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Research report

# Is suicide an option?: The impact of disability on suicide acceptability in the context of depression, suicidality, and demographic factors

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ABSTRACT

*Background:* Suicide is a major clinical and public health issue, especially in people with disabilities. However, research on the acceptability of suicide in people with disabilities has not directly compared the relative acceptability of suicidality in people with and without disabilities.
*Method:* An online sample of five hundred American adults read five pairs of vignettes about individuals who were experiencing suicidal ideation following a life stressor. Each pair contained a disability and no-disability condition; a sixth pair of vignettes discussed suicidal ideation in an elderly individual and contained physical and cognitive disability conditions. Participants completed questions regarding the relative acceptability of suicidality for each vignette as well as demographic items and measures of suicidality, depressive symptoms, and attitude towards disability.
*Results:* In all vignette five pairs, suicidality was seen as significantly more acceptable in the disability condition; this was true even when the participants themselves had disabilities or friends or family members with disabilities. Suicidality, depressive symptomology, and more negative attitudes towards disability predicted greater acceptability in both conditions; no factors predicted greater differences between the two conditions.
*Limitations:* The vignettes in this study focused primarily on individuals in their 20s and most did not compare two disabling conditions.
*Conclusions:* The greater social acceptability of suicidality in people with disabilities may be taken by individuals with disabilities who are suicidal as implicit permission to end their lives. The potential impact of such social influences should be assessed and addressed by clinicians and suicide prevention advocates.

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## 1. Introduction

Suicide is the 10th leading cause of death in the United States, accounting for over 41,149 deaths in 2013 (Centers for Disease Control and Prevention, n. d.). Further, increased rates of suicidality among individuals with diverse disabilities have been well documented in the literature (e.g., Pompili et al., 2012; Giannini et al., 2010; Wetzel et al., 2011). However, most of the literature regarding acceptability of suicide in people with disabilities has focused on physician-assisted suicide among people with disabilities and terminal illnesses (e.g., see Achille and Ogloff, 2003; Emanuel et al., 1996). Some people feel that the availability of assisted suicide provides people greater autonomy over their bodies, while others feel that it devalues life (Fadem et al., 2003; Krahn, 2010). The topic is perhaps particularly divisive among people with disabilities, with some groups strongly and vocally opposed (Amudsen and Tairia, 2005; Krahn, 2010), and other groups showing a general approval of the option (see Achille and Ogloff, 2003; Emanuel et al., 1996).

Individual differences, such as religiosity and depression, may affect attitudes towards assisted suicide. For example, research has demonstrated that depression was associated with a greater likelihood of endorsing physician-assisted suicide among people with ALS, while involvement in weekly religious services predicted a lower likelihood of endorsement (Achille and Ogloff, 2003). Similarly, Fishbain et al. (2012) found that, among people with chronic pain, past and current suicidality predicted a greater preference for death over the experience of life with disability. Emanuel et al. (1996) also found that depression predicted greater interest in

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assisted suicide among cancer patients, although religiosity was associated with lower interest. This is similar to studies in the general population, which have consistently found that religiosity and religious involvement is a protective factor against general suicide acceptability (Neeleman et al., 1998; Stack, 1998a,b; Stack and Kposowa, 2011). Conversely, depression (Gibb et al., 2006; Zhang et al., 2014) and suicidality (Gibb et al., 2006; Li et al., 2009; Kleiman, 2015) have been shown to be risk factors for greater general suicide acceptability. Higher education has also been frequently found to be a risk factor for greater general suicide acceptability in the general population (e.g., Stack 1998a,b; Zhang et al., 2014).

Outside of the debate over assisted suicide specifically, a small body of literature has examined attitudes toward suicide among people in general. In a sample of 80 undergraduate students, Droogas et al. (1982) found that physical deterioration and pain were viewed as significantly more acceptable reason to commit suicide than were mental deterioration or pain. Similarly, Deluty (1989) surveyed 780 undergraduate students and found that suicide was more acceptable if the hypothetical suicidal person had terminal cancer than depression, with non-terminal chronic pain being more acceptable than depression and less acceptable than terminal cancer. Additionally, suicide was seen as more acceptable in and by men and in elderly (versus middle-aged) hypothetical individuals.

