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Is counseling ready for rational suicide?

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A Dissertation

Entitled

Is Counseling Ready for Rational Suicide?

By

Robin M. DuFresne

Submitted to the Graduate Faculty as partial fulfillment of the requirements for the

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An Abstract of

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Counselors serve clients at all developmental stages of life. Individuals who are terminally ill seek counseling for various reasons, including discussing rational suicide (Danaker, 2006). Rational suicide is the desire to hasten one's death when terminally ill (Werth & Cobia, 1995). Models for conceptualing the process of dying do not address the concept of rational suicide (Kubler-Ross, 1969; Rando, 1984). Previous research has demonstrated that counselors belief that suicidal ideation in a terminally ill client can be a rational construct (Rogers et al, 2001). The goal of this study is to investigate whether counselors perceive themselves as competent to counsel individuals who are expressing rational suicidal ideation. 68.2% of participants rated themselves competent to provide this service. Participants with more education, more years of service, and experience with terminally ill clients rated themselves more competent than other participants.

Keywords: counseling, suicide, rational suicide, competence

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Chapter I

Introduction

Chapter 1 includes an introduction to the concept of rational suicide including etiology, interaction with the counseling process, and the ethical and legal considerations relevant to clients considering rational suicide. Chapter 1 includes a description of the research problem, the purpose of the study, the research hypotheses, and the significance of the present study. The chapter concludes with a definition of terms and an overview of the organization of the dissertation.

1.1 Background of the Problem

Individuals who are terminally ill seek counseling services for various reasons, including processing their emotions and participating in end-of-life planning (Danaker, 2006). Veatch (1988) defines terminal illness as

> an illness in which, on the basis of the best available diagnostic criteria and in light of available therapies, a reasonable estimation can be made prospectively and with high probability that a person will die within a relatively short time (p. 34).

Kubler-Ross (1969) and Rando (1984) described the stages that characterize an individual's progress toward death once diagnosed with a terminal illness. These stages provide a framework for counselors to conceptualize the process of dying when providing counseling services to terminally ill individuals. Yet, these authors do not address within their respective frameworks how a counselor should respond when a terminally ill client expresses a desire to hasten their death, or rational suicide.

Rational suicide is the desire to hasten one's death when terminally ill (Werth & Cobia, 1995). The idea that suicide can be rational is dependent on three components. First, the person considering hastening their death must have a terminal illness with a prognosis of six months to live that is confirmed by a medical professional. Next, the individual is capable of making an informed decision based on the consideration of all alternatives and in the absences of a diagnosis that would impede this competence. Lastly, the individual is making the decision of their own free will (Werth & Crow, 2009; Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). Washington, Oregon, and Montana have laws that permit terminally ill individuals, who have a prognosis of less than six months, to request physician assistance to hasten their death, also known as physician-assisted suicide (Winograd, 2012). California approved physician-assisted suicide legislation in 2015 (California SB-128). Individuals in these states may seek counseling to discuss their decision to seek physician-assisted suicide. Twenty-four additional states have initiated legislation addressing physician-assisted suicide.

Research conducted with counselors who are members of American Mental Health Counseling Association (AMHCA) has concluded that approximately 80% of counselors agree that suicide can be rational for an individual who is terminally ill and has less than six months to live (Rogers, et. al, 2001). Individuals who support the concept of rational suicide view permitting terminally ill individuals as having a right to have autonomy over their decisions regarding the remaining time of their life (Biller-Andorno, 2013; Schramme, 2013). Biller-Andorno (2013) reports, in Switzerland where physician assisted suicide has been legal longer than in the United States, that with safeguards in place there has not been an increase in abuse and that the number of

suicides has declined. Additionally, only a minority of those who requested physician assistance to die in Oregon and Washington (Oregon DWDA report, 2013; Washington DWDA report, 2013) implement the assistance, indicating a lack of widespread abuse of the legalization of physician-assisted suicide.

Counselors who agree that suicide can be rational identify reasons for their assertion. Terminally ill individuals struggle with five distinct issues that may impact their ability to make a rational decision about how to end their life. These include: (a) physical suffering with no end in sight, (b) lack of control over their illness, (c) lack of empowerment to express their wishes, (d) depression, and (e) lack of knowledge about their options for treatment and care (Winograd, 2012). Counselors who do not agree that suicide can be rational are concerned that legitimizing suicide may lead to the terminally ill person being coaxed into hastening death to prevent the person from being a burden on their family (Siegle, 1986). Chronic pain or mental health concerns, such as depression or anxiety, may distort the terminally ill person's judgment (Siegle, 1986). Boudrea and Somerville (2013) suggest that a terminally ill individual may struggle with issues of morality or religion that cloud their judgment. Previous research has explored counselor's views on rational suicide (Rogers, et. al, 2001). However, there is no research on counselors' self-reported competency to work with clients who express rational suicidal ideation.

1.2 Statement of the Problem

The current study filled a gap in the literature by addressing counselors' self-described competence to provide counseling to terminally ill clients expressing rational suicide. Counselors have a responsibility to practice within the boundaries of their

competence based on education and experience (ACA, 2014), personal characteristics and ability to develop a therapeutic relationship (Luborsky et al., 1985; Lubrosky et al, 1986; Strupp & Hadley, 1979), and application of clinical research (Herman, 1993). Counselor Education programs can educate students about rational suicidal ideation, but lack the ability to schedule an experience with a client who is terminally ill and wants to hasten their death.

1.3 Purpose of the Study

The purpose of this study was to determine if counselors perceive themselves as competent to provide counseling to terminally ill clients who are expressing rational suicidal ideation. Additionally, this researcher explored what characteristics predict counselors' perceived competence to provide counseling with individuals expressing rational suicidal ideation. Finally, this researcher explored counselors' perceptions of (a) how a client's prognosis impacts the counselors' determination of rational suicide suicidal ideation, and (b) how counselors' perceived competence changes based on a client's prognosis.

1.4 Hypotheses

The following research hypotheses will be addressed in this study:

Research Hypothesis #1: Counselors who have a doctoral degree will rate themselves more competent than counselors who have a master's degree will rate themselves.

Specific RH_1: Counselors who have completed a doctoral degree will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have completed a master's degree.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have completed a doctoral degree and counselors who have completed a master's degree.

Research Hypothesis #2: There will be a relationship between counselor's number of years of experience and overall competence

Specific RH_2: There will be a statistically significant ($p < .05$) positive relationship between counselor's number of years of experience and overall competence.

Specific RH_0: There will be no statistically significant between counselor's number of years of experience and overall competence.

Research Hypothesis #3: Counselors who do not hold a religious belief will rate themselves more competent than counselors who do hold religious beliefs.

Specific RH_3: Counselors who do not hold a religious belief will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who do hold a religious belief.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who hold a religious belief and those who do not hold a religious belief

Research Hypothesis #4: There will be a difference in overall competence rating between counselors who have counseled a terminally ill client and counselors who have not counseled a terminally ill client.

Specific RH_4: Counselors who have counseled a terminally ill client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a terminally ill client.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have counseled a terminally ill client and counselors who have not counseled a terminally ill client.

Research Hypothesis #5: There will be a difference in overall competence rating between counselors who have counseled a suicidal client and counselors who have not counseled a suicidal client.

Specific RH_5: Counselors who have counseled a suicidal client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a suicidal client.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have counseled a suicidal client and counselors who have not counseled a suicidal client.

Research Question #6: There will be a difference in overall competence rating between counselors who have contemplated suicide for themselves and counselors who have not contemplated suicide for themselves.

Specific RH_6: Counselors who have contemplated suicide for themselves will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not contemplated suicide for themselves.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have contemplated suicide for themselves and counselors who have not contemplated suicide for themselves.

Research Hypothesis #7: There will be a difference in clinician's determination of a client's suicidal ideation based on the client's prognosis.

Specific RH_7: There will be a statistically significant difference ($p < .05$) in clinician's determination of a client's suicidal ideation based the client's prognosis.

Specific RH_0: There will be no difference in clinician's determination of a client's suicidal ideation based on client's prognosis.

Research Hypothesis #8: There will be a difference in clinician's determination of whether a client is expressing rational suicide based on client's prognosis.

Specific RH_8: There will be a statistically significant difference ($p < .05$) in a clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis.

Specific RH_0: There will be no difference in clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis.

Research Hypothesis #9: There will be a difference in clinician's competence rating based on client's prognosis.

Specific RH_9: There will be a statistically significant difference ($p < .05$) in clinician's perceived competence rating based on client's prognosis.

Specific RH_0: There will be no difference in clinician's perceived competence rating based on client's prognosis.

1.5 Significance of the Study

Competent counselors are needed to provide counseling to terminally ill clients who are expressing rational suicidal ideation. Research has demonstrated that approximately 80% of professional counselors have agreed that suicide can be a rational choice for terminally ill individuals who are within six months of their death (Rogers, et al, 2001). In 2004, Westefeld, Sikes, Ansley, and Yi surveyed psychologists, nurses, and

politicians. They found 25% of their respondents had encountered someone who was terminally ill and expressing rational suicide. However, current models (Kubler-Ross, 1969; Rando, 1984) used to conceptualize the process of natural death do not sufficiently explain rational suicidal ideation in terminally ill individuals. Research has not addressed the counselor competencies needed to provide counseling to terminally ill individuals who are expressing rational suicidal ideation. Therefore, this study will investigate the factors that predict counselors' competence to provide counseling to individuals expressing rational suicidal ideation. Additionally, this study will explore whether or not prognosis predicts if a counselor identifies the suicidal ideation as rational or not.

1.6 Research Design

The researcher used an ex post facto research design to test the research hypotheses. In this study, the researcher explored which characteristics are related to counselors' perceived competence to provide e counseling to a client who is reporting rational suicidal ideation.

Ex post facto literally insinuates "from what is done afterwards" (Cohen, Manion, and Morison, 2000). An ex post facto investigation is used in social science research to investigate potential relationships by examining plausible contributing factors of existing conditions (Kerlinger & Rint, 1986). Ex post facto design can be used when it is impractical or unethical to use an experimental or quasi-experimental design to test hypothesis about cause-and-effect or correlational relationships (Cohen, et al, 2000). For this particular study, the researcher explored if counselors' competence to provide counseling to individuals with rational suicidal ideation is related to multiple demographic factors, which cannot be manipulated by the investigators.

An ex post facto experiment design starts with groups that differ in some respect and looks back to determine what factors, such as age, education, or gender, may correspond to those differences (Cohen, et al, 2000). In this study, the researcher explored whether or not counselor's competencies to provide counseling to individuals with rational suicidal ideation are related to multiple demographic factors. Based on the inability to manipulate the predictor (i.e., demographic) variables, the ex post facto design is the best choice to answer the research questions of this study.

The population of interest for this study is mental health counselors. The researcher used archival, quantitative data that was collected via survey. Research participants included counselors who subscribe to the Counselor Educator and Supervisors Network (CESNET) listserv used by counselor educators, counselor education students and practicing counselors. This is a sample of convenience. Participants received a link to the survey on Surveymonkey.com via an email to the listserv that includes the informed consent document and a link to the survey on surveymonkey.com.

This study has four criterion variables and nine predictor variables. The criterion variable for the first eight research hypotheses is the counselor's rating of overall competence to provide counseling for a client who is expressing rational suicidal ideation. This variable is a categorical variable. The predictor variables for the first eight research hypotheses are highest degree achieved, age, number of years of practice, religious affiliation, experience with terminally ill client, experience with suicidal client, and contemplation of suicide on the part of the counselor. The highest degree achieved variable is a dichotomous variable (masters or doctoral degree). Age and years of

practices are categorical variables; each variable was divided in to groups of five. Religious affiliation is a dichotomous variable. Although there were six choices (Christian, Muslim, Jewish, Hindu, Non-religious, or Other), there were not enough responses for the choices of Muslim, Jewish, Hindu or Other to compare groups. This data was divided into two groups: religious and non-religious. Experience with a terminally ill client, experience with a suicidal client, and contemplation of suicide on the part of the counselor are all dichotomous variables (yes or no).

There was one predictor variable for the last three research hypotheses. This variable is client's prognosis and is a categorical variable. Each category represents a different prognosis. The criterion variables are clinician's determination of suicidal ideation, clinician's determination of rational suicidal ideation, and scenario specific competence rating. The first two criterion variables are dichotomous (yes or no) and the counselor's scenario specific competence rating is categorical.

Data wasa analyzed using non-parametric statistics. The researcher determined kurtosis and skewness for the criterion variables of overall competence and scenario specific competence for each predictor variable. To test research questions one, three, four, five, and six, the researcher used a Mann-Whitney t test. A Mann-Whitney test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003). The researcher used a Kruskal-Wallis one-way ANOVA to test research questions two and nine. A Kruskal-Wallis one-way ANOVA is used to compare differences between 3 or more categorical groups (Hinkle, Weirsma, & Jurs, 2003). A Chi Square test was used to test the research hypotheses seven and eight. The Chi Square test is used

to compare two more independent groups when the data is nominal or ordinal (Hinkle, Weirsman, & Jurs, 2003)

1.7 Definition of Terms

For the purpose of this study, the following terms will be utilized as defined:

- Rational Suicide is defined as suicidal ideation that occurs when an individual is diagnosed with a terminal illness and, further is not experiencing symptomology of depression or anxiety that rises to the level of a diagnosable disorder that interferes with the individual's ability to make a rational decision (Rogers, et. al, 2001; Werth Jr. & Crow, 2009).

