Annona Nova XVI.

Annona Nova XVI.
A Kerényi Károly Szakkollégium évkönyve

Pécsi Tudományegyetem Bölcsészet- és Társadalomtudományi Kar
Kerényi Károly Szakkollégium
Pécs, 2025

Szakmai lektorok:
András Csaba, Bérdi Márk, Csapó Gyöngyvér, Csönge Tamás, Flach Richárd, Serdült Sára, Polyák Petra

A kiadvány a *Hallgatói Szolgáltatási Központ* támogatásával jött létre.

PTE Tehetségpont
A Pécsi Tudományegyetem Hallgatói Szolgáltatási Központ támogatásával

HSZK
Hallgatói Szolgáltatási Központ

Kiadó:
Kerényi Károly Szakkollégium

Felelős kiadó:
Ónya Balázs

Szerkesztő:
Mihályi Emese Dorka

Olvasószerkesztők:
Bakonyi Márton, Hegedüs Ferenc, Lajó Odil, Mihályi Emese Dorka, Rottler Lili

ISSN: 2061-4926

Tartalomjegyzék

Hajma Noémi

To Leave the Boat for the Sea

Attitudes Toward Euthanasia, the Good Death, and Toward Suicide, the Invited Death

Introduction

Euthanasia

The term "euthanasia" was derived from Greek, taking together the word "eu" meaning good, and "thanatos" meaning death, thus euthanasia literally means good death. Despite this seemingly positive connotation, euthanasia has been and continues to be an intensely debated topic and a public concern, especially in more affluent cultures and countries where there is a steady increase in age in the population alongside improved medical services like life-support technology.[1] In practice, euthanasia can be categorized in several ways, the most frequent distinction being that of active and passive euthanasia.[2] The former refers to cases where a doctor actively participates in the process of death by prescribing or administering a lethal drug that terminates the life of a patient, while in the latter case, there is no additional prescription of any

1 Wasserman, Jason, Clair, Jeffrey M., & Ritchey, Ferris J., "A scale to assess attitudes toward euthanasia", *OMEGA – Journal of Death and Dying*, 51, 3. (2005): 229–237.

2 Keown John, *Euthanasia, ethics and public policy: An Argument Against Legalisation* (Cambridge University Press, Cambridge, 2002)

medication, but most regularly the refusal of life-prolonging technology and treatments thus allowing the patient to die. The right to refuse any medical treatment, even life-saving or prolonging ones, is commonly recognized by law, thus many countries allow passive euthanasia, which is occasionally also called "mercy killing".[3] Finally, physician-assisted suicide, the most controversial form of euthanasia, where the patient self-administers the lethal drug prescribed by the physician.

Despite the ongoing debates and controversies surrounding euthanasia, the practice has been legalized in several countries, mainly in a few Western and Northern European countries and some US states.[4] Hungary is not included in this list, as based on The Health Care Act, only the refusal of life-sustaining technology and treatments is allowed. However, this law can only be practiced by those who have such a disease which requires these technologies even in the earlier stages of their illness, thus it can be argued that the law discriminates against those who have another type of terminal illness, for instance, amyotrophic lateral sclerosis (ALS), in which affected patients only need breathing-aid technology at the very last stage of their diseases, and preceding that they suffer greatly mainly mentally as a result of the undignified state of their condition which seriously compromises subjective quality of life.[5] Such was the case of Dániel Karsai, who was diagnosed with ALS and was working toward the change of the criminal law that targets people who aid others to commit suicide regardless of the motivation and health condition of the person who wishes to die. While he lost the case against the Hungarian government, his story, which was continuously communicated publicly, made the question of end-of-life decisions

3 Chowdhury, Rezawana, "The role religion plays in attitudes toward euthanasia" Doctoral dissertation, University of Central Florida (2012)

4 Karumathil, Anjana, & Tripathi, Ritu, "Culture and attitudes towards euthanasia: An integrative review" *SSRN Electronic Journal* (2021): 1–33.

5 Tóth Gábor Attila, "Eutanázia és Egyenlő Méltóság" *Fundamentum Az Emberi Jogok Folyóirata* 28, 2. sz. (2024): 6–23.

a particularly prominent public discussion preceding the writing of this paper reflecting the topic's relevance.

For & Against Euthanasia

To prevent abuses of the law, in every jurisdiction laws and safeguards have been put in place in order to minimize or as aimed, completely eliminate the possibility of misuse.[6] Nonetheless, critics of the practice warn the public that these safeguards can be bypassed and that there is a very real chance of broadening the law regarding the people who are eligible for euthanasia.[6] Opponents highlight the hazard of going down the so-called "slippery slope", referring to a situation in which an innovation follows through an uncontrolled and unintended extension finally reaching a way broader boundary compared to the initial aims and borders.[7] In the case of legalization of euthanasia, this argument alarms of the chance of starting from only terminal patients who are eligible to die in this way to people who do not suffer from such severe conditions all the way to those who are agonized by a mental illness alone or to people who are vulnerable and not even capable of consciously consenting, including children who have a disability.[8] In support of euthanasia, considered as a right to die, arguments focus on such concepts as dignity, autonomy, and free will, allowing the individual freedom of choice and the opportunity to

6 Pereira, Jose, "Legalizing euthanasia or assisted suicide: The illusion of safeguards and controls" *Current Oncology* 18, 2. (2011): 38–45.

7 Montagna, Giacomo, Junker, Christoph, Elfgen, Constanze, Schneeberger Andres R., & Güth, Uwe, "Long-term development of assisted suicide in Switzerland: Analysis of a 20-Year experience (1999–2018)" *Swiss Medical Weekly* 153, 3. (2023): 1–9.

8 Sulmasy, Daniel P., Finlay, Ilora, Fitzgerald, Faith, Foley, Kathleen, Payne, Richard, & Siegler, Mark, "Physician-assisted suicide: Why neutrality by organized medicine is neither neutral nor appropriate" *Journal of General Internal Medicine* 33, 8. (2018): 1394–1399.

express their needs and desires even if it means that a merciful death is requested.[9] Following this logic, patients must have the right to autonomously choose when and how to die, as their body is their own thus they have the right to control what happens to it. Regarding dignity, many people do not wish to reach such a state where their consciousness, mental and physical abilities, and thus their quality of life are seriously compromised by a disease that also brings unbearable pain and suffering. In a sense, the notion of the right to life can be honored by respecting the right to die with dignity.[9] The right to die thus has the chance to contribute to an actual good death, fulfilling the meaning of the word 'euthanasia' by preventing suffering people from committing suicide, which would be highly distressing not just for them but for their loved ones as well.[10]

Suicide

Suicide is recognized as a global health issue by the World Health Organization as more than 700.000 individuals take their lives every year globally, thus suicide is one of the leading causes of death worldwide.[11] Considering Hungary, suicide as a public health concern is highly relevant since among European

9 Math, Suresh B. & Chaturvedi, Santosh K., "Euthanasia: Right to life vs right to die", *Indian J Med Res* 136, 6. (2012): 899–902.

