Is Counseling Ready for Rational Suicide? A Study of Perceived Competence

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M*any counselors believe suicidal ideation in a terminally ill client can be rational (Rogers et al, 2001). One hundred and fifty-three counselors rated their perceived competence to counsel individuals who are rationally suicidal. Data were analyzed with non-parametric statistics. Findings suggest participants with more education, more years of service, and more experience with terminally ill clients rated themselves more competent to work with rationally suicidal clients. Implications for counselors and counselor educators are discussed.*

Terminally ill individuals seek counseling services for various reasons such as processing their emotions and end-of-life planning, including discussing rational suicide (Daneker, 2006). Rational suicide is the desire to hasten one's death when terminally ill (Werth & Cobia, 1995). Rational suicide is based on three concepts. First, the person considering hastening their death must have a terminal illness with a prognosis of six months to live confirmed by a medical professional (Rogers et al., 2001; Werth & Crow, 2009). Second, the individual is capable of making an informed decision based on the consideration of all alternatives and in the absence of a diagnosis that would impede this competence (Rogers et al., 2001; Werth & Crow, 2009). Third, the individual is making the decision of their own free will (Rogers et. al., 2001; Werth & Crow, 2009). To determine that the person requesting physician-assisted suicide is making a rational decision each state with physician-assisted suicide laws, physicians refer their patients for a psychological exam with a mental health provider. (General Assembly of State of Vermont, 2013; Oregon Public Health Division, 2013; People of the State of California, 2015; Washington State Department of Health, 2009). From 2012 to 2016, physicians in the Oregon made 36 referrals to a counselor for a mental health exam (Oregon Public Health Division, 2016) Yet, research is lacking on how to best assist counselors with discussing rational suicide with clients including counselors' self-reported confidence. In counselor training programs, two models often serve as guidelines for conceptualizing the dying process with terminally ill clients (Erford, 2015; James & Gilliland, 2013). Kubler-Ross (1969, 2014) and Rando (1984) described the stages that characterize a terminally individual's progress toward death, including accepting their

impending death. Neither Kubler-Ross (1969, 2014) nor Rando (1984) address the experiences of a terminally ill client who wants determination of when and how they die. As state legislatures consider physician-assisted suicide laws, counselors need to be competent to counsel those who are considering rational suicide. Accordingly, the current study was intended to investigate counselors' reported competence in addressing rational suicide for terminally-ill clients.

Rational Suicide and Physician-assisted Suicide

Washington, Oregon, Montana, Colorado, Hawaii, Maine, New Jersey, Vermont, and California have laws that permit terminally ill individuals, who have a prognosis of less than six months, to request physician assistance to aid-in-dying also known as physician-assisted suicide (eg: General Assembly of State of Vermont, 2013; Oregon Public Health Division, 2013; People of the State of California, 2015; Washington State Department of Health, 2009). Eighteen states are considering physician-assisted suicide legislation in 2019.

Each of the current laws regarding physician-assisted suicide require an assessment of decision-making ability to determine if the individual seeking physician-assisted suicide is making an informed decision (General Assembly of State of Vermont, 2013; Oregon Public Health Division, 2013; People of the State of California, 2015; Washington State Department of Health, 2009). This assessment of individuals' capacity for rational decision making serves three purposes: (a) determines whether the individual seeking physician-assisted suicide is reacting to symptoms of depression which may be influencing the suicidal ideation and refer for treatment, (b) identify whether the terminally ill person is being coerced into their decision and (c) identify whether the individual has considered all of their options (Werth Jr & Holdwick Jr, 2000). Using a decision-making assessment with rationally suicidal clients enables counselors to explore a holistic view and examine all options thoroughly. Essentially, the assessment requirement reinforces the idea that as more states legalize physician-assisted suicide, counselors will be more likely to engage with clients expressing rational suicidal ideation.

Counselors' views of Rational Suicide

Research conducted with counselors who are members of the American Mental Health Counseling Association (AMHCA) suggests approximately 81% 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). Counselors who agree that suicide can be rational identify reasons for their assertion. Terminally ill individuals struggle with five distinct issues that may influence 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 disagree that suicide can be rational are concerned that legitimizing suicide may lead to coercion of the terminally ill individuals by family members who view them as a burden on their family (Siegle, 1986). Boudrea and Somerville (2013) suggest that a terminally ill individual may struggle with issues of morality or religion that cloud their judgment. While research suggests that counselors agree that suicide can be a rational construct for terminally ill clients, the literature does not address whether counselors perceive

themselves as competent to provide appropriate counseling services to a client considering physician-assisted suicide.