- Terminal Illness is defined as "an illness in which, on the basis of the best available diagnostic criteria and in light of available therapies, a reasonable estimation can be made prospectively and with high probability that a person will die within a relatively short time" (Veatch, 1988, p. 34)

- End-of-Life Counseling is defined as counseling that occurs with a terminally ill client.

- Education level is defined as the highest level of education that the counselor has achieved at the time of the survey.

- Years of Experience is defined as the number of years that the counselor has been practicing. This category will be divided into blocks of 5 years (0-5 years, 6-10 year, etc.)

- Religion is defined as the religious affiliation that the counselor endorses at the time of the survey.

- Competence is defined as the therapist's ability to facilitate positive change in a client (Hermann, 2011) based on education and skills (ACA, 2014a). Competence will be measured on a scale of 1-5. Endorsing a 1 on the scale indicates that the respondent is not competent and endorsing a 5 indicates that the respondent is competent and would provide supervision in this area.

1.8 Summary

Terminally ill individuals seek counseling for a variety of reasons including discussing end-of-life planning. Counselors need to be competent to provide counseling to clients who express rational suicide. This researcher explored if counselors perceive themselves as competent to provide counseling to individuals expressing rational suicidal ideation, and what factors influence this reported competence. Understanding whether counselors describe themselves as competent and which factors impact competence in this area will provide direction for training future counselors.

Chapter II

Literature Review

Chapter 2 provides the reader with a background on the problem, which is a lack of understanding about whether counselors perceive themselves to be competent to provide counseling services to a client who is terminally ill and expressing rational suicidal ideation. This researcher presented a review of the literature on counseling needs of the terminally ill via two similar frameworks, describe the construct of rational suicide, and provide an overview of physician-assisted suicide legislation. This chapter includes a discussion of the counselor characteristics that may predict competence to work with a client who is expressing rational suicidal ideation, such as education, years of experience, religion, licensure, experience with a terminally ill client, experience with a suicidal client, contemplation of suicide on the counselor's part, and client's prognosis. Lastly, the rationale for the study based on trends and gaps in the literature was addressed.

2.1 Introduction

Individuals with a terminal illness seek counseling to process their emotions and options for treatment (Daneker, 2006). Kubler-Ross (1969) and Rando (1984) describe models for counselors to conceptualize the process of dying from a terminal illness. Many counselors may encounter the death of a client by competed suicide; however, the potential of losing a client to a natural death is discussed less frequently (Dwyer, Deshields, & Nanna, 2012). There are no studies about clients who are terminally and are expressing his or her desire to hasten death, otherwise known as rational suicide. The models detailed by Kubler-Ross and Rando do not address the needs of someone who is rationally suicidal. As technology continues to advance, the number of choices for

medical treatment increases to provide a better quality of life than in the past (Arias, 2014). Fewer people are dying from opportunistic infections and are enduring chronic extensive illness (Rogers, et. al, 2001). A counselor can encounter a client who is terminally ill at any point in their counseling relationship (Dwyer, Deshields, & Nanna, 2012).

When presented with a client who is expressing rational suicidal ideation, counselors may struggle with various legal, ethical, and political issues. Legally, a counselor who fails to prevent a completed suicide may be charged with a wrongful death suit (Kjervik, 1984). Counselors may struggle with the ethics involved in balancing promoting autonomy of the client to make what may be seen as a health care decision and with preventing the loss of life (Werth, Jr. & Crow, 2009). Politically, counselors may find themselves wading through the legislation to determine what their role is in the state in which they reside. A review of the literature indicates that while there has been research on whether counselors agree that suicide can be a rational decision for individuals who are terminally ill (Rogers, et. al, 2001); there is no research in the area of counselor competencies for providing counseling services to those who are expressing rational suicidal ideation.

2.2 Terminal Illness Defined

Veatch (1988) defines terminal illness as

> an illness in which, on the basis of the best available diagnostic criteria and in light of available therapies, a reasonable estimation can be made prospectively and with high probability that a person will die within a relatively short time (p. 34).

Terminal illness may also be defined by the state in which the client resides. For example, in Ohio, to receive hospice care, terminal illness is defined to include that that individual has less than 6 months to live (OAC, 3701-19-01). The average life expectancy in the United States in 2013 was 78.8 years. Men had a life expectancy of 76.4 years and women had a life expectancy of 81.2 years (Kochanek, Murphy, Zu, & Arias, 2014). From 1980 to 2010, the life expectancy has increased as follows: 8.0 years for black males, 5.8 years for white males, 5.5 years for black females, and 3.2 years for white females (Arias, 2014). In the 75-year period of 1935 to 2010, the risk of mortality has decreased 60 percent (Hoyert, 2012). The ten leading causes of death for 2013 in order from most frequent to least frequent were heart disease, cancer, chronic lower respiratory diseases, unintentional injuries, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, kidney disease, and suicide (Kochanek et al., 2014). Heart disease, cancer and stroke have been among the five leading causes of death each year from 1935 to 2010 (Hoyert, 2012).

Five factors reportedly impact individuals diagnosed with a terminal illness as they progress toward natural death. These include (a) intrinsic factors such as bodily state and ability to function; (b) extrinsic factors such as interpersonal responses, and navigating the health care and social services systems; (c) identifying prospects for the future while having some perception of normality; (d) having self-determination to manage their symptoms; and (e) exploring the meaning of their life in the face of death (Carter, MacLeod, Brander, & McPherson, 2004). One way to increase terminally ill clients' level of self-determination in managing their symptoms is to provide them with a multitude of treatment options, including the right to refuse treatment (Rogers et al.,

2001). Counseling can be utilized to assist the client to manage these factors and make informed decisions about their progress toward natural death, including exploring rational suicide (Daneker, 2006).

2.3 Conceptualizing the Process of Dying

Counseling can be an important part of the dying process for someone with terminal illness. Counselors can help the client to normalize the emotions that come with the process of dying (Daneker, 2006). Ohio law requires that individuals in hospice care have access to counseling services to address their "dietary, spiritual, bereavement, and any other counseling services" (OAC, 2015, 3701-19-18 A). Terminally ill individuals have complex needs that range from physical needs like pain management to emotional and spiritual needs (Daneker, 2006). While it may not seem that counselors can be helpful with physical needs of the terminally ill, techniques such as relationship or imagery can help increase the client's awareness and control of the pain (Daneker, 2006). Counselors also assist with processing emotions that come with the changes that are occurring to the client's bodily functions and abilities. Additionally, counselors can work with their clients to develop skills to talk with their medical providers. In counseling, the counseling needs of a dying client are conceptualized with two frames: Kubler-Ross's five stages of death and dying and Rando's three phases of the living-dying interval.

2.3.1 Five Stages of Dying

Kubler-Ross (1969) described five stages that a person who is dying may experience with the intention of helping caregivers understand their loved one's experience. These stages are denial and isolation, anger, bargaining, depression, and

acceptance. These stages are also helpful for counselors to understand the needs of their terminally ill client (Manis & Bodenhorn, 2006).

The denial stage frequently occurs at the initial diagnosis of the terminal illness and may continue throughout the course of their illness (Kubler-Ross, 1969). Terminally ill clients may need assistance processing the reality of death and recognizing the motivation for their denial (Manis & Bodenhorn, 2006). A client may not accept that death is a natural conclusion to life that everyone experiences (Flaskerud, 2011). They may find it more comfortable to deny death will occur and fail to plan for the future. This may protect the client from fear and distress that may have to be experienced (Flaskerud, 2011). Terminally ill clients may also feel that talking about death is giving up hope that treatment may work (O'Brien, 2011).

Kubler-Ross (1969) described the anger stage as one that arises from the question "why me?" (p. 44) and is characterized by feelings of anger, rage, envy, and resentment. Many times the anger is directed toward the individual's closest family and friends (Manis & Bodenhorn, 2006; Kubler-Ross, 1969). During the anger stage, a counselor may provide an outlet to process these feelings to assist the client. Many of the caregivers in the client's life, particularly the medical personnel, do not take the time to put themselves in the client's place to understand where the anger originates (Kubler-Ross, 1969).

The bargaining phase describes the terminally ill individual's bartering for more time or the ability to live until a significant event occurs, such as a family reunion or a child's graduation (Kubler-Ross, 1969). During this phase, counselors may find themselves helping those who are dying with their spiritual needs. Clients may have a

desire to find meaning in their life and in the illness that is ending it (Daneker, 2006; Manis & Bodenhorn, 2006). Clients may want to form a definition of what death looks like to them. This phase may not be addressed in counseling because frequently the bargains are directed at the client's higher power and may never be verbalized in the company of others (Kubler-Ross, 1969).

Once a terminally ill person can no longer deny their illness, they may move into the fourth stage, depression (Kubler-Ross, 1969). This depression can be either reactive or preparatory. Reactive depression is characterized as stemming from some consequence of the illness (Kubler-Ross, 1969). An example of reactive depression would be a depression that occurs post-mastectomy for a woman with breast cancer as she deals with losing her breast. This type of depression may alleviate with assurances that the client's concerns are valid and that the client is supported (Kubler-Ross, 1969). Preparatory depression is a depression that occurs as one anticipates impending losses (Kubler-Ross, 1969). This depression is more difficult to lessen as a client is prepares for the loss of resources, possessions, familiar routines, and loved ones. Kubler-Ross suggests that a client experiencing preparatory depression may benefit from being allowed to express their sorrow.

The fifth and final stage of Kubler-Ross's stages is acceptance. This stage will be reached when the terminally ill individual has had the ability to express feelings of anger and loss as well as envy. The individual will also have mourned their upcoming loss (Kubler-Ross, 1969). At this stage, clients who are terminally ill may want to discuss end-of-life planning. End-of-life planning can include determining who will assist with personal care, whether to sign a power of attorney, creation of a living will, or

determining when and if to hospice (Flaskerud, 2011). Other task that can be included in end-of-life planning may be to decide who will have custody of minor children, who will pay the bills when the client becomes incapable, or even who may take care of a beloved pet. The counselor can also help the client to plan how to discuss these decisions with loved ones (Daneker, 2006). End-of-life planning may involve discussing funeral services and plans for burial.

2.3.2 Phases of Living-Dying Interval

Rando (1984) described three phases of the Living-Dying Interval that a person experiences between their diagnosis of a terminal illness and their death. This interval includes multiple problems that a terminally ill person must face including remissions, disruption of family, periods of uncertainty, decision making and treatment choices, and pressures around finances, physical capabilities, and social functioning (Rando, 1984). The three phases are the acute crisis phase, the chronic living-dying phase, and the terminal phase.

Rando (1984) describe the acute crisis phase as being characterized by anxiety and helplessness. During this phase, the counselor's role is one of reduction of this anxiety (Manis & Bodenhorn, 2012). The trajectory of the client's illness will impact the level of anxiety they experience. Rando identifies four different trajectories for a terminal illness. The first is that the certain death is in a known time period (Rando, 1984). An example of this trajectory is when the client is given a time period, such as six months, to live. The second trajectory occurs when the timeframe until death is unknown (Rando, 1984). This trajectory applies to many chronic illnesses. The third trajectory occurs when the individual receives a diagnosis of terminal illness, but must await further testing to

determine the length of time until impending death (Rando, 1984). The final trajectory encompasses an uncertain death and an uncertain timeframe; this may occur with serious chronic illness such as multiple sclerosis (Rando, 1984). The acute crisis phase may correspond with Kubler-Ross's stage of denial.

The chronic living-dying phase is marked by adaptive concerns that occur when one is integrating their living and dying (Rando, 1984). During this phase, the terminally ill individuals are tasked with considering treatment options, while reconciling that the options may only delay the inevitable death (Rando, 1984) The counselor's role in this phase may be assisting with arranging affairs, end-of-life planning, psychosocial problems, and anticipation of future pain, discomfort, and loss of abilities (Manis & Bodenhorn, 2006). Rando (1984) felt this stage was categorized by a vacillation between planning for impending death and completing the tasks of daily life. For example, a mother may be weighing her options for medical treatment while also ensuring that her children's day-to-day needs are met. This phase may be seen as similar to the middle three stages of Kubler-Ross's Five Stages of Death and Dying in areas that the counselor may assist the client.

The terminal stage encompasses the terminally ill individual beginning to respond to inner cues that death is impending (Rando, 1984). During this phase, the counselor assists the client to have an appropriate death. An appropriate death is defined as one in which the individual has reached point where they are at ease with their impending death (Rando, 1984). This death is achieved when inner conflict has been reduced, the individual has maintained their basic sense of identity in death, any unfinished business

has been resolved, and any last wishes have been accomplished (Rando, 1984). This final phase is similar to Kubler-Ross's acceptance stage.

Both Kubler-Ross (1969) and Rando (1984) indicate in their frameworks for conceptualizing natural death that clients identify a time when they are prepared to accept their impending death. The terminally ill client's focus switches to end-of-life planning, such as estate or funeral planning (Daneker, 2006; Kubler-Ross, 1969; Rando, 1984). Counselors can assist the terminally ill client to be able to have end-of-life planning discussions with their family members as part of the counseling process (Daneker, 2006; Manis & Bodenhorn, 2006). Both Kubler-Ross's and Rando's models do not conceptualize the experiences of a terminally ill client who is expressing rational suicidal ideation. Based on the criteria for requesting physician-assisted suicide (having a prognosis of six months to live) (DWDA 127.8, RCW Chapter 70.245, Act 39, & California SB-128), it could be expected that counselors may encounter rational suicidal ideation in the final phases of each of these frameworks. Counselors are directed to these frameworks as guidelines for conceptualizing the dying process in their terminally ill clients during their training in the textbooks that are used (Erdford, 2015; James & Gilliland, 2013). Therefore it is important that these frameworks address the needs of a terminally ill client who is expressing rational suicidal ideation.

2.4 Physician-assisted Suicide

Physician-assisted suicide involves a terminally ill person requesting from their physician aid-in-dying. Aid-in-dying is the act of a physician prescribing a patient with the method to die and the person self-administers the medication (Werth Jr & Holdwick,

Jr, 2000). Physician-assisted suicide is legal in four states: Oregon (DWDA 127.8), Washington (RCW Chapter 70.245), Vermont (Act 39), and California (SB-128).

In 1994, Oregon approved the Oregon Death With Dignity Act (DWDA) legalizing physician-assisted suicide. This law permits terminally ill patients to request that their physician prescribe medication that will help them achieve a dignified death. Individuals who are eligible must have a terminally ill condition and their judgment must not be impaired by a psychiatric or psychological disorder. Oregon law also stipulates that the terminal illness must lead to death within 6 months (DWDA 127.8 (12)). Since 1997, prescriptions have been written for 1,173 people under the DWDA and 752 of people have died using those prescriptions (DWDA Report, 2013). For 2013, the most frequently cited reasons for requesting physician-assisted suicide were loss of autonomy (93%), decreasing ability to participate in activities that made life enjoyable (88.7%), and loss of dignity (73.2%) (DWDA Report, 2013).

The State of Washington also has passed a Death with Dignity Act that is similar to the Oregon DWDA in 2008 (RCW Chapter 70.245). The Washington law states that an adult can request in writing a prescription meant to facilitate the ending of the patient's life. The patient must have a terminal disease, defined as an incurable and irreversible disease that will produce death within six months (RCW Chapter 70.245). Since 2009, 549 individuals have requested the means to end their own life and 525 have died (Death With Dignity Act Report, 2013). Participants in Washington cited similar end-of-life concerns as in Oregon: losing autonomy (91%), less able to engage in activities that make life enjoyable (89%), and loss of dignity (79%) (Death With Dignity Act Report, 2013).

The Vermont's Patient Choice at End of Life Act, passed in 2013, was written in a similar manner to both Oregon and Washington's Acts (V.S.A. chapter 113). This researcher was unable to find information regarding the patient access rates to this act. The Vermont bill was introduced in response to an increase in enrollment in hospice care in the state of Vermont and compared to the rate of usage of the Oregon DWDA by Oregon patients in hospice (V. SB 77). California passed a Right to Die bill in September of 2015 modeled after previously existing acts (California SB-128).

While Montana does not have a specific law legalizing physician-assisted suicide, the Montana Supreme Court ruled that physicians who assist a terminally ill patient to die is not "against public policy" and the physician is not legally responsible for the death (*Baxter v. Montana,* 2009). Twenty-three states have had Right to Die or Death With Dignity bill introduced in 2015.

Table 1: Death With Dignity Proposed Legislation by State. Retrieved from DeathwithDignity.org

STATE	BILL	DATE INTRODUCED
ALASKA	HB99	2/15
COLORADO	HB 15-1136	1/15
CONNECTICUT	HB 7015	1/15
DELAWARE	HB 150	5/15
DISTRICT OF COLUMBIA	B21-0035	1/15
IOWA	HF 65	1/15
KANSAS	HB 250	1/15
MAINE	SP 452/LD 1270	4/15
MARYLAND	SB 0676 & HB 1021	2/15 (Senate), 2/15 (House)
MASSACHUSETTS	H 1991	1/15
MINNESOTA	SF 1880 & HF 2095	2/15 (Senate) 2/15 (House)
MISSOURI	HB 307	1/15
MONTANA	SB 302	1/15
NEVADA	SB 336	1/15
NEW HAMPSHIRE	HB 151	1/15
NEW JERSEY	Assembly 2270 & S 382	2/15 (Assembly), 1/15 (Senate)
NEW YORK	AO2129 & SB 2685-2015	1/15 (Assembly), 2/15 (Senate)
NORTH CAROLINA	HB 611	4/15
OKLAHOMA	HB 1675	1/15
RHODE ISLAND	HB 5507 & SB 598	2/15
TENNESSEE	HB 1040 & SB 1362	3/15
UTAH	HB391	2/15
WISCONSIN	AB 67 & SB 23	3/15 (Assembly), 2/15 (Senate)
WYOMING	HB 119	TBD

Each of the current laws regarding physician-assisted suicide require an assessment decision making ability to determine if the individual requesting physician assistance is making an informed decision (DWDA 127.8, RCW Chapter 70.245, Act 39, & California SB-128). This mental health assessment accomplishes several things. The first concern is that the terminally ill patient is not clinically depressed and seeking suicide due to the pain of depression (Werth Jr & Holdwick Jr, 2000). Counselors can assess for treatable mental health conditions and provide treatment. A second concern is that terminally ill patients are being coerced into making the decision to hasten death (Werth Jr. & Holdwick Jr, 2000). The counselor can assess where the motivation to seek physician-assisted suicide originates. The final concern is that the terminally ill patient will not fully consider all of their options to prevent pain on the survivors that they leave behind (Werth Jr & Holdwick Jr, 2000). Counselors will explore a holistic view with the client to examine all options thoroughly.

2.5 Rational Suicide

Suicidal ideation is the desire to take one's own life (Kjervik, 1984). Counselors are mandated to disclose clients' confidential information when it can be used to prevent serious and foreseeable harm, such as when someone is considered at risk for attempting or completing suicide (ACA, 2014a). Counselors may face legal action, such as a wrongful death suit, should a client complete suicide and the counselor failed to act to prevent it (Kjervik, 1984). Counselors also have emotional reactions to losing a client to completed suicide. Counselors may experience emotional distress (Rothes, Scheerder, Van Audenhove, & Henriques, 2013; Wurst et al, 2013), perseverate on their relationship with the client and experience self-blame (Rothes et al, 2013), and, counselors who lose a

client to suicide may question their professional competence (Christianson & Everall, 2009).

Rational suicide is the desire to hasten one's death when terminally ill (Werth & Cobia, 1995). The idea that suicide can be rational is dependent on three components. First, the person considering hastening their death has a terminal illness confirmed by a medical professional. Next, the individual must be capable of making an informed decision based on the consideration of all alternatives and in the absences of a diagnosis that would impede this decision making process. Additionally, the individual is making the decision of their own free will (Werth & Crow, 2009; Rogers, et. al, 2001).

Terminally ill individuals struggle with five issues that may impact their ability to make a rational decision about how to end their life. These include: (a) physical suffering with no end in sight, (b) lack of control over their illness, (c) lack of empowerment to express their wishes, (d) depression, and (e) lack of knowledge about their options for treatment and care (Winograd, 2012). Siegle (1986) suggests that legitimizing rational suicide may lead to the terminally ill person being coaxed into hastening death to prevent the person from being a burden on their family. Chronic pain or mental health concerns, such as depression or anxiety, may cloud the terminally ill person's judgment (Siegle, 1986). Boudrea and Somerville (2013) suggest that terminally ill individuals may struggle with issues of morality or religion that cloud their judgment.

Supporters of suicide as a rational construct view permitting terminally ill individuals as having a right to have autonomy over their decisions regarding the remaining time of their life (Biller-Andorno, 2013; Schramme, 2013). Those who do not view suicide as a rational construct have concern about coercion and abuse of those who

are terminally ill (Biller-Andorno 2013; Schramme, 2013). Biller-Andorno (2013) reports that with safeguards in place in Switzerland, where physician-assisted suicide has been legal longer than in the United States, there has not been an increase in abuse and that the number of suicides has declined. Additionally, only a minority of those who requested assistance to die in Oregon and Washington follow through with use of the medication (Oregon DWDA report, 2013; Washington DWDA report, 2013) indicating a lack of widespread abuse of the legalization of physician-assisted suicide.

Debate has occurred surrounding whether suicide can be rational (Werth, Jr & Holdwick, Jr, 2000). Rogers, et al. (2001) surveyed professional members of the American Mental Health Counselors Association (AMHCA) regarding their attitudes toward rational suicide. When posed with the question of whether the participants believed in rational suicide, 80% of the respondents indicated some level of agreement with the concept of rational suicide (Rogers, et al, 2001). Participants identified many circumstances that would warrant a decision to committee suicide to be rational including, but not limited to, terminal illness, severe physical pain, nonimpulsive consideration of alternatives, and unacceptable quality of life (Rogers, et al, 2001). These results are similar to other studies involving different populations. Werth and Liddle (1994) found that 81% of members of Division 29 of the American Psychological Association believed that suicide could be rational at times. In 2004, Westefeld, Sikes, Ansley, and Yi surveyed state legislators, nurses, and psychologists in a rural Midwestern state. This research team found that 57% of respondents thought that rational suicide was an acceptable option for terminally ill people.

Survey respondents who supported the idea of rational suicide endorsed a number of reasons (Rogers, et. al, 2001, Werth and Cobia, 1995; Westefeld, et. al, 2004). For example, Werth and Cobia (1995) found that those who support rational suicide felt that individuals have the ability to make rational decisions, should have the right to choose how and when they will die, and experience terminal illness that have no hope of recovery and may involve pain from which there is no relief. In 2001, counselors indicated that suicide could be rational in the following circumstances: (a) terminal illness, (b) severe physical pain, (c) unacceptable quality of life, (d) with a clear state of mind, and (e) after consulting with significant others and professionals to consider all other alternatives (Rogers et al, 2001). Westefeld et al. (2004) concluded that there is a stronger disposition toward rational suicide if the terminally ill person has suffered long and is an adult. Physical debilitation rather than mental illness was also favored as a reason for accepting that suicide can be rational (Westefeld et al, 2004).

Those respondents who did not believe that suicide could be rational based their decision on their moral or religious beliefs (Rogers, et al, 2001; Westefeld, et al, 2004). Four responses specifically referenced God in their reasoning for finding rational suicide unacceptable (Westefeld, et al, 2004). There were differences between religious affiliations. Methodists identified rational suicide as more acceptable than other denominations (Westefeld, et al, 2004). Werth Jr. and Cobia (1995) noted that those who did not believe in rational suicide felt that the terminally ill individual had (a) not explored all options, (b) that suicide would be devastating to the client's significant others, and (c) that suicide is psychologically and emotionally based so it cannot be rational.

One of the fundamental principles of counseling is the idea of nonmaleficence; counselors work to avoid actions that cause harm to their clients (ACA, 2014a). This principle may seem to be in conflict with endorsing rational suicidal ideation. In 1996, when the state of Washington was involved with the United States Supreme Court over their proposed Death with Dignity Act, the ACA signed an *amicus brief* supporting a terminally ill individual's autonomy to decide when they choose to die (Rogers et al, 2001). The conflict within the profession regarding how to address terminally ill clients who wish to hasten their death can be seen in the recent change in the ACA *Code of Ethics*. The 2005 version of the *Code of Ethics* encouraged counselors to allow clients the space to

> be given every opportunity possible to engage in informed decision making regarding their end-of-life care and to receive complete and adequate assessment regarding their ability to make confident, rational decisions on their own behalf from a mental health professional who is experienced in end-of-life care practice(ACA, A.9.a, 2005).

The updated 2014 Code of Ethics has removed this statement and replaced it with

> Counselors who provide services to terminally ill individuals who are considering hastening their own deaths have the option to maintain confidentiality, depending on applicable laws and the specific circumstances of the situation and after seeking consultation or supervision from appropriate professional and legal parties (ACA, B.2.b, 2014a)

Although the leadership of the ACA signed an *amicus brief* in support of the decision of states to allow physician-assisted suicide, there was little input from the membership

causing a backlash among the members (Rogers, et al, 2001). The backlash from this action may have been one of the factors for changing the wording of the ethical code.

In addition to nonmaleficence, counseling is also based on the principle of autonomy, encouraging one to feel they have the right to control the decisions for their own life (ACA, 2014a). Counselors should facilitate informed decision making for those by minimizing factors that could impair this ability (Werth Jr & Crow, 2009). Fear that a counselor could be breaking the laws regarding assisted suicide may prevent the counselor from being open to these discussions in states where physician-assisted suicide is not legal.

