To leave the boat for the sea:

Attitudes towards euthanasia, the good death, and towards suicide, the invited death

Hajma Noémi
Neptune code: F04BQQ

University of Pécs

Supervisor: Dr. Teleki Szidalisz Ágnes, senior lecturer

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Abstract

Objectives The aim was to investigate a Hungarian general population sample's attitude towards euthanasia and suicide taking into consideration the roles of relevant predictors. Correlation between the two attitudes were also explored in order to better understand their connection.

Methods The final sample consisted of 264 respondents, with a majority of women (74.2%) and a mean age of 37.3 years (SD=16.1). Attitudes were measured by The Euthanasia Attitudes Scale and The Attitudes Towards Suicide. Relevant demographic data were collected as potential predictors. An open-ended question was provided in order to gain further insights. Data analysis was performed using the computer software program Jamovi (Version 2.3). Assessment of differences were based on Pearson's r tests, independent samples t-tests and ANOVA measures. Significance level was set at < 0.05.

Results The mean score for euthanasia was 119 out of 150 (SD=26), while for suicide the mean was 44 out of 70 (SD=12). A significant positive correlation was found between the scores on the EAS and the ATTS's three factors measuring acceptance of suicide ($p < .001$). Significant differences were found in relation to sex ($p = 0.009$ for euthanasia, $p = 0.046$ for suicide), age ($p = 0.006$ for euthanasia, $p < .001$ for suicide), religion ($p < .001$ for both), religion's effect $p < .001$ for both) and political affiliations ($p < .001$ for both) in predicting attitudes. Results of the qualitative part further supported those of the quantitative part, mainly focusing on support for euthanasia.

Conclusions The sample was permissive towards euthanasia and were understanding and acceptive towards suicide as a solution and as a right, which conclusion were supported both by the quantitative and the qualitative analysis. Sex, age, religion, religion's effect in one's life and political affiliations are all associated with attitudes towards euthanasia and suicide. Precisely, being an atheist, having no religious affiliation at all, or having other equally or more important deciding factors in one's life other than one's religion, being a woman and a liberal and of a younger age are predictors of a permissive attitude towards euthanasia and suicide. Those who were permissive towards suicide were likely to accept euthanasia.

Keywords; Euthanasia • Suicide • Attitude • Predictor

Table of contents

Introduction.... 4
Euthanasia.... 4
Classification of Euthanasia.... 5
For & Against Euthanasia.... 5
Suicide.... 7
The Role of Stereotypes.... 8
Research Problem.... 9
The Role of Religion & Politics.... 9
The Role of Age & Sex.... 10
The Connection Between Euthanasia & Suicide.... 11
Hypotheses.... 11
Methods.... 12
Instruments.... 12
Participants.... 13
Procedure & Data Analysis.... 14
Results.... 14
The Sample.... 14
The Connection Between the Attitudes - Hypothesis 5.... 15
The Role of Religion - Hypothesis 1.... 16
Other Factors - Hypotheses 2., 3. & 4.... 17
Other Factors within the ATTS.... 18
The Open-ended Question.... 19
EUTHANASIA.... 20
SUICIDE.... 23
Discussion.... 24
The General Population's Attitude Towards Euthanasia and Suicide.... 24
The Role of Religiosity Regarding End-of-Life Issues.... 29
Limitations.... 30
Conclusion.... 31
References.... 32

Introduction

Measuring attitudes is highly relevant both in the case of euthanasia and suicide, although with differing focuses as to where and in what way are they the most useful. Considering euthanasia, attitudes might have to do more in regard to a potential legalization, further legislations and the creation of safeguards (Pereira, 2011), while in the case of suicide, attitudes are mostly important in the clinical field serving as a basis for prevention programmes and interventions for suicidal persons (Wallace, 1994).

The scientific study of attitudes within the field of psychology has long been an important area since attitudes can be used for the creation of guidelines and decision making, even legal ones, thus they have a significant role in determining behaviors (Rokeach, 1973). Several definitions exist but among the most widely accepted and cited ones, there is the definition given by Thurstone (1928), defining attitude as the "sum of personal tendencies and feelings, prejudice and bias, thought, belief, fear and anxiety on any subject" (cited in Kayagil, 2012, p. 3598). Additionally, an attitude is "an individual's disposition to respond favorably or unfavorably to an object, person, institution, or event" (Ajzen, 1989, p. 241).

In a practical sense, attitudes are expressed in one's affects, behaviors and cognitions (Myers, 1993), and they are regarded as important parts of personality as they have the power to predict one's behavior and they also tend to be stable over time (Larsen & Buss, 2005). In contrast, others argue that attitudes are not necessarily permanent and certainly not unchangeable and this have critical importance especially in regard to suicide prevention programs (Diekstra & Kerkhof, 1989).

Euthanasia

The term "euthanasia" was derived from Greek, taking together the word "eu" meaning good and "thanatus" meaning death, thus euthanasia literally means good death. Despite this seemingly positive connotation, euthanasia has been and still continues to be an intensely debated topic and a public concern, especially in more affluent cultures and countries where there is a steady increase of age in the population alongside with improved medical services like life-support technology (Wasserman et al., 2005). In this technology dominated culture advanced medicine has the chance to challenge human limitations; we can not only live in ways that were previously impossible, but we can also die in novel ways. Particularly so if we

look at the so-called ‘Sarco Suicide Pod’, a capsule developed and used in Switzerland, which assists people in suicide, providing a painless and quick death (Kochan, 2022).

The emphasis on either the quality or quantity of life brings another meaningful aspect to this debate. Personal suffering, be it physical or mental, pain and dignity are important factors when discussing end-of-life issues, as usually the experience of these constitute the basis of a final decision whether to actively terminate life or allow it to end on its own by the refusal of life-sustaining treatments. In this sense, euthanasia could be understood as a mean of enhancing the quality of life versus prolonging it at all costs (Holloway et al., 1995).

Classification of Euthanasia

In practice, euthanasia can be categorized in several ways, the most frequent distinction being that of active and passive euthanasia (Keown, 2002). The former one refers to cases where a doctor actively participates in the process of death by prescribing or administering a lethal drug that terminates the life of a patient, while in the latter case there is no additional prescription of any medication, but most regularly the refusal of life-prolonging technology and treatments thus allowing the patient to die. The right to refuse any medical treatment, even life-saving or prolonging ones, is commonly recognized by law, thus many countries allow passive euthanasia, which is occasionally also called as “mercy killing” (Chowdhury, 2012). Finally, physician-assisted suicide, the most controversial form of euthanasia, where the patient self-administers the lethal drug prescribed by the physician (Wasserman et al., 2005). Passive euthanasia typically has the strongest support out of all forms of euthanasia, but certainly in opposition to its active form (Wasserman et al., 2005).

