The relationship between Spirituality, Personality and Attitudes towards Euthanasia

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Abstract:

Context: Euthanasia is becoming an increasingly popular topic of debate amongst european countries, including Ireland (Picón-Jaimes et al., 2022). Ireland have previously considered a referendum to question legalising euthanasia. Following several of their fellow european countries legalising euthanasia, it could be foreseen that this topic may rise again within the Irsh government (Clarke et al., 2021).

Aims: This study aims to study the attitudes towards Euthansia in a sample of Irish residents above the age of 18 and factors that may impact these attitudes

Settings and Design: A cross-sectional survey of 97 Irish residents was conducted to determine their attitudes towards Euthanasia

Materials and methods: Three self-administered questionnaires were used to assess attitudes towards euthanasia, levels of spirituality and personality factors

Statistical analysis used: Multiple Regression was used to assess the potential relationship between spirituality, personality and attitudes towards Euthanasia

Results: There was no statistically significant correlation between spirituality levels, personality factors and attitudes towards euthanasia ($p > 0.5$)

Conclusion: Spirituality and personality did not effectiveky predict attitudes towards euthansia in this study's sample fo Irish residents which could conclude the mitigation of these factors when controlling for Irish residents' attitudes towards Euthanasia.

Keywords: *Spirituality, personality, euthanasia*

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Understanding Attitudes toward Euthansia

"Research is to see what everybody else has seen, and to think what nobody else has thought"
- Albert Szent Gyorgyi

The opinions of a nation's population on the topic of euthanasia are greatly influenced by the attitudes of the individuals (Lee et al., 2017), communities and organisations within it (Danyliv and O'Neill 2015). Starting the debate, by being the first to legalise euthanasia was The Netherlands in 2001 (Wise, 2001) and since then several nations have followed suit by either legalising or decriminalising euthanasia in their country (Picón-Jaimes et al., 2022). Some countries have started debating the issue in their legislative bodies. Others, like Chile, are now debating the issue in congress (Picón-Jaimes et al., 2022). In recent times Ireland has passed multiple controversial laws, by means of statutory referendums, such as the legalisation of abortion and same-sex marriage (Clarke et al., 2021). During this period of social upheaval and in response to the legalisation of euthanasia in several European nations, Ireland has already begun debating the potential of also legalising euthanasia (Clarke et al., 2021). A measure to legalise euthanasia was developed in 2018 ("Dying with Dignity Bill, 2020") but did not pass due to a lack of regulations to prevent excessive pressure being put on vulnerable individuals to use assisted dying in particular (Clarke et al., 2021). There is speculation that this topic is not finished and there could be a new bill formed to discuss this topic once again for Ireland (Clarke et al., 2021). As a result, this study will aim to produce a generalisable estimate of the attitudes towards the subject of Euthanasia amongst the Irish population. In this review of the existing literature, the bulk of the information resourced was on the attitudes towards euthanasia in Iran and the United States of America with particular focus on Islamic and Christian religiosity, and the correlation between agreeableness, openness and attitudes towards euthanasia.

Existing Nomenclature and History of Euthanasia

The Hippocratic Oath contains one of the earliest known allusions to euthanasia in scientific literature, where doctors were cautioned against "giving a deadly drug to any patient." (Emanuel, 1994). This opposition was a minority viewpoint as the Hippocratic theory of euthanasia did not come to dominate medical ethics until sometime between the 12th and the 15th century (Amundsen, 1978). In the proceeding centuries, other authors supported the use of euthanasia by doctors, including Sir Thomas More and Francis Bacon (Emanuel, 1994). The issue of euthanasia has recently drawn a lot of interest from experts from a range of disciplines, including medical, psychological, social, and philosophical (Aghababaei et al., 2013). Much of the discussion of euthanasia has been sparked by political campaign slogans and media coverage resulting in important distinctions that are subtle but vital being frequently overlooked (Emanuel, 1994). Before branching into some of the overlooked areas of distinction within the term euthanasia, (involuntary, non-voluntary, active, passive, and voluntary euthanasia), it may be summed up in general terms as the expediting of an individual's death to relieve pain (Chao et al., 2002). When a clearly competent individual expresses a voluntary and persistent wish to be aided in dying, it is considered voluntary euthanasia (Young, 1996). This concept also applies when an authorized proxy renders a substituted judgment by choosing the course of action that the incompetent person would have taken if they had remained competent (Young, 1996). Involuntary euthanasia is the act of assisting a patient to die without the patient's consent or desire, even while the patient is competent to do so. In contrast, non-voluntary euthanasia operates on the

same principle but involves patients without the physical or legal capacity to consent or request euthanasia (Allen, 2005). Lastly, the difference between passive and active euthanasia is that the former just "allows" the patient to pass away, whilst the latter entails taking physical or medical action, causing the patient to die (Rachels, 1975).