In 2009, Werth Jr and Crow proposed the following guidelines for counselors who are providing end-of-life care to terminally ill individuals. Based on the ACA 2005 *Code of Ethics*, Werth Jr and Crow advocate for comprehensive end-of-life care that encompasses all issues that a terminally ill client may struggle with. Counselors assess for diagnosable mental health concerns so that they can provide treatment to ensure that the client is able to make rational decisions (Werth Jr & Crow, 2009). Counselors are encouraged to assist the terminally ill client to address issues of grief and spirituality that may accompany end-of-life care. Particularly, Werth Jr and Crow stress maximizing the terminally ill individual's self-determination and engaged the client in informed decision-making.

While research has shown that counselors endorse the idea that suicide can be rational under specific circumstances with individuals who are terminally ill (Rogers, et al, 2001), there is no research that counselors rate themselves as competent to provide end-of-life counseling to terminally ill clients who are expressing rational suicidal

ideation. Counselors need to be prepared to have open discussions with individuals who are expressing rational suicidal ideation and are seeking counseling.

2.6 Counselor Competence

Shaw and Dobson (1988) define counselor competence as the ability to promote positive change. Patient outcomes are attributed to a therapist competence level. Research has shown that therapist competence impacts patient outcomes when using Cognitive Behavioral Therapy (CBT). Patients demonstrated less self-harm and suicidal behavior when CBT was implemented by therapists rated as more competent than those who were rates as less competent (Davidson et al, 2004; Norrie, Davidson, Tata & Gumley, 2013). The importance of competence in treatment outcomes has been demonstrated with respect to implementing treatment for social phobia (Olivares, Olivares-Olivares, Rosa-Alcazar, Montesions, & Maica, 2014), cognitive therapies (James, Blackburn, Milne, & Reichfelt, 2001), depression (Shaw et al, 1999), and treatment fidelity in community based programs (Campbell, 2013).

There is some contention in the field of counseling as to what factors predict counselor competence (Herman, 1993). Three groupings of factors are thought to influence competence: education and experience (Berman & Norton, 1985; Hattie, Sharpley, & Rogers, 1984; Shaw & Dobson, 1988), personal characteristics and ability to develop a therapeutic relationship (Luborsky et al., 1985; Lubrosky et al, 1986; Strupp & Hadley, 1979), and application of clinical research (Herman, 1993).

2.6.1 Education

Emphasis has been on education as the cornerstone of developing therapist competence (Herman, 1993). Each of the 50 states within the United States has licensure

standards that require a master's degree (ACA, 2014b). Two hundred and eighty master's programs for training counselors are accredited by the Council for Accreditation of Counseling and Related Education Programs (CACREP). CACREP standards for training counselors indicate that there are eight core areas that counselors should develop knowledge and skills: (a) professional orientation and ethical practice, (b) social and cultural diversity, (c) human growth and development, (d) career development, (e) helping relationships,(f) group work, (g) assessment, and (h) research and program evaluation (CACREP, 2009). Shaw and Dobson (1985) indicate that knowledge of, skill, and appropriate use of interventions relate to competence. Two studies found that educated professional helpers were more competence and effective than those who were not educated (Berman & Norton, 1985; Hattie et al, 1984). Education level has also been identified as a factor impacting competence with specific populations, such as Lesbian, Gay, Bisexual (LGB) competence (Graham, Carney, & Kluck, 2012) and multicultural competence (Barden & Greene, 2015).

2.6.2 Counseling Experience

Experience counseling has also been heralded as an important part of developing counselor competence (Herman, 1993). Licensure standards written by state boards emphasize that a clinical or experiential component be included in training standards before licensure (ACA, 2014b). Programs that are accredited by CACREP include at least 700 hours of clinical experience as a part of training (CACREP, 2009). Certain licensure boards distinguish between a provisional license and independent license based on years of post-graduate experience. For example, the states of Ohio, Michigan, and Texas has a two tiered system that allow individuals to be independently licensed after

3000 hours of practice post-graduation and at least two years of experience (ORC 4757.22, MI Section 333.18107, TX chapter 681 section H).

Research has countered the assertion that competence is developed through only education and experience. Personal factors and ability to develop a therapeutic relationship have been indicated as important aspects of counselor competence. Particularly, the importance of the therapeutic bond has been emphasized (Schaffer 1982; Luborsky et al, 1986; Orlinsky & Howard, 1986). Specific factors that may impact a counselor's ability to develop a relationship with a client expressing rational suicidal ideation will be discussed here. These factors include (a) specific counseling experiences, (b) personal contemplation of suicide, (c) religious affiliation, and (d) prognosis of the client.

2.6.3 Specific Counseling Experiences

Werth Jr. et al, (2001) included in his survey of AMHCA members' questions pertaining to whether the respondents had counseled a client who attempted suicide or committed suicide. The team found that a high percentage of their respondents (72%) had a client attempt suicide and a low percentage (28.7%) had a client commit suicide. There was no significant difference between those who have had a client attempt and those who have not had a client attempt suicide in response to the question regarding whether suicide could be rational (Werth Jr. et al, 2001). Additionally, there was no significant difference in those who had a client commit suicide and those who have not (Werth Jr. et al, 2001). While experience with a suicidal client did not have an impact on whether a counselors believed suicide could be rational, counselors develop competence to assess for suicidal ideation and provide counseling based on the experience and practice (Erford,

2015; Remley & Herlihy, 2016). Based on this it was proposed that experience with a suicidal client might influence a counselor's perception of their competence to work with a client who is expressing rational suicidal ideation, a form of suicidal ideation.

2.6.4 Personal Contemplation of Suicide

One personal factor that may impact counselors' competence is their own personal contemplation of suicide. A question regarding whether the participant had contemplated suicide was included in the Werth Jr's et al (2001) study. The research team noted that one fifth of the sample had reported considering suicide as an option during their lifetime (Werth Jr. et al, 2001). Werth Jr. et al found that there was no significant difference in response to whether suicide could be rational based on this factor. This researcher thought that it was possible that those who had contemplated suicide for themselves may indicate a higher competence level to work with a client expressing rational suicidal ideation based on their ability to empathize with the client than those who had not.

2.6.5 Religious Affiliation

Rogers et al (2001) surveyed members of the American Mental Health Counselor Association (AMHCA) regarding their attitudes about whether suicide can be rational. The team found that those participants who indicated a religious affiliation may allow their religion to impact their judgment process when working with a terminally ill client who is expressing rational suicidal ideation (Rogers et al, 2001). Rogers et al. suggests that counselors may need to engage in person value clarification to ensure that they provide unbiased counseling services. Furthermore, the 2005 American Counseling Association Code of Ethics indicated:

> Recognizing the personal, moral, and competence issues related to end-of-life decisions, counselors may choose to work or not work with terminally ill clients who wish to explore their end-of-life options. Counselors provide appropriate referral information to ensure that clients receive the necessary help. (ACA, A.9.b, 2005)

Werth, Jr & Cobia (1995) surveyed psychotherapists and found that one reason listed for not believing that suicide could be rational is that it is immoral. In 2004, nurses, psychologists, and state legislators were asked about whether suicide can be rational for those who are terminally ill. Westefeld et al. (2004) found that participants responded with "God does not allow suicide or the time of death is God's decision" (p. 366). Based on these findings, it is thought that a counselor's religious belief may impact their ability to develop a relationship with a client who is expressing rational suicidal ideation; thus impacting their perception of their competence to provide counseling to this client.

2.6.6 Prognosis

The current legislation in states where physician-assisted suicide is legal include a stipulation that the patient must have a diagnosis that will lead to imminent death within six months (Oregon DWDA, Washington DWDA, V.S.A. chapter 113, & California SB-128). This six month criteria is also included in the proposed legislation in twenty-four other states. Research on whether suicide can be a rational construct stipulates that the terminally ill client has a prognosis of six months (Rogers et al, 2001; Werth Jr & Cobia, 1995; Werth Jr. et al, 2001; Westefeld et al, 2004). Based on this stipulation, it was thought that when presented with vignettes that represented different prognoses,

counselors would have varying opinions regarding what constitutes as rational suicide versus what is suicidal ideation that counselors must take action to prevent.

2.7 Use of Vignettes in Clinical Research

Vignettes serves as a viable method for measuring differences in clinical settings (Shulman et al. 1999; Martinez & Guarnaccia 2007), because they can systematically adjusted for factors, such as race, ethnicity, and gender, while holding all other factors constant. Kerlinger (1986) describes the use of scenarios, or vignettes, to measure variables within a realistic manner. Details of the vignettes were varied to assess the participant's reactions to the variations (Kerlinger, 1986). They have been used to analyze perceptions, beliefs, and attitudes of respondents toward health care concerns such as depression and violence (Barter & Renold 2000; Cabassa 2007) or clinician decision making with patients of different ethnicities (Shulman et al. 1999; Schoenberg & Ravdal 2000; Green et al.. 2007). Clinical vignettes have been used to measure inter-rater reliability for diagnoses (Gude, Dammon, & Friis, 1997).

This study uses vignettes to vary the prognosis of the client presented and collect information regarding the counselor's perceptions of whether the client is expressing suicidal ideation, rational suicidal ideation, and the counselor's perceived competence to provide counseling to the client. The first of the vignettes describes a client who will die within six months; the second describes a client who will die in a year to a year and a half; and the third describes a client whose prognosis is unknown. The purpose of using vignettes in this study is to ascertain how a terminally ill client's prognosis impacts counselors' differentiation between suicidal ideation and rational suicidal ideation.

2.8 Summary

Counselors provide counseling services to terminally ill individuals and can be expected to encounter a client who wants to hasten their own death, a phenomenon known as rational suicide. Westefeld, et. al. (2004) indicated that 25% of their survey respondents, nurses, psychologists, and politicians, had encountered someone who was expressing rational suicide. The frameworks currently used to conceptualize the natural dying process do not address terminally ill clients who are expressing rational suicidal ideation (Kubler-Ross, 1969; Rando, 1984). No research exists addressing what factors predict counselors' competence to work with terminally ill individuals who are expressing rational suicidal ideation. Training counselors who are competent to counsel terminally ill clients who are rationally suicidal is difficult without understanding how counselor competence to provide counseling to clients expressing rational suicidal ideation is developed. Without competent counselors, these terminally ill individuals who are contemplating rational suicide could be underserved.

This study serves as a first step in filling the gap in the literature by identifying factors that predict counselor competence to counsel terminally ill individuals who are considering rational suicide. This researcher studied factors that traditionally predict competence, such as education and experience (Herman, 1993; Shaw & Dobson, 1988). Factors that predict counselors' ability to identify what constitutes rational suicide, such as religious affiliation, experience with terminally ill clients, experience with suicidal clients, and counselor's personal contemplation of suicide (Rogers, et. al, 2001), were also examined. Additionally, this researcher explored the impact of the terminally ill

client's prognosis on counselors' perceived competence and differentiation between suicidal ideation and rational suicidal ideation.

The results of this study inform counselor educators about how to prepare counselors who are competent to counsel terminally ill individuals expressing rational suicidal ideation. Practicum and internship site supervisors can utilize the results of this study to inform their supervision of counselors developing these competencies. This study provides information regarding how prognosis impacts counselors' conceptualization of what constitutes rational suicidal ideation. This information can augment the current frameworks that are used to conceptualize the process of natural death to account for terminally ill individuals who are expressing rational suicidal ideation.

Chapter III

Methods

3.1 Introduction

Chapter 3 addressed the research hypotheses being investigated in this study, followed by a discussion of the research design. A description of the instrument that was developed for the study, and the procedures for conducting the study will also be included in Chapter 3. Additionally, an explanation of data analysis is provided. Chapter 3 concluded with a review of potential ethical considerations and limitations involved in this study. The data used in this study were collected from September 2013 to May 2014. At that time, a survey was distributed via an email listserv that is counselors, counselor educators, and counseling students subscribe. Non-parametric statistics were used to explore what characteristics predict a counselor's perceived competence to provide counseling to a terminally ill individual with rational suicidal ideation.

3.2 Research Design

The investigator used an ex post facto research design to explore which counselor characteristics are related to counselor's perceived competence to provide end-of-life counseling to a terminally ill client who is reporting rational suicidal ideation. This researcher also explored the impact of prognosis on characterization of suicidal ideation, rational suicidal ideation, and perceived competence.

Ex post facto literally means "from what is done afterwards" (Cohen, Manion, & Morison, 2000). The ex post facto design can be used to test hypothesis about cause-and-effect or correlational relationships, where it is not practical or ethical to use an experimental or a quasi-experimental design (Cohen et al, 2000). When utilized in the

context of social science research, an ex post facto investigation seeks to unveil potential relationships by searching for plausible contributing factors of existing conditions (Kerlinger & Rint, 1986).

Ex post facto research can be viewed as an experimental research in reverse. An ex post facto experiment design starts with groups that differ in some respect and looks back to determine what factors, such as age, education, or gender, may correspond to those differences (Cohen et al, 2000).. In this study, the researchers will explore whether counselors' competence to provide counseling to individuals with rational suicidal ideation are related to multiple demographic factors which cannot be manipulated by the investigators. Based on the inability to manipulate the predictor variables, the ex post facto design is the best choice to answer the research questions of this study.