For & Against Euthanasia

Despite the ongoing debates and controversies surrounding euthanasia, the practice has been legalized in several countries, mainly in a few Western European countries and some US states (Karumathil & Tripathi, 2021). Hungary is not included in this list, as based on The Health Care Act (1997. CLIV.) only the refusal of life-sustaining technology and treatments is allowed. However, this law can only be practiced by those who have such a disease which requires these technologies even in the earlier stages of their illness, thus it can be argued that the law discriminates against those who have another type of terminal illness, for instance amyotrophic lateral sclerosis (ALS), in which affected patients only need breathing-aid technology at the very last stage of their diseases, and preceding that they suffer greatly

mainly mentally as a result of the undignified state of their condition which seriously compromises subjective quality of life (Frank, 2023). Such is the case of Karsai Dániel, a hungarian lawyer who was recently diagnosed with ALS and now he is working towards the change of the criminal law that targets people who aid others to commit suicide regardless of the motivation and health condition of the person who wishes to die. His case makes the question of end-of-life decisions a particularly prominent public discussion in Hungary at the exact time of writing this paper reflecting the topic's relevance.

To prevent abuses of the law, in every jurisdiction laws and safeguards have been put in place in order to minimize or as aimed, completely eliminate the possibility of misuse (Pereira, 2011). For instance, explicit consent by the person who wishes to end his or her life is a basis along with administration of the lethal substance only by physicians after consulting with a second, independent physician who also approved of the practice, and lastly, mandatory reporting of all cases is also required. Nonetheless, critics of the practice warn the public that these safeguards can be bypassed and that there is a very real chance of broadening the law in regard to the people who are eligible for euthanasia (Pereira, 2011).

Commonly and firstly euthanasia is considered both in practice and in theory in case of terminally ill patients who are suffering greatly and their pain cannot effectively be controlled anymore (Levin et al., 2018). However, opposers highlight the hazard of going down the so-called "slippery slope", referring to a situation in which an innovation follows through an uncontrolled and unintended extension finally reaching a way broader boundary compared to the initial aims and borders (Montagna, 2023). In the case of legalization of euthanasia this argument alarms of the chance of starting from only terminal patients who are eligible to die in this way to people who do not suffer from such severe conditions all the way to those who are agonized by a mental illness alone or to people who are vulnerable and not even capable of consciously consenting, including children who have a disability. Those who protest against the legalization of euthanasia are specifically concerned about the vulnerable members of society who could potentially be pressured into wishing to die by making them feel as if they are no longer "useful" for society and a burden to their loved ones either because of their advanced age or their physical and/or mental health (Sulmasy et al., 2018). Thus, euthanasia for some can be associated with the idea of killing the weak, and that consequently this practice could lead doctors to not treating patients to the best of their abilities as death is an option easily accessed and available. Such opposers are also regularly

referring to the Hippocratic oath which binds every single physician as they must partake in it, clearly stating that one must not cause harm to others and that their primary aim as professionals is to protect life (Chowdhury, 2012). Euthanasia can also be portrayed as unnatural and an upsetting experience not just for physicians but for relatives as well (Kouwenhoven et al., 2013).

In support of euthanasia, considered as a right to die, arguments are focusing on such concepts as dignity, autonomy and free will, allowing the individual freedom of choice and the opportunity to express his or her needs and desires even if it means that a merciful death is requested (Math & Chaturvedi, 2012). Following this logic, patients must have the right to autonomously choose when and how to die, as their body is their own thus they have the right to control what happens to it. Regarding dignity, many people do not wish to reach such a state where their consciousness, mental and physical abilities and thus their quality of life is seriously compromised by a disease which also brings unbearable pain and suffering. In a sense, the notion of the right to life can be honored by respecting the right to die with dignity (Math & Chaturvedi, 2012). The right to die thus have the chance to contribute to an actual good death, fulfilling the meaning of the word 'euthanasia', by means of preventing suffering people from committing suicide which would be highly distressing not just for them but for their loved ones as well (Kouwenhoven et al., 2013). Personal choice, autonomy and the subjective assessment of the situation is also highlighted in the argument that focuses on those people for whom the continuation of life in a minimally or totally unconscious state would be actually worse than death itself. Following this logic, once people deem their life to be not worth living anymore in a given condition then it is a violation of human freedom to force them to carry on, the exact same way as it would be an unjustified interference to force people to die when they think that life is worth continuing (Benatar, 2011).

Suicide

Suicide is recognized as a global health issue by the World Health Organization as more than 700.000 individuals take their life every year globally, thus suicide is one of the leading causes of death worldwide. In fact, more people die by suicide than victims of malaria, HIV/AIDS, breast cancer, or war and homicide taken together. It is also the fourth leading cause of death in the young generation, among 15-29 year olds (WHO, 2019). Considering Hungary, suicide as a public health concern is highly relevant since among European countries Hungary registered the second highest rate of deaths by suicide (Eurostat, 2020).

Attitudes towards suicide constitutes to how we approach this topic both on a personal and on a societal level as they play a significant role in our behaviour (Rokeach, 1973). Attitudes make themselves manifest in the classification system as well, since based on a popularized view outlined by Shneidman (1985), suicide attempts were categorized as ‘parasuicides’ and actual suicide attempts. Parasuicides refer to those attempts that researchers viewed as lacking in the potential of ending life in contrast to those actual ones that had this potential. This categorization implies that the fundamental motivation differs between these two, stating that a ‘true’ suicide attempt’s ultimate aim is to escape from the unbearable psychological pain experienced by the suffering individual while those who commit a ‘parasuicidal’ act first and foremost aim at communicating their need for help, thus these actions are “cries for help”, without the real intention to die (Shneidman, 1992).

However, this method of classification has been criticised and attacked from several fronts since such a view fails to take into account the accessibility of certain means, the public’s general lack of knowledge of the lethality of a tool, the well-documented sex difference in the choice of means and lastly the true intent of the suicidal individual which could differ vastly case by case (e.g., Canetto, 1992). Additionally, even in the case of nonsuicidal self-harm, while it is documented that most of those people who engage in self-destructive behaviours are not likely to commit suicide, previous history of self-harm is nonetheless the strongest predictor of future suicide and/or a suicide attempt, thus any kind of underlying motivation deserves careful and serious attention (Bennardi et al., 2016).

The Role of Stereotypes

Stereotypes play an important role in connection to suicide as they have the potential to shape attitudes which could even result in an intentionally or unintentionally harmful manner when dealing with a suicidal person. Common stereotypes include categorising suicidal people as emotionally weak, attention-seeker, selfish, cowardly and malinger, while also considering them as impious with notions such as they are not praying enough or that their belief is not strong enough. Furthermore, the idea that suicide is a betrayal to the family is also widespread (Sheehan et al., 2017). Stigmatisation can also be manifested within the suicidal individual through internalization, thus negative attitudes from the external world can develop into self-stigmatisation (Corrigan et al., 2005). The given person can have the belief that the stereotypes and prejudices of society are actually true and applicable to him or her, thus the individual will start to think of itself as devalued, unworthy and a misfit in relation to

others. Consequently, search for help can be significantly negatively affected, as the main reasons that condition the willingness to ask for help are prejudice (expressed by negative cognitions and emotions) and discrimination (expressed by behavior) towards the person who is stigmatized either by society or by him/herself or even by both avenues. This can eventually lead to social exclusion, avoidance, limited employment opportunities and more (Henderson et al., 2013).