10 Kouwenhoven, Pauline S., Raijmakers, Natasja J., van Delden, Johannes J., Rietjens, Judith A., Schermer, Maartje H., van Thiel, Ghislaine J., Trappenburg, Margo J., van de Vathorst, Suzanne, van der Vegt, Bea J., Vezzoni, Cristiano, Weyers, Helen, van Tol, Donald G., & van der Heide, Agnes, "Opinions of health care professionals and the public after eight years of euthanasia legislation in the Netherlands: A mixed methods approach", *Palliative Medicine* 27, 3. (2012): 273–280.

11 WHO, *Suicide worldwide in 2019*, World Health Organization, Hozzáférés: 2025.03.15. https://www.who.int/publications-detail-redirect/9789240026643.

countries Hungary registered the third highest rate of deaths by suicide.[12]

Stereotypes play an important role in connection to suicide as they have the potential to shape attitudes which could result in an intentionally or unintentionally harmful manner when dealing with a suicidal person. Common stereotypes include categorizing suicidal people as emotionally weak, attention-seekers, selfish, cowardly, and malinger, while also considering them as impious with notions such as they are not praying enough or that their belief is not strong enough. Furthermore, the idea that suicide is a betrayal of the family is widespread.[13] Stigmatization can also be manifested within the suicidal individual through internalization, thus negative attitudes from the external world can develop into self-stigmatization.[14] Consequently, the search for help can be significantly affected, as the main reasons that condition the willingness to ask for help are prejudice (expressed by negative cognitions and emotions) and discrimination (expressed by behavior) toward the person who is stigmatized either by society or by him/herself or even by both avenues. This can eventually lead to social exclusion, avoidance, limited employment opportunities, and more.[15]

Similarly to euthanasia, suicide is also a complex personal and societal issue, although, in regard to suicide, there might be more universally accepted statements, such as that generally cultures

12 Eurostat, *Deaths by suicide in the EU down by 13% in a decade.* Hozzáférés: 2025.03.15. Deaths by suicide in the EU down by 13% in a decade - News articles - Eurostat.

13 Sheehan, Lindsay L., Corrigan, Patrick W., & Al-Khouja, Maya A., "Stakeholder perspectives on the stigma of suicide attempt survivors", *Crisis: The Journal of Crisis Intervention and Suicide Prevention. Hogrefe Publishing* 38, 2. (2017): 73–81.

14 Corrigan, Patrick W., Kerr, Amy, & Knudsen, Lisa, "The stigma of mental illness: Explanatory models and methods for change", *Applied and Preventive Psychology* 11, 3. (2005): 179–190.

15 Henderson, Claire, Evans-Lacko, Sara & Thornicroft, Graham, "Mental illness stigma, help seeking, and public health programs", *American Journal of Public Health* 103, 5. (2013): 777–780.

and countries around the world differ in terms of suicide rates, motives for suicide and methods used for it, social support and meanings given for suicide and maybe most importantly the availability and quality of health care provided for suicidal individuals.[16] Despite the prevailing differences, however, condemnation of suicide can be found in virtually every culture. Even the term "committed suicide" reflects an attitude that evokes the relatively recent past when suicide was legally considered a crime and a sin, deserving of abomination. Legislation has changed but society changes more slowly and as a result, stigmatization is still very prevalent and strong.[17]

Research Problem

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

The Role of Religion & Politics & Age & Sex

Religiosity has been proven to be of utmost importance, as it is consistently shown to have a strong negative influence on attitudes toward euthanasia and suicide, that is, those who are highly

16 Lester, David, Colucci, Erminia (editors), *Suicide and culture: Understanding the context* (Cambridge: Hogrefe Publishing, 2012)

17 Sudak, Howard, Maxim, Karen, & Carpenter, Maryellen, "Suicide and stigma: A review of the literature and personal reflections", *Academic Psychiatry* 32, 2. (2008): 136–142.

religious are very likely to have negative attitudes.[18] More specifically, the more religious a person is, the higher the importance of religion the stronger the opposition toward both euthanasia and suicide.[19] Reversely, those who are either religious but not as strongly or not as committed to their religion's teachings – those who are more secularised – those who do not believe in any religion are likely to be more accepting, thus having a more positive attitude toward both euthanasia and suicide.[20] Liberals are shown to be more supportive of euthanasia, while those who have a conservative mindset are likely to oppose it.[21] Politically right-wing individuals are also more likely to have stigmatizing attitudes toward suicide, along with stereotypes and social distance

18 Chowdhury, Rezawana, "The role religion plays in attitudes toward euthanasia" Doctoral dissertation, University of Central Florida (2012); Saiz, Jesús, Ayllón-Alonso, Elena, Sánchez-Iglesias, Iván, Chopra, Deepak, & Mills, Paul J., "Religiosity and suicide: A large-scale international and individual analysis considering the effects of different religious beliefs", *Journal of Religion and Health* 60, 4. (2021): 2503–2526.

19 Singh, B. K., "Correlates of attitudes toward euthanasia", *Social Biology* 26, 3. (1979): 247–254.; Foo, Xiang Y., Alwi, Muhd N., Ismail, Siti I., Ibrahim, Normala, & Osman, Zubaidah J., "Religious commitment, attitudes toward suicide, and suicidal behaviors among college students of different ethnic and religious groups in Malaysia", *Journal of Religion and Health* 53, 3. (2012): 731–746.; Inglehart, Ronald C., Nash, Ryan, Hassan, Quais N., & Schwartzbaum, Judith, "Attitudes toward euthanasia: A longitudinal analysis of the role of economic, cultural, and health-related factors", *Journal of Pain and Symptom Management* 62, 3. (2021): 559–569.

20 Danyliv, Andriy, & O'Neill, Ciaran, "Attitudes towards legalising physician provided euthanasia in Britain: The role of religion over time", *Social Science & Medicine*, 128. (2015): 52–56.; Solomon, Pearce, & Peterson, Sean, „Religion and Suicide: The Consequences of a Secular Society", *Sigma: Journal of Political and International Studies* 37, 6. (2020): 53–86.