There are both strengths and weaknesses to using an ex post facto research design. One major advantage of conducting this type of study is that the data are already collected. This decreases the amount of time involved in obtaining new data and enrolling the participants in the study is not as involved as when the researcher needs to obtain permission to conduct the study. (Kerlinger & Rint, 1986). Cohen et all (2000) also suggest that the ex post facto design is particularly useful in social, educational, and psychological studies when the independent variable is outside of the researcher's control.

The researcher identified two weaknesses of the ex post facto research design. The inability to use random assignment to treatment group as in an experimental design is a weakness of this type of design; there may be intrinsic confounds in the variables studied (Cohen et al, 2000). This type of design is appropriate in instances where a more

powerful experimental method is not possible (i.e. when it is not possible to select, control, and manipulate the factors for a cause-and-effect type of study).

The data set for this study was collected via a survey. Survey design has limitations that may impact generalizability of the results. Steps can be taken to control for these limitation allowing the researcher to benefit from the advantages of a survey design without impacting the generalizability (Kelly et al, 2003). A measurement error may occur if the survey does not have clear, unambiguous questions (Creswell, 2012). If the questions are difficult to understand or require the participant to infer information, then the survey may not be measuring what the author expects of it. This limitation can be controlled for by pilot testing the survey before administering it to the sample (Etchegaray & Fischer, 2011; Kelley et al, 2003). The author completed a pilot study in August 2013 before collecting responses. The author requested feedback from 5 counselor educators on clarity of the questions and incorporated suggestions from the participants. A limitation of survey design is that the researcher cannot infer cause and effect from the data produced (Creswell, 2012).

3.3 Instrument

The survey instrument (Appendix A) used to collect the original data set was created based on a review of the literature that describes how counselors develop competence and a literature review of counselor's views about rational suicide. The researcher developed the survey as a part of a study conducted prior to this dissertation. The survey consisted of 3 parts. The first part included ten questions regarding demographic.

The survey asked questions about gender, age, race, and religious affiliation were included to describe the sample. Religious affiliation has been shown to correspond with counselor's attitudes regarding rational suicide (Rogers, et al., 2001) therefore it was thought that these factors could be associated with perceived competence. Items inquiring about education level (masters vs. doctoral) and number of years practicing were included as these factors are generally associated with relating counselor competence (Herman, 1993). Three questions regarding experience with a suicidal client, a terminally ill client, and counselor's personal contemplation of suicide were included as these factors were found to predict counselors' attitudes about whether suicide could be rational under specific conditions (Rogers, et al, 2001) and were expected to impact perceived competence.

The second part consisted of a definition of rational suicide, 1 question regarding attitude toward rational suicide and 1 question requesting participants to rate their competence using a 5 point Likert scale that was anchored on both ends (1 being not competent and 5 being competent, I would provide supervision). Based on a review of the literature (Rogers et al, 2001; Werth, Jr.& Crow, 2009), the following definition of rational suicide was provided to participants for their consideration: rational suicide is defined as suicidal ideation that occurs when one is diagnosed with a terminal illness and is absent of clinically diagnosable depressive or anxious symptoms that would otherwise interfere with one's individual's ability to make a rational decision.

The rational for defining competence as a perceived ability to provide supervision stems from several sources. Competence is defined as the therapist's ability to facility positive change in a client (Hermann, 1993). Sue, Arrendondo, and McDavis (1992)

proposed that competence is divided into three dimensions: beliefs and attitudes, knowledge, and skills. Stemming from the dimension of knowledge, one of the functions of providing supervision to a novice counselor is to be able to assess what one knows and does not know to foster the novice counselor's professional development (Bernard & Goodyear, 2014). Therefore, this researcher had chosen to define competence as one's perception of whether they have the knowledge to provide supervision to a novice counselor.

The third part consisted of three scenarios describing terminally ill clients who have differing prognosis. After reading each of these scenarios, participants were prompted to answer four questions. The participants were asked to determine if the client in the scenario was suicidal (yes or no), rationally suicidal (yes or no), whether they would be willing to counsel the client (yes or no) and to rate their competence on a 5 point Likert scale that was anchored on both ends (1 being not competent and 5 being competent and willing to provide supervision).

Three scenarios were provided that involved a terminally ill client who was expressing the desire to end their life. Each scenario varied by prognosis measured in time until expected death from the condition threatening their life. Scenario 1 was less than 6 months, scenario 2 was 1-1.5 years with intervention, and scenario 3 time of expected death was unpredictable. The time frames were chosen based on the legal definition of when one can enter hospice (ORC, 2015, 3701-19-18 A) or can access physician-assisted suicide (Oregon DWDA 127.8 (12), Washington RCW Chapter 70.245) is 6 months. It is expected that as prognosis is extended the number of counselors who indicated that suicide is rational will decrease.

3.4 Procedures

This study used data that were accumulated at a point prior to the start of this dissertation and have not otherwise been analyzed. The previous study's participants were recruited between September 2013 and May 2014. Recruitment took place via the Counselor Educator and Supervisor Network (CESNET) listserv used by counselor educators, counselor education students, and practicing counselors. The email utilized to solicit volunteers included the informed consent document and a link to the survey on Surveymonkey.com. Once the participants selected the link, they were again presented the informed consent before proceeding with the survey. Email requests for participants were made three times over the course of data collection.

At the time of the solicitation, the listserv had 3008 subscribers (M. Jencius, personal communication, October 2, 2015). Of these subscribers, one hundred and fifty-three individuals responded to the request for participation. The response rate was 5%. Granello and Wheaton (2004) reviewed the literature about the difference in response rates to surveys that are collected electronically and those that are collected via the mail. They found that both email surveys and web-based surveys produced a lower response rate than those mailed through the United States Postal Service. Van Horn, Green, and Martinussen (2009) completed a meta-analysis of survey response rates in published research in counseling and counseling psychology journals over the twenty-year span (1985-2005). The average response rate was 49.6%. Additionally, Van Horn et. al. found that response rate has decreased over the twenty-year period ($r = -.41$, $p < .01$). Shih and Fan (2008) found that the response rate for web surveys was about 11% higher than those

of mail surveys (34% for web surveys and 45% for mail surveys). The response rate of this survey is significantly lower than the average for mail surveys.

3.4.1 Sample

There were 153 participants in this study. Of these, 49 (32.0%) identified as male, 103 (67.3%) identified as female, and one (0.7%) did not identify their gender. Twenty-one (13.7%) individuals identified themselves as between the ages of 21-29, 53 (34.6%) identified themselves as between 30-39, 33 (21.6%) as between 40-49, 28 (18.3%) as between 50 and 59 and 18 (11.8%) identified as older than 60. With regard to race, eight participants (5.2%) indicated they were African American or Black, five (3.3%) were Asian American, four (2.6%) were Hispanic, 133 (86.9) were European American and three (2.0%) chose other. Of the participants, 88 (57.5%) indicated that they were Christian, one (0.7%) indicated Jewish, four (2.6%) indicated Buddhist, one (0.7%) indicated Muslim, eleven (7.2%) indicated other, 47 (30.7%) indicated not religious, and one (0.7%) did not answer the item.

Ninety (58.8%) participants indicated that they have a master's degree and 63(41.2 %) participants indicated that they have a doctoral degree. Eighty-two participants (53.6%) indicated that they are a licensed professional counselor; 50 (32.7%) indicated that they are licensed professional clinical counselor; 21 (13.7%) did not indicate their licensure level. This may be due to the ambiguity with which the question was written. Sixty (39.2%) participants indicated they have been counseling for 0 to 5 years. Twenty-eight (18.3%) responded that they have been counseling for 6 to 10 years, 26 (17.0 %) indicated 11 to 15 years, 19 (12.4%) indicated 16 to 20 years, and 19 (12.4 %) indicated more than 21 years.

One hundred and forty-two (92.8%) participants indicated that they have counseled a suicidal client and ten (6.5%) participants indicated they have not counseled a suicidal client. One participant did not indicate whether they counseled a suicidal client. Sixty-five (42.5%) participants indicated they have counseled a terminally ill client and 87 (56.9%) indicated they have not counseled a terminally ill client. One participant did not indicate whether they had counseled a terminally ill client. Fifty-five (35.6%) participants indicated they have considered suicide for themselves and 98 (64.1%) indicated they have not.

3.5 Research Hypothesis

The following hypotheses were generated to address the study's problem statement:

Research Hypothesis #1: Counselors who have a doctoral degree will rate themselves more competent than counselors who have a master's degree will rate themselves.

Specific RH_1: Counselors who have completed a doctoral degree will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have completed a master's degree.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have completed a doctoral degree and counselors who have completed a master's degree.

Research Hypothesis #2: Counselors who have more years of experience will rate themselves as more competent than counselors who have fewer years of experience.

Specific RH_2: There will be a statistically significant ($p < .05$) difference on overall competence based counselor's number of years of experience.

Specific RH_0: There will be no statistically significant difference on overall competence between counselor's number of years of experience and overall competence.

Research Hypothesis #3: Counselors who do not hold a religious belief will rate themselves more competent than counselors who do hold religious beliefs.

Specific RH_3: Counselors who do not hold a religious belief will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who do hold a religious belief.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who hold a religious belief and those who do not hold a religious belief

Research Hypothesis #4: There will be a difference in overall competence rating between counselors who have counseled a terminally ill client and counselors who have not counseled a terminally ill client.

Specific RH_4: Counselors who have counseled a terminally ill client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a terminally ill client.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have counseled a terminally ill client and counselors who have not counseled a terminally ill client.

Research Hypothesis #5: There will be a difference in overall competence rating between counselors who have counseled a suicidal client and counselors who have not counseled a suicidal client.

Specific RH_5: Counselors who have counseled a suicidal client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a suicidal client.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have counseled a suicidal client and counselors who have not counseled a suicidal client.

Research Question #6: There will be a difference in overall competence rating between counselors who have contemplated suicide for themselves and counselors who have not contemplated suicide for themselves.

Specific RH_6: Counselors who have contemplated suicide for themselves will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not contemplated suicide for themselves.

Specific RH_0: There will be no statistically significant difference on overall competence rating between counselors who have contemplated suicide for themselves and counselors who have not contemplated suicide for themselves.

Research Hypothesis #7: There will be a difference in clinician's determination of a client's suicidal ideation based on the client's prognosis.

Specific RH_7: There will be a statistically significant difference ($p < .05$) in clinician's determination of a client's suicidal ideation based the client's prognosis.

Specific RH_0: There will be no difference in clinician's determination of a client's suicidal ideation based on client's prognosis.

Research Hypothesis #8: There will be a difference in clinician's determination of whether a client is expressing rational suicide based on client's prognosis.

Specific RH_8: There will be a statistically significant difference ($p < .05$) in a clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis.

Specific RH_0: There will be no difference in clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis.

Research Hypothesis #9: There will be a difference in clinician's competence rating based on client's prognosis.

Specific RH_9: There will be a statistically significant difference ($p < .05$) in clinician's perceived competence rating based on client's prognosis.

Specific RH_0: There will be no difference in clinician's perceived competence rating based on client's prognosis.

3.6 Variables

This study used four criterion variables and seven predictor variables. The criterion variable for the first eight research hypotheses is the counselor's rating of overall competence to provide counseling for a client who is expressing rational suicidal ideation. This variable is a categorical variable. The predictor variables for the first six research hypotheses are highest degree achieved, number of years of practice, religious affiliation, experience with terminally ill client, experience with suicidal client, and contemplation of suicide on the part of the counselor. The highest degree achieved variable is a dichotomous variable (masters or doctoral degree). Years of practice is a categorical variable; this variable was divided in to groups of five years. Religious affiliation is a dichotomous variable. Although there were six choices (Christian, Muslim, Jewish, Hindu, Non-religious, or Other), there were not enough responses for the choices

of Muslim, Jewish, Hindu or Other to compare groups. This data was divided into two groups: religious and non-religious. Experience with a terminally ill client, experience with a suicidal client, and contemplation of suicide on the part of the counselor are all dichotomous variables (yes or no).

There is one predictor variable for the last three research hypotheses. This variable is client's prognosis and is a categorical variable. Each category represents a different prognosis. The criterion variables are clinician's determination of suicidal ideation, clinician's determination of rational suicidal ideation, and scenario specific competence rating. The first two criterion variables are dichotomous (yes or no) and the counselor's scenario specific competence rating is categorical.

3.7 Data Analysis

Estimates of power (McNeil, Newman, & Kelly 1996; Stevens, 1996) were conducted based upon the most conservative estimates and a total sample size of 153. Power estimates give one an estimate of the Type II error rate for different size effects that may exist in the population. Cohen (1992) suggested three levels of effect sizes (f^2): small (.10), medium (.30), and large (.50) for a Chi Square. The levels of effect size for Mann-Whitney test and Kruskal-Wallis one-way ANOVA are small (.20), medium (.50) and large (.80). The investigator decided to calculate an estimate of power for each suggested effect size. Based upon these estimates, if there is a significant relationship in the population and the effect size is small, power will be .995 for the Mann-Whitney t-test and Krusal-Wallis one-way ANOVA and .97 for the Chi Square. If the effect size is at least medium or large, power will be .995 for all three tests. Therefore, the researcher

is confident that if relationships exist, the statistical procedures and designs will be able to detect them even if the effect size is small (.02)

This study's a priori alpha level is set at .05. To avoid making a Type II error, that is, failing to reject a false null hypothesis (Newman, Benz, Weis, & McNeil, 1997), the researcher conducted a Bonferroni correction technique (Newman, Fraas & Laux, 2000). In simple terms, the Bonferroni correction technique effectively spreads the a priori alpha level across the number of hypotheses. In this way, the chance of making a Type II error rate is consistent across the study, yet the researcher can control for family-wise error rates associated with multiple comparisons. The researcher is testing nine hypotheses. As such, the Bonferroni corrected alpha rate to be tested for each hypothesis is .0056 (.05/9).