Similarly to euthanasia, suicide is also a complex personal and societal issue, although in regard to suicide there might be more universally accepted statements, such as that generally cultures and countries around the world differ in terms of suicide rates, motives for suicide and methods used for it, social support and meanings given for suicide and maybe most importantly the availability and quality of health care provided for suicidal individuals (e.g. Lester, 2013; Siau et al., 2017). Despite the prevailing differences however, condemnation of suicide can be found in virtually every culture. Even the term "committed suicide" reflects an attitude which evokes the not so long-ago past when suicide was legally considered a crime and a sin, deserving of abomination. Legislation has changed but society changes more slowly and as a result stigmatization is still very prevalent and strong (Sudak et al., 2008).

Research Problem

Several predictors have previously been identified as playing an important role in relation to an individual's attitude both towards euthanasia and suicide. These predictors are investigated in this paper as well with the aim of either strengthening the already existing literature, to pose some challenges regarding the established knowledge, or simply to explore and deepen the understanding of different predictors' roles in relation to end-of-life issues.

The Role of Religion & Politics

First and foremost, religiosity has been proven to be of utmost importance, as it is consistently shown to have a strong negative influence on attitudes towards euthanasia and suicide, that is, those who are highly religious are very likely to have negative attitudes (Aghababaei & Wasserman, 2013; Televantos et al., 2013; Chowdhury, 2012; Saiz et al., 2021; Eskin et al., 2020). More specifically, the more religious a person is; the higher the importance of religion the stronger the opposition towards both euthanasia and suicide (Singh, 1979; Foo et al., 2012; Stack, 2013; Terkamo-Moisio, 2016; Ziebertz & Reindl, 2013;

Inglehart et al., 2021). Reversely, those who are either religious but not as strongly, or not as committed to their religion's teachings; those who are more secularised; those who do not believe in any religion are likely to be more accepting, thus having a more positive attitude towards both euthanasia and suicide (Steck et al., 2014; Cohen et al., 2012; Danyliv & O'Neill, 2015; Verbakel & Jaspers, 2010; Solomon & Peterson, 2020; Cohen et al., 2006).

Liberals are shown to be more supportive of euthanasia, while those who have a conservative mindset are likely to oppose it (Lester et al., 1990; Caddell & Newton, 1995; DeCesare, 2000; Moulton et al., 2006; Dworkin, 2013; Aghababaei et al., 2013, Bulmer et al., 2017). Additionally, politically right wing individuals are also more likely to have stigmatizing attitudes towards suicide, along with stereotypes and social distance in relation to mental illness (Diekstra & Kerkhof, 1988; DeLuca & Yanos, 2015), and parallel to this conservatives are also more likely to have negative attitudes towards suicide, while liberals are more likely to approve of it (Sawyer & Sobal, 1987; Agnew, 1998; Stack & Kposowa, 2008).

The Role of Age & Sex

In regard to age, younger generations are shown to be more accepting both of euthanasia and suicide (e.g. Singh, 1979; Cohen et al., 2006; Li & Philips, 2010; Bartolomé & Coromina, 2020; Chowdhury, 2012; Na et al., 2018; Pereira & Cardoso, 2019), while also being less stigmatizing towards suicidal people as they were less likely to conceptualize it as an individual failure, but rather as a societal malfunction (Boldt, 1983). Contradicting this finding however, more recently Batterham and colleagues (2013) found that young adults, despite having higher levels of suicide literacy, are actually more stigmatizing. Nonetheless, looking at an analysis of age-cohort from 1977 to 2016 in the USA, while the general pattern is that the majority of people support both euthanasia (68%) and also suicide for terminally ill persons (57%), the groups that tend to be more supportive are younger (Attell, 2017).

With respect to sex, while findings are more likely to be contradictory, women are in many instances shown to be less accepting of suicide while also being less supportive of euthanasia (DeCesare, 2000; Finlay, 1985; Cohen et al., 2006; Televantos et al., 2013; Singh, 1979; Attel, 2017; Deluty, 1989). According to Finlay's view, this gender difference could be associated with the gender correlation with religiosity, as women tend to be more religious than men (Finlay, 1985). However, there are several studies that could not find any significant differences between the two genders (Stronegger et al., 2013; Terkamo-Moisio, 2016; Zou et

al., 2016). In fact, one of the most stable socioeconomic factors associated with assisted suicide in Switzerland over a 12-year-old period is being a female (Steck et al., 2014). Furthermore, across several different studies women are shown to be more empathetic and sympathetic towards suicidal people (Stillion et al., 1984; White & Stillion 1988), while simultaneously are also more likely to express the intention to help, although in regard to the general acceptability of suicide, there were no gender differences (Wallace, 1994). Be that as it may, harsher and more stigmatising attitudes towards suicide and suicidal individuals are shown to be more characteristic of men, even though most men do not have an intensely negative attitude (Pereira & Cardoso, 2019; Batterham et al., 2013; Oliffe et al., 2016).

The Connection Between Euthanasia & Suicide

Three factors within the questionnaire measuring attitudes towards suicide were found to be a solid basis for the general acceptance of suicide and its normative valuation, taken as a unity (Stecz, 2021). In regard to the acceptability of suicide in case of terminally ill persons, the trend is that across all survey years, approval of euthanasia is higher compared to suicide (Attel, 2017). Those who already have a more permissive attitude to the more stigmatized way of terminating life, might also be more ready to accept euthanasia as a legalized practice, especially since many people may see it as a safe and controlled death as a result of the medical professionals presence (Attel, 2017).

Hypotheses

Considering all of the above, the current study operates based on the following hypotheses.

1. Religious people compared to atheists are expected to have more negative attitudes both towards euthanasia and suicide, the most negative ones possessed by those who are the most intrinsically religious.
2. Younger people compared to older participants are expected to have more positive attitudes both towards euthanasia and suicide.
3. In relation to gender, no specific hypothesis is set up connected to euthanasia, instead sex differences will be investigated with an exploratory aim. Towards suicide however, men are expected to have stronger negative attitudes.
4. Liberals are expected to have more positive attitudes towards both euthanasia and suicide, while conservatives are expected to show more negative attitudes.

5. Those who are more permissive of suicide are expected to be more acceptive of euthanasia.

Methods

Instruments

At the beginning of the questionnaire, participants were asked to provide some of their essential demographic data such as sex, age, educational background, permanent residency, political affiliation along with its intensity, and occupation, where if someone was a university student, he or she had to indicate if he or she belongs to a healthcare faculty (medical school or psychology) or studies on another faculty and similarly, within occupation respondents had the chance to indicate if they work in a field related to either physical or mental healthcare. Regarding religion, participants had to choose between the five main world religions or they could declare themselves either an atheist or an agnostic and lastly, the opportunity for a more personal religion was also given with the statement "I am religious/spiritual and/or I am a believer on my own personal terms and ways". Those who wished could also indicate their religious sect such as Catholic or Protestant. Finally, religion's effect on the respondents life was also inquired with the pregiven answers ranging from strong intrinsic religiosity ("My whole approach to life is based on my religion, and I try hard to live all my life according to my religious beliefs") to moderate (Although I believe in my religion, many other things are equally or even more important in my life") and total a-religiousness ("I am not religious") with two additional ways of how religion's effect could manifest ("I practice my religion mainly because of the of opportunity of social bonding, to spend time with my loved ones"; "What religion offers me most is comfort in times of trouble and sorrow").

The Euthanasia Attitudes Scale (EAS) is a 30-item questionnaire (Holloway et al., 1995). Within the 30 questions 16 are positively and 14 are negatively structured, balancing between passive and active euthanasia. Five factors were extracted, accounting for 54% of the common variance. Factors were labeled as follows; general orientation toward euthanasia, patients' rights issues, role of life-sustaining technology, professional's role, ethics and values. The scale possesses excellent psychometric properties exhibiting stability over time, internal consistency, and discriminant validity. Euthansia was defined within the questionnaire as

“acting to terminate or failing to act in such a way as to extend the life of persons who are hopelessly sick or injured for reasons of mercy” (Holloway et al., 1995, p. 58).

Changes in the current study were made in regard to the structure of the possible answers. Contrary to the original where there is no chance to take an undecided position with the 4-point Likert scale, this study allowed it using a 5-point Likert scale, ranging from strongly agree to strongly disagree at the two ends. This change also resulted in the need to alter the point system of evaluation, as based on the original scores below 75 are indicative of an overall negative attitude, while above and to the maximum (75-120), attitudes are considered as positive. In the current system, where the maximum score is 150, the threshold was altered to negative attitudes below 90, while a score in between 90 and 150 means a positive attitude.

The Attitudes Towards Suicide (ATTS) is a 37-item questionnaire developed by Renberg and Jacobsson (2003). Answers are given on a 5-point Likert scale, ranging from strongly agree to strongly disagree. Higher scores are indicative of a more positive attitude and vice versa (Renberg et al. 2008). The scale has a ten-factor model, explaining 60% of the total variance. The factors are as follows; suicide as a right, incomprehensibility, noncommunication, preventability, tabooing, normal-common, suicidal process, relation-caused, preparedness to prevent and resignation.

Lastly, at the very end of the questionnaire, an open-ended question was placed in order to give an opportunity for the participants for a more free and detailed response. The wording of the instruction was the following; “Here you have the opportunity to express your thoughts on the topic in your own words instead of the pre-given options. Please take advantage and share your opinion in this informal form, touching any part of the questionnaire. This is a list of free ideas. This part is optional.”

Participants

In total, 270 individuals responded to the questionnaire, however the final sample included the answers of 264 people. Exclusion criteria was primarily based on the attention-check questions (“In order to verify that you pay attention, please select the number (...) option), as those who failed to give the correct answers on both of these were automatically excluded. Answers sheets of those who gave a wrong answer on only one of these checks were carefully examined to see if their responses are otherwise consistent or not. If they were in fact consistent, then these respondents were included in the final analysis. The questionnaire

was distributed and advertised mainly through social media (Facebook & Instagram) while a few printed versions were also given out within the local community of the author. Answers from these printed versions were copied to the online form by the author. All respondents were informed that their anonymity will be protected and their answers will only be used as part of a research practice completion. Importantly, at the front page of the questionnaire, potential participants were informed about where could they seek help in case if the questions were too upsetting for them or if they themselves have suicidal thoughts or one of their loved ones; several phone numbers and websites were provided ready to help those in need.

Procedure & Data Analysis

The Hungarian version of the ATTS was given to the author by one of PhD student of the University of Pécs who conducts research concerning suicide, suicidal literacy and behavior. On the other hand, the EAS had to be translated into Hungarian during the course of this study. Back translation method was implemented by individuals who are related to the field of psychology, including both the author and the supervisor of this study. Descriptive statistics were used to describe the characteristics of the sample and for the reporting of the majority consensus on the ATTS' questions. Data analysis was performed using the computer software program Jamovi (Version 2.3). Assessment of differences were based on Pearson's r tests, independent samples t-tests and ANOVA measures. A significance level of 0.05 was considered.

Results

The Sample

The sample's (n=264) mean age was 37.3 years (SD=16.1), the youngest being 18 years old while the oldest participant was 82. Further relevant data are presented in the table below.

Table 1

Sociodemographic characteristics of the sample

Variables	n	%
Sex		
Women	196	74.2
Men	68	25.8

Education		
High school	121	45.8
University degree & above	138	52.2
Occupation		
Student	90	34.1
Permanent residency		
Village & small city	130	49.3
Bigger city & capital & agglomeration	134	50.7
Religion		
Christian	132	50
Muslim	6	2.3
Buddhist	15	5.7
Atheist	38	14.4
Agnostic	11	4.2
Spiritual/religious in a personal way	54	20.5
Religion's Effect		
Whole life approach based on religion	43	16.3
Many other things are more or equally important	93	35.2
Comfort & peace in times of trouble	50	18.9
Social bonding	4	1.5
Not religious	74	28
Political affiliation		
Left-leaning	112	42.5
Center	89	33.7
Right-leaning	63	23.8

The Connection Between the Attitudes - Hypothesis 5.

Overall, the sample was generally permissive towards euthanasia, as the mean score was 119 out of 150 (SD=26), where scores over 90 indicate a positive attitude. Moreover, the acceptance and understanding of suicide were also quite high, as out of the maximum 70

points measured by three factors within the ATTS (factors titled as “suicide as a right”, “incomprehensibilty” and “resignation/suicide as a solution”), where higher scores indicate higher permissiveness, the sample’s mean score was 44 (SD=12). In this case, scores over 42 would constitute as a positive attitude based on the same metric system as in the case of the euthanasia scale. Consequently, there was also a significant positive correlation between the score on the EAS and the ATTS’s three factors measuring acceptance of suicide. Those who were permissive towards suicide were more likely to accept euthanasia ($r=0.758$, $p < .001$).

The Role of Religion - Hypothesis 1.

There was a significant main effect for religiosity in relation to euthanasia ($F(13, 250) = 3.08$, $p < .001$). Post-hoc tests revealed that this difference was driven by significant differences between atheists and Christians ($t(250) = 4.24$, $p = 0.003$) and Muslims ($t(250) = 3.91$, $p = 0.010$), in both cases atheists showing stronger positive attitudes towards euthanasia. Similarly, a significant main effect was found for religion’s effect on participants' lives ($F (4, 259) = 18.9$, $p < .001$). Based on the post-hoc analysis this difference was due to the significant differences between those who base their whole approach to life on their religion and those for whom religion is mainly a source of comfort and peace ($t(259) = -4.19$, $p < .001$), and those for whom many other things are equally or more important in life ($t(259) = -6.96$, $p < .001$), while also differing from those who do not consider themselves as religious ($t(259) = -8.25$, $p < .001$). Additionally, there was also a significant difference between those for whom religion is a source of comfort and those who are not religious at all ($t(259) = -3,87$, $p = 0.001$). Those who are the most intrinsically religious are the same participants who are the most likely to be against euthanasia, while atheists were the most supportive of it (see Table 2).

Analogously, a main effect for religiosity regarding the permissibility and understanding of suicide were also found ($F(13, 250) = 2.85$, $p < .001$). Correspondingly to the attitudes towards euthanasia, post-hoc analysis showed that this was the result of significant differences between atheists and Christians, atheists again being more permissive ($t(250) = 4.11$, $p = 0.005$). However, in the case of suicide there was also a significant difference between Christians and those who consider themselves religious on their on personal terms, the latter more likely to have positive attitudes ($t(250) = -4.07$, $p = 0.006$). Religiosity’s effect was again found to be significant ($F (4, 259) = 11.4$, $p < .001$), driven by the differences between those who base their whole approach to life on their religion and those for whom

religion is mainly a source of comfort and peace (t(259) = -4.27, p < .001), and those for whom many other things are equally or more important in life (t(259) = -5.75, p < .001), while also differing from those who do not consider themselves as religious (t(259) = -6.40, p < .001), exactly like in the case of euthanasia (see Table 2). Thus, again, the more intrinsically religious a person is, the more likely that he or she will be dismissive of suicide and will show less understanding towards it.

Table 2

Mean differences with regards to religion on the EAS and the three factors of the ATTS

Variables	Mean (EAS)	SD (EAS)	Mean (ATTS)	SD (ATTS)
Religion				
Christians	113	28.1	40.9	12.1
Muslims	90	40.3	35.2	16.9
Buddhists	109	33.4	43.3	12.6
Atheists	133	13.1	49.8	10.6
Spiritual in p.w.	126	20	48.6	11.5
Religion's Effect				
1.	94.1	34.1	34.2	14
2.	124	19.2	46.3	9.98
3.	114	28.3	44.3	12.9
4.	131	14.8	48.2	10.1

Note. p.w. (personal way) 1. (Whole life approach based on religion) 2. (Many other things are more or equally important) 3. (Comfort & peace in times of trouble) 4. (Not religious)

Other Factors - Hypotheses 2., 3. & 4.

Regarding age there was a significant negative correlation between age and acceptance of euthanasia, which means that older participants had a greater likelihood of having negative attitudes towards both euthanasia (r= -0-153, p = 0.006) and suicide (r= -0.194, p < .001). In relation to gender there was a significant difference between men and women, as females were more likely to accept both euthanasia (t(262) = -2.65, p = 0.009) and suicide (t(262) = -2.00, p = 0.046) compared to males (see Table 3). Concerning political affiliations, liberals

compared to conservatives were shown to be significantly more permissive towards both euthanasia (r= -0.402, p < .001) and suicide (r= -.0371, p < .001).

Table 3

Mean sex differences based on the EAS and the three factors of the ATTS

Sex	Mean (EAS)	SD (EAS)	Mean (ATTS)	SD (ATTS)
Women	122	24.7	45.3	11.6
Men	112	29.1	41.8	13.6

Other Factors within the ATTS

While the EAS's aims to assess the general permissiveness towards euthanasia, the ATTS is more nuanced in its factor structure, assessing much more than solely the acceptability of suicide in different circumstances. Thus, it is worthwhile to investigate them one by one. If found, significant differences between the sample's groups are reported. Conversely, if no significant differences were found, then only the overall mean points are mentioned.

Preventability & Preparedness to Prevent

Most people in the sample are quite optimistic in regards to the preventability of suicide, while many of them are also ready to help others in a suicidal crisis. Out of the maximum 20 points, where higher scores indicate a more positive perspective, the sample's mean was 14.1. Men were more likely to think that suicide is preventable and they would be able to help (t(262) = 2.80, p = 0.006), as men had a mean of 14.9 (SD=2.56) while women's mean was 13.8 (SD=2.86). Younger respondents were also more likely to be optimistic in regard to suicide's preventability (r= -0.243, p < .001).

Noncommunication

This factor includes statements such as "people who talk about suicide do not die by suicide", or "suicide happens without warning" and "most people avoid talking about suicide". Higher scores indicate a general agreement with the notion that suicidal intents and thoughts are generally not communicated and that people avoid talking about suicide. Out of the maximum 25 points, the mean was 14.6, which means that while not so strongly, but many participants were likely to think that suicide is generally non-communicated. In contrast,

older respondents were significantly more likely to think that suicide is most often communicated ($r= -0.139$, $p = 0.012$).

Tabooing

On a positive note, majority of the sample do not consider suicide to be a taboo topic, as out of the maximum 15 points, the mean was only 5.75.

Normal/Common

The majority thought that suicide is actually quite common and normal inasmuch as having the opinion that everyone can commit suicide and that almost everyone has suicidal thoughts at some point in their life. Out of the maximum 10 points the mean was 7.48. Young participants were more likely to have higher scores ($r= -0.207$, $p < .001$), just like liberals ($r= -0.181$, $p = 0.002$), thus the younger and more liberal someone was, the more likely he or she thought that suicide can be considered as normal/common. In connection to religiosity, those participants who base their whole life approach on religion (mean= 6.67, SD=2.15) were significantly less likely to think that suicide is normal/common compared to those for whom religion is mainly a comfort (mean=7.88, SD=1.61) as the statistical difference was significant ($t(259) = -3.06$, $p = 0.024$).

Relation-Caused

This factor investigates how much people think that suicide is a primarily a result of interpersonal conflicts and problems. Out of the maximum 15 points, the mean was 7.91, which demonstrates that the sample was the most undecided in relation to this factor.

Suicidal Process

This factor is a collection of differing views regarding suicide and suicidal people. These expressions of views are not so closely related to each other that a mean score could be a meaningful inference, thus they are examined separately. Most individuals in the sample *disagree* with the following statements; “most suicide attempts are impulsive actions (by nature)” (57.2%); “people who take their own lives are usually mentally ill” (52.6%);“a person once they have suicidal thoughts will never let them go” (61.4%), while they *agree* with the following ones; “when a person dies by suicide it is something that he/she has considered for a long time” (48.1%); “a suicide attempt is essentially a cry for help” (79.1%).

The Open-ended Question

Out of the 264 participants, 83 responded to the open-ended question. The majority expressed their more detailed view regarding euthanasia, while many of them commented in connection to both, and a minority shared their opinions exclusively in relation to suicide. Relevant comments are organised according to the measurements' factors, but starting with these phenomena's perceived relationship a few quotes alluded to the connection and similarity between euthanasia and suicide, mainly expressing their understanding views towards both.

"It is very thought-provoking that the outcome of the two topics is the same and yet can be interpreted so differently. For me, suicide could be prevented if much more emphasis was placed on mental health in the world, while euthanasia would facilitate and in many cases prevent us from becoming an aging society, and those who are no longer fit for a quality life could leave in peace."

"I agree with both. The decision should be my right as a citizen, in every case."

"For me, there are similarities between suicide and euthanasia. Both are a response to some form of unbearable suffering. According to my experience, those people reject these "solutions" who cannot put themselves in the patient's perspective. Perhaps euthanasia finds more understanding than suicide. Maybe because fewer people experience pain caused by mental illness than physical pain."

EUTHANASIA

General Orientation Toward Euthanasia

Most participants used this opportunity to further reveal their stances with respect to their generalized view of euthanasia. However, several respondents expressed discontent with the fact that the questions were meant universally, as they stated that their answers depend on the particular scenario at hand, thus their answers could potentially change when faced with a similar situation in real life rather than in an anonymous questionnaire. Several participants also stated that while they do think that euthanasia should be legalized, it should be done only with strict rules and safeguards, so that abuse of the law is minimized. On the whole, explicitly religious comments predominated not only this section, but the entirety of the

comments part, since many religious participants took the chance to elaborate their standpoints based on their beliefs.

“I don't think euthanasia is acceptable, even if the person is suffering greatly. When some kind of medicine is administered to a person in order to hasten death, we are playing God, which we have no right to do.”

“The following opinion follows from my trust in God: If someone asks not to be artificially kept alive, then this is OK (natural death) - If someone asks to end their life artificially, it is not OK (murder).”

“As a Muslim, one can only judge one's own life. One cannot criticize the life and actions of another person. A Muslim rejects suicide or murder, but if another person commits it, one cannot judge him or her. Islam forbids all forms of suicide and murder.”

Nonetheless, several religiously affiliated participants expressed their views in contrast to their religion’s beliefs, while an atheist expressed his discontent with religion’s influence.

“Everyone has one life. How you live and how you end it should be your own decision. There is no ideology that has the right to override this. Be it any supported religion. No one should be allowed to extend the rules of his own religion to the life and death of other people.”

“It is precisely because of this topic that I am only partially religious. I understand if someone doesn't want to suffer anymore and would ask to end their life. It's their decision.”

“As a practicing Buddhist, I believe that it can be a mistake to choose this way of death, or to "participate" in this in any form, but it is by no means a crime. I understand and accept it, since every situation is different. Whatever the "participants" choose, they cannot avoid the "consequences" of their decision, the law of karma. Either way, the decision is important.”

Personal investments also has the power to influence people’s attitude;

“Half a year ago, when my grandmother contracted another hospital infection in addition to a stroke and I saw her suffering and collapsing both mentally and physically almost every single day, I would have liked to give her a death without suffering, but unfortunately it was not possible, so body and spirit exhaustion killed her.”

Two participants explicitly alluded to the case of Karsai Dániel, the Hungarian lawyer who has ALS and went to the European Court of Human Rights in order to gain the right to make more extensive end-of-life decisions within the border of Hungary.

“For me, the issue of euthanasia is much more related to undignified situations and helplessness, than to pain, which can be alleviated quite well at the moment. In the euthanasia debate that has recently emerged in connection with ALS, it can be observed what situations a person can end up in at the end of his life depending on his illness.”

Patients' Rights Issues

“Human rights should be two-way. Ideally, I should have the opportunity to end my life, but it should also be possible to keep me alive with the help of medical science.”

“The key criterion in the matter of euthanasia is the patient's self-determination. Active euthanasia in any form is not acceptable without the patient's consent or advance directive, and it is equally unacceptable to deny the patient assisted suicide. (If it can be ensured that the patient's free decision is involved, even psychiatric patients must be given the opportunity.)”

Role of Life-Sustaining Technology

“Protecting life is very important, but it cannot be protected infinitely. If it only prolongs suffering, it is harmful.”

Professional's Role

“It is a very bad medical practice when professionals do not provide sufficient information or they are intentionally silent about the patient’s condition. In such a case, the patient cannot make a responsible decision regarding his own treatment, even though his life is at stake. The decisions should be made by him, not by the doctors. If we are responsible for our actions according to the law, then the law should provide the right and the opportunity to make the decisions about our life and death ourselves, and not let outsiders decide for us.”

Ethics and Values

“I also thought about what happens if someone has been struggling with severe depression for years and wants to request euthanasia. After all, in this case he does not have a terminal illness, but he still suffers. I don't know what the ethically correct thing to do here would be.”

SUICIDE

In regard to suicide, considerably less participants expressed their views, thus not all of the ATTS’s factors could be demonstrated with a relevant quote and even those that can, contain less comments compared to euthanasia. Those who did express their opinions mentioned potential preventive ways; their general understanding even though they may not themselves think of suicide as a rightful solution to life’s hardships; or they elaborated on their dismissivenss based on religious convictions. Thus, while based on the quantitative measurement of the ATTS regarding the acceptability of suicide the sample was found to be generally permissive, those who took the opportunity to comment with their own words were substantially more likely to express views of dismissiveness.

Incomprehensibility

“I can only understand one form of suicide: if it saves the lives of many people. In such a case, I consider it a sacrifice.”

Preventability

“Suicides because of mental ill health can be prevented and avoided because there are people who love and help.”

“I think that people struggling with mental problems and suicidal thoughts can all be brought back with the right kind of help.”

Tabooing

“The suicide of non-patients should be talked about without taboos. If we made suicide accessible (with abuse-preventing conditions) and stopped "saving" suicidal people, we could eliminate "cry for help" self-harm and threatening suicide for emotional blackmail.”

Normal-Common

“Suicide is not a good way for an individual to end suffering, but it is understandable why many choose it.”

Relation-Caused

“Suffering is not the problem, but leaving someone alone is. The problem is not loving someone, not caring about someone.”

“My father committed suicide knowing that my brother and I would become orphans. He had an alcohol problem that no one helped him with. He lost his job during the regime change and went completely downhill. I am aware that I could not have saved him at the age of 11, but the guilt haunts me to this day. And the what if...questions. This is why I will never commit suicide because I know what this kind of death does to a family. I hate him for leaving me here, but I also love him because he was a very lovable father.”

Resignation/Suicide as a Solution

“I think that even in a very bad situation, if you have the right people by your side, they can help you, but if someone can't be helped, then it's better if they go. (..) Suicide is an interesting thing for me and I think that those who commit suicide do not deserve life because they cannot appreciate what they have because there is a solution for everything.”

“Death should not be hastened in any way, because it is possible that they can help as a result of the treatments, and there is no problem in life for which the only solution is suicide. These people turn away from God and choose the easy way. Everyone has their own written path and what trials they have to go through until the time of their death, which no one can take away except God.”

Discussion

The General Population’s Attitude Towards Euthanasia and Suicide

This study aimed at investigating attitudes towards euthanasia and suicide based on a Hungarian sample. Relevant factors were also examined in order to strengthen or weaken the results from other international studies inquiring the role of these predictors. As the results have shown, the sample was permissive towards euthanasia, and were quite understanding and acceptive towards suicide as solution and as right as well. Specifically, those who

approved of either were significantly more likely to approve of the other too. With respect to the predictors' roles, the results indicated that religion, religion's effect on one's life, age, gender and political affiliation are all important factors in both cases. Precisely, being an atheist, having no religious affiliation at all, or having other equally or more important deciding factors in one's life other than one's religion, being a woman and a liberal and of a younger age are all predictors of a more permissive attitude both towards euthanasia and suicide. Thus, the hypotheses on which the current study operated were all proven to be supported by the results which are also in line with previous studies.

As the first hypothesis predicted, a negative correlation was indeed found between being religious and attitudes towards both euthanasia and suicide, foreseeing negative, thus dismissive attitudes on the part of religious groups, while also predicting that the more intrinsically religious someone is the more likely he or she will have negative attitudes. These results strengthen the previously well-established findings in regard to religion (e.g. Aghababaei & Wasserman, 2013; Danyliv & O'Neill, 2015 Terkamo-Moisio, 2016; Eskin et al., 2020; Solomon & Peterson, 2020; Saiz et al., 2021; Inglehart et al., 2021). In accordance with the second hypothesis, significant age differences were found both in the case of euthanasia and suicide, anticipating that younger participants will be more permissive, which was indeed the result, supporting previous studies (e.g. Singh, 1979; Cohen et al., 2006; Li & Philips, 2010; Chowdhury, 2012; Attell, 2017; Na et al., 2018; Pereira & Cardoso, 2019; Bartolomé & Coromina, 2020). With regards to sex differences no specific hypothesis was set in connection to euthanasia, only to suicide, predicting that men on average will have a more dismissive attitude compared to women, which proved to be right as they were less accepting towards suicide conceptualized as a solution and as a right, which is line with previous findings predicting stigmatising attitudes more likely to be characteristic of men (e.g. Wellman & Wellman, 1986; Batterham et al., 2013; Oliffe et al., 2016). While no speculation was made regarding euthanasia, the current study's result, showing that women are more likely to accept and endorse the right to die, is in contradiction with several preceding studies showing the opposite; that men are more acceptive, or that there is no significant sex differences (e.g. Singh, 1979; Finlay, 1985; DeCesare, 2000; Cohen et al., 2006; Televantos et al., 2013; Stronegger et al., 2013; Terkamo-Moisio, 2016; Zou et al., 2016; Attel, 2017). This contradiction highlights the need for further studies in regards to sex differences, especially since when it comes to real life choices instead of hypothetical attitude questions, women are more likely to die by euthanasia (George, 2007; Steck et al., 2014; Doherty et al.,

2022). According to the fourth hypothesis liberals are more likely to accept the right to die in the form of euthanasia while they are also more permissive towards suicide, which was indeed the case as politically conservative respondents were significantly less permissive towards both, again strengthening previous results (e.g. Sawyer & Sobal, 1987; Agnew, 1998; Moulton et al., 2006; Stack & Kposowa, 2008; Dworkin, 2013; Aghababaei et al., 2013, Bulmer et al., 2017). Finally, as the last hypothesis forecasted, those who are understanding and acceptive towards suicide are also more likely to be permissive towards euthanasia. Direct comparison on this basis is not possible however, since no previous study examined the attitudes of the same population on these two end-of-life issues using the measures of the EAS and the ATTS, thus, in this sense, the current study serves as a pioneer.

The qualitative part, providing an open-ended question to the participants, further strengthens the above results as most comments were an elaboration on why the respondents support euthanasia, while many of those who were dismissive towards it referenced their religious beliefs as the basis of their negative attitudes. The comments most often were related to the participants' general orientation towards euthanasia based on their ethics and values, while the issue of patients' rights was also frequently mentioned, highlighting the importance of personal autonomy and choice, even to the point of mental suffering, such as in the case of psychiatric patients. In regard to suicide, substantially less participants expressed their detailed views while those who were dismissive were in the majority, expressing their views on what could be the reason why others choose suicide and what could we do to help them, in which most referred to the need for strong and supportive interpersonal and professional help. Interestingly, while the general acceptance and understanding of suicide was quite high considering the whole sample, those who took the opportunity to reveal their attitude and thoughts in their own words were more likely to express views of dismissiveness, mainly based on their religious morals and values.

With respect to suicide attitudes it has also been found that the sample was quite optimistic in relation the preventability of suicide while many of them feel ready to help other in a crisis if needed. Men and young participants were more likely to think that suicide is preventable and that they would be able to help. While the general consensus was that suicide and suicidal intents and thoughts are non-communicated and that close relationships partners are unable to truly understand what a suicidal person goes through, older respondents were more likely to disagree with these statements. Regarding tabooing, most participants did not consider

suicide to be a taboo topic, however, the fact that they were willing to take part in a survey focused on voluntary death may speak of their unrepresentativeness compared to the whole population. Perhaps consequently, the overall consensus was that suicide is quite common and normal inasmuch as everyone can take their life or could have suicidal thoughts. The younger and more liberal someone was, the more likely he or she thought that suicide was common/normal, while those for whom religion is the most important factor leading their life approach disagreed with this notion the most. Lastly, the sample was the most undecided in regards to the question whether suicide is primarily relation-caused or not.

Since there is no previous study that investigated the attitudes towards both euthanasia and suicide on the same Hungarian sample, direct comparison is not possible. However, the general attitudes of Hungarians towards euthanasia using other measures have been examined before and very recently as well, as a result of Karsai Dániel's case who brought euthanasia, or more precisely the topic of end-of-life decisions, forward into the public sphere. The two most recent surveys were carried out by the online market research institutes of Opinio and IDEA, using nationally representative samples. Based on the latter's results 62% of the adult population supports active euthanasia for terminally ill patients (IDEA, 2023). In line with the current study's findings, women and voters of liberal political parties were more permissive. In contrast however, older people were more likely to be supportive compared to 18-29 year olds. Comparably, based on the results of Opinio, 79% of Hungarians consider euthanasia acceptable; 20% of those surveyed fully support the right to self-determination, while 59% support it under certain circumstances. Only 7% are completely opposed to people being able to decide on the manner and time of their own death, while 14% were undecided (Opinio, 2023). Based on a recent doctoral thesis however, in case on a painful incurable illness, only 27.1% would accept physician assisted suicide regarding their family member, while 36.3% would accept it for themselves. In case of euthanasia, 28.9% would be supportive of their relative's decision asking a physician to administer a lethal drug for them, while 38% would accept it as a possibility for themselves (Busa, 2023).

Comparing Hungary to other nations, taking an international perspective comparing 62 countries all around the world, Hungary ranks as the 25th, the first being the most permissive (Netherlands) and last being the most dismissive (Jordan), as measured by the World Values Survey (Inglehart et al., 2021). Before Hungary, thus the more accepting countries are mostly part of Western and Northern Europe, while after Hungary the countries are mostly from

Eastern Europe, the Balkan, South America, Asian and Middle Eastern countries along with some African ones. Surveys were administered in 7 different waves, starting from 1981 finishing with 2018. Answers ranged from 1 = "never justifiable" to 10 = "always justifiable." Hungarians were the least permissive towards euthanasia in the 1981-1984 period (mean = 2.67) while the most permissive score was in the period of 1994-1998 (mean = 6.17). Most recently, according to the data from 2018, the mean is 4.93, thus slightly below the half point, which means that while not so strongly, Hungarians are more likely to be against euthanasia on a large, representative scale (Inglehart et al., 2021).

Literature on measuring attitudes towards suicide using a representative Hungarian sample is severely scarce, if studies on physician assisted suicide are excluded, and they are, since the current study handles PAS within the framework of euthanasia. Nonetheless, there have been some studies investigating attitudes towards suicide within selected populations.

