

How & why?: Third-person perceptions of people with terminal illnesses' suicides as a function
of suicide method & motive

by

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M.S., Kansas State University, 2023

AN ABSTRACT OF A DISSERTATION

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Abstract

Suicide and terminal illness are two phenomena that are stigmatized independently of one another (e.g., Batterham et al., 2013; Epley & McCaghy, 1978). However, suicide by people with severe physical health states is perceived fairly positively in general (e.g., Schiffer & Saucier, 2024) as well as more acceptable compared to suicides precipitated by other situations (e.g., interpersonal issues; Winterrowd et al., 2015). For further insight on the coexistence of suicide and terminal illness, this research quantitatively assessed how third-person perceptions of people with terminal illnesses' suicides (e.g., acceptability, stigma) vary as a function of situational factors related to the suicide as well as individual differences among participants related to pride and existential considerations. Vignettes were used in between-groups designs to manipulate situational factors including a target person's suicide method (Study 1) and primary motive (Study 2). On average, participants reported generally favorable attitudes toward this phenomenon across studies. In Study 1, medical methods (e.g., physician-assisted death) were perceived more favorably than traditional methods (e.g., hanging), but minimal differences in perceptions emerged across various suicide motives (e.g., mental health concerns, wanting control over death) in Study 2. Masculine Honor Beliefs were positively associated with stigmatizing attitudes toward the target. The effects of Free Will Beliefs were often moderated by the conditional manipulations. Self-directed and other-directed Fear of Death yielded contradictory effects. Suicide Acceptability was consistently positively associated with favorable attitudes toward this phenomenon. Overall, this program of research has important implications for understanding nuances in third-person perceptions of this phenomenon as a function of relevant situational factors (e.g., method, motive) and individual differences, while advancing suicide theories to be more comprehensive and inclusive of severe physical health states.

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Chapter 1 - Introduction

Suicide and terminal illness are two stigmatized phenomena in our society, but the combination of suicide and terminal illness may not be as stigmatized as each of its components. These phenomena are often examined independent of one another, except for physician-assisted death (PAD), which is one specific suicide method for people with terminal illnesses (and shall be discussed later). Given the nature of these topics, existing research is commonly done in either medical and/or qualitative manners (e.g., Chochinov et al., 2002), meaning there is ample opportunity for social-personality psychological research to advance our understanding of these phenomena.

Accordingly, my most recent program of research has begun to investigate third-person perceptions of the unique combination of suicide and terminal illness (Schiffer & Saucier, 2024; under review), which has served as the inspiration and foundation for this research. It is important to clarify this research as only focusing on third-person perceptions of this phenomena. It does not examine first-person perceptions of people with terminal illnesses debating suicide. It does not examine first-person perspectives of the loved ones of people who had terminal illnesses and died by suicide. Specifically, this program of research samples (via online sources) the general public, which helps contextualize the findings and implications of this research.

The objective of this research was to quantitatively examine how third-person perceptions of suicide among people with terminal illnesses may vary as a function of the suicide method used (Study 1) and the primary motive for the suicide (Study 2). Moreover, sociodemographic variables (e.g., religiosity) and individual differences have been shown to affect perceptions of suicide among people with terminal illnesses (e.g., Schiffer & Saucier, 2024; under review). Specifically, individual differences associated with pride, like Masculine Honor Beliefs (MHB; i.e., the

prioritization of having a tough social reputation), and existential considerations, like Free Will Beliefs (FWB), Fear of Death, and Suicide Acceptability, are important for understanding further nuances in these perceptions. Overall, this program of research has great implications for contextualizing perceptions of people with terminal illnesses' suicides as a function of situational factors (e.g., method, motive) and relevant individual differences.

Suicide

Suicide refers to a behavior in which one intentionally ends their own life (e.g., Mayo, 1992), and is one of the leading causes of death in the United States (US; [CDC | Data & Statistics](#)). Before suicidal behavior occurs, it is often preceded by suicidal ideation (i.e., thinking about engaging in suicide; [National Institute of Mental Health | Suicide](#)), which is much more common than actual suicidal behavior and/or attempts. Numerous theories from various disciplines have been proposed to explain why suicide occurs, with the interpersonal theory of suicide being the leading theory in psychology. This theory helps explain when suicidal ideation occurs and how it translates into suicidal behavior (Van Orden et al., 2010).