Before hypothesis testing can occur, normality testing must occur. Two tests were used to determine if the criterion variable is normally distributed for each of the predictor variables. The first test is to determine the skewness *z* value and the kurtosis *z* value. If each z value is within -1.96 to 1.96, then the dependent variable approximates normal distribution (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011). The second test is the Shapiro Wilk *p* value. If the Shapiro Wilk *p* value is significant ($p < .05$), then the criterion variable is not normally distributed for the predictor variable (Razali & Wah, 2011; Shapiro & Wilk, 1965).

The criterion variable is not normally distributed for each of the predictor variables; the researcher used non-parametric tests to analyze the data. A Mann-Whitney test was used for those variable that have two groups (education, experience counseling a suicidal client, experience counseling a terminally ill client, and counselor's

contemplation of suicide) and a Kruskal-Wallis one-way ANOVA was used for those criterion variables that have more than two groups (number of years practicing and prognosis) (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #1, counselors who have completed a doctoral degree will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have completed a master's degree, the researcher used a Mann-Whitney t test to analyze the data. A Mann-Whitney test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #2, there will be a statistically significant ($p < .05$) positive relationship between counselor's number of years of experience and overall competence., the researcher used a Kruskal-Wallis one-way ANOVA to analyze the data. A Kruskal-Wallis one-way ANOVA test is used to compare differences between three or more categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #3, counselors who do not hold a religious belief will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who do hold a religious belief, the researcher used a Mann-Whitney t test to analyze the data. A Mann-Whitney t test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #4, counselors who have counseled a terminally ill client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a terminally ill client, the researcher used a Mann-Whitney t test to analyze the data. A Mann-Whitney t test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #5, counselors who have counseled a suicidal client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a suicidal client, the researcher will use a Mann-Whitney t test to analyze the data. A Mann-Whitney t test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #6, counselors who have contemplated suicide for themselves will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not contemplated suicide for themselves, the researcher used a Mann-Whitney t test to analyze the data. A Mann-Whitney t test is used to compare differences between two categorical groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #7, there will be a statistically significant difference ($p < .05$) in clinician's determination of a client's suicidal ideation based the client's prognosis, the researcher used a Chi Square test to analyze the data. The Chi Square test is used to compare categorical responses between two or more independent groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #8, there will be a statistically significant difference ($p < .05$) in a clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis, the researcher used a Chi Square test to analyze the data. The Chi Square test is used to compare categorical responses between two or more independent groups (Hinkle, Weirsma, & Jurs, 2003).

To test research hypothesis #9, there will be a statistically significant difference ($p < .05$) in clinician's perceived competence rating based on client's prognosis, the researcher used a Kruskal-Wallis one-way ANOVA to analyze the data. A Kruskal-

Wallis one-way ANOVA test is used to compare differences between three or more categorical groups (Hinkle, Weirsma, & Jurs, 2003).

3.8 Ethical Considerations

This study's methods were approved by the author's university Institutional Review Board (IRB). This study's procedures followed the ethical guidelines for research as set forth by the American Counseling Association Code of Ethics (2014a).

3.9 Limitations

There are several limitations that should be considered when reviewing the results of this study. The study used an ex post facto design. The lack of random assignment to treatment groups is a weakness of this type of design and there may be intrinsic confounds in the variables studied (Cohen et al, 2000). Additionally, the sample cannot be considered random, so generalization is limited. Data collection was archival in nature, and limited to those participants who completed the survey from September 2013 to May 2014. As such, time constraints and the number of participants who completed treatment in this time frame limited the data collection process. There may have been response bias in this study. Of the one hundred and fifty-three participants, one hundred and forty-three (94.8%) responded that they believed that suicide could be rational based on the definition provided. The non-experimental research design indicates that the researchers cannot determine a cause and effect relationship between the variables.

3.10 Summary

The purpose of this study is to determine whether counselors perceive themselves as competent to provide counseling to terminally ill clients who are expressing rational suicidal ideation. Additionally, this study explored what factors impact a counselor's

perceived competence to provide counseling with this population. Finally, this study explored counselors' perceptions of what constitutes rational suicide when presented with scenarios that differ by client's prognosis and whether they rate themselves at competent to counsel the individual described in the scenario.

An ex post facto research design was used to examine the characteristics that influence counselor's perceptions of their competence to provide counseling to terminally individuals who are expressing rational suicidal ideation. This type of design utilizes data that to describe factors that relate to groups which differ on a characteristic that cannot be manipulated (Cohen, Manion, & Morison, 2000). An additional goal of this survey was to determine counselor's attitudes toward scenarios that differ based on client' prognosis. Both descriptive and inferential statistics will be used to answer the identified research questions. It should be noted that all methods and procedures involved in this study were approved by the University's Institutional Review Board (IRB) and are in accordance with the American Counseling Association's Code of Ethics (2014a).

Chapter 4

Results

4.1 Introduction

Chapter four begins with a review of the sample included in the study. It then provides the descriptive data obtained from the survey used in the study. The researcher conducted tests of normality (skewness and kurtosis) to determine if the criterion variable approximates normality for each predictor variable to establish whether to use parametric or non-parametric statistical analysis. The researcher then tested the nine research hypotheses posed in the study using the appropriate statistical measures including post hoc analysis when necessary. The chapter concludes with a summary of the findings.

4.2 Descriptive Data

One hundred forty-five (94.8%) of participants indicated they believe that suicide can be rational and eight (5.2%) indicated they did not believe that suicide can be rational. Of the 153 participants, 24 (15.7%) rated their competence to work with a terminally ill client expressing rational suicidal ideation as a 1, 20 (13.1%) rated their competence a 2, 60 (39.2%) indicated a 3, 34 (22.2%) indicated a 4, and 15 (9.8%) indicated a 5.

For the first scenario, representing a terminally ill client with a prognosis of six months to live, seven (4.6%) considered this person to be expressing suicidal ideation and 146 (95.4%) considered this person not be expressing suicidal ideation. Forty-seven (30.7%) considered this person to be expressing rational suicidal ideation, 104 (68.0%) did not consider this client to be expressing rational suicidal ideation, and two (1.3%) did

not respond to this question. One hundred and forty-seven (96.1%) participants indicated they would be willing to counsel this individual and six (3.9%) indicated they would not be willing to counsel this individual. Seven (4.6%) indicated their competence to work with this client as a 1, 11 (7.2%) indicated a 2, 41 (26.8%) indicated a 3, 55 (35.9%) indicated a 4, and 39 (25.5%) indicated a 5.

For the second scenario, representing a terminally ill client with a prognosis of six months to a year and a half, 26 (17.0%) considered this person to be expressing suicidal ideation and 127 (83.0%) considered this person not to be expressing suicidal ideation. Eighty-two (53.6%) considered this person to be expressing rational suicidal ideation, and 71 (46.4%) did not consider this client to be expressing rational suicidal ideation. One hundred and forty-five (94.8%) participants indicated they would be willing to counsel this individual and five (3.3%) indicated they would not be willing to counsel this individual. Three (2.0%) did not respond to this question. Seven (4.6%) indicated their competence to work with this client as a 1, 15 (9.8%) indicated a 2, 46 (30.1%) indicated a 3, 55 (35.9%) indicated a 4, and 29 (19.0%) indicated a 5. One participant (.7%) did not respond to this question.

For the third scenario, representing a terminally ill client with an indefinite prognosis, 116 (75.8%) considered this person to be expressing suicidal ideation and 37 (24.2%) considered this person to not be expressing suicidal ideation. Eighty-three (54.2%) considered this person to be expressing rational suicidal ideation, and 69 (45.1 %) did not consider this client to be expressing rational suicidal ideation. One respondent (.7%) did not answer this question. One hundred and thirty-three (86.9%) participants indicated they would be willing to counsel this individual and 20 (13.1%) indicated they

would not be willing to counsel this individual. Fifteen (9.8%) indicated their competence to work with this client as a 1, 19 (12.4%) indicated a 2, 64 (41.8%) indicated a 3, 37 (24.2%) indicated a 4, and 18 (11.8%) indicated a 5.

4.3 Tests of Normality

The researchers tested the data to determine if the criterion variable data were normally distributed for all predictor variables. Normal distribution is measured by determining the skewness *z* value and the kurtosis *z* value for all categories in each of the predictor variables. Each *z* value must be within -1.96 to 1.96 to indicate that the dependent variable is normally distributed (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011). The Shapiro Wilk *p* value must also be significant ($p > .05$), to determine that the criterion variable is normally distributed for the predictor variable (Razali & Wah, 2011; Shapiro & Wilk, 1965).

A Shapiro-Wilk's test ($p > .05$) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed for individuals with master's degrees and doctoral degrees (Razali & Wah, 2011; Shapiro & Wilk, 1965). The skewness was -.213 (SE = .254) and the kurtosis was -.277 (SE = .503) for those with master's degrees. The skewness was -.858 (SE = .302) and the kurtosis was .307 (SE = .595) for those who indicated a doctoral degree (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test ($p > .05$) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed based on years of experience (Razali & Wah, 2011; Shapiro & Wilk, 1965).

The skewness was -.363 (SE = .309) and the kurtosis was -.799 (SE = .608) for respondents who indicated they have 0 to 5 years of experience. The skewness was -.383 (SE = .441) and the kurtosis was -.440 (SE = .858) for respondents who indicated 6 to 10 years of experience. The skewness was -.712 (SE = .456) and the kurtosis was .419 (SE = .887) for respondents who indicated they have 11 to 15 years of experience. The skewness was -1.234(SE = .524) and the kurtosis was 1.656 (SE = 1.014) for respondents who indicated 16 to 20 years of experience. The skewness was -1.229 (SE = .524) and the kurtosis was 1.366 (SE = 1.014) for respondents who indicated 16 to 20 years of experience. (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test (p >.05) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed for based on whether the respondent indicated that they were religious or not (Razali & Wah, 2011; Shapiro & Wilk, 1965). The skewness was -.238 (SE = .347) and the kurtosis was -.350 (SE = .681) for respondents who indicated they are not religious. The skewness was -.442 (SE = .236) and the kurtosis was -.267 (SE = .467) for those who indicated they are religious (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test (p >.05) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed for based on whether the respondent has counseled a terminally ill client (Razali & Wah, 2011; Shapiro & Wilk, 1965). The skewness was -.190 (SE = .297) and the kurtosis was .114 (SE = .586) for respondents who indicated they have counseled a terminally ill client. The skewness was -.160 (SE = .258) and the kurtosis was -.660 (SE

= .511) for those who indicated a doctoral degree (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test (p >.05) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed based on whether the respondent has counseled a suicidal client (Razali & Wah, 2011; Shapiro & Wilk, 1965). The skewness was -.374 (SE = .203) and the kurtosis was -.251 (SE = .404) for respondents who indicated that they have counseled a suicidal client. The skewness was -.661 (SE = .687) and the kurtosis was -.709 (SE = 1.334) for respondents who indicated that they have not counseled a suicidal client (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test (p >.05) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed based whether the respondent has contemplated suicide themselves (Razali & Wah, 2011; Shapiro & Wilk, 1965). The skewness was -.377 (SE = .322) and the kurtosis was -.598 (SE = .634) for respondents who indicated that they have considered suicide. The skewness was -.426 (SE = .302) and the kurtosis was .029 (SE = .483) for those who indicated they have not contemplated suicide themselves (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

A Shapiro-Wilk's test (p >.05) and a visual inspection of the histograms, Q-Q plots and box plots showed that the competence scores were not approximately normally distributed based for each of the scenarios (Razali & Wah, 2011; Shapiro & Wilk, 1965). For scenario 1, the skewness was -.664 (SE = .196) and the kurtosis was .021 (SE = .390). For scenario 2, the skewness was -.519 (SE = .196) and the kurtosis was -.169 (SE

= .390) For scenario 3, the skewness was -.226 (SE = .196) and the kurtosis was -.334 (SE = .390). (Cramer, 1998; Cramer & Howitt, 2004; Doane & Seward 2011).

The tests for normality indicate that the criterion variable was not normally distributed for any of the predictor variables. The researcher will use non-parametric statistical analysis to test the hypotheses.

4.4 Research Hypotheses

Research hypothesis one stated counselors who have completed a doctoral degree will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have completed a master's degree. The researchers used a Mann-Whitney to analyze the data. There is a statistically significant difference in competence rating between participants with a master's degree and those with a doctoral degree ($z = -3.483$, $p = .000$). Participants who indicated they have a doctoral degree (Md = 4, $n = 63$) rated their competence higher than those who indicated they have a master's degree (Md = 3, $n = 90$).