Comparing regional politicians among 5 European countries, the results indicated that those politicians held more permissive attitudes towards suicide, where suicide rates are higher and there are no developed state-supported prevention strategies (Hungary, Lithuania, Austria), while politicians from Sweden and Norway held less permissive attitudes, their countries having lower suicide rates and developed prevention strategies (Skruibis et al., 2010). As the current study's results shows, this permissiveness is not only characteristic of Hungarian politicians but of the average Hungarian citizen as well. However, this permissiveness does not necessarily entail a less judgemental attitude, quite the contrary, as Hungarian politicians (along with Lithuanian ones) mentioned personality traits as a main cause of suicide, implying that the suffering individual is to blame for his or her mental constitution. Additionally, within psychological causes, Hungarians and Lithuanians were the only politicians to mention such causes as "weakness and lack of maturity", "laziness to live" and "egoism" (Knizek et al., 2008). In relation to the other factors related to suicide, regarding preparedness to help, Hungarians were in the middle of the five countries representatives, indicating that they did not feel neither incapable of help, nor were they too hopeful about their abilities, although they were more optimistic about general preventability than Austrians, a country with lower suicide rate (Skruibis et al., 2010). Hungarians were also more likely to see suicide as relation-caused compared to their Northern European counterparts. Lastly, the only significant difference between male and female politicians was found with respect to perceived preventability of suicide, man being slightly more optimistic

than women (Skruibis et al., 2010), which is in line with the current study's findings. While it seems that there is no significant difference in regard to the acceptability of suicide between Hungarian politicians and a general citizen, helping professionals were found to be more likely to have a dismissive attitude, denying the right to commit suicide more often than the general population (Susánszky et al., 2008). However, in relation to a terminally ill person wishing to die their opinion was similar to that of the general population.

The Role of Religiosity Regarding End-of-Life Issues

Christians in the sample were significantly more likely to be against both euthanasia and suicide as solutions to life's hardships, especially those Christians who were the most intrinsically religious as measured by how important do they consider their religion and religious beliefs. As a demonstrative example, all of the four pastor included in the sample had lower scores on the ATTS's three factors combined measuring permissiveness and understanding of suicide, while 3 of them had negative attitudes towards euthanasia as well. One of them however, reached a score beyond the cutting point for a positive attitude towards euthanasia, which exemplifies that while the role of religiosity as a predictor is reliably strong, the association between these factors are not set in stone. In fact, differing religious groups have all been shown to liberalize their stances on euthanasia over the years to varying degrees, Protestants exhibiting the most substantial change of view (Moulton et al., 2006).

Muslims, compared to atheists, were significantly less likely to consider both euthanasia and suicide as acceptable, thus as a group they were adhering to their religions' teachings and morals, especially in contrast to non-believers. Individually however, there were important differences in the sample, as only half of the Muslims had a low score with regards to the acceptability of euthanasia, while the other half had actually scored beyond the cut-off point for permissiveness. Consequently, just like in the case of Christianity, while it is safe to predict that religious groups on the whole will be less permissive towards euthanasia compared to atheists as a group, this does not mean that individual differences within the same religious groups are nonexistent nor that these differences are without significance. Nonetheless, the results from the quantitative measurements comparing religious groups to non-believers and showing that religious people are substantially more likely to be dismissive towards both euthanasia and suicide were supported by the findings of the qualitative part as well. Comments explicitly referencing religious teachings and beliefs as justifications for not

accepting these ways of death were dominating, clearly showing that religious participants took a great interest in expressing their views in regard to end-of-life issues.

Out of the three world religion investigated in this study, Buddhists were the only religious group which did not differ from atheists with regards to the acceptability of suicide and euthanasia, thus Buddhists were quite permissive towards both similarly to those respondents who did not consider themselves as religious. As a matter of fact, out of the 15 Buddhist participants, only three of them had a low score on the EAS, indicating a dismissive attitude, while three of them had a very high score (above 140 out the maximum 150) implying a strong acceptance of euthanasia. Even in the qualitative part, a few Buddhists expressed their views of acceptance and understanding in contrast to their religion's teachings, instead highlighting the role and importance of personal decisions and individual responsibility. Despite the theoretical background, this result is actually in line with other findings examining practicing Buddhists' views on death and dying. In relation to suicide, Buddhists had higher acceptance rate compared to Muslims (Foo et al., 2012), while it has also been shown that the more intrinsically religious a Buddhist is, the more likely that he or she will have a favourable attitude towards suicide (Saiz et al., 2021). With respect to euthanasia, some Buddhists supported it under certain conditions, in opposition to their vows, because they believed that not disrupting a patient's agency and viewing each patient as a unique being was more important than the moral correctness of the action (Larm, 2019).

Limitations

Despite its contributions in the field of attitudes towards euthanasia and suicide concerning a Hungarian population, the current study and its results are not without limitations. Several important limitations relate to the sample. Firstly, the number of participants were not enough for a nationally representative sample, thus, while this study investigated the attitudes of the general population, its results cannot be generalized to the whole Hungarian population. Additionally, women, liberals and highly educated individuals along with university students were overrepresented; groups that have a greater likelihood to accept both euthanasia and suicide, thus the overall positive attitude towards both could be the direct result of their impacts. The case of women and liberals were elaborated previously, but it has also been found that students, along with their generally younger ages, and highly educated persons are more permissive towards both euthanasia and suicide (e.g. Singh, 1979; DeCesare, 2000; Horsfall et al., 2001; Cohen et al., 2006; Televantos et al., 2013; Nathan & Nathan, 2020).

There are also additional limitations beyond the sample that must be taken into consideration when interpreting the results of this study. While attitudes are a tool to predict behavior, their strength may not be that reliably strong in certain circumstances (Nelson & Bernat, 1989; Glasman & Albarracín, 2006), while some people may also change their view as time passess due to several reasons (Wolfe et al., 1999; Albarracin & Shavitt, 2018; Itzchakov & DeMarree, 2022). Moreover, specifically related to euthanasia and suicide, in both cases the type and specific circumstances of life termination, or even simply the wording of the questions matter greatly in affecting attitudes towards them (Deluty, 1989; Huber et al., 1992; Hagelin, 2004). Thus, for all of the above mentioned reasons, this study's results should be interpreted and generalized with caution.

Conclusion

To conclude, this study contributes to the literature on attitudes towards euthanasia and suicide in two key ways. First and foremost, no previous study has investigated these two attitudes on the same Hungarian sample before, exploring them separately and in connection to each other, thus this paper opened up and explored in depth an important area of study that has been neglected so far. Additionally, the study included both a quantitative and a qualitative part, supporting and further elaborating each other's results, giving participants the chance to provide information about their attitudes in an exhaustive manner.

Secondly, in investigating the roles of several predictors, the findings were consistent and thus strengthened previous studies using international samples, highlighting similarities across different countries and cultures. As the results suggested, sex, age, religion, religion's effect in one's life and political affiliations are all associated with attitudes towards both euthanasia and suicide. More specifically, being a woman, younger in age, an atheist or considering many other things equally or even more important than one's religion and being a liberal are predictors of a permissive attitude both towards euthanasia and suicide. Additionally, those who approved of suicide in certain circumstances and were understanding towards it were significantly more likely to approve of euthanasia as well and vice versa. Taken together, the majority of the sample was permissive towards euthanasia, and were quite understanding and acceptive towards suicide as a solution and as a right.

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