Prevailing Theories on Attitude

Numerous purposes are served by attitudes, including knowledge, ego protection, social adjustment, and utilitarianism (Ajzen, 2001). Allport defined attitude as a mental or neutral state of readiness, defined empirically, exerting a specific response to all objects and situations it relates to (Pickens, 2005). Pickens found that attitudes influence our decisions and behaviours and impact our selective memory which may not be what we heard or experienced (2005). Attitudes come in different strengths and can be measured and changed (Pickens, 2005). The attributed dimensions of good-bad, harmful-beneficial, pleasant-unpleasant, and likeable-dislikeable can be used to categorise attitudes in general terms (Ajzen, 2001). According to a recent study, it is over simplistic to assume that humans have only one attitude on a certain topic(Wilson et al, 2000). For instance, as attitudes change, a new attitude toward a topic may emerge, but it may not completely replace or erase the prior one. Looking at the dual attitude paradigm, individuals might have two distinct attitudes toward the same subject, one of which is habitual or implicit, while the other is stated explicitly (Wilson et al, 2000). The most popular theory, the expectancy-value model, states that each attitude links an item to a particular feature, and that an individual's overall attitude toward an object is determined by the subjective values of the object's qualities combined with the strength of the associations (Ajzen, 2001). Ajzen notes that although people can have several attitudes toward the same thing, only attitudes that are immediately accessible in

memory can affect attitude at any particular time (2001). Personality is linked to both attitudes and behaviors (Chirumbolo and Leone, 2010). Although sociological elements like class or religion may have an impact on personality, it is appropriate to conceive of these larger-scale social issues as one step removed from attitudes and that personality serves as the mediator in the interaction (Saroglou, 2002). In essence, social settings frame individual experiences that contribute to the development of dispositional tendencies in persons, even though some personality variance may be explained independently of social effects (like genetics). They, in turn, translate into attitudes toward specific concerns, such as euthanasia (Wasserman et al., 2016).

Independent Variables Impacting Attitudes towards Euthanasia

The social environment one is raised in creates the conditions for personal experiences that give rise to one's dispositional inclinations (Aghababaei et al., 2013). In turn, these inclinations are seen in one's views toward certain subjects. As such, the sociological variables' observed trends seem to indicate that experience or, at the very least, membership in a group likely to share some experiences, is important in the creation of broad dispositional frames that correlate to various sets of attitudinal outcomes (Aghababaei et al., 2013).

Aghababaei et al. found that spirituality may be the most rigorous predictor of views regarding euthanasia and is most frequently adversely associated with those attitudes (2013). Additionally, according to Klessig, fundamental disparities in American attitudes about euthanasia might be attributed to conventions with a religious basis (1992). Rogers hypothesised that personal experience with death anxiety, religiosity, and locus of control play important roles when trying to understand and define attitudes towards euthanasia (1996).

Similarly, Danyliv and O'Neill discovered that religiosity, as gauged by participation in religious institutions and religious connection, were the primary causes of unfavourable attitudes of the British population towards the legalisation of euthanasia in Britain (2015). In an additional euthanasia-focused study, Iranian students are expected to oppose euthanasia more than their American counterparts (Wasserman et al., 2013). This is because it is believed that euthanasia is unequivocally forbidden in Islam, but there are several views and interpretations of euthanasia within the Christian religion. Due to the impact of Islamic law, Klessig discovered that Iranian doctors were among the most in favour of beginning life support and the most against discontinuing it (1992). The consensus is that the practice of euthanasia is strictly prohibited by virtue of prohibitions against suicide/homicide in Islam, despite disagreement over the role of forgiveness in establishing an exemption for mercy killing and reports of the occasional case of euthanasia in an Iranian survey conducted by Taghaddosinejad et al in 2003. In 2016, Wasserman et al. discovered that while socioeconomic level and educational attainment typically have a favourable influence on views about euthanasia, age, race, and religion all negatively impacted attitudes toward euthanasia. These findings align with studies of Klessig in 1992, Lee et al. in 2017 and Danyliv and O'Neill in 2015, in that the main influences on views regarding euthanasia, according to research, are spirituality and religion, which are typically associated negatively with both Christian and Muslim contexts (Wasserman et al., 2016). However, Sabriseilabi and Williams found that not all aspects of religiosity or spirituality have a negative impact on attitudes toward euthanasia, or any impact at all (2022).

Similar to the findings of Lee et al. in 2017, Wasserman et al. found that opinions regarding euthanasia are favourably related to personality factors like openness to new experiences and adversely associated with attributes like agreeableness (2016). Bulmer et al. found contradicting results which showed that 4 out of five "Big Fiver personality factors

were non significant when measured to predict attitudes towards euthanasia (2017). The New Zealand Attitudes and Value Survey looked at attitudes toward euthanasia in relation to "The Big Six" personality traits and discovered that people who scored highly on extraversion, conscientiousness, and neuroticism were more in favour of euthanasia than those who scored highly on agreeableness and honesty-humility (Lee et al., 2017). Additionally, they discovered that religious convictions were strongly connected with the honesty-humility attribute and disfavour towards euthanasia (Lee et al., 2017). These findings concur with those of studies conducted in Australia, the UK, and certain EU nations (Young et al., 2019). Wasserman et al. also found that while gender studies have shown conflicting findings, women generally had lower levels of support for euthanasia (2016). Cohen et al. discovered that whilst social class and education were favourably predictive of views toward euthanasia across Eastern and Western European countries, age was considerably adversely predictive (2006). Lee et al. found that education, assessment of population density, and traditional family values were associated with views about euthanasia in the Chinese culture but not the American in a study on the attitudes towards geronticide and infanticide of American and Chinese students (1996). In the US, euthanasia is viewed by many as a highly beneficial counterpoint to an overly medicalized death process (Wasserman et al., 2016). Results of Wasserman et al's investigations indicated that the honesty-humility personality characteristic was adversely related to euthanasia in both the Iranian and the American groups, demonstrating that euthanasia is perceived as a moral issue (1992). Overall results of their study revealed that among US and Iranian university students, openness is continuously favourably predictive of opinions regarding euthanasia (Wasserman et al., 1992). In their study on personality traits and attitudes toward euthanasia in Iran, Aghababaei et al. discovered a substantial correlation between personality traits and attitudes toward euthanasia (2013). These findings are supported by Klessig's research on the distinctions between Iranians and White Americans

(1992), as well as additional studies by Aghababei from 2021 and 2014.