## 2. Purpose of the present study

Although studies have examined whether terminal illness or physical deterioration affect an individual's view of suicide acceptability, this research has yet to examine the impact of disability status directly. Thus, it is unclear how the presence of a significant but non-terminal disability affects suicide acceptability. Second, the existent studies are rather old, and it is very possible that attitudes toward suicide acceptability in individuals with disabilities and chronic health conditions has changed over the past 20–30 years. Third, the current empirical literature draws exclusively from undergraduate populations and may not be generalizable to the broader population. Fourth, these studies only examined non-disabled people's attitudes toward suicide acceptability in hypothetical people with disabilities. Thus, it is unclear if or how the relative acceptability of suicide for people with disabilities differs from people without disabilities. Therefore, we sought to expand the literature by answering the following questions using an online, non-clinical sample of 500 American adults:

1. How do attitudes toward suicidal ideation differ in vignettes where the hypothetical suicidal person does and does not have a disability?

**$H_1$.** : We predicted that suicidal ideation would be seen as more acceptable in vignettes where the person was identified as having a disability, as compared to similar vignettes where disability status was not mentioned.

2. What factors predict a lower difference in the acceptability of suicidal ideation in hypothetical people with versus without disabilities?

**$H_2$.** : We predicted that more positive attitudes towards disability, personal experience with disability, and having friends and family members with disabilities would result in smaller differences in acceptability between the disability and no-disability conditions.

3. What factors predict greater acceptability of suicidal ideation in hypothetical people with versus disabilities?

**$H_3$.** : We predicted that suicidality, depressive symptoms, less frequent religious participation, and more negative attitude toward disability would predict greater acceptability of suicidal ideation in both the disability and no-disability conditions.

## 3. Method

### 3.1. Recruitment and procedures

Five hundred participants completed an online survey concerning personal attitudes about acceptability of suicide by people with and without disabilities. Participants were recruited from Amazon Mechanical Turk (MTurk), an online participant recruitment system that produces valid data that is generally demographically representative of the general population (Buhrmester et al., 2011; Shapiro et al., 2013), with roughly equal male–female gender distribution and a mean age in the mid-30s. To participate, MTurk users must be 18 or older; participation was also restricted to those currently living in the United States. After being recruited via MTurk, participants completed the questionnaires on via Qualtrics online survey software (Qualtrics, 2015). The informed consent discussed attitudes towards suicide and the presence of suicidality but did not specifically mention disability as an area of key interest. After completing the survey, participants were provided with information on national emergency, crisis, and suicide hotlines and were provided with a code that they could enter to receive compensation of $0.25 from MTurk. The survey itself was hosted on a secure server, and participants' responses were collected completely anonymously and could not be linked to their MTurk accounts.

### 3.2. Participants

Five hundred participants completed the survey. A majority were female (60.4%; $n=302$) and Caucasian (74.4%; $n=372$), with a mean age of 35.92 years (SD=13.85, range: 18-75). Participants were fairly well-educated, with two-fifths of respondents ($n=203$; 40.6%) having earned a bachelor's degree or higher and an additional 43.0% ($n=215$) having completed an associate's degree or some college. Most reported working full-time ($n=178$; 35.7%) or part-time ($n=75$; 15.0%); about a fifth were full-time students ($n=94$; 18.8%). A majority of participants reported being married ($n=153$; 30.6%) or in a committed relationship ($n=105$; 21.0%), but over a third ($n=183$; 36.6%) were single.

About two-fifths ($n=211$; 42.2%) of the sample identified as adherents to either Protestant, Roman Catholic, or evangelical Christianity. Over a quarter ($n=140$; 28.0%) identified as agnostic or atheist, with the remainder of the sample endorsing a wide variety of religious and spiritual beliefs including Judaism, Islam, Buddhism, and Hinduism. Just over half ($n=251$; 51.8%) reported attending religious services.

Ninety-two of the 485 participants (19.0%) who responded to the disability question endorsed having one or more disabilities. The most common types of disabilities reported were psychiatric ($n=25$; 27.2%), physical ($n=23$; 25.0%), and chronic health

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