Research hypothesis two stated that there will be a statistically significant ($p < .05$) positive relationship between counselor's number of years of experience and overall competence. The researchers used a Kruskal-Wallis to analyze the data. There is a statistically significant difference in competence rating based on years of experience ($\chi^2 = 20.841$, $p = .000$). Mann-Whitney post hoc tests to determine statically significant differences between individual groups. There was a statistically significant difference between those who have 0 to 5 years of experience (Md = 3, $n = 60$) and those who have 16-20 years of experience(Md= 4, $n = 19$) ($z = -3.214$, $p = .001$, $r = .36$). There was a

statistically significant difference between those who have 0 to 5 years of experience and those who have 21 or more years of experience (Md = 4, n = 19) (z = -3.529, p = .000, r = .40). There was no statistically significance difference between other groups (Table 2).

Table 2: Post Hoc z scores for Years of Experience

	0 -5	*6-10*	*11-15*	*16-20*	*21+*
0-5		z = -.578	z = -2.580	z = -3.214*	z = -3.529*
6-10			z = -1.671	z = -2.251	z = -2.584
11-15				z = -.609	z = -1.023
16-20					z = -.534

*=p < .0056

Research hypothesis three states counselors who do not hold a religious belief will rate themselves statistically significantly (p < .05) higher in overall competence than counselors who do hold a religious belief. The researchers used a Mann-Whitney to analyze the data. There is not a statistically significant difference in competence rating between participants who indicated they have a religious belief and those who did not (z = -.33, p = .974).

Research hypothesis four stated counselors who have counseled a terminally ill client will rate themselves statistically significantly (p < .05) higher in overall competence than counselors who have not counseled a terminally ill client. The researchers used a Mann-Whitney to analyze the data. There is a statistically significant difference in competence rating between participants who have counseled a terminally ill client and those who have not (z = -4.733, p = .000, r = .39). Participants who indicated they have a counseled a terminally ill client (Md = 3, n = 65) rated their competence higher than those who have not (Md = 3, n = 87).

Research hypothesis five stated counselors who have counseled a suicidal client will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not counseled a suicidal client. The researchers used a Mann-Whitney to analyze the data. There is no statistically significant difference in competence rating between participants who have counseled a suicidal client and those who have not ($z = -.345$, $p = .730$).

Research hypothesis six stated counselors who have contemplated suicide for themselves will rate themselves statistically significantly ($p < .05$) higher in overall competence than counselors who have not contemplated suicide for themselves. The researchers used a Mann-Whitney to analyze the data. There is no statistically significant difference in competence rating between participants who have considered suicide for themselves and those who have not ($z = -.594$, $p = .552$).

Research hypothesis seven stated there will be a statistically significant difference ($p < .05$) in clinician's determination of a client's suicidal ideation based the client's prognosis. The researchers used a Chi Square test for independence to analyze the data. There is no statistically significant difference in clinician's determination of suicidal ideation between scenario one and scenario two [χ^2 (1, n=153) = 5.67, $p = .017$], between scenario one or scenario three [χ^2 (1, n=153) = 1.16, $p = .281$] or between scenario two and scenario three [χ^2 (1, n=153) = 1.964, $p = .161$].

Research hypothesis eight stated there will be a statistically significant difference ($p < .05$) in a clinician's determination of whether a client is expressing rational suicidal ideation based on client's prognosis. The researchers used a Chi Square test for independence to analyze the data. There is a statistically significant difference in

clinician's determination of suicidal ideation between scenario one and scenario two [χ^2 (2, n=153) = 20.323, p = .000, *phi* = .364], and between scenario one or scenario three [χ^2 (4, n=153) = 177.978, p = .000, *phi* = .505]. There is not a statistically significant difference between scenario two and scenario three [χ^2 (2, n=153) = .935, p = .627].

Research hypothesis nine stated there will be a statistically significant difference ($p < .05$) in clinician's perceived competence rating based on client's prognosis. The researchers used a Kruskal-Wallis to analyze the data. There is a statistically significant difference in competence rating based on scenario ($\chi^2 = 21.562$, p = .000). Mann-Whitney post hoc tests to determine statically significant differences between individual groups. There was a statistically significant difference of competence between scenario 1 and scenario 3 (z = -4.498 , p = .000, r = -.26). There was a statistically significant difference between scenario 2 and scenario 3 (z = -3.154, p = .002, r = .18). There was no statistically significance difference between scenario 1 and scenario 2 on competence (z = -1.468, p = .142) (Table 3).

Table 3: Post Hoc z scores for Competence Based on Scenario

	Scenario 1	*Scenario 2*
Scenario 2	z = -1.468	
Scenario 3	z = -4.498*	z = -3.154*

*=$p < .0056$

4.5 Summary

The researcher began the chapter by describing participants. Descriptive data obtained by the survey was described. The researcher tested the criterion variable for normality on all the predictor variables. The criterion variable did not estimate normality and the researcher concluded that non-parametric tests would be used to test the research

hypotheses. The researcher then tested the nine research hypotheses. Education level, years of experience, and experience counseling a terminally ill individual influenced perceived competence level. Religious affiliation, experience counseling a suicidal client, and personal contemplation of suicide did not influence competence level. The three scenarios did not different on clinician's determination of whether the client described is suicidal, but did differ on whether they are rationally suicidal. There was a significant difference on competence between scenarios 1 and 3 and scenarios 2 and 3.

In chapter 5, the researcher will discuss these findings. This will include integrating the findings into the existing literature, presenting the implications of these findings, identifying the limitations of the study, and providing the reader with suggestions for future research.

Chapter 5

Discussion

5.1 Introduction

Chapter 5 begins with a brief summary of the available literature, which justifies the research presented and then conducted in this study. The researcher then summaries the purpose of the study, the procedures, and the findings which are integrated into the current literature base. Finally, implications will be presented for counselors and counselor educators. The researcher identifies the limitations of the current study. The chapter concludes with suggestions for future research resulting from this study.

5.2 Background and Study Findings

Individuals who are terminally ill seek counseling services for various reasons, including processing their emotions and participating in end-of-life planning, which may include a discussion of hastening their own death (Danaker, 2006). Rational suicide is the desire to hasten one's death when terminally ill (Werth & Cobia, 1995). Definitions regarding rational suicide include a stipulation that the client's prognosis must be six months or less before death (Rogers, et al, 2001; Werth & Cobia, 1995; Werth Jr. et al, 2001). Additionally, legislation pertaining to physician-assisted suicide specifies the terminally ill individual must have a prognosis of 6 months or less (Oregon DWDA, Washington DWDA, V.S.A. chapter 113, & California SB-128). Counselors provide counseling to clients at all stages of life and it is expected that counselors will encounter clients who are terminally ill who are expressing rational suicidal ideation (Daneker, 2006). Therefore, counselors need to be competent to serve this population. Research has

demonstrated that approximately 80% of professional counselors have agreed that suicide can be a rational choice for terminally ill individuals who are within six months of their death (Rogers, et al, 2001). Westefeld, Sikes, Ansley, and Yi (2004) surveyed psychologists, politicians, and nurses and found that 25% of their respondents had encountered someone who was expressing rational suicide. However, current models (Kubler-Ross, 1969; Rando, 1984) used to conceptualize the process of natural death do not sufficiently address rational suicidal ideation in terminally ill individuals. Research has not addressed the counselor competencies needed to provide counseling to terminally ill individuals who are expressing rational suicidal ideation. Therefore, this study investigated the factors that predict counselors' competence to provide counseling to individuals expressing rational suicidal ideation. Additionally, this study explored whether or not prognosis predicts if a counselor identifies the suicidal ideation as rational or not.

The purpose of this study is to determine if counselors perceive themselves as competent to provide counseling to terminally ill clients who are expressing rational suicidal ideation. Additionally, the researcher investigated what characteristics predict counselors' perceived competence to provide counseling with individuals expressing rational suicidal ideation. Finally, the counselors' perceptions explored in this study are: (a) how a client's prognosis impacts the counselors' determination of rational suicide suicidal ideation, and (b) how counselors' perceived competence changes based on a client's prognosis. To accomplish this task, the researcher used archival data that was collected via survey from September 2013 to May 2014. Potential participants were contacted through the Counselor Educator and Supervisors Network (CESNET) listserv.

Participants received a link to the informed consent and survey on Surveymonkey.com. This study was an ex post facto research design; due to all data examined being archived. This study used both descriptive and inferential statistics.

Of the one-hundred and fifty-three participants, one hundred and nine (68.2%) of participants rated their competence to provide counseling to individuals who are expressing rational suicidal ideation as a 3, 4, or 5. Forty-four of the participants (28.8%) rated their competence as a 1 or 2. A larger percentage of counselors indicated that they would be competent to provide counseling to this population. This percentage is much lower than the percentage of counselors who agree that suicide can be a rational construct from this study (94.8%) and previous research (Werth Jr. et al, 2001). This finding may indicate that further preparation is needed for counselors who will work with rationally suicidal individuals, particularly counselors who are working with individuals who are terminally ill.

The first research hypothesis stated that counselors with a doctoral degree would rate themselves statistically significantly higher than counselors with a master's degree. The research rejected the null hypothesis; counselors with a doctoral degree rated themselves as statistically significantly higher than those with a master's degree. This is consistent with previous research that indicates that competence has been positively correlated with education level (Barden & Greene, 2015; Graham, Carney, & Kluck, 2012; Hermann, 1999).

The second research hypothesis states that counselors with more years of experience will rate themselves higher than those with fewer years of experience. The researchers rejected the null hypothesis; counselors with a higher number of years of

experience rated themselves as more competent than those with a lower number of years. Specifically, there was a significant difference between those who reported 0 to 5 years of experience and those who reported 16 to 20 years of experience as well as a significant difference between those who reported 0 to 5 years of experience and those who reported 21 years or more of experience. This is consistent with previous research that indicates that experience and training with counseling interventions (Berman & Norton, 1985; Hattie et al, 1984) as well as experience with specific populations (Barden & Greene, 2015; Graham, Carney, & Kluck, 2012) is predictive of counselor competence.

The third research hypothesis stated that counselors with no religious beliefs will rate themselves as more competent that those who hold a religious belief. The researchers accepted the null hypothesis as there was no statistically significant difference between those who hold religious beliefs and those who do not. It was hypothesized that there would be a difference based on religious beliefs based on previous research stating that counselors who did not believe that suicide could be a rational option cited their religious beliefs as a reason (Rogers et al, 2000; Werth & Cobia, 1995; Westefeld, 2004).

Research hypothesis number four stated that counselors who have counseled a terminally ill client will rate themselves higher than those who have not counseled a terminally ill client. The researchers rejected the null hypothesis; counselors who have counseled a terminally ill client rated their competence as higher than those who have not counseled a terminally ill client. This is consistent with previous research stating that specific experience with a population predicts competence (Barden & Greene, 2015; Graham, Carney, & Kluck, 2012). Additionally, those who had counseled a terminally ill

client were more likely to believe that suicide could be a rational option (Werth Jr, et al, 2001).

The fifth research hypothesis stated that counselors who have counseled a suicidal client would rate themselves higher than counselors who have not. The researcher accepted the null hypothesis as there is no statistically significant difference in competence between counselors who have counseled a suicidal client and those who have not. Previous research has indicted that previous experience counseling a suicidal client does not predict whether counselors agree that suicide can be a rational construct (Werth Jr. et al, 2001).The results of this study align with this previous research. These findings conflict with research that indicates specific experience predicts competence (Barden & Greene, 2015; Graham, Carney, & Kluck, 2012).

Research question number six stated that counselors who have contemplated suicide for themselves will rate themselves as statistically significantly higher in competence than counselors who have not. The researchers accept the null hypothesis; there is no difference in competence between counselors who have contemplated suicide and those who have not. Werth Jr. et al (2001) proposed found that one-fifth (20%) of his sample had considered suicide as an option. This study found that 35.9% of participants reported considering suicide. In the Werth Jr. study, there was no difference in belief about whether suicide could be rational based on whether the counselor has contemplated suicide.

The seventh, eight, and ninth research questions related to the prognosis of the terminally ill client. Prognosis was based upon time until death. The first prognosis was 6 months, the second was 1 year to 1 ½ years, and the third prognosis was undetermined.

These prognoses were developed based on physician-assisted suicide laws. In Oregon, Washington, Vermont, and California, where physician-assisted suicide is legal, for a terminally ill person who is expressing rational suicidal ideation to be approved for physician-assisted suicide their terminal ill diagnosis must lead to imminent death within six months (Oregon DWDA, Washington DWDA, V.S.A. chapter 113, & California SB-128). The expectation is that as prognosis increases the number of counselors who determine that the client is expressing suicidal ideation will increase and the number of counselors who determine that the client is expressing rational suicidal ideation will decrease.