To decide if a single line of best fit is acceptable for a collection of data or whether it should be divided into many pieces, one must consider the findings of the Chow test (Wasserman et al., 2016). Here, the findings show statistical proof that, despite the presence of some comparable predictors, the structural differences between the Iranian and American samples indicate that it is preferable to analyse them independently (Wasserman et al., 2016). In terms of substance, we may state that even while there are certain parallels between personality, spirituality, and views toward euthanasia, there are also fundamental paradigmatic cultural distinctions that must be taken into account. Social circumstances nonetheless shape individual experiences that aid in the creation of dispositional tendencies in people, even though some diversity in personality may be explained independently of social effects (genetics). These are then reflected in views toward specific topics such as euthanasia (Wasserman et al., 2016).

Similar to the findings of Lee et al. in 2017, Wasserman et al. found that opinions regarding euthanasia are favourably related to personality factors like openness to new experiences and adversely associated with attributes like agreeableness (2016).

According to the existing literature, there are correlations between both spirituality and personality traits regarding attitudes toward euthanasia. This review concludes based on the current evidence that spirituality and ‘agreeableness’ are both associated with negative attitudes towards euthanasia, unlike those with an ‘openness’ personality disposition who possess a more favourable attitude to euthanasia.

Overview

The reviewed literature suggests an existing cross-cultural relationship between spirituality and certain personality traits concerning euthanasia. Associations between religious and spiritual beliefs regarding attitudes toward euthanasia have been consistently documented throughout the literature (Danyliv and O'Neill, 2015; Aghababaei et al., 2013). Similarly, associations with agreeableness and negative attitudes towards euthanasia, and contrasting positive attitudes in individuals with the openness personality trait, have been purported by several studies throughout this review (Wasserman et al., 2016; Lee et al., 2017). Current research suggests that there is much literature based on these topics, however, there is a considerable lack of research specified to the Irish communities. While we can make some extrapolations from these findings, considering Ireland is a largely Christian country (Mutwarasibo, 2002), and while there are some personality studies conducted in Ireland, it is important to specify the topic of consideration, in this case, the relationship between spirituality, personality and the attitudes attributed to euthanasia as a form of end of life service (Wasserman et al., 2016). The impact of culture and personality on end-of-life desires should be further investigated in future studies, as well as the nuanced interaction between the two. Future studies on euthanasia should investigate why cultural differences in views toward euthanasia exist, for instance, Romania and Malta tend to have less acceptable attitudes than France and Sweden do (Wasserman et al., 2016)

Method:

Research Philosophy

The three primary scientific philosophies that influence psychology are empiricism, social constructionism, and scientific realism (Haig, 2013). The statistical approaches developed in such intellectual contexts are still used extensively in psychological statistical research. For example, the creator of Pearson's correlation coefficient considered it to be the quantitative explanation of an empiricist's understanding of a causal link (Haig, 2013). Similarly, Fisher's allegiance to the empiricism of his day led him to promote inductive techniques as the ideal scientific process perspective. Despite the modern post-positivist intellectual climate, authors of research methodology textbooks occasionally describe quantitative research as inherently positivist in its empiricist principles (Haig, 2013). Positivism, among other things, limits its focus to what can be seen and views theories as tools for organizing statements about observables without trying to explain them by pointing to hidden causes (Ryan, 2006). Post-positivism is now most commonly linked with quantitative techniques for data collection and analysis (Ryan, 2006). Post-Positivists believe that each piece of research is influenced by a number of well-developed ideas other than, and in addition to, the one being researched. The term was developed to explain the evolution of the Positivist philosophical stance (Ryan, 2006).

For this research, a quantitative approach was applied through the use of three surveys and the results of the consequential analysis of that data through IBM SPSS statistics. Even though the data for this study was collected empirically and statistically, the interpretation of the results were based on previously formed assumptions from studies of the relationship between personality, spirituality, and views toward euthanasia. This allows for the combination of data

collection theory with the author's power to influence data analysis. Using a deductive method, the author hypothesized that an individual's spirituality and personality would be related to their sentiments regarding euthanasia and developed a quantitative survey to test this assumption.

Participants

The participants for the quantitative analysis were a sample of Irish residents, at and above the age of 18. As this was a non-probability-based study the author used a convenience sampling technique. Other examples of nonprobability sampling techniques include snowball sampling and quota sampling (Bourque & Fielder, 2003). The questionnaire was distributed through word of mouth and via Instagram. The participants mainly stemmed from the word of-mouth avenue and therefore were mainly composed of colleagues, college peers, friends and family of the author. Following Green's "rule of thumb" for multiple regression which states the N should be 8 times greater than the number of independent variables plus 50 (N>50+8m) (VanVoorhis and Morgan, 2007), the survey closed with 106 participants aligning with N>50+8(6); N>98. Through inspection of the qualifying criteria (residing in Ireland, being the age of 18 or over, and completing all questions in the three questionnaires), upon data cleaning, 8 participants were discounted, leaving the final sample size to attribute to the results of this study at 95. The age of the participants ranged from 19 to 71 with a mean age of 34 and a gender female:male ratio of 2.9:1.