According to this theory, suicidal ideation increases as one's hopelessness about their interpersonal relationships increases, namely by way of experiencing a lack of belonging as well as perceiving oneself as a burden on others. Importantly, suicidal ideation is necessary but not sufficient for suicidal behavior. Suicidal behavior, according to this theory, depends upon one having an acquired capability to die by suicide. Capability, in this context, refers to beliefs that the person can successfully complete the suicide, specifically by tolerating the pain involved in the chosen suicide method and having less fear of death. Ultimately, this theory posits that suicidal behavior is more likely to occur when someone feels deficient in their interpersonal relationships coupled with sufficient beliefs that they can execute the suicide. See Figure 1.1.

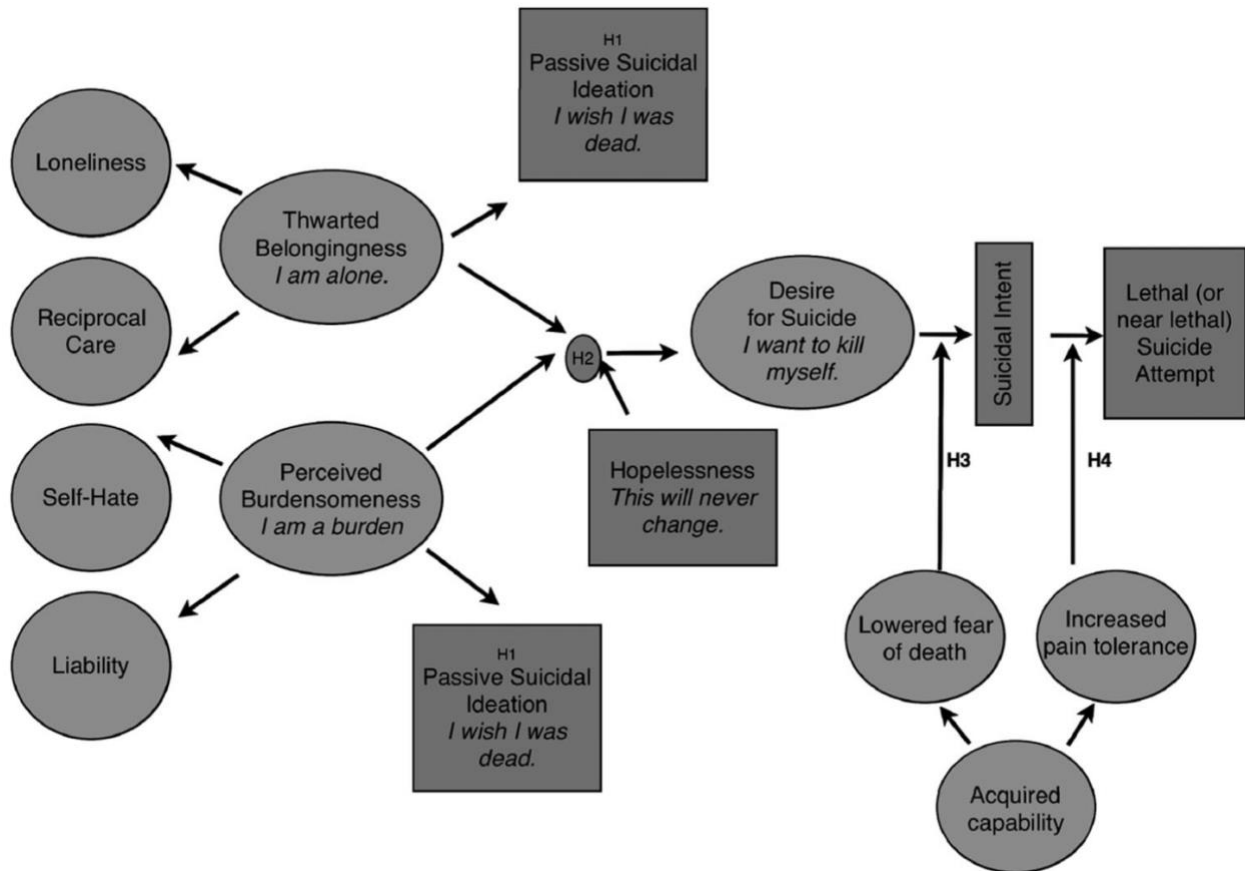


Figure 1.1. The image above is from Van Orden et al. (2010). It depicts the factors that contribute to the interpersonal issues of thwarted belongingness and perceived burdensomeness. When perceived as permanent or stable (i.e., hopeless), these can elicit desires for suicide. If someone has acquired the capability for suicide, this is when greater suicidal intent will be present and potentially attempts are made.

The present research tests part of this theory in terms of third-person perceptions of suicide in a specific population, the terminally ill. Specifically, Study 2 focuses on motives for suicide, including some that reflect traditional motives from the general population like burdensomeness, as proposed by the interpersonal theory of suicide, as well as motives that are more unique to people with terminal illnesses (discussed later), allowing for potential expansion of the interpersonal theory of suicide. In any case, suicide and its perceptions are nuanced, so the following sections will overview its stigmatization as well as notable contributing factors that help inform the current research.

Suicide Stigma

Stigma refers to the social devaluation of someone based on an identifying characteristic (Goffman, 1963). Although stigma directed toward individuals with mental health issues has been decreasing in recent years, reductions in suicide stigma have not matched this trend (e.g., Sudak et al., 2008). Public suicide stigma may be perpetrated by various people, most commonly by one's social network and non-mental health medical providers (Frey et al., 2015) and is often a barrier to seeking help (e.g., Corrigan, 2004). Common stereotypes that pervade suicide include assumptions of the