21 Bulmer, Maria, Böhnke, Jan R., & Lewis, Gary J., "Predicting moral sentiment towards physician-assisted suicide: The role of religion, conservatism, authoritarianism, and big five personality", *Personality and Individual Differences* 105. (2017): 244–251.

in relation to mental illness.[22] Parallel to this, conservatives are also more likely to have negative attitudes toward suicide, while liberals are more likely to approve of it.[23] In regard to age, younger generations are shown to be more accepting of both euthanasia and suicide,[24] while also being less stigmatizing toward suicidal people as they were less likely to conceptualize it as an individual failure, but rather as a societal malfunction.[25] Contradicting this finding, however, more recently Batterham and colleagues[26] found that young adults, despite having higher levels of suicide literacy, are actually more stigmatizing. Nonetheless, looking at an analysis of age-cohort from 1977 to 2016 in the USA, while the general pattern is that the majority of people support both euthanasia (68%) and also suicide for terminally ill persons (57%), the groups that tend to be more supportive are younger.[27] Concerning

22 Deluca, Joseph S., & Yanos, Philip T., "Managing the terror of a dangerous world: Political attitudes as predictors of Mental Health Stigma", *International Journal of Social Psychiatry* 62, 1. (2015): 21–30.

23 Agnew, Robert, "The approval of suicide: A social-psychological model", *Suicide and Life-Threatening Behavior* 28, 2. (1998): 205–225.; Stack, Steven, & Kposowa, Augustine J., "The association of suicide rates with individual-level suicide attitudes: A cross-national analysis", *Social Science Quarterly* 89, 1. (2008): 39–59.

24 Singh, B. K., "Correlates of attitudes toward euthanasia", *Social Biology* 26, 3. (1979): 247–254.; Cohen, Joachim, Van Landeghem, Paul, Carpentier, Nico, & Deliens, Luc, "Different trends in euthanasia acceptance across Europe: A study of 13 western and 10 central and Eastern European countries, 1981–2008", *European Journal of Public Health* 23, 3. (2012): 378–380.; Pereira, Adelino A., & Cardoso, Francisco, "Stigmatising attitudes towards suicide by gender and age", *Ces Psicología* 12, 1. (2019): 3–16.

25 Boldt, Menno, "Normative evaluations of suicide and death: A cross-generational study", *OMEGA - Journal of Death and Dying* 13, 2. (1983): 145–157.

26 Batterham, Philip J., Calear, Alison L., & Christensen, Helen, "Correlates of suicide stigma and suicide literacy in the community", *Suicide and Life-Threatening Behavior* 43, 4. (2013): 406–417.

27 Attell, Brandon K., "Changing attitudes toward euthanasia and suicide for terminally ill persons, 1977 to 2016", *OMEGA - Journal of Death and Dying* 80, 3. (2017): 355–379.

sex, while findings are more likely to be contradictory, women are in many instances shown to be less accepting of suicide while also being less supportive of euthanasia.[28] However, there are studies that could not find any significant differences between the two genders.[29] In fact, one of the most stable socioeconomic factors associated with assisted suicide in Switzerland over a 12-year-old period is being a female.[30] Furthermore, across several different studies women are shown to be more empathetic and sympathetic toward suicidal people,[31] while simultaneously are also more likely to express the intention to help, although in regard to the general acceptability of suicide, there were no gender differences.[32]

28 Singh, B. K., "Correlates of attitudes toward euthanasia", *Social Biology* 26, 3. (1979); Cohen, Joachim, Van Landeghem, Paul, Carpentier, Nico, & Deliens, Luc, "Different trends in euthanasia acceptance across Europe: A study of 13 western and 10 central and Eastern European countries, 1981–2008", *European Journal of Public Health* 23, 3. (2012): 378–380.; Attell, Brandon K., "Changing attitudes toward euthanasia and suicide for terminally ill persons, 1977 to 2016", *OMEGA - Journal of Death and Dying* 80, 3. (2017): 355–379.; Deluty, Robert H., "Factors affecting the acceptability of suicide", *OMEGA - Journal of Death and Dying* 19, 4. (1989): 315–326.

29 Stronegger, Willibald J., Burkert, Nathalie T., Grossschädl, Franziska, & Freidl, Wolfgang, "Factors associated with the rejection of active euthanasia: A survey among the general public in Austria", *BMC Medical Ethics* 14, 1. (2013); Zou, Yaming., Leung, Ricky, Lin, Shao, Yang, Mingan, Lu, Tao, Li, Xianyun, Gu, Jing, Hao, Chun, Dong, Guanghui & Hao, Yuantao, "Attitudes towards suicide in urban and rural China: A population based, cross-sectional study", *BMC Psychiatry* 16, 1. (2016): 1–11.

30 Steck, Nicole, Junker, Christoph, Maessen, Maud, Reisch ,Thomas, Zwahlen, Marcel, & Egger, Matthias, "Suicide assisted by right-to-die associations: A population based Cohort Study", *International Journal of Epidemiology* 43, 2. (2014): 614–622.

31 Stillion, Judith M., McDowell, Eugene E., & May, Jacque H., "Developmental trends and sex differences in adolescent attitudes toward suicide", *Death Education* 8, 1. (1984): 81–90.; White, Hedy, & Stillion, Judith M., "Sex differences in attitudes toward suicide: Do males stigmatize males?", *Psychology of Women Quarterly* 12, 3. (1988): 357–366.

32 Wallace, Michael D., "Sex differences, previous experience with suicide, and attitudes towards suicide", Master Thesis. University of Windsor. (1994)

Be that as it may, more stigmatizing attitudes toward suicide and suicidal individuals are shown to be more characteristic of men, even though most men do not have an intensely negative attitude.[33]

The Connection Between Euthanasia & Suicide

Three factors within the questionnaire measuring attitudes toward suicide were found to be a solid basis for the general acceptance of suicide and its normative valuation, taken as a unity.[34] In regard to the acceptability of suicide in the case of terminally ill persons, the trend is that across all survey years, approval of euthanasia is higher compared to suicide.[35] Those who already have a permissive attitude to the more stigmatized way of terminating life might also be more ready to accept euthanasia as a legalized practice, especially since many people may see it as a safe and controlled death as a result of the medical professionals' presence.[35]

Hypotheses

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

33 Batterham, Philip J., Calear, Alison L., & Christensen, Helen, "Correlates of suicide stigma and suicide literacy in the community", *Suicide and Life-Threatening Behavior* 43, 4. (2013): 406–417.; Pereira, Adelino A., & Cardoso, Francisco, "Stigmatising attitudes towards suicide by gender and age", *Ces Psicología* 12, 1. (2019): 3–16.