Research Design

Research on correlations aims to find connections between two or more variables without assuming causality (Dillman, 2002). The starting point for both causal-comparative and correlational research is typically a hypothesis derived from theory. In descriptive research, surveys are used to gather information on people, groups, organizations, etc. It serves to list the characteristics of the domain (Dillman, 2002). For examining large populations and extrapolating results from the study sample to more generalized populations, quantitative approaches excel (Holton and Burnett, 2005). Qualitative methods are excellent at comprehending a specific group or sample in-depth, but they compromise generalizability in the process. Each approach has benefits and drawbacks, and depending on the aim of the study, each one may be effective.(Holton and Burnett, 2005). Following the aforementioned information, this study adopted a quantitative methodology since the author's major objective was to generalize findings on the relationship between spirituality, personality and attitudes towards euthanasia back to the public, rather than placing a primary emphasis on a thorough comprehension of the sample group.It was determined that a self-administered questionnaire would be the most efficient tool for quantitative analysis in the current study. The goal of survey research in organizations is to gather data from one or more persons on a variety of variables that are pertinent to organizations (Dillman, 2002). There are currently at least five primary survey methods in use, including touch-tone input (also known as interactive voice response), telephone interviews, postal surveys, and internet surveys. Surveys have historically been split into two basic categories: questionnaires and interviews (Dillman, 2002). The Spirituality Self Rating Scale (SRSS) was considered to be an appropriate model to measure spirituality in this study (Galanter et al., 2007). This scale was conducted to measure spirituality in the context of its relationship with personality and attitudes toward euthanasia in a study of an Iranian sample (Wasserman et al., 2016). A similar study to that of

this author was conducted using the Big Five Personality Scale (Goldberg,1990) to measure personality traits and their effects on attitudes toward Euthanasia in Iran (Aghababaei, Wasserman and Hatami, 2013). A similar study by Aghababaei et al. was conducted to measure personality and its impact on attitudes toward euthanasia using Wasserman's ATE (Attitudes Towards Euthanasia Scale). These questionnaires were effective in collecting data from a diverse group of respondents and providing usable information. The use of the survey in the study design was influenced by questionnaire quantitative analysis, which was employed in the aforementioned studies on attitudes toward euthanasia by Galanter et al., Wasserman et al., and Aghababaei et al.

Measures/Materials

In order to effectively design the quantitative study three previously validated surveys were utilised to test the research objectives and hypotheses. The questions used to measure spirituality were taken from the Spirituality Self Report Survey (SSRS) (Galanter et al., 2007). All items on this scale were to be reverse scored if measured 1-5, 1 being strongly agree, 2 being agree, 3 being neutral, 4 being disagree and 5 being strongly disagree. As the other questionnaires in this research were measured in the opposite format, i.e 5 being strongly agree and 1 being strongly disagree, to avoid confusion among the participants, the scales were measured in the same format, rendering reverse scoring unnecessary. The Spirituality Scale had a Cronbach's alpha of .91 proving to be a very reliable scale. The Euthanasia Scale was this study's key dependent variable. Its questions, used to measure an individual's attitudes towards euthanasia, were taken from Wasserman's ATE Scale (Wasserman et al., 2005), and were ranked on a Likert scale similar to the SSRS. Questions 6 and 9 were to be reverse coded meaning their answers now ranged from 1- Strongly agree to 5- Strongly disagree. This Scale had a Cronbach's alpha of .9, rating it as very good reliability

also. This research question's final survey was that of an individual's personality traits. The author aimed to study Extroversion, Agreeableness, Conscientiousness, Neuroticism and Openness (OCEAN) using the “Big Five Personality Questionnaire” in its 50-item scale version (Goldberg, 1990). As per the aforementioned scales, this survey also used a Likert scale ranging from 1-strongly disagree to 5-strongly agree. 25 out of the 50 questions were to be reverse scored (2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 26, 28, 29, 30, 32, 34, 36, 38, 39, 44, 46, 49). This Scale had an overall reliability of .85 and its subscales had a Cronbach's alpha of; Extroversion .84, Agreeableness .8, Conscientiousness .8, Neuroticism .87 and Openness .78. All of these meet the Cronbach alpha criteria for a good-excellent reliability score.

Research Procedure

Typically, self-administered surveys are filled out by the respondents and submitted electronically over the internet, via mail, or by delivery and pickup (Holton and Burnett, 2005, pp. 102–109). Researchers may get information from participants anywhere in the globe via online surveys. Everyone with access to the Internet may get surveys promptly, and data can be automatically preserved in electronic form. This lowers the cost of space, specialised equipment, paper, shipping, and manpower. Lastly, if a survey is properly constructed, data may be saved in a manner that is ready for analysis, reducing expenses associated with data coding and input, which formerly required a significant investment of time and money (Holton and Burnett, 2005, pp. 102-109) Given these factors, the author determined that distributing the survey by email, publishing the link on Instagram, and disseminating it to peer groups using messaging apps on mobile devices was the most efficient strategy.

Before agreeing to participate, the study's participants were advised that the survey was optional and anonymous and given access to an introduction page that explained the study's goals and the kinds of information that would be needed (See Appendix 2). They were informed that only the research author was allowed access to the data, and it may be kept in an online data retention system for future studies. An ethics form was submitted to the National College of Ireland (NCI) Ethics Committee as part of the research proposal for assessment, and it was determined to be morally sound and appropriate for this study's research. The questionnaire was thought to be simple to browse, the questions were straightforward and the survey took the convenience sample about 10.5 minutes to complete on average.

Results

Descriptive statistics for demographic variables are presented in Table 1. 74.7% of the sample were female (N = 71) and 25.5% were male (N = 24).

Table 1

Frequencies for the current sample of Irish residents on each demographic variable (n = 97)

Variable	Frequency	Valid Percentage
Gender		
Female	73	75.3
Male	24	24.7
Age		
18-24	19	19.6
25-34	45	46.4
35-44	12	12.4
12	11	11.3
45-54	9	9.3
55-64	1	1.0
65+		

Means (M) and standard deviations (SD) for all continuous variables are presented in Table 2.