person as being weak, lonely, unable to cope with their problems, and/or attention-seeking (e.g., Batterham et al., 2013). Moreover, although suicide is thought to violate the moral domain of purity, it is often met with sadness more so than disgust (Allam et al., 2022). There is also stigma by association (Goffman, 1963), and, as evidence of this, family members of someone who died by suicide report experiencing greater stigma from others compared to family members who lost someone due to other sudden deaths (e.g., Cvinar, 2005; Pitman et al., 2016; Sveen & Walby, 2008). In other words, suicide stigma is pervasive and affects more than just the individual attempting or completing suicide.

Contributing Factors

Mental Health

Poor mental health is usually at the forefront of suicidal behavior, which can take the form of psychiatric disorders and diagnoses and/or lower-level psychological stressors. Most suicides are completed by people who have major psychiatric disorders at their time of death, especially mood disorders like depression (e.g., Bertolote & Fleischmann, 2002; Holma et al., 2014). However, the role of various psychological stressors is also important to consider given that they often precede suicide attempts (e.g., Paykel, 1976). For instance, these stressors can include psychosocial vulnerability factors (e.g., social alienation; Bonner & Rich, 1990) and situational life events (e.g., job loss, breaking up with a romantic partner; e.g., Brent et al., 1993; Heikkinen et al., 1993). Ultimately, while poor mental health has historically thought to have been the primary impetus for suicide, other factors may be present as well, like one's physical health.

Physical Health

Physical health issues are estimated to be present in approximately 30-40% of suicides (e.g., Mackenzie & Popkin, 1990). In fact, most physical health conditions (e.g., traumatic brain injury, sleep disorders) are associated with increased suicide rates, even when controlling for other relevant diagnoses (e.g., mental health, substance use; Ahmedani, 2017). Moreover, the type of condition matters, with suicide likelihood varying depending on disease site (e.g., lung cancer, testicular cancer; Zaorsky et al., 2019). Chronic health conditions specifically are associated with more strongly viewing death as a means of escape (e.g., Lockhart et al., 2001) and greater suicide rates (e.g., Fiske et al., 2008). Beyond chronic conditions, Kaplan et al. (2007) suggest the severity of one's functional limitations resulting from their condition is a stronger predictor of suicide. In

sum, the relationship between physