mean Differences on Personal Attitudes Towards Assisted Suicide Factor Score for Oneself using the Death Penalty Outcome Variable

	n	*M (SD)*	*n*	*M (SD)*	*P*
	Disapprove of death penalty		**Approve of death penalty**		
Death penalty	204	-0.41 (0.92)	507	0.25 (0.93)	< 000.1***

* *p* < 0.05
***p* < 0.01
*** *p* < 0.001

In this section, we examine mean differences among outcome variables on the factor score for *personal attitudes towards assisted suicide for oneself*. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of assisted suicide for man in coma from stroke* (*M* = -0.81, *SD* = 0.96) and *approving of assisted suicide for man in a coma from stroke* (*M* = 0.15, *SD* = 0.94); *t*(718) = -7.649, *p* < 0.001. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of assisted suicide for woman with a heart attack* (*M* = -0.76, *SD* = 0.91) and *approving of assisted suicide for woman with a heart attack* (*M* = 0.21, *SD* = 0.92); *t*(690) = -9.630, *p* < 0.001. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of assisted suicide for woman in coma* (*M* = -0.38, *SD* = 0.97) and *approving of assisted suicide for woman in a coma* (*M* = 0.31, *SD* = 0.90); *t*(661) = -9.381, *p* < 0.001. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of assisted*

suicide for man with AIDS (*M* = 0.21, *SD* = 0.96) and *approving of assisted suicide for man with AIDS* (*M* = -0.05, *SD* = 1.00); *t*(676) = 2.383, *p* < 0.05. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of assisted suicide for a new born baby with genetic disorder* (*M* = 0.33, *SD* = 0.96) and *approving of assisted suicide for a new born baby with genetic disorder* (*M* = 0.33, *SD* = 0.91); *t*(668) = -9.175, *p* < 0.001. Using an Independent Samples *t*-test results in table 3, we found that there was a statistically significant mean difference between *disapproving of death penalty* (*M* = -0.41, *SD* = 0.92) and *approving of death penalty* (*M* = 0.25, *SD* = 0.93); *t*(709) = -8.535, *p* < 0.001.

6.3. Multiple regression analysis

Table 6 Multiple Regression Analysis for Predicting Personal Attitudes Towards Assisted Suicide for Oneself

Variable (Groupings)	Model 1 B	Model 2 B	Model 3 B	Model 4 B
Socio-demographic				
Age	-0.007**	-0.005	-0.005	-0.002
Male	0.053	0.015	0.066	-0.029
White	0.494*	0.447*	0.518**	0.368*
Black	-0.087	-0.047	-0.092	-0.092
Married / In a relationship	-0.027	-0.106	-0.073	-0.026
Education and employment				
High school diploma or less	-	0.034	-0.007	-0.029
Employed	-	-0.073	-0.032	-0.032
$29,999 or less	-	-0.395**	-0.390**	-0.345**
$30,000 to $49,999	-	-0.1	-0.127	-0.155
$50,000 to $74,999	-	0.013	-0.003	-0.018
Political orientation				
Liberal	-	-	0.473*	0.400*
Conservative	-	-	-0.304	-0.217
Moderate	-	-	0.265	0.224
Religious orientation				
Protestant	-	-	-	0.127
Catholic	-	-	-	-0.183+
Not at all	-	-	-	0.955***
Somewhat important	-	-	-	0.866***
Pretty important	-	-	-	0.502***
R-Square	.057	.075	.174	.339
R-Square change	0.057	0.018	0.10	0.16
F	6.24***	4.12***	8.26***	14 34***

+*p* < 0.10
* *p* < 0.05
** *p* < 0.01
*** *p* < 0.001

We conducted a hierarchical multiple regression to examine changes in the significance of the model specification as theoretical variables are added to predicting the factor score for *personal attitudes towards assisted suicide for oneself*. The results of the hierarchical multiple regression, in table 6, demonstrate that the F-value and R-square significantly improves as variable groupings are added to the model. In model 1, we observe that the socio-demographic variable grouping

statistically significantly explains only 5.7 percent of the variation in the factor score ($p < 0.001$). In each subsequent model, the R-square improves as additional variable groupings are included and the models are statistically significant ($p < 0.001$). By model 4, we observe that the R-square of the full model explains 33.9 percent of the variation in the factor scores for predicting *personal attitudes towards assisted suicide for oneself*.