Participants had a mean age of 33.5 years (SD=1.25), ranging from 18 to 71. Six of the seven variable scores were normally distributed with a skewness of - 0.082 (*SE* = 0.245); kurtosis of -0.554 (*SE* = 0.485) for euthanasia, a skewness of 0.422 (*SE* = 0.245); kurtosis of -0.994 (*SE* = 0.485) for Spirituality, a skewness of -0.534 (*SE* = 0.245); a kurtosis of -0.117 (*SE* = 0.485) for Openness, a skewness of -0.429 (*SE* = 0.245); a kurtosis of -0.205 (*SE* = 0.485) for Extroversion, a skewness of -0.305 (*SE* = 0.245); a kurtosis of -0.570 (*SE* = 0.485) for Conscientiousness, a skewness of 0.041 (*SE* = 0.245); a kurtosis of -0.741 (*SE* = 0.485) for Neuroticism. Agreeableness was not normally distributed with a skewness of -1.618 (*SE* = .245) and kurtosis of 4.890 (*SE* = .485). All Scale scores were normally distributed apart from Agreeableness (negatively skewed), as assessed by visual inspection of Normal Q-Q Plots. Although the aforementioned results indicate that some research variables are not normally distributed, the present sample size is sufficient to infer that the sample means are adequately approximated by a normal distribution, and as a consequence, the distribution of scores will be considered normal. After carefully examining the data, it was discovered that there was only one significant outlier and that the answers were within the range of probable results for the measures. Nonetheless, due to the sample's apparent homogeneity, these results could appear to be outliers. As there was no difference in the results when the outliers were eliminated from the study, they were kept in the final analysis.

Table 2

Descriptive statistics of all continuous variables

	Mean (95% Confidence Intervals)	Std. Error Mean	Median	SD	Range
Euthanasia	33.37 (31.55-35.19)	.92	33	9.04	10-50
Spirituality	15.12 (13.67-16.58)	.73	14	7.20	6-30
Extroversion	31.91 (30.44-33.39)	.74	33	7.30	11-48
Agreeableness	42.37 (41.23-43.51)	.58	44	5.66	15-50
Conscientiousness	36.16 (34.65-37.68)	.76	37	7.51	18-49
Neuroticism	27.68 (25.78-29.58)	.96	28	9.41	10-49
Openness	36.03 (34.75-37.32)	.65	37	6.38	20-49

A Pearson's product-moment correlation was run to assess the relationship between attitudes towards euthanasia and spirituality, extroversion, agreeableness, conscientiousness, neuroticism and/or openness in Irish residents aged 18+. Ninety-seven participants were recruited.

There was no statistically significant correlation between the independent variables and attitudes towards euthanasia (ATE). Spirituality and ATE, r(95) = -0.066, p = .522, Extroversion and ATE, r(95) = -0.023, p = o.821, Agreeableness and ATE, r(95) = -0.025, p = 0.806, Conscientiousness and ATE, r(95) = -0.159, p = .121, Neuroticism and ATE, r(95) = -0.080, p =0.435 and Openness and ATE, r(95) = -0.038, p =0.715.

The relationship between attitudes towards euthanasia and the 6 independent variables were not statistically significant. Therefore, we cannot reject the null hypothesis and cannot accept the alternative hypothesis.

Table 3

Correlations between all continuous variables

Variables	1	2	3	4	5	6	7
1. Euthanasia	1						
2. Spirituality	-.07	1					
3. Extroversion	-.02	.15	1				
4. Agreeableness	-.03	.08	.25**	1			
5. Conscientiousness	-.16	.06	.10	.58	1		
6. Neuroticism	-.08	.11	.11	-.21*	.26**	1	
7 .Openness	-.04	.09	.36***	.26**	.11	.11	1

Note. Statistical significance: *$p < .05$; **$p < .01$; ***$p < .001$

R^2 for the overall model was 3% with an adjusted R^2 of -3.4%, a small size effect according to Cohen (1988).

Spirituality and personality (OCEAN) did not statistically significantly predict attitudes towards euthanasia, $F(6, 90) = 0.468$, $p > .001$.

A multiple regression was run to predict attitudes towards Euthanasia from Spirituality and personality (extroversion, agreeableness, conscientiousness, neuroticism and openness). The multiple regression model did not statistically significantly predict attitudes towards euthanasia, $F(6, 90) = 0.468$, $p > .001$, adj. $R^2 = -0.034$. All six variables failed to add statistically significantly to the prediction, $p > .05$. Regression coefficients and standard errors can be found in Table 4 (below).

Table 4

Multiple regression model predicting attitudes towards Euthanasia

	R^2	β	B	$SE\ B$	CI 95% (B) LL/UL
Model	.03				
Constant			43.30***	9.32	24.79/61.81
Spirituality		-.05	-.07	.13	-.33 / .20

Extroversion	.01	.02	.14	-.27 / .30
Agreeableness	-.02	-.03	.18	-.40 / .32
Conscientiousness	-.14	-.17	.13	-.43 / .08
Neuroticism	-04.	-.04	.11	-.26 / .18
Openness	-.01	-.02	.16	-.34 / .31

Note. Model = "Enter" method in SPSS Statistics; *B* = unstandardized regression coefficient; CI = confidence interval; *LL* - lower limit; *UL* = upper limit; *SE B* = standard error of the coefficient; β = standardized coefficient; R^2 = coefficient of determination; N = 97; Statistical significance: **p* < .05; ***p* < .01; ****p* < .001