34 Stecz, Patryk, "Psychometric Evaluation of the questionnaire on attitudes towards suicide (ATTS) in Poland", *Current Psychology* 40, 5. (2021): 2528–2542.

35 Attell, Brandon K., "Changing attitudes toward euthanasia and suicide for terminally ill persons, 1977 to 2016", *OMEGA - Journal of Death and Dying* 80, 3. (2017): 355–379.

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

Methods

Instruments

At the beginning of the questionnaire, participants were asked to provide some of their essential demographic data such as sex, age, educational background, permanent residence, political affiliation along with its intensity, and occupation. If someone was a university student, they were asked to indicate if they belonged to a healthcare faculty (medical school or psychology) or studied in another faculty. Similarly, within occupation, respondents had the chance to indicate whether they worked in a field related to either physical or mental healthcare. Regarding religion, participants had to choose between the five main world religions, or they could declare themselves either atheists or agnostics. Additionally, the opportunity for a more personal religion was also given with the statement "I am religious/spiritual and/or

I am a believer on my own personal terms and ways". Those who wished could also indicate their religious denomination such as Catholic or Protestant. Finally, religion's effect on the respondents' life was also assessed with the pregiven responses ranging from strong intrinsic religiosity ("My whole approach to life is based on my religion, and I try hard to live all my life according to my religious beliefs") to moderate ("Although I believe in my religion, many other things are equally or even more important in my life") and total a-religiousness ("I am not religious"), along with two additional ways in which religion's effect could manifest ("I practice my religion mainly because of the of opportunity of social bonding, to spend time with my loved ones"; "What religion offers me most is comfort in times of trouble and sorrow").

The Euthanasia Attitudes Scale (EAS) is a 30-item questionnaire.[36] Of the 30 questions, 16 are positively and 14 are negatively structured, balancing between passive and active euthanasia. Five factors were extracted, accounting for 54% of the common variance. The factors were labelled as follows: general orientation toward euthanasia, patients' rights issues, role of life-sustaining technology, professional's role, ethics and values. The scale possesses excellent psychometric properties exhibiting stability over time, internal consistency, and discriminant validity. Euthanasia was defined within the questionnaire as "acting to terminate or failing to act in such a way as to extend the life of persons who are hopelessly sick or injured for reasons of mercy".[48] In the current study changes were made regarding the structure of the possible responses. Contrary to the original where there is no chance to take an undecided position with the 4-point Likert scale, this study

36 Holloway, Harold D., Hayslip, Bert, Murdock, Melissa E., Maloy, Robyn, Servaty, Heather L., Henard, Kristan, Lopez, Luis, Lysaght, Rosemary, Moreno, George, Moroney, Thomas, Smith, David, & White, Susanne, "Measuring attitudes toward euthanasia", *OMEGA - Journal of Death and Dying* 30, 1. (1995): 53–65, 58.

allowed it using a 5-point Likert scale, ranging from strongly agree to strongly disagree at the two ends. This change also resulted in the need to alter the point system of evaluation, as based on the original scores below 75 are indicative of an overall negative attitude, while above and to the maximum (75-120), attitudes are considered positive. In the current system, where the maximum score is 150, the threshold was altered to negative attitudes below 90, while a score between 90 and 150 means a positive attitude.

The Attitudes Towards Suicide (ATTS) is a 37-item questionnaire developed by Renberg and Jacobsson.[37] Responses are given on a 5-point Likert scale, ranging from strongly agree to strongly disagree. Higher scores indicate a more positive attitude and vice versa.[38] The scale is based on a ten-factor model, explaining 60% of the total variance. The factors are as follows: suicide as a right, incomprehensibility, noncommunication, preventability, tabooing, normal/common, suicidal process, relation-caused, preparedness to prevent and resignation.

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

37 Renberg, Ellinor S., & Jacobsson, Lars, "Development of a questionnaire on attitudes towards suicide (ATTS) and its application in a Swedish population", *Suicide and Life-Threatening Behavior* 33, 1. (2003): 52–64.

38 Renberg, Ellinor S., Hjelmeland, Heidi & Koposov, Roman, "Building models for the relationship between attitudes toward suicide and suicidal behavior: Based on data from general population surveys in Sweden, Norway, and Russia", *Suicide and Life-Threatening Behavior* 38, 6. (2008): 661–675.

Participants

In total, 270 individuals responded to the questionnaire, however, the final sample included the answers of 264 people. The exclusion criteria was primarily based on the attention-check questions ("In order to verify that you pay attention, please select the number (...) option), as those who failed to give the correct answers on both were automatically excluded. Answer sheets of those who gave a wrong answer on only one of these checks were carefully examined to see if their responses are otherwise consistent or not. If they were, in fact, consistent, then these respondents were included in the final analysis. The questionnaire was distributed and advertised mainly through social media (Facebook & Instagram) while a few printed versions were also given out within the local community of the author. Responses from these printed versions were copied into the online form by the author. All respondents were informed that their anonymity will be protected and their answers will only be used as part of a research practice completion. Importantly, on the front page of the questionnaire, potential participants were informed about where could they seek help in case if the questions were too upsetting for them or if they themselves have suicidal thoughts or one of their loved one did. Several phone numbers and websites were provided ready to help those in need.

Procedure & Data Analysis

The Hungarian version of the ATTS was given to the author by a PhD student from the University of Pécs who conducts research concerning suicide, suicidal literacy, and behavior. On the other hand, the EAS was translated into Hungarian during the course of this study. The back-translation method was implemented by individuals who are related to the field of psychology, including both the author and the supervisor of this study. Descriptive statis-

tics were used to describe the characteristics of the sample and for the reporting of the majority consensus on the ATTS questions. Data analysis was performed using the computer software program Jamovi (version 2.3). Assessment of differences were based on Pearson's r, independent samples t-tests and ANOVA measures. A significance level of $p < 0.05$ was considered.

Results

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

Table 1

Sociodemographic characteristics of the sample

Variables	n	%
Sex		
Women	196	74.2
Men	68	25.8
Education		
University degree & above	138	52.2
Occupation		
Student	90	34.1
Permanent residency		
Village & small city	130	49.3
Bigger city & capital & agglomeration	134	50.7
Religion		
Christian	132	50
Muslim	6	2.3
Buddhist	15	5.7
Atheist	38	14.4
Agnostic	11	4.2
Spiritual/religious in a personal way	54	20.5

Religion's Effect		
Whole life approach based on religion	43	16.3
Many other things are more or equally important	93	35.2
Comfort & peace in times of trouble	50	18.9
Social bonding	4	1.5
Not religious	74	28
Political affiliation		
Left-leaning	112	42.5
Center	89	33.7
Right-leaning	63	23.8

The Role of Religion - Hypothesis 1.

There was a significant main effect for religiosity in relation to euthanasia ($F(13, 250) = 3.08$, $p < .001$). Post hoc tests revealed that this effect was driven by significant differences between atheists and Christians ($t(250) = 4.24$, $p = .003$) and Muslims ($t(250) = 3.91$, $p = .010$), atheists showing stronger positive attitudes towards euthanasia in both cases. Similarly, a significant main effect was found for religion's effect on participants' lives ($F (4, 259) = 18.9$, $p < .001$). Based on the post hoc analyses this effect was due to the significant differences between those who base their whole approach to life on their religion and those for whom religion is mainly a source of comfort and peace ($t(259) = -4.19$, $p < .001$), and those for whom many other things are equally or more important in life ($t(259) = -6.96$, $p < .001$), while also differing from those who do not consider themselves religious ($t(259) = -8.25$, $p < .001$). Additionally, there was also a significant difference between those for whom religion is a source of comfort and those who are not religious at all ($t(259) = -3,87$, $p = .001$). Participants who reported the highest levels of intrinsic religiosity were the most likely to oppose euthanasia, while atheists were the most supportive of it (see Table 2).

Analogously, a main effect for religiosity regarding the permissibility and understanding of suicide was also found ($F(13, 250) = 2.85$, $p < .001$). Correspondingly to the attitudes towards euthanasia, post hoc analysis showed that this was the result of significant differences between atheists and Christians, atheists again being more permissive ($t(250) = 4.11$, $p = .005$). However, in the case of suicide, there was an additional significant difference between Christians and those who consider themselves religious on their own personal terms, the latter being more likely to have positive attitudes ($t(250) = -4.07$, $p = .006$). Religiosity's effect was again found to be significant ($F(4, 259) = 11.4$, $p < .001$), driven by the differences between those who base their whole approach to life on their religion and those for whom religion is mainly a source of comfort and peace ($t(259) = -4.27$, $p < .001$), and those for whom many other things are equally or more important in life ($t(259) = -5.75$, $p < .001$), while also differing from those who do not consider themselves as religious ($t(259) = -6.40$, $p < .001$), exactly like in the case of euthanasia (see Table 2). Thus, again, the more intrinsically religious a person is, the more likely that they will be dismissive of suicide and will show less understanding towards it.

Table 2

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

Variables	Mean (EAS)	SD (EAS)	Mean (ATTS)	SD (ATTS)
Religion				
Christians	113	28.1	40.9	12.1
Muslims	90	40.3	35.2	16.9
Buddhists	109	33.4	43.3	12.6
Atheists	133	13.1	49.8	10.6
Spiritual in p.w.	126	20	48.6	11.5

Religion's Effect				
1.	94.1	34.1	34.2	14
2.	124	19.2	46.3	9.98
3.	114	28.3	44.3	12.9
4.	131	14.8	48.2	10.1

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

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

Regarding age, there was a significant negative correlation between age and acceptance of euthanasia, indicating that older participants had a greater likelihood of having negative attitudes towards both euthanasia ($r = -0.153$, $p = .006$) and suicide ($r = -.194$, $p < .001$). In relation to gender, there was a significant difference between men and women, as female participants were more likely to accept both euthanasia ($t(262) = -2.65$, $p = .009$) and suicide ($t(262) = -2.00$, $p = .046$) compared to males (see Table 3). Concerning political affiliation, liberal participants compared to conservatives were shown to be significantly more permissive towards both euthanasia ($r = -.402$, $p < .001$) and suicide ($r = -.0371$, $p < .001$).

Table 3
Mean sex differences based on the EAS and the three factors of the ATTS

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

The Connection Between the Attitudes – Hypothesis 5.

Overall, the sample was generally permissive towards euthanasia, as the mean score was 119 out of 150 (SD=26), where scores over 90 indicate a positive attitude. Moreover, the acceptance and understanding of suicide were also quite high, as out of the maximum 70 points measured by three factors within the ATTS (factors titled as "Suicide as a right", "Incomprehensibility" and "Resignation/Suicide as a solution"), where higher scores indicate higher permissiveness, the sample's mean score was 44 (SD=12). In this case, scores over 42 would constitute as a positive attitude based on the same metric system as in the case of the euthanasia scale. Consequently, there was also a significant positive correlation between the score on the EAS and the ATTS's three factors measuring acceptance of suicide. Those who were permissive towards suicide were more likely to accept euthanasia ($r=0.758$, $p < .001$).

The Open-ended Question

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

"It is very thought-provoking that the outcome of the two topics is the same and yet can be interpreted so differently. For me, suicide could be prevented if much more emphasis was placed on mental health in the world, while euthanasia would

facilitate – and in many cases prevent us from becoming – an aging society, and those who are no longer fit for a quality life could leave in peace."

Euthanasia

Most participants used this opportunity to further reveal their stances regarding their generalized view of euthanasia, fitting the EAS questionnaire original factor analysis, naming the first factor *General orientation toward euthanasia,* while many of them made it clear that their general orientation is based on their *Ethics and values,* an other factor of the EAS, most of the times connecting these ethics to the values of their religion. However, several respondents expressed discontent with the fact that the questions were meant universally, as they stated that their answers depend on the particular scenario at hand, thus their answers could potentially change when faced with a similar situation in real life rather than in an anonymous questionnaire. Several participants also stated that, while they do think that euthanasia should be legalized, it should be done only with strict rules and safeguards, so that abuse of the law is minimized. Further ethical questions were also raised by a few respondents, thinking about the possible borders of euthanasia, as shown by the following quote: "I also thought about what happens if someone has been struggling with severe depression for years and wants to request euthanasia. After all, in this case he does not have a terminal illness, but he still suffers. I don't know what the ethically correct thing to do here would be."