In the fourth and final model, we observe that specific variables are statistically significant and we will interpret the magnitude and direction of their relationship with the factor score. When examining the socio-demographic variable grouping we found that those respondents who self-reported being racially *White* were 0.368 units higher in their factor score with reference to being *other race* ($p < 0.05$). This means that *Whites* were statistically significantly more likely to support assisted suicide for oneself ($p < 0.05$).

When examining our education and employment variable group we found that those respondents who self-reported making *$29,000 or less* were 0.345 units lower in their factor score with reference to making *$75,000 or more*. This means that those making *$29,000 or less* were statistically significantly less likely to support assisted suicide for oneself ($p < 0.01$).

When examining our political orientation variable grouping we found that those respondents who self-reported being *liberal* were 0.400 units higher in their factor score with reference to *no political preference*. This means that those respondents who self-identified as *liberal* were statistically significantly more likely to support assisted suicide for oneself ($p < 0.05$).

When examining the religious orientation variable grouping we found that those respondents who self-reported being *Catholic* were 0.183 units lower in their factor score with reference to *other religion*. This means that those respondents who self-identified as *Catholic* were moderately significantly less likely to support assisted suicide for oneself ($p < 0.10$). We found that those respondents who self-reported that their religion was *not at all important* in their lives were 0.955 units higher in their factor score with reference to religion being *very important* in their lives. This means that those respondents who self-reported religion as being *not at all important* were statistically significantly more likely to support assisted suicide for oneself ($p < 0.001$). We found that those respondents who self-reported that their religion was *somewhat important* in their lives were 0.866 units higher in their factor score with reference to religion being *very important* in their lives. This means that those respondents who self-reported religion as *somewhat important* were statistically significantly more likely to support assisted suicide for oneself ($p < 0.001$). We found that those respondents who self-reported that their religion was *pretty important* in their lives were 0.502 units higher in their factor score with reference to religion being *very important* in their lives. This means that those respondents who self-reported religion as *pretty important* were statistically significantly more likely to support assisted suicide for oneself ($p < 0.001$).

6.4. Logistic regression analysis

Table 7 Logistic Regression Analysis for Predicting Medical and Death Penalty Outcomes for Supporting Assisted Suicide for Others

Variable (Groupings)	Model 1 Exp (B)	Model 2 Exp (B)	Model 3 Exp (B)	Model 4 Exp (B)	Model 5 Exp (B)	Model 6 Exp (B)
Socio-demographic						
Age	1.016	1.003	1.000	0.995	1.022*	0.998
Male	1.733	0.904	1.317	0.667	0.723	2.668***
White	3.279+	0.797	1.309	0.773	1.955	0.736
Black	1.04	0.294	0.623	0.802	1.353	0.503
Married / In a relationship	0.601	0.909	0.930	0.872	1.054	1.375
Education and employment						
High school diploma or less	0.757	1.24	1.823*	0.63	0.826	2.791**
Employed	0.957	0.505	0.486*	1.361	0.929	1.2
$29,999 or less	0.805	0.451	1.127	0.875	0.648	1.125
$30,000 to $49,999	0.683	0.714	0.877	1.746	0.795	0.701
$50,000 to $74,999	1.682	1.595	2.212*	0.723	1.069	0.755
Political orientation						
Liberal	0.819	1.729	0.926	0.531	2.317	0.411
Conservative	0.874	1.938	1.662	0.926	2.366	1.485
Moderate	0.797	2.253	1.706	0.744	2.494	0.569
Religious orientation						
Protestant	1.304	1.774	1.551	0.638	0.929	1.633
Catholic	0.800	1.151	1.116	0.51	0.788	0.745
Not at all	2.060	0.508	0.402+	0.7	1.465	1.076
Somewhat important	1.694	0.738	0.653	1.08	1.348	1.753+
Pretty important	2.718+	1.465	0.793	0.853	2.053**	0.933
Personal attitudes towards assisted suicide for oneself						
Factor score	1.624*	2.420***	2.126***	0.832	1.566**	2.420***
-2 Log likelihood ratio	226.257	332.448	530.24	372.301	575.421	479.088
Chi-square	35.264*	66.957***	84.967***	23.307	60.804***	126.013***

+$p < 0.10$
* $p < 0.05$
** $p < 0.01$
*** $p < 0.001$

We conducted logistic regression on 6 different models in order to examine the odds-ratio of predictor variables on support for assisted suicide and the death penalty for others. In particular, we are interested in examining the magnitude and direction of the relationship of the factor score for *personal attitudes towards assisted suicide for oneself* and its relationship with supporting the state sanctioned death of others in terms of assisted suicide and the death penalty. We found that our first logistic regression model was statistically significant for predicting *attitudes towards assisted suicide for a man in coma from stroke* ($p < 0.05$). We found that a one unit increase in the factor score *for personal attitudes towards assisted suicide for oneself* statistically significantly increases the odds of *supporting assisted suicide for a man in coma from stroke* by 1.6 times ($p < 0.05$).

Our second logistic regression model was statistically significant for predicting *attitudes towards assisted suicide for a woman with heart attack* ($p < 0.001$). We found that a one unit increase

in the factor score *for personal attitudes towards assisted suicide for oneself* statistically significantly increases the odds of *supporting assisted suicide for a woman with a heart attack* by 2.4 times ($p < 0.05$). However, none of the other variable groupings were found to be moderately or statistically significant ($p > 0.10$).

Our third logistic regression model was statistically significant for predicting *attitudes towards assisted suicide for a woman in coma* ($p < 0.001$). We found that those respondents who self-reported having a *high-school education or less* were 1.8 times, statistically significantly, more likely to support assisted suicide for a woman in coma, than those with *some college education or more* ($p < 0.05$). We found that those respondents who reported being *employed* were 0.48 times, statistically significantly, less likely to *support assisted suicide for a woman in* coma, compared to being *unemployed* ($p < 0.05$). We found that those respondents who self-reported making \$50,000 to \$74,999 were 2.2 times, statistically significantly, more likely to *support assisted suicide for a woman in coma* than the reference of \$75,000 or more ($p < 0.05$). We found that a one unit increase in the factor score for *personal attitudes towards assisted suicide for oneself* statistically significantly increases the odds of *supporting assisted suicide for a woman in coma* by 2.1 times ($p < 0.001$).

In our fourth logistic regression model we examined *support for assisted suicide for a man diagnosed with AIDS* and it was found to be not moderately or statistically significant ($p > 0.10$). In our fifth logistic regression, we found that our model statistically significantly predicted *support for assisted suicide for a baby born with a genetic disorder* ($p < 0.001$). A one unit increase in the respondents' *age* increased the odds of supporting assisted suicide for a baby born with a genetic disorder by 1.02 times ($p < 0.05$). We found that a one unit increase in the factor score for *personal attitudes towards assisted suicide for oneself* statistically significantly increases the odds of *supporting assisted suicide for a baby born with a genetic disorder* by 1.5 times ($p < 0.01$).

In our sixth and final logistic regression model, we found that our model statistically significantly predicted *support for the death penalty* as a punishment ($p < 0.001$). *Males* are 2.6 times, statistically significantly, more likely to *support the death penalty* compared to *females* ($p < 0.001$). Respondents with a *high school education or less* are 2.7 times, statistically significantly, more likely to support the death penalty compared to respondents with *some college education or more*. We found that a one unit increase in the factor score for *personal attitudes towards assisted suicide for oneself* statistically significantly increases the odds of *supporting death penalty* by 2.4 times ($p < 0.001$).

7. Discussion

Using contemporary data and statistical analyses, we tested Durkheim's (1897) theory of egoistic suicide by examining sociological data collected from the Detroit Area Study and examining its impact on support for state sanctioned death. Results from our study generally support a number of the theoretical assumptions about egoistic suicide made by Durkheim (1897).

We found evidence to support our first hypothesis, that there exist a number of socio-demographic variables that are strongly linked to attitudes towards assisted suicide for oneself. More specifically, male respondents were found to have significantly higher support for assisted suicide

for oneself compared to female respondents. The gender difference in support for assisted suicide for oneself replicates Durkheim's (1897) results that demonstrate that males commit higher rates of suicide compared to females (Table 8, in appendix).

Also, we found that race is associated with support for assisted suicide for oneself. White respondents had significantly higher support for assisted suicide compared to Blacks. Durkheim (1897) did not explicitly detail statistical racial differences in his examination of the suicide rate. However, racial differences are important for understanding attitudes towards assisted suicide because our findings replicate previous findings where Blacks are less supportive of assisted suicide compared to Whites (Emanuel et al., 2000).

Our study replicates Durkheim (1897) study because we found that religious preference does affect attitudes towards assisted suicide for oneself. Catholics and Protestants did have moderately statistically significant differences in their attitudes towards assisted suicide for oneself. Similarly, we found that religious orientation in terms of the strength of an individual's religious beliefs has a statistically significant impact on support for assisted suicide for oneself. We found that respondents who rated their religious beliefs as very important had significantly lower support for assisted suicide. Durkheim's (1897) theory of suicide never controlled for strength of religious beliefs when examining differences between Catholics and Protestants. Our results allow us to interpret this as evidence of how respondents who value their religious beliefs as very important may be consequently promoting strong social bonding and increased valuation of life.

We found evidence that may refute Durkheim's (1897) claim that "widowed persons kill themselves more often than married person (p. 136)." Our data demonstrated that single individuals had lower support for assisted suicide for oneself compared to those who are married or in a relationship. This finding is interesting because it contradicts the dominant research narrative about how single individuals experience depression or anxiety more because of loneliness and alienation. Interestingly, our results indicate that being in a relationship is associated with increased support for assisted suicide for oneself. Durkheim (1897) found that nations with lower rates of married individuals have higher suicide rates (Table 8, in appendix). Our findings may reflect a significant change in how the quality of life is perceived by those who are married or in a relationship when compared to those who are single.

Also, we found respondents support for assisted suicide for oneself was related to political orientation. More specifically we found that respondents who self-identified as liberal had significantly higher support for assisted suicide for oneself compared to those respondents who self-identified as conservative and moderate. Although, Durkheim (1897) did not explicitly control for political orientation in his study of the suicide rate, we suspect that religious identification may be analogous to political orientation. We assume that those respondents who self-identify as liberal may have more progressive views that promote individualism and respect for social rights. Similarly, we suspect that those who self-identify as conservative may have beliefs that promote moral values and adherence to religious dogma that outright rejects suicide. However, more research is needed to understand how religious orientation and political orientation interact to impact support for assisted suicide for oneself.

While further examining our first research question, we demonstrate how a hierarchical and additive multivariate model allows us to improve predictability of assisted suicide for oneself, while controlling for the independent variable groupings: socio-demographic characteristics, education and employment characteristics, political orientation, and religious orientation. When including all predictors variable groupings into the model we find that being White is our strongest socio-demographic characteristic for predicting support for assisted suicide for oneself. Age, gender, and relationship status were not significant predictors of assisted suicide for oneself.

We find that our strongest education and employment characteristic is the respondents' income-level for predicting support for assisted suicide for oneself. More specifically, we find that respondents who earn $29,999 or less a year have significantly lower support for assisted suicide. Income is a stronger predictor of support for assisted suicide for oneself compared to education level and employment status. Durkheim (1897) found that nations with higher rates of literacy have higher suicide rates (Table 8, in appendix). It is possible that income-level is a more proximate measure of material and intellectual capital rather than education and employment status alone. This finding demonstrates how Durkheim's (1897) theory of suicide requires considerable theoretical refinement for measuring suicide in the 21st century.

For our second research question, we examine how our multivariate model predicts support for assisted suicide for others in a medical context. We examined responses from five different medical scenarios under which respondents would have to consider support for assisted suicide. For our second research question, our most consistent predictor across the five different outcomes for supporting assisted suicide for others in a medical context is supporting assisted suicide for oneself. Therefore, supporting assisted suicide for oneself is closely associated with supporting assisted suicide for others. Among the other sociological variables we analyzed, we did not find consistency in their predictability of assisted suicide for others in a medical context. We did not find strong support for our hypothesis that sociological variables are significant predictors of assisted suicide for others. This finding is generally inconsistent with Durkheim's (1897) theorization of suicide. Therefore, other variables that are unrelated to sociological considerations may be impacting support for suicide for oneself and others. Further research is needed to understand how individual level psychological characteristics and factors related to mental health diagnosis and psychiatric treatment dosage impact support for assisted suicide towards oneself and others. Interestingly, in model 4, in table 7, we did not find that support for assisted suicide for oneself is predictive of support for assisted suicide for a man with AIDS. Therefore, respondents may not view assisted suicide for patients with AIDS with the same moral beliefs or health priority as they view assisted suicide for other terminal conditions.

Finally, for research question 3, we hypothesized sociological variables and support for assisted suicide for oneself is predictive of support for the death penalty. Interestingly, we found that respondents who were males, had a high school education or less, and had strong support for assisted suicide for oneself were significantly more supportive of the death penalty. The significant relationship between gender and support for the death penalty is important because it adds support to the generalizability of Durkheim's (1897) theory of suicide. Although, Durkheim (1897) found evidence that suicide rates are higher among men than women, we believe this phenomenon may be generalizable toward attitudes related to the death penalty.

Also, findings from gender differences in support of the death penalty in our study are inconsistent with findings published by Soss, Langbein, & Metelko (2003). They found that gender was not a major predictor of attitudes towards the death penalty among white Americans. Instead, they found that the primary variable that predicts support for the death penalty is prejudice. Soss, Langbein, and Metelko (2003) discuss how support for the death penalty has to be understood in the context of the political psychology of capital punishment. Soss, Langbein, and Metelko (2003) state that "The legal and political viability of capital punishment hinges on both its consequences in practice and its meaning in the public mind (p. 415)." Therefore, research on state sanctioned death in general needs to consider the political psychological implications when measuring attitudes towards the death penalty. Narrowly, focusing on sociological concepts when developing a general theory of state sanctioned death may lead to poorly specified statistical models which can cause researchers to over-generalize their observations when interpreting results. We recommend more complex and interdisciplinary theoretical models when examining attitudes towards state sanctioned death.

8. Conclusion

In sum, the results we achieved from testing our hypotheses based on our research questions regarding the impact of sociological variables on state sanctioned death outcomes highlight the continuing importance of Durkheim's (1897) theory of suicide as a general theory for understanding assisted suicide and the death penalty. Also, given numerous inconsistencies in our findings, we promote theoretical refinement or the restructuring of sociological variables in order to conceptualize and measure support for state sanctioned death. In our search for a general theory of state sanctioned death, we believe that research and scholarship using interdisciplinary approaches are needed, such as, using integrative public health, sociological, psychological, and criminological approaches when specifying statistical models. Discussion and integration of paradigms would provide the foundations for developing a strong model for understanding and measuring attitudes towards state sanctioned death. Findings from our study are important because they highlight how assisted suicide and the death penalty have similar underlying sociological foundations.

Some of the sociological variables we specified for predicting assisted suicide for others are stronger predictors of support for the death penalty. These findings are important because they highlight how sociological variables may be more important for understanding support for the death penalty and less important for understanding support for assisted suicide. Although, both outcome groups are related to support for state sanctioned death, they may diverge in terms of their underlying sociological assumptions and conceptualization. More research on the theoretical foundations of state sanctioned death is needed for examining attitudes towards assisted suicide and the death penalty.

8.1. Limitations

The primary limitation of our study is that we cannot establish internal validity between our sociological predictor variables and outcome variables for assisted suicide and death penalty. The internal validity of this research is limited due to the removal of cases that had missing data in their survey responses from the analysis. Although, removing cases with missing data allowed

the researcher to analyze the data with more efficiency, missing data is a threat to validity and reliability and may cause type 1 and type 2 errors.

8.2. Ethical Considerations

This study is designated as exempt by the Institutional Review Board at California State University, Stanislaus. This study used secondary data that was publicly available from Inter-university Consortium for Political and Social Research (Anspach, 1999).

9. Acknowledgements

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10. Appendix

Number of Suicides per million inhabitants in the Cantons of Switzerland (Durkheim, p. 108)
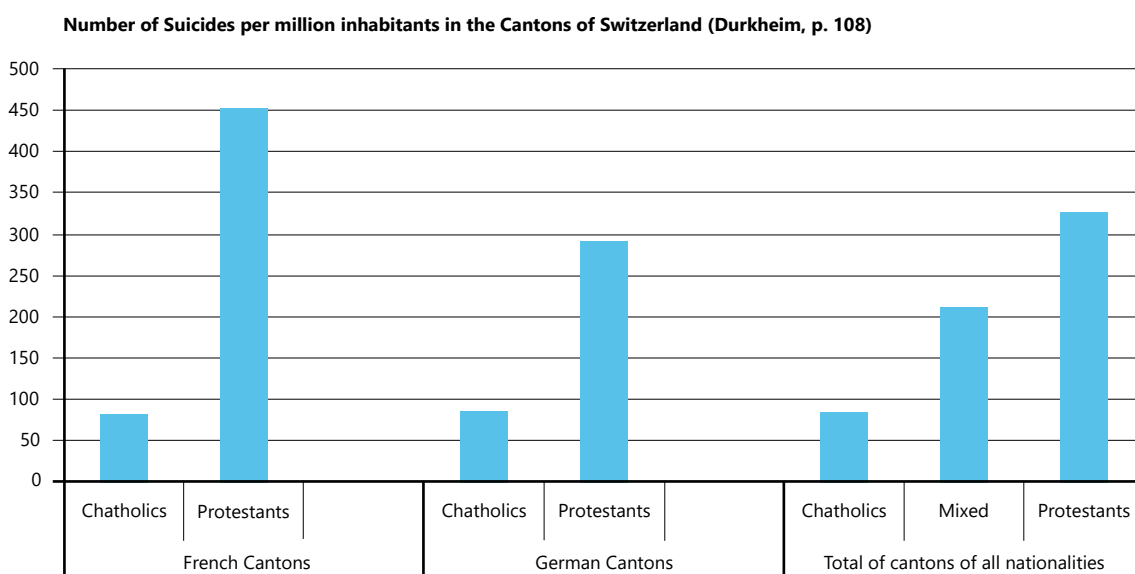

Figure 1 Number of Suicides per million inhabitants in the Cantons of Switzerland (Durkheim, 1897)

Table XXIX Proportional share of each sex in suicides of each category of martial status in different countries of Europe (Durkheim, p. 231)
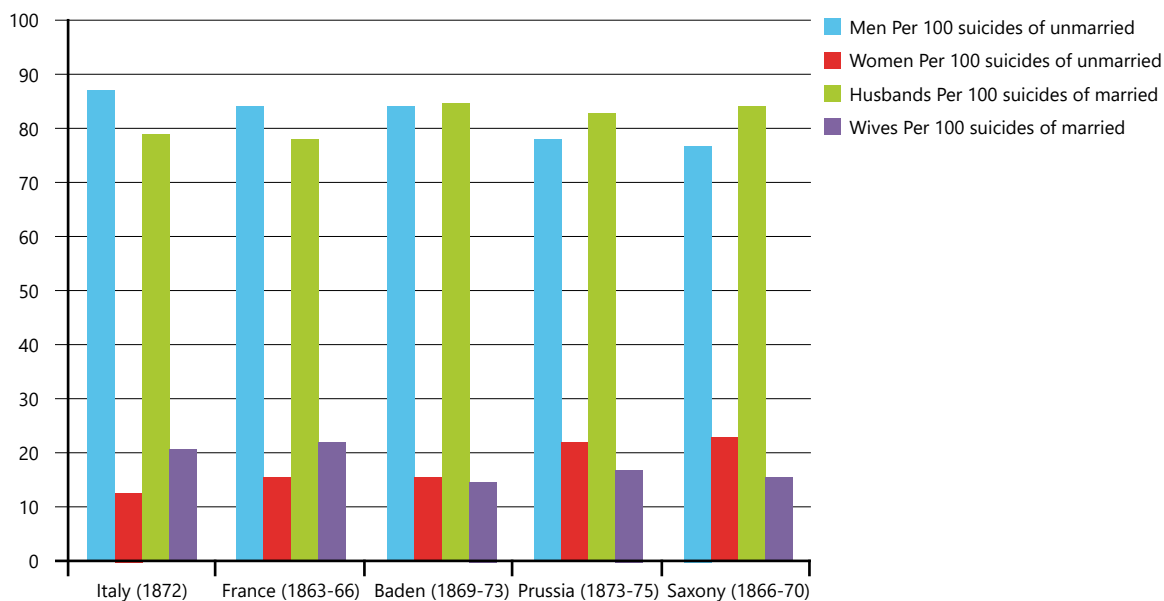

Figure 2 Comparison between genders and marital status influencing suicide rates across nations (Durkheim, 1897)