Discussion

Euthanasia is the Greek term for “a good death” and is commonly referred to as “mercy killing” (Lau and Wong, 2022).The phrase "euthanasia" refers to ending someone's life, especially if they are terminally ill, in order to relieve their pain and suffering (Lau and Wong, 2022). To the best of this author’s knowledge, little to no other published studies have covered this topic regarding spirituality and personality’s effect on attitudes towards euthanasia in Ireland. While there are a number of variables that may influence attitudes towards Euthanasia, this study sought to control for six such variables that the literature has identified as being associated with attitudes towards Euthanais - those of Spirituality and The Big Five personality types; extroversion, agreeableness, conscientiousness, neuroticism and openness (Aghababaei et al., 2011). When such variables were taken into account, this study sought to ascertain if spirituality and/or personality (OCEAN) had any additional predictive value for the ATE scale. The final model accounted for 3% of the variance in attitudes towards euthanasia and all six variables showed non-statistically significant results in predicting attitudes towards euthanasia. As such this study’s hypothesis was not supported.

This study contradicts the previous literature in that spirituality is a strong predictor of attitudes toward euthanasia. Previous research has purported that spirituality/religiosity, age, gender, personality and culture, amongst others, are factors that influence attitudes toward euthanasia (Lau and Wong, 2022; Aghababaei et al., 2013). This study aimed to predict attitudes towards euthanasia, particularly that H1; High levels of spirituality would impact attitudes towards euthanasia negatively, H2; High levels of Agreeableness would also pose a negative impact on ATE and H3; Individuals with a strong Openness disposition would be more accepting of Euthanasia. In the present research, 69% of participants had a score of

above or equal to 30 - indicating positive attitudes towards euthanasia and 31% displayed negative attitudes. When testing for H1, 38% of participants scored above or equal to 18 on the SRSS, showing high levels of spirituality and of the 38% of participants who showed high levels of spirituality, 74% of them showed high levels of acceptance towards euthanasia, meaning only 26% of participants who had high levels of spirituality had low acceptance of euthanasia. Similarly, when testing for H2, 98% of participants scored high on agreeableness and of which, 68% also scored high on the ATE scale, meaning 32% only of participants who scored high on agreeableness scored low on ATE. Lastly, 85% of participants scored high on the openness scale and of those participants, 68% also scored high on ATE (55 participants equating to just over half) as such, the data from this research did not support the study's initial predictions, also producing non-significant relationships between the dependent variable and all independent variables through SPSS multiple regression analysis. These findings align with that of Bulmer et al. who conducted a study to examine whether age, gender, race, religion, and/or personality were predictive of attitudes toward euthanasia (2017). Their findings showed non-significant results for a relationship between agreeableness, conscientiousness, neuroticism, openness and ATE, however, they did find a significant relationship between extroversion and ATE (Bulmer et al., 2017). While spirituality and religiosity have been demonstrated to be predictive of attitudes toward euthanasia in previous studies it is generally and most frequently associated with fear of death, death anxiety and suicide rather than attitudes towards assisted dying (Chan and Yap, 2009; Neeleman et al., 1997). Of the large sample of previous research examined, the majority of studies have focused solely on religiosity rather than spirituality (Anderson and Caddell (1993); Burdette et al., (2005); Danyliv and O'Neill (2015); Emmanuel et al., (1996)) Age and gender has been shown to be statistically significant predictors of attitudes towards euthanasia (Lau and Wong, 2022). The present study did not include age and gender as independent variables, however, the males in this study did show lower levels of

acceptance towards euthanasia than the female participants (Mean score: 26.29 and 33.69 respectively). Similarly, the age band of 25-34 not only had the highest percentage of participants but also scored the highest mean level of acceptance towards euthanasia on the ATE scale (35/50). Perhaps age and gender may have been more significant predictors of attitudes toward euthanasia.

The scale used for measuring attitudes towards euthanasia in this study was Wassermans "ATE" scale, however, previous research shows that using the "EAS" scale instead results in lower levels of opposition towards euthanasia (Aghababaei, 2011). This study also neglected to differentiate between "active", "passive", "voluntary" and "involuntary" euthanasia. As there is a distinct difference between the four variations of euthanasia, results may have differed if the participants had been made aware of said difference, and which questions of the ATE were referencing which variation, as done by several researchers in the present literature who found strong significant relationships in their studies (Ho, 1998; Ho and Penny, 1992; Holden, 1993; Aghababaei, Hatami and Rostami, 2011). This aligns with Kamath et al., in their findings that defining the euthanasia variable would likely result in less/more favourable attitudes towards euthanasia, at least partially (2011). This assumption of potential difference would align with this study's feedback from several of the participants who advised that the euthanasia scale (ATE) was difficult to interpret and led to confusion regarding what the question was asking, resulting in answering the questions proving difficult.

Limitations and Future Research

The present study's attempt to build on earlier research in a novel way is one of its merits. To the researcher's knowledge, previous studies have failed to examine if the effects of spirituality using the SRSS and Personality using The Big Five 50-item personality scale were predictive of levels of acceptance towards Euthanasia in Ireland using the ATE scale. As this study found no significant difference in attitudes toward euthanasia it suggests that any effects of spirituality and/or personality could be mitigated when controlling for ATE among the Irish population, however, there are still a number of limitations to be considered in the present study.

Firstly, no causation can be deduced because this is a cross-sectional design. This is not a severe restriction in the current research given no statistically significant findings were obvious, yet longitudinal research in the future might better effectively address the research topics posed. This would be especially pertinent considering the prospect of extra education on the topic of euthanasia and the likelihood of Ireland enacting euthanasia legislation altering the participants' findings of attitudes towards Euthanasia in later life, if longitudinal research were to be applied in a study such as this one may witness oscillations in such views, which could be crucial for highlighting whether legalisation of the issue may be more predictive of attitudes towards euthanasia in later life.

Secondly, this study used a self-report questionnaire to ascertain individuals' views on euthanasia. It's probable that a social desirability bias is at play as a result, with individuals maybe ranking themselves either consciously or unconsciously lower on questions regarding neuroticism/acceptance of euthanasia or higher on questions about extraversion/agreeableness, for example. Future research may benefit from adopting an implicit association measure to assess spirituality, personality, and attitudes toward euthanasia

because these factors may be more suggestive of any concealed biases. Furthering this point, Aghababaei et al., 2011 found that using the "Euthansia attitude scale" (EAS) instead of the ATE scale (used in the present study) results in lower levels of opposition against euthanasia. They also found that the EAS scale is more sensitive toward characteristics. Using the EAS scale of Euthanasia may have produced more conclusive and significant results based on its sensitivity to characteristics such as those used in this study. Future research could benefit from scale association and scale synergy testing prior to choosing measures to study the impact of spirituality, personality and attitudes toward euthanasia.

Another limitation of this study is the lower number of male participants. There were 73 female respondents and 24 male respondents in the present sample. Perhaps a more balanced sample might have shown different results, as prior research has shown that men tend to score higher on acceptability scales for euthanasia than women. Additionally, the number of participants as a whole may also be a limitation of this study's research. Following Green's rule of thumb, N>5+8m (VanVoorhis and Morgan, 2007), our number of participants should have been greater than 98, however, this study fell slightly short with a sample of 97 participants. Furthermore, a sample of 97 has a relatively small effect size, leaning on the current literature, perhaps a medium effect size would have been the more appropriate choice for optimal significance.

Conclusion

In the current study, there was no discernible relationship between spirituality and/or personality traits and models of views regarding euthanasia. The findings of this study suggest that spirituality alone is not statistically substantially predictive of attitudes toward euthanasia, despite previous research showing that high levels of spirituality and religiosity can result in low levels of euthanasia (Wasserman et al., 2016). Religion may be a stronger predictor of opinions against euthanasia given that there was no discernible difference between spirituality, personality, and attitudes toward the practice. Additionally, the results may be more significant if the independent and dependent variables are measured using different scales. While this study aimed to add to existing knowledge, future research may benefit from using implicit association measures and longitudinal data to ascertain whether attitudes toward euthanasia can be predicted by individual characteristics and how those characteristics may be influenced by the culture of the individual's residency.

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Appendix

A) Participant Information Leaflet

The relationship between Personality, Spirituality and attitudes towards Euthanasia in Ireland.

Thank you for considering taking part in my Final Year Project. Before consenting to take part please take time to carefully read this information sheet and ensure you understand the topic and the role you will play in this study. If you have any queries on any of this information or if you have any confusion please do not hesitate to contact me at x19162731@student.ncirl.ie.

My name is Katie Moran and I am a final-year psychology student at NCI college in Dublin, Ireland. The reason for this study is to investigate opinions towards Euthanasia in Ireland in relation to six variables (personality types and levels of spirituality). Euthanasia is the assisted or direct ending of an individual's life who is in great pain and or suffering ("Euthanasia and assisted suicide", 2022). To achieve this study's aims there will be a series of questions.
This Study will be supervised by Dr. Lynn Farrell.
What will taking part in the study involve?
If you decide to take part in this research, you will be asked to…
● Take part in a survey composed of a series of questions. The questions will include topics of death, spirituality and personality tendencies. Essentially this study aims to study your personality type and level of spirituality and what your attitude is toward euthanasia in general and if it were to be legalised in Ireland. It further aims to study and analyze any correlations between the 3 variables.
● The study will be entirely anonymous and the survey submissions will be completely untraceable or identifiable to the individual.
Who can take part?
This study applies to individuals residing in Ireland who are above the age of 18 and who are eligible to complete their own informed consent.
Do I have to take part?
Partaking in this survey is entirely voluntary and each individual is within their rights to refuse participation. Similarly, each individual has the right to cease participation at any time throughout this survey with no consequence whatsoever. Each question must be completed for the survey to be submitted. Once the survey has been submitted it cannot be redacted as all data is anonymous and unidentifiable.

What are the possible risks and benefits of taking part?
There are no individual benefits to taking part in this survey. However, your participation will contribute to the research of attitudes towards euthanasia in Ireland and the potential reasoning for these attitudes. As some of the questions center around the topic of death, I would advise with caution that this is adequately considered in advance of participation. Relevant support links and numbers can be found at the end of the debrief sheet and once again do not hesitate to contact me at x19162731@student.ncirl.ie.

Will taking part be confidential and what will happen to my data?

Confidentiality is at the core of this study and will be treated with the utmost importance. Once collected your data will be analyzed for the purpose of the study and will then be retained on a monitored database by NCI with the option of secondary data analysis.
If you have any queries regarding your data and its protection feel free to contact NCI's data protection officer Niamh Scannell at Niamh.Scannell@ncirl.ie.

What will happen to the results of the study?
It is important to note that these results will be presented to NCI academic professionals for review and the results of the project may be presented at conferences and/or submitted to an academic journal for publication.

I have read and understand the above ⬜

I do not wish to continue ⬜

B) Consent form

In agreeing to participate in this research I understand the following:

- The method proposed for this research project has been approved in principle by the NCI Ethics Committee, which means that the Committee does not have concerns about the procedure itself as detailed by the student. It is, however, Katie Moran's responsibility to adhere to ethical guidelines in their dealings with participants and the collection and handling of data.

- If I have any concerns about participation, I understand that I may refuse to participate or withdraw at any stage by exiting the survey.

- I understand that once I have submitted my completed questionnaire, I cannot withdraw my data as it will be fully anonymised.

- I have been informed as to the general nature of the study and agree voluntarily to participate.

- All data from the study will be treated confidentially. The data from all participants will be compiled, analysed, and submitted in a report to the Psychology Department in the School of Business.

- I understand that my data will be retained and managed in accordance with the NCI data retention policy and that my anonymised data may be archived in an online data repository and may be used for secondary data analysis. No participants' data will be identifiable at any point.

- At the conclusion of my participation, any questions or concerns I have will be fully addressed.

By clicking "Agree" you consent to your participation and to the use and retention of your data.

C) Spirituality Assessment Survey

This Survey will be used to assess levels of Spirituality among participants.

This questionnaire will consist of a series of statements where you can rank your answers from 1. “Disagree”, 2. “Slightly disagree”, 3. “Neutral”, 4. “Slightly agree” or 5. “Agree”.

What is your age?

Do you live in Ireland?

Gender:

Male ⬜

Female ⬜

Transgender ⬜

Non-Binary ⬜

Other ⬜

Prefer not to say ⬜

Question

It is important for me to spend time in private spiritual thought and meditation.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I try hard to live my life according to my religious beliefs.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

The prayers or spiritual thoughts that I say when I am alone are as important to me as those said by me during services or spiritual gatherings.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I enjoy reading about my spirituality and/or my religion.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

Spirituality helps to keep my life balanced and steady in the same ways as my citizenship, friendships, and other memberships do.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

My whole approach to life is based on my spirituality.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

Personality Survey

This Survey will be used to asses The Big 5 personality traits in participants.

This questionnaire will consist of a series of statements where you can rank your answers from 1. “Disagree”, 2. “Slightly disagree”, 3. “Neutral”, 4. “Slightly agree” or 5. “Agree”.

I am the life of the party.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I feel little concern for others

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜.

I am always prepared.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I get stressed out easily.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have a rich vocabulary.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I don't talk a lot.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am interested in people.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I leave my belongings around.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am relaxed most of the time.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have difficulty understanding abstract ideas.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I feel comfortable around people.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I insult people.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I pay attention to details.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I worry about things.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have a vivid imagination.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I keep in the background.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I sympathize with others' feelings.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I make a mess of things.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I seldom feel blue.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am not interested in abstract ideas.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I start conversations.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am not interested in other people's problems.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I get chores done right away.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am easily disturbed.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have excellent ideas.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have little to say.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have a soft heart.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I often forget to put things back in their proper place.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I get upset easily.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I do not have a good imagination.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I talk to a lot of different people at parties.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am not really interested in others.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I like order.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I change my mood a lot.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am quick to understand things.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I don't like to draw attention to myself.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I take time out for others.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I shirk my duties.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I have frequent mood swings.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I use difficult words.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I don't mind being the center of attention.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I feel others' emotions.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I follow a schedule.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I get irritated easily.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I spend time reflecting on things.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am quiet around strangers.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I make people feel at ease.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am exacting in my work.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I often feel blue.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

I am full of ideas.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

Attitudes towards Euthanasia

This Survey will be used to measure attitudes towards Euthanasia in Ireland.

This questionnaire will consist of a series of statements where you can rank your answers from 1. “Disagree”, 2. “Slightly disagree”, 3. “Neutral”, 4. “Slightly agree” or 5. “Agree”.

Question

If a patient is in severe pain a doctor should remove the life support and allow the patient to die.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

It is ok for a doctor to administer enough medicine to end a patient’s life if the doctor does not believe that they will recover.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

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

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

It is ok for a doctor to remove life-support and let a patient die if the doctor does not believe the patient will recover.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

It is okay for a doctor to administer enough medicine to a suffering patient to end that patient’s life if the doctor thinks that the patient’s pain is too severe.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

Even if a doctor does not think a patient will recover, it would be wrong for the doctor to end a patient’s life.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

It is okay for a doctor to remove a patient's life-support and let the patient die if the doctor thinks the patient's pain is too severe.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

If a dying patient requests it, a doctor should prescribe enough medicine to end a patient's life.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

Even if a doctor knows a patient is in severe, uncomfortable pain, it would be wrong for the doctor to end the life of that patient.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

If a dying patient requests it, a doctor should remove their life support and allow them to die.

1.⬜ 2.⬜ 3.⬜ 4.⬜ 5.⬜

D) Debrief Sheet.

Thank you for Participating in my Final Year Project Research Study. Your participation will contribute to our knowledge of attitudes towards Euthanasia in Ireland in relation to spirituality and personality types.

Once again I would like to remind you that you have the right to withdraw from this study and are not obliged to submit your questionnaire. If you submit your questionnaire you will no longer be able to withdraw from this study.

If you know anyone who might be open to taking part in the research study please feel free to share this survey with your friends/family/colleagues

If you are feeling distressed or upset after participating in this survey please follow this link to get support about the personal experience surrounding the death of a loved one https://hospicefoundation.ie/ or call them on 1800 80 70 77

Alternatively if you feel distressed regarding thoughts about death please follow this link for support https://www.samaritans.org/ireland/samaritans-ireland/ or call them on 166 123

If you would like to reach out to me regarding this study and or your participation in the Study please do so via x19162731@student.nicrl.ie.

Once again, your participation is greatly appreciated and I am hugely grateful to have had you contribute to my research.

I wish to Submit ⬜

I do not want to Submit ⬜