Overall, explicitly religious comments predominated not only this section, but the entirety of the comments portion, since many religious participants took the chance to elaborate their standpoints based on their beliefs, as exemplified by the following quotes: "I don't think euthanasia is acceptable, even if the person is suffering greatly. When some kind of medicine is administered

to a person in order to hasten death, we are playing God, which we have no right to do." "As a Muslim, one can only judge one's own life. One cannot criticize the life and actions of another person. A Muslim rejects suicide or murder, but if another person commits it, one cannot judge him or her. Islam forbids all forms of suicide and murder." Nonetheless, several religiously affiliated participants expressed their views in contrast to their religion's beliefs, while an atheist expressed his discontent with religion's influence, as one participant explained:"It is precisely because of this topic that I am only partially religious. I understand if someone doesn't want to suffer anymore and would ask to end their life. It's their decision." Out of the world religions represented in this study by the participants, Buddhists were more likely to be understanding even though admitting that according to their religion, this way of death is not acceptable.

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

Two participants explicitly alluded to the case of Dániel Karsai, who went to the European Court of Human Rights in order to gain the right to make more extensive end-of-life decisions within the border of Hungary, connecting the ideas here to the factor of *Patients' rights issues.*

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

"The key criterion in the matter of euthanasia is the patient's self-determination. Active euthanasia in any form is not acceptable without the patient's consent or advance directive, and it

is equally unacceptable to deny the patient assisted suicide. (If it can be ensured that the patient's free decision is involved, even psychiatric patients must be given the opportunity.)"

Lastly, the *Role of life-sustaining technology* was also mentioned, as exemplified by the following quote:"Protecting life is very important, but it cannot be protected infinitely. If it only prolongs suffering, it is harmful." Closely connected to this, the *Professional's role* was raised as an important issue as well, highlighting the importance of the right and the chance to make decisions in the medical context.

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

Suicide

With regard to suicide, considerably fewer participants expressed their views, thus not all of the ATTS's factors could be demonstrated with a relevant quote and even those that can, contain less comments compared to euthanasia. Those who did express their opinions mentioned potential preventive ways; their general understanding even though they may not themselves think of suicide as a rightful solution to life's hardships, demonstrating the factor named *Normal-Common*, with the following quote: "Suicide is not a good way for an individual to end suffering, but it is understandable why many choose it" or they elaborated on their dismissiveness based on religious convictions. Thus, while based on the quantitative measurement of the ATTS regarding the accepta-

bility of suicide the sample was found to be generally permissive, those who took the opportunity to comment with their own words were substantially more likely to express views of dismissiveness, as under the factor of *Resignation/Suicide as a Solution*, suicide was firmly rejected by most religious participants, as exemplified by the following quote:

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

Similarly to the above, different kinds of suicide were identified by a few respondents, explaining a general *Incomprehensibility* regarding most types, except for one as the following quote shows: "I can only understand one form of suicide: if it saves the lives of many people. In such a case, I consider it a sacrifice." The general consensus however focused on *Preventability*, highlighting that suicidal thoughts should not necessarily lead to suicide, as expressed by a respondent: "I think that people struggling with mental problems and suicidal thoughts can all be brought back with the right kind of help." This right kind of help is fundamentally social in its essence according to a few participants who emphatised the importance of caring and loving a suffering person, which idea can be categorized under the factor of *Relation-Caused*, signifying that suicide is highly connected to the given social context, as expressed by the following quote as well: "Suffering is not the problem, but leaving someone alone is. The problem is not loving someone, not caring about someone."

Discussion

The General Population's Attitude Towards Euthanasia and Suicide

This study aimed at investigating attitudes toward euthanasia and suicide within a Hungarian sample. Relevant factors were also examined in order to support or challange the results from other international studies inquiring the role of these predictors. As the results have shown, participants were permissive towards euthanasia, and were quite understanding and acceptive towards suicide as solution and as right as well. Specifically, those who approved of either were significantly more likely to approve of the other too.

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

The qualitative component, which included an open-ended question to the participants, further strengthened the results as most comments were an elaboration on why the respondents supported euthanasia, while many of those who were dismissive toward it referenced their religious beliefs as the basis of their negative attitudes. The comments most often were related to the participants' general orientation towards euthanasia based on their ethics and values, while the issue of patients' rights was also frequently mentioned, highlighting the importance of personal autonomy and choice, even to the point of mental suffering, such

as in the case of psychiatric patients. In regard to suicide, substantially less participants expressed their detailed views, while those who were dismissive were in the majority, expressing their views on what could be the reason why others choose suicide and what could we do to help them, in which most referred to the need for strong and supportive interpersonal and professional help. Interestingly, while the general acceptance and understanding of suicide was quite high considering the whole sample, those who took the opportunity to reveal their attitude and thoughts in their own words were more likely to express views of dismissiveness, mainly based on their religious morals and values.

Since no previous study has examined the attitudes towards both euthanasia and suicide on the same Hungarian sample, direct comparison is not possible. However, general attitudes of Hungarians toward euthanasia using other measures have been examined before and recently as well, prompted by Dániel Karsai's case who brought euthanasia, or more precisely the topic of end-of-life decisions, forward into the public sphere. The two most recent surveys were carried out by the online market research institutes of Opinio and IDEA, using nationally representative samples. Based on the latter's results 62% of the adult Hungarian population supports active euthanasia for terminally ill patients.[39] Consistent with the findings of the present study, women and voters of liberal political parties were more permissive. However, in contrast to the present results older people were more likely to be supportive compared to 18–29-year-olds. Comparably, based on the results of Opinio, 79% of Hungarians consider euthanasia acceptable: 20% of those surveyed fully support the right to self-determination, while 59% support it under certain circumstances. Only 7% are completely opposed to people being able to decide on the

[39] Idea, *Az aktív és passzív eutanáziával kapcsolatos attitűdök a magyar felnőtt népességben. Országosan reprezentatív, kérdőíves felmérés.* IDEA Intézet. 2023. november 26.

manner and time of their own death, while 14% were undecided.[40] Based on a recent doctoral thesis, however, in case of a painful incurable illness, only 27.1% would accept physician assisted suicide regarding their family member, while 36.3% would accept it for themselves. In case of euthanasia, 28.9% would be supportive of their relative's decision asking a physician to administer a lethal drug for them, while 38% would accept it as a possibility for themselves.[41]

Taking an international perspective, comparing 62 countries all around the world, Hungary ranks as the 25th, the first being the most permissive (Netherlands) and last being the most dismissive (Jordan), as measured by the World Values Survey.[42] Before Hungary, thus the more accepting countries are mostly part of Western and Northern Europe, while after Hungary the countries are mostly from Eastern Europe, the Balkan, South America, Asian, and Middle Eastern countries along with some African ones. Surveys were administered in 7 different waves, starting from 1981 and finishing with 2018. Answers ranged from 1 = "never justifiable" to 10 = "always justifiable." Hungarians were the least permissive towards euthanasia in the 1981-1984 period (mean = 2.67) while the most permissive score was in the period of 1994 –1998 (mean = 6.17). Most recently, according to the data from 2018, the mean is 4.93, thus slightly below the half point, which means that while not so strongly, Hungarians are more likely to be against euthanasia on a large, representative scale.[42]

40 Opinio, *A magyarok négyötöde támogatná az eutanáziát*. Hozzáférés: 2025.03.16.https://opinio.hu/a-magyarok-negyotode-tamogatna-az-eutanaziat/

41 Busa Csilla. "Az ellátás előzetes tervezése (advance care planning) és alkalmazási lehetőségei Magyarországon", Doktori értekezés (2023)

42 Inglehart, Ronald C., Nash, Ryan, Hassan, Quasis N., & Schwartzbaum, Judith, "Attitudes toward euthanasia: A longitudinal analysis of the role of economic, cultural, and health-related factors", *Journal of Pain and Symptom Management* 62, 3. (2021): 559–569.

Literature on measuring attitudes toward suicide using a representative Hungarian sample is severely scarce, if studies on physician assisted suicide are excluded, and they are, since the current study handles PAS within the framework of euthanasia. Nonetheless, some studies have investigated attitudes towards suicide within selected populations. For example, a comparative study of regional politicians in five European countries found that permissive attitudes toward suicide were more prevalent in countries with higher suicide rates and underdeveloped state-supported prevention strategies—namely Hungary, Lithuania, and Austria. In contrast, politicians from Sweden and Norway held less permissive attitudes, their countries having lower suicide rates and developed prevention strategies.[43] As the current study's results shows, this permissiveness is not only characteristic of Hungarian politicians but of the average Hungarian citizen as well. However, this permissiveness does not necessarily entail a less judgemental attitude, quite the contrary, as Hungarian politicians (along with Lithuanian ones) mentioned personality traits as a main cause of suicide, implying that the suffering individual is to blame for their mental constitution. Additionally, within psychological causes, Hungarians and Lithuanians were the only politicians to mention such causes as "weakness and lack of maturity", "laziness to live" and "egoism".[44] Regarding other factors related to suicide, for example preparedness to help, Hungarians were in the middle of the five countries' representatives, indicating that they did not feel neither incapable of help, nor were they too hopeful about their abilities, although they were more optimistic about general

[43] Skruibis, Paulius, Gailiene, Danute, Hjelmeland, Heidi, Fartacek, Reinhold, Fekete, Sándor, Knizek, Birthe L., & Rohrer, Rudolf R., "Attitudes towards suicide among regional politicians in Lithuania, Austria, Hungary, Norway and Sweden", *Suicidology Online* 1. (2010): 79–87.

[44] Knizek, Birthe L., Hjelmeland, Heidi, Skruibis, Paulius, Fartacek, Reinhold, Fekete, Sándor, Gailiene, Danute, Osváth, Péter, Renberg, Ellinor S., & Rohrer, Rudolf R., "County Council politicians' attitudes toward suicide and suicide prevention", *Crisis* 29, 3. (2008): 123–130.

preventability than Austrians, a country with lower suicide rates.[55] Hungarians were also more likely to see suicide as relation-caused compared to their Northern European counterparts. Lastly, the only significant difference between male and female politicians was found with respect to perceived preventability of suicide, men being slightly more optimistic than women.[45]

While it seems that there is no significant difference in regard to the acceptability of suicide between Hungarian politicians and the general public, helping professionals were found to be more likely to have a dismissive attitude, denying the right to commit suicide more often.[46] However, in relation to a terminally ill person wishing to die, their opinion was similar to that of the general population.

The Role of Religiosity Regarding End-of-Life Issues

In the current study, Christians were significantly more likely to be against both euthanasia and suicide as solutions to life's hardships, especially those Christians who were the most intrinsically religious as measured by how important they consider their religion and religious beliefs. As a demonstrative example, all four pastor included in the sample had lower scores on the ATTS's three factors combined measuring permissiveness and understanding of suicide, while three of them had negative attitudes towards euthanasia as well. One of them, however, reached a score beyond the cutting point for a positive attitude towards

45 Skruibis, Paulius, Gailiene, Danute, Hjelmeland, Heidi, Fartacek, Reinhold, Fekete, Sándor, Knizek, Birthe L. & Rohrer, Rudolf R., "Attitudes towards suicide among regional politicians in Lithuania, Austria, Hungary, Norway and Sweden", *Suicidology Online* 1. (2010): 79–87.

46 Susánszky, Éva, Hajnal, Ágnes & Kopp, Mária, "Knowledge about and attitudes toward suicide in the Hungarian general population and in the helping professions", *Psychiatria Hungarica: A Magyar Pszichiátriai Társaság Tudományos Folyóirata* 23, 5. (2008): 376–384.

euthanasia, which exemplifies that while the role of religiosity as a predictor is reliably strong, the association between these factors is not set in stone. In fact, differing religious groups have all been shown to liberalize their stances on euthanasia over the years to varying degrees, Protestants showing the most substantial change of view.[47]

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

Out of the three world religion investigated in this study, Buddhist participants were the only religious group which did not differ from atheists with regards to the acceptability of suicide and euthanasia, thus Buddhists were quite permissive towards

47 Moulton, Benjamin E., Hill, Terrence D., & Burdette, Amy M., "Religion and trends in euthanasia attitudes among U.S. adults, 1977–2004", *Sociological Forum* 21, 2. (2006): 249–272.

both similarly to those respondents who did not consider themselves as religious. As a matter of fact, out of the 15 Buddhist participants, only three of them had a low score on the EAS, indicating a dismissive attitude, while three of them had a very high score (above 140 out the maximum 150) implying a strong acceptance of euthanasia. Even in the qualitative part, a few Buddhists participants expressed their views of acceptance and understanding in contrast to their religion's teachings, instead highlighting the role and importance of personal decisions and individual responsibility. Despite the theoretical background, this result is in line with other findings examining practicing Buddhists' views on death and dying. In relation to suicide, Buddhist participants had higher acceptance rate compared to Muslims,[48] while it has also been shown that the more intrinsically religious a Buddhist is, the more likely that they will have a favorable attitude towards suicide.[49] With respect to euthanasia, some Buddhist participants supported it under certain conditions, in opposition to their vows, because they believed that not disrupting a patient's agency and viewing each patient as a unique being was more important than the moral correctness of the action.[50]

48 Foo, Xiang Y., Alwi, Muhd N., Ismail, Siti I., Ibrahim, Normala, & Osman, Zubaidah J., "Religious commitment, attitudes toward suicide, and suicidal behaviors among college students of different ethnic and religious groups in Malaysia", *Journal of Religion and Health* 53, 3. (2012): 731–746.