Table XIX Comparison of italian provinces with reference to suicide and education (Durkheim, p. 119)
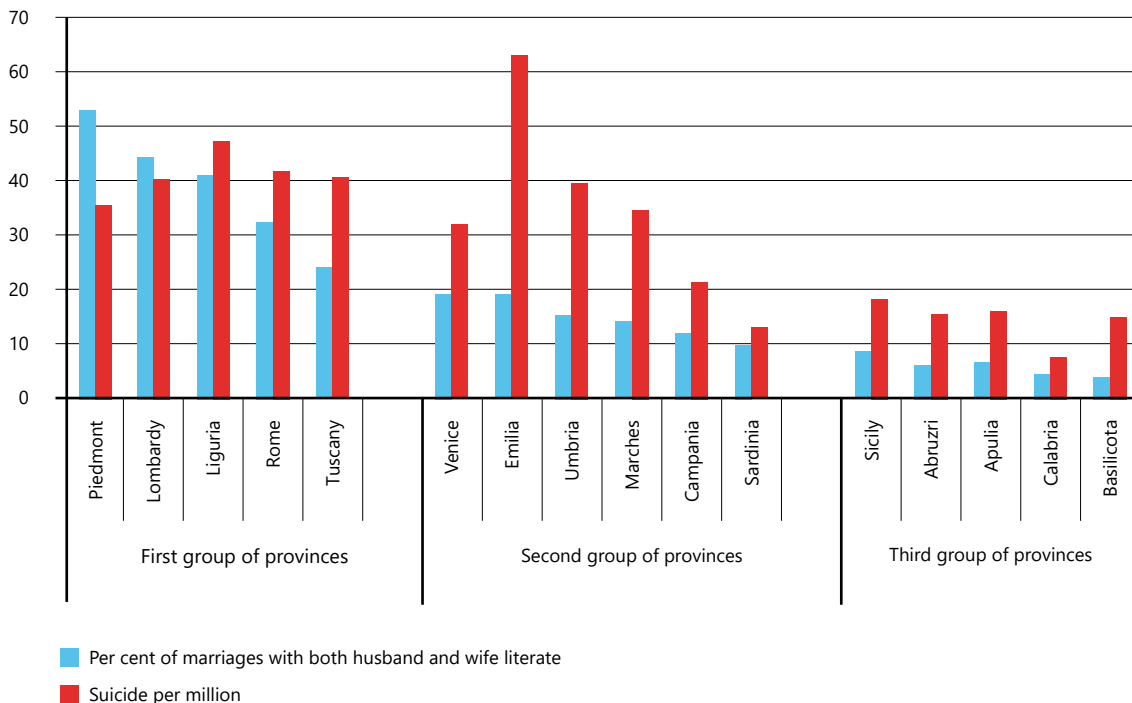

Figure 3 Comparison of Italian provinces with reference to suicide and education (Durkheim, 1897)

Table 8 Descriptive Statistics and Factor Scores

	n (%)	Missing n (%)	Factor Score
N	1109 (100)	0 (0)	-
Factor analysis variables **Support for removing oneself from life support to end your life**			
I would never consider ending my life under any circumstance	93 (8)	136 (12)	0.778
Definitely not consider	81 (7)	-	-
Probably not consider	149 (13)	-	-
Probably consider	316 (29)	-	-
Definitely consider	334 (30)	-	-
Support for using prescribed medications to end your life			
I would never consider ending my life under any circumstance	150 (14)	142 (13)	0.933
Definitely not consider	203 (18)	-	-
Probably not consider	161 (15)	-	-
Probably consider	204 (18)	-	-
Definitely consider	249 (23)	-	-
Support for using lethal injection to end your life			
I would never consider ending my life under any circumstance	166 (15)	150 (14)	0.94
Definitely not consider	216 (20)	-	-
Probably not consider	134 (12)	-	-
Probably consider	208 (19)	-	-
Definitely consider	235 (21)	-	-
Support for having friend or family to end your life			
I would never consider ending my life under any circumstance	167 (15)	154 (14)	0.865
Definitely not consider	351 (32)	-	-
Probably not consider	216 (20)	-	-
Probably consider	124 (11)	-	-
Definitely consider	97 (9)	-	-
Support for using Kevorkian assistance to end your life			
Strongly Disapprove	287 (26)	144 (13)	0.78
Disapprove	189 (17)	-	-
Approve	302 (27)	-	-
Strongly Approve	187 (17)	-	-

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