Guidelines for Counselors

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 American Counseling Association (2005) *Code of Ethics*, Werth, Jr and Crow (2009) advocate for comprehensive end-of-life care that encompasses all issues that might affect a terminally ill client. 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 (2009) stress maximizing the terminally ill individual's self-determination and engaged the client in informed decision-making.

While Werth Jr. and Crow (2009) proposed guidelines and speak about the importance of providing counseling services to individuals who are rationally suicidal, they do not address what specific competencies would be needed to effectively provide these services. Additionally, they do not address whether counselor's express competence to provide these counseling services.

Counselor Competence

Shaw and Dobson (1988) define counselor competence as the ability to promote positive change. 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: (a) education and experience (Berman & Norton, 1985; Hattie, Sharpley, & Rogers, 1984; Shaw & Dobson, 1988), (b) personal characteristics and ability to develop a therapeutic relationship (Lubrosky et. al., 1985; Lubrosky et. al, 1986; Strupp & Hadley, 1979), and (c) application of clinical research (Herman, 1993). There has be no specific research regarding counselor's competence to work with rationally suicidal individuals.

Education and experience counseling. Emphasis has been on education and experience as the cornerstones of developing counselor competence (Herman, 1993). Each of the 50 states within the United States has licensure standards that require a master's degree and a clinical or experiential component (ACA, 2014b). The Council for Accreditation of Counseling and Related Education Programs (CACREP) accredits master's programs for counselor education providing a minimum level of education and 700 hours of clinical experience that a professional counselor should have before licensure. 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 and experience have been identified as factors influencing competence with specific populations, such as Lesbian, Gay, and Bisexual (LGB) (Graham, Carney, & Kluck, 2012) and multicultural clients (Barden & Greene, 2015). Based on this and previous literature regarding counselor's beliefs about rational suicide (Rogers et. al., 2001), the authors

hypothesize that experience counseling a terminally ill client or a suicidal client may affect counselors perceived competence. Additionally, the authors hypothesized that personal experience contemplating suicide may affect counselor's perceived competence.

Religious affiliation. Religious beliefs are a factor that influences whether an individual believes that suicide can be a rational construct. 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 who were asked about whether suicide can be rational for those who are terminally ill responded that religious beliefs influenced their decision (Westefeld et. al., 2004). Additionally, Rogers et. al. (2001) found that those with a religious affiliation influenced the counselor's acceptance of suicide as a rational construct. Based on these findings, the authors hypothesize 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.

Purpose of the Study

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. 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. 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, the researchers explored whether education, years of experience or religion predict counselors' perceived competence to provide counseling with individuals expressing rational suicidal ideation. Finally, the researches explored whether specific experiences, counseling a terminally client, counseling a suicidal client, or personal contemplation of suicide, predict counselors' perceived competence to provide counseling with individual expressing rational suicidal ideation. Specifically, the authors addressed the following research hypotheses:

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.
   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.
2. There will be a statistically significant ($p < .05$) positive relationship between counselor's number of years of experience and overall competence.
   RH_0: There will be no statistically significant between counselor's number of years of experience and overall competence.
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.

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

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.
   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.
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.
   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.
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.
   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.

Methods

The authors used an ex post facto design. 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). 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.

A request to participate in a survey was sent to a sample of convenience (Hinkle, Wiersma, & Jurs, 2013). Participants completed survey items about their perception of whether suicide can be rational and whether they felt competent to work with this population, as well as providing demographic information.

Participants

A convenience sample of 153 participants was used to assess counselor's perceived competence to provide counseling to individual expressing rational suicidal ideation. Of the 153 participants, 49 (32.0%) identified as male, 103 (67.3%) identified as female, and one (0.7%) did not identify

a gender. Twenty-one (13.7%) participants 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. Regarding 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 earned a master's degree and 63(41.2 %) participants indicated that completed a doctoral degree. 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, 19 (12.4 %) indicated more than 21 years, and one person did not respond to the question.

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.

Procedures

This study's methods were approved by the first 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's Code of Ethics (2014a). Participants were recruited via a listserv between September 2013 and May 2014. 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) found that both email surveys and web-based surveys produced a lower response rate than those mailed through the United States Postal Service. Shih and Fan (2008) found that the response rate for web surveys was about 11% lower 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.

Survey

The survey instrument used to collect the data set was developed based on a review of the literature that describes how counselors develop competence and a literature review of counselor's views about rational suicide. Literature indicates that education and experience level impact how counselors develop competence (Barden & Green, 2015; Graham, Carney, & Kluck, 2012). Previous literature on whether suicide can be rational indicates that religion and experience with suicidal ideation impacts views (Rogers et. al., 2001; Werth Jr. & Cobia, 1995). The survey consisted of two parts. The first part included ten questions regarding the participants' demographic information, such as their gender, age, race, and religious affiliation. Gender, education level, and licensure level were dichotomous variables. Race and Religion had multiple options. Years of experience was divided into five year bands (0-5 years, 6-10 years, 11-15 years, 16-20 years and 20+ years) Additionally, participants were asked to respond yes or no to three questions: "Do you have experience counseling a terminally ill client", "Do you have experience counseling a suicidal client", and "Have you contemplated suicide for yourself"

For the second part of the survey, participants were provided the following definition of rational suicide based on the work of Rogers et. al., 2001 and Werth Jr. and Crow, 2009: "Rational suicide is 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." Participants were then asked to respond yes or no to whether they thought suicide could be rational according to this definition. Participants were also asked to rate their perceived competence on a Likert Scale anchored at both end (1 means not competent, 5 means competent, I would provide supervision in this area) to provide counseling to a client expressing rational suicidal ideation. (Appendix A)

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). Based on the work of Bernard & Goodyear (2014), Herman (1993), and Sue et al (1992), the researchers defined competence as one's perception of whether they have the knowledge to provide supervision to a novice counselor.

Data Analysis

The researchers conducted two tests to determine if the data could be analyzed with parametric or non-parametric tests of statistical analysis. The first test was a calculation of each variables' skewness *z* value and the kurtosis *z* value. Z values that fall between -1.96 and 1.96 are considered to be distributed normally (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). In all cases, the variables were not normally distributed. Therefore, a Mann-Whitney test was used for those variables that had two groups (education, experience counseling a suicidal client, experience counseling a terminally ill client, and

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

Estimates of power (McNeil, Newman, & Kelly 1996; Stevens, 1996) were conducted based upon the most conservative estimates and a total sample size of 153. 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. A Bonferroni correction technique (Newman, Fraas & Laux, 2000) was conducted so chance of making a Type II error rate was consistent across the study, while controlling for family-wise error rates associated with multiple comparisons.

Results

One hundred forty-five (94.8%) participants indicated they believed 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 not competent, 20 (13.1%) rated their competence as low, 60 (39.2%) indicated they were neither competent, nor not competent, 34 (22.2%) indicated they were competent, but would not provide supervision, and 15 (9.8%) indicated they were competent and would provide supervision.

A Mann-Whitney U test was used to determine whether there was a difference in perceived competence based on education level. There was 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). These results indicate a small effect size for education (r = *.28)*. Participants who held a doctoral degree (Md = 4, n = 63, M = 3.35, SD = 1.22) rated their competence higher than those who had a master's degree (Md = 3, n = 90, M = 2.71, SD = 1.07).

A Kruskal-Wallis test was used to determine if there was a difference in competence based on years of experience. There is a statistically significant difference in competence rating based on years of experience (χ^2 = 20.841, p = .000). Mann-Whitney post hoc tests were used to determine if there statically significant differences between individual groups. There was a statistically significant difference between those who had 0 to 5 years of experience (Md = 3, n = 60, M = 2.58, SD = .96) and those who had 16-20 years of experience (Md= 4, n = 19, M = 3.47, SD = 1.17) (z = -3.214, p = .001). There was a statistically significant difference between those who had 0 to 5 years of experience and those who had 21 or more years of experience (Md = 4, n = 19, M = 3.63, SD = 1/26) (z = -3.529, p = .000). The effect size for years of practice was small (r = *.36)* and medium (r = *.40)*. There were no statistically significance differences between the other groups.

A Mann-Whitney U test was used to determine if there was a difference in perceived competence based on religion. There is not a statistically significant difference in competence rating between participants who indicated they have a religious belief (M= 2.93, SD = 1.30) and those who did not (z = -.33, p = .974, M = 2.98, SD = 1.13).

A Mann-Whitney U test was also used to determine if there is a difference in perceived competence based on experience counseling a terminally ill client. There was a statistically

significant difference in competence rating between participants who had counseled a terminally ill client and those who had not (z = -4.733, p = .000). The effect size was medium (r = .39) for experience with a terminally ill client. Participants who indicated they had a counseled a terminally ill client (Md = 3, n = 65, M = 3.5, SD = .95) rated their competence higher than those who had not (Md = 3, n = 87, M = 2.57, SD = 1.18). A Mann-Whitney U test was used to determine if there was a difference in perceived competence based on experience counseling a suicidal client. There was no statistically significant difference in competence rating between participants who had counseled a suicidal client (M=2.97, SD = 1.13) and those who had not (z = -.345, p = .730, M = 2.80, SD = 1.13). A Mann-Whitney U test was used to determine if there is a difference in perceived competence based on personal contemplation of suicide. There is no statistically significant difference in competence rating between participants who had considered suicide for themselves (M = 3.03, SD 1.28) and those who had not (z = -.594, p = .552, M = 2.93, SD = 1.12).

Discussion

Findings from this study identify whether counselors perceived themselves as competent to provide counseling to individuals who are expressing rational suicidal ideation as well as what factors may influence this competence. Implications of these findings impact counselors who want to counsel this population and counselor educators who educate them. The design of the survey, response rate, and response bias may be limitations, which is addressed along with suggestions for future research.

Counselor Competence

Of the 153 participants, 145 (94.8%) participants agreed that suicide could be a rational construct. This is higher than previous literature (Rogers et. al., 2001). Regarding perceived competence109 (68.2%) of participants rated their competence to provide counseling to individuals who express rational suicidal ideation as a 3, 4, or 5. Forty-four of the participants (28.8%) rated their competence as a 1 or 2. More counselors rated themselves competent to provide counseling to rationally suicidal clients than those who did not. 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 (Rogers 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.

Education and experience counseling. Counselors who had more years of experience, held a higher educational degree, and had experience counseling terminally ill clients rated themselves higher in competence than those who did not have higher education or experiences. This study's findings align with previous research suggesting that competency has been positively correlated with education and both general and specific counseling experience (Barden & Greene, 2015; Graham, et. al., 2012; Hermann, 1999). There was no difference in perceived competence to counsel a rationally suicidal client based on reported experience with suicidal clients. This deviates from previous literatures regarding experience (Rogers, et. al., 2001). This study also did not find a difference in perceived competence based on personal contemplation of suicide.

These findings may indicate that counselors conceptualize suicidal clients and rationally suicidal clients differently.

Religious affiliation. Religious affiliation was identified as potentially influencing counselors' perceived competence. No differences were found in counselors' perceived competence based on religious affiliation. This deviates from previous literature that states that religious affiliation influences whether counselors agreed that suicide could be rational (Rogers et. al., 2001). This finding may be impacted by the high response rate of counselors who believed that suicide could be a rational construct.

Implications

The findings suggest that while counselors may believe that suicide is a rational construct, few counselors identify themselves as competent to provide rationally suicidal clients with counseling services. The findings also identify factors that influence a counselors' perceived competence to provide counseling to terminally ill individuals who are expressing rational suicidal ideation. Three factors that influence perceived competence (i.e., education, counseling experience, and counseling experience with terminally ill clients) have implications for counselors and counselor educators

Counselors

Counselors 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 who want to work with rationally suicidal clients should seek out educational opportunities, such as professional development workshops.

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 may be used to assess whether mental health concerns are influencing the ability of the client to make a rational decision. Counselors should also familiarize themselves with documentation required.

Counselor Educators

Counselor Educators are impacted by the findings that education and experience influence perceived competence. Within a curriculum that is heavily prescribed for counselors (CACREP, 2016), 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 experiences with a terminally ill client may be difficult to accomplish, counselor educators can add the topic of rational suicide to the educational experience in other ways. For example, ethical discussion can include scenarios involving rational suicidal ideation.

Students may 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 (eg, Washington or Oregon) 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 they reside in and educate themselves about these tools so that they can provide instruction. 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.

Limitations and Suggestions for Future Research

Despite the innovation of the study, there are limitations that should be considered. There are limitations to using an ex post facto design. (Cohen, et al., 2000; Okolo, 1990). Data collection was limited to a convenience sample of participants. The response rate for this survey was significantly lower than desired (Shih & Fan, 2008; Van Horn et al, 2009). These factors may limit the generalizability of the data. Additionally, there may have been response bias such as counselors who do not believe that suicide can be rational may have chosen not to participate.

The design 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.

Researchers interested in rational suicide could 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 with counseling clients who are expressing rational suicidal ideation than counselors 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.

Qualitative research with counselors who have provided counseling to terminally ill individuals who are expressing rational suicidal ideation would inform best practices for training counselors for serving this population as well as provide factors that may have impacted the effect size of this study. Furthermore, qualitative themes could be used assist practitioners with creating models for conceptualizing the dying process.

Further inquiry about whether the term suicide is appropriate for describing the phenomenon of wanting to hasten one's death when terminally ill. Investigating counselors' perceptions of the term "suicide" may increase our understanding of the professional language contextualized with terminal illness.

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Appendix: Rational Suicide 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: Licensed Professional Counselor License Mental Health 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