49 Saiz, Jesús, Ayllón-Alonso, Elena, Sánchez-Iglesias, Iván, Chopra, Deepak, & Mills, Paul J., "Religiosity and suicide: A large-scale international and individual analysis considering the effects of different religious beliefs", *Journal of Religion and Health* 60, 4. (2021): 2503–2526.

50 Larm, Jackie, "Good deaths: Perspectives on dying well and on medical assistance in dying at Thrangu Monastery Canada", *Religions* 10, 2. (2019): 1–13.

Limitations

Despite its contributions to field of attitudes towards euthanasia and suicide, the current study and its results are not without limitations. Firstly, the number of participants were not enough for a nationally representative sample, thus, while this study investigated the attitudes of the general population, its results cannot be generalized to the whole Hungarian population. Additionally, women, liberals and highly educated individuals along with university students were overrepresented; groups that have a greater likelihood to accept both euthanasia and suicide, thus the overall positive attitude towards both could be the direct result of their impacts. The case of women and liberals were elaborated previously, but it has also been found that students, along with their generally younger ages, and highly educated individuals are more permissive towards both euthanasia and suicide.[51]

There are also additional limitations beyond the sample that must be taken into consideration when interpreting the results of this study. While attitudes are a tool to predict behavior, their

51 Singh, B. K., "Correlates of attitudes toward euthanasia", *Social Biology* 26, 3. (1979): 247–254.; Cohen, Joachim, Van Landeghem, Paul, Carpentier, Nico, & Deliens, Luc, "Different trends in euthanasia acceptance across Europe: A study of 13 western and 10 central and Eastern European countries, 1981–2008", *European Journal of Public Health* 23, 3. (2012): 378–380.; Decesare, Michael A., "Public attitudes toward euthanasia and suicide for terminally ill persons: 1977 and 1996", *Biodemography and Social Biology* 47, 3. (2000): 264–276.; Horsfall, Sara, Alcocer, Cristian, Temple, Duncan C., & Polk, Jonathan, "Views of euthanasia from an East Texas University", *The Social Science Journal* 38, 4. (2001): 617–627.; Televantos, Anastasios, Talias, Michael A., Charalambous, Marianna, & Soteriades, Elpidoforos S., "Attitudes towards euthanasia in severely ill and dementia patients and cremation in Cyprus: A population-based survey", *BMC Public Health* 13, 1. (2013): 1–7.; Nathan, Nila A., & Nathan, Kalpana I., "Suicide, stigma, and utilizing social media platforms to gauge public perceptions", *Frontiers in Psychiatry* 10. (2020): 1–7.

strength may not be that reliably strong in certain circumstances,[52] while some people may also change their view as time passes due to several reasons.[53] Moreover, specifically related to euthanasia and suicide, in both cases the type and specific circumstances of life termination, or even simply the wording of the questions matter greatly in affecting attitudes towards them.[54] Thus, for all of the above mentioned reasons, this study's results should be interpreted and generalized with caution.

Conclusion

To conclude, this study contributes to the existing literature on attitudes towards euthanasia and suicide in two key ways. First and foremost, no previous study has investigated these two attitudes on the same Hungarian sample before, exploring them

52 Nelson, William A., & Bernat, James L., "Decisions to withhold or terminate treatment", *Neurologic Clinics* 7, 4. (1989): 759–774.; Glasman, Laura R., & Albarracín, Dolores, "Forming attitudes that predict future behavior: A meta-analysis of the attitude-behavior relation", *Psychological Bulletin* 132, 5. (2006): 778–822.

53 Wolfe, Joanne, Fairclough, Diane L., Clarridge, Brian R., Daniels, Elisabeth R., & Emanuel, Ezekiel J., "Stability of attitudes regarding physician-assisted suicide and euthanasia among oncology patients, physicians, and the general public", *Journal of Clinical Oncology* 17, 4. (1999): 1274–1274.; Itzchakov, Guy, & DeMarree, Kenneth G., "Attitudes in an interpersonal context: Psychological safety as a route to Attitude Change", *Frontiers in Psychology* 13. (2022): 1–15.; Albarracin, Dolores, & Shavitt, Sharon, "Attitudes and attitude change", *Annual Review of Psychology* 69, 1. (2018): 299–327.

54 Deluty, Robert H., "Factors affecting the acceptability of suicide", *OMEGA – Journal of Death and Dying* 19, 4. (1989): 315–326.; Hagelin, John, Nilstun, Tore, Hau, Jann, & Carlsoon, Hans-Erik, "Surveys on attitudes towards legalisation of euthanasia: Importance of question phrasing", *Journal of Medical Ethics* 30, 6. (2004): 521–523.; Huber, Ruth, Cox, Virginia M., & Edelen, William B., "Right-to-die responses from a random sample of 200", *The Hospice Journal* 8, 3. (1992): 1–19.

separately and in connection to each other, thus this paper opened and explored in depth an important area of study that has been neglected so far. Additionally, the study included both a quantitative and a qualitative part, supporting and further elaborating each other's results, giving participants the chance to provide information about their attitudes in an exhaustive manner. Secondly, in investigating the roles of several predictors, the findings were consistent and thus strengthened previous studies using international samples, highlighting similarities across different countries and cultures. As the results suggested, sex, age, religiosity, and political affiliations are all associated with attitudes towards both euthanasia and suicide. More specifically, being a woman, younger in age, an atheist or considering many other things equally or even more important than one's religion and having liberal political views are predictors of a permissive attitude both towards euthanasia and suicide. Additionally, those who approved of suicide in certain circumstances and were understanding towards it were significantly more likely to approve of euthanasia as well. Taken together,the findings indicate that the majority of the participants were permissive towards euthanasia and were quite understanding and acceptive towards suicide as a solution and as a right.