The seventh research question stated that there will be a difference in the clinician's determination of whether the client is having suicidal ideation based on the client's prognosis. The null hypothesis was accepted as there was no difference in clinician's determination based on prognosis. The researcher expected that as prognosis increased that counselors would be more likely to identify the client as suicidal based on the six month criteria in legislation that permits physician-assisted suicide (Oregon DWDA, Washington DWDA, V.S.A. chapter 113, & California SB-128). Additionally research on whether suicide can be a rational construct stipulates that the terminally ill client has a prognosis of six months (Rogers et al, 2001; Werth Jr & Cobia, 1995; Werth Jr. et al, 2001; Westefeld et al, 2004) indicating that the six month time period is a guideline for when suicide can be considered rational.

The eighth research question stated that there would be a difference in clinician's determination of whether the client is expressing rational suicidal ideation based on prognosis. There was a statistically significant difference between a prognosis of 6

months and a prognosis of 1 to 1 ½ years and between the prognosis of 6 months and indefinite. There was no statistically significant difference between a prognosis of 1 to 1 ½ years and indefinite. The researcher did not expect this result; the determination of rational suicidal ideation increased rather than decreased. Forty-seven counselors determined that a client with a prognosis of 6 months was expressing rational suicidal ideation, eight-two determined that a client with a prognosis of 1 to 1 ½ years was expressing rational suicidal ideation, and eighty-three determined that a client with an indefinite prognosis was expressing rational suicidal ideation.

The ninth research hypothesis stated that there would be a difference in clinician's competence based on prognosis. There was a statistically significant difference in competence between scenarios 1 and 3 and scenarios 2 and 3. Counselors rated themselves more competent to work with a client expressing rational suicidal ideation with a prognosis of six month (scenario 1, Md = 4, n = 153) and with a prognosis of 1 year to 1 ½ years (scenario 2, Md = 4, n = 153) than a client with an indefinite prognosis (scenario 3, Md = 3, n = 153). The researcher expected to find that counselors would rate themselves more competent to work with clients who were closer to the accepted six-month time frame for requesting physician-assisted suicide (Oregon DWDA, Washington DWDA, V.S.A. chapter 113, & California SB-128) and used as the benchmark for determining if suicide is rational in recent literature (Rogers et al, 2001; Werth Jr & Cobia, 1995; Werth Jr. et al, 2001; Westefeld et al, 2004).

Overall, the researcher found that while counselors consider rational suicide to be acceptable for terminally ill clients, they did not express that they felt competent to provide these clients counseling services. Those who did rate themselves as competent

had more years of experience, held a higher educational degree, and had experience counseling terminally ill clients. Based on the responses to the different scenarios, the respondents rated the client who had the longest prognosis as someone who was rationally suicidal more frequently than they rated the client with the shortest prognosis.

5.3 Implications

There are a number of implications for counselors, counselor educators, and the profession of counseling in general. The findings support that while counselors may believe that suicide is a rational construct, fewer counselors identify themselves as competent to provide rationally suicidal clients with counseling services. The findings also identify factors that impact a counselors' perceived competence to provide counseling to terminally ill individuals who are expressing rational suicidal ideation.

5.3.1 Counselors

Counselors need to be aware of the legislation in their state regarding physician assisted suicide to inform their counseling practice. Whether the counselor in is a state where physician assisted suicide is legal or not, experience influences perceived competence level. Counselors who are interested in counseling terminally ill clients should seek out work sites where they may increase their contact with this population, such as hospice or a hospital setting. Additionally, counselors can increase their exposure to client's who may be terminally ill by advocating for Medicare reimbursement for counselors. Although individuals who are older and eligible for Medicare are not the only population that would be terminally ill, gaining reimbursement for Medicare will expand counselor's ability to interact with terminally ill individuals. Additionally, the results of

this study indicate that education predicts perceived competence. Counselors who want to work with terminally ill clients should seek out educational opportunities pertaining to this population, such as professional development workshops. Finally, counselors need to be prepared to examine their own biases about death and their ability to provide counseling services.

Counselors who reside in states where physician assisted suicide is legal will have different training needs as well. These counselors will need to familiarize themselves with the physician assisted suicide legislation to be able to provide ethical services. Additionally, counselors should familiarize themselves with assessment tools, such as the Beck Depression Inventory, that will be needed to assist with determining if clients requesting physician assisted suicide are making a rational decision. Counselors should also familiarize themselves with documentation required.

5.3.2 Counselor Educators

Counselor Educators are impacted by the findings that education and experience influence competence. Within a curriculum that is heavily prescribed for counselors, this instructional and practical foundation needs to be added as the population who wish to die rationally will continue to grow. Counselor educators should advocate for practicum or internship placements that will specifically expose counselors-in-training to a terminally ill population, such as hospice or a hospital setting.

While scheduling time with a terminally ill client may prove to be difficult, counselor educators can add the topic of rational suicide to the educational experience in other ways. Counselor educators can incorporate scenarios including clients who are

expressing rational suicidal ideation into ethical discussions. Students can be asked to role-play assessing a client who is terminally ill for suicidal ideation and determining whether they would consider the client to be making a rational choice. Counselor educators who teach a lifespan course can integrate information on rational suicide as a developmental part of the process of dying.

Counselor educators who teach in states where physician assisted suicide is legal will also have to integrate material regarding the legislation into their curriculum to ensure that students have a legal overview of their role in the process of determining whether a terminally ill client is making a rational decision. These educators will want to explore the assessment tools used in the state their reside in and educate themselves about these tools so that they can provide instructions. Additionally, Counselor educators in states where physician assisted suicide is legal will need to explore their own biases regarding death and physician assisted suicide to provide impartial feedback to their students.

5.3.3 Counseling Profession

From an ethical perspective, the 2005 ACA Code of Ethics broke new ground in addressing the needs of the terminally ill and end-of-life care (Standard A.9.). This standard provided guidance, not support or endorsement, in training counselors how to ethically deal with the increasing state assisted suicide laws such as in Oregon. In terms of client care, ACA affirmed the right of a person to determine their level of care, and how counselors should be prepared to counsel their clients about hastening death. However, in the 2014 ACA Code of Ethics, guidance on training counselors in the ethical process of working with clients who choose end-of-life as an expression of one's

autonomy was relegated to a simple exception in B.2.a. moreover, addressed in terms of confidentiality in B.2.b. This was, in part, due to the concern that the professional organization was taking a moral stance on end-of-life or promoting physician-assisted suicide. Further exploration and a willingness to reinstate the ethical guidance for counselors to work with individuals who choose to end their own lives should be advocated for; this will help counselors feel, and be, more competent in assisting an individual determine their own choice to live or die.

5.4 Limitations

There are several limitations that should be considered when reviewing the results of this study. The study used an ex post facto research design. There are limitations to using an ex post facto design. First, this type of design is weaker than experimental designs. This type of research lacks control due to a) the inability to randomize, and b) the inability to manipulate variables due its retrospective nature (Cohen, et al., 2000; Okolo, 1990) Without the ability to manipulate the data, the researchers cannot determine a cause and effect relationship. Data collection was archival in nature, and limited to those participants who completed the survey from September 2013 to May 2014. As such, time constraints and the number of participants who completed treatment in this time frame limited the data collection process. The response rate for this survey was 5% which is significantly lower than desired (Shih & Fan, 2008; Van Horn et al, 2009). These factors may limit the generalizability of the data.

There may have been response bias in this study. Of the one hundred and fifty-three participants, one hundred and forty-three (94.8%) responded that they believed that

suicide could be rational based on the definition provided. Counselors who do not belief that suicide can be rational may have chosen to not participate.

The design of the questions of the survey is a limitation to consider. The Likert scale was not anchored as each of the data points and the measurement scale was used as an ordinal scale. The survey's author created categorical variables of two variables that could have been continuous, age and number of years practicing. Allowing participants to enter a number rather than check a category for these two variables would have provided more specific information. These two choices in question construction indicated that the researcher had to use non-parametric statistical procedures which are less powerful because the procedures use less information in the calculation (Hinkle, Weirsma, & Jurs, 2003). The Likert scale was anchored at both ends, but with a vague description that could be left to the interpretation of the participant. This may have contributed to the skewness and kurtosis of the criterion variable.

5.5 Suggestions for Future Research

This researcher would replicate this study with better survey construction. The Likert Scale would be anchored at all points and more clearly to allow the researcher to assume normal distribution. The predictor variables of age and years of experience would be structured as continuous variables rather than categorical to determine a correlation and increase the strength of the results. This researcher would add a question regarding the state of residence of the respondent to determine if counselors in the four states where physician-assisted suicide is legal rate their competence as higher. Counselors in states where physician-assisted suicide is legal may have more experience than those who are not living in one of these states. The researcher would request the contact information,

email addresses, from the licensure boards in the states where this information is public record to be able to track response rate more accurately.

Counselors rely on two models for conceptualizing the process of dying and how counselors interact with individuals who are terminally ill (Kubler-Ross, 1969; Rando, 1984). Neither of these models describe how to interact with an individual who is terminally ill and expressing rational suicidal ideation. Qualitative research with counselors who have provided counseling to terminally ill individuals who are expressing rational suicidal ideation. This researcher would identify themes that are identified by these counselors and integrate them into the currently used models for conceptualizing the dying process.

This researcher would like to explore whether the term suicide is appropriate for describing the phenomenon of wanting to hasten one's death when terminally ill. This researcher wonders whether the term "suicide" is too stigmatizing and elicits a negative response even when contextualized with terminal illness.

5.6 Summary

Research has been conducted determining whether counselors believe that suicidal can be a rational construct for an individual who is terminally ill and what factors impact this belief. This study attempted to understand what factors impact counselors' perceived competence to provide counseling to a client who is expressing rational suicidal ideation. Despite the mixed results of this study, the researcher did identify factors that impact counselors' competence to work with a client expressing rational suicidal ideation: (a) education level, (b) experience, and (c) experience with a terminally

ill client. There were limitations to this study in reference to sample, generalizability, and research design. However, this is still an area of need based on the increasing number of states where legislation will allow individuals who are terminally ill and rationally suicidal to request physician-assisted suicide to hasten their death.

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Appendix A: Competence Survey

Demographic Information

Gender: Male Female

Age:

Race: Caucasian African American Hispanic Asian Native American Other

Religious Affiliation: Christian Muslim Jewish Hindu Other

Education level: Master's degree Doctoral Degree

Licensure level: Professional Counselor Professional Clinical Counselor

Number of years practicing: 0-5 years 6-10 years 11-15 years 16-20 year 21+ years

Have you worked counseled a suicidal client? Yes No

Have you counseled a terminally ill client? Yes No

Have you considered suicide yourself? Yes No

Definition of Terms

Rational Suicide is defined as suicidal ideation that occurs when one is diagnosed with a terminal illness and is not experiencing symptomology of a depression or anxiety that rises to the level of a diagnosable disorder that interferes with the individual's ability to make a rational decision (Rogers, et. al, 2001; Werth Jr. & Crow, 2009).

Do you believe that Suicide can be rational? Yes No

Please rate your competence to work with a terminally ill client who is expressing rational suicidal ideation as described above. 1 means not competent, 5 means competent, I would provide supervision in this area.

1 2 3 4 5

Scenarios

Scenario 1:

A female client is in your office and has been diagnosed with terminal cancer. According to two separate oncologists, she has exhausted all of her options medically and has less than 6 months to live. This client would like you to help her process her feelings toward entering hospice. She would also like your help with developing skills to discuss this decision with her family. After administering the Beck Depression Inventory, you determine that although she has mild depressive symptoms, she does not have a diagnosable disorder.

Do you consider this suicidal ideation? Yes No

Would you consider this a rational suicide? Yes No

Would you be willing to counsel this individual? Yes No

On a scale of 1-5 rate your competence to work with this client:

1 = meaning not competent to 5 = competent, I would provide supervision in this area,

1 2 3 4 5

Scenario 2:

A female client is in your office and has been diagnosed with cancer of the esophagus and can no longer swallow food. Her oncologist and primary care giver have both recommended that she have a feeding tube placed. Without this feeding tube, the client would have 1-3 months to live. With the feeding tube, the client would have a life expectancy of 1 to 1.5 years to live. The client has decided that she will not have the feeding tube placed. She would like you to help her to develop skills to talk with her family regarding the decision. After administering the Beck Depression Inventory, you determine that she does not have any symptoms of depression.

Do you consider this suicidal ideation? Yes No

Would you consider this a rational suicide? Yes No

Would you be willing to counsel this individual? Yes No

On a scale of 1-5 rate your competence to work with this client:

1 = meaning not competent to 5 = competent, I would provide supervision in this area,

1 2 3 4 5

Scenario 3:

A female client has gotten genetic testing that concludes that she has a combination of genes that could indicate early onset Alzheimer's Disorder. Although not symptomatic, her physician and a geneticist have told her that she could develop dementia symptoms in 1 to 2 years but could remain physically healthy for many years and live into her 70s. You have administered the Beck Depression Inventory and find her to have mild depressive symptoms, but not a diagnosable disorder. The client states that when her first dementia symptoms begin she will take her own life to prevent being a burden on her family. She would like to work with you to develop skills for discussing her decision with her family.

Do you consider this suicidal ideation? Yes No

Would you consider this a rational suicide? Yes No

Would you be willing to counsel this individual? Yes No

On a scale of 1-5 rate your competence to work with this client:

1 = meaning not competent to 5 = competent, I would provide supervision in this area

1 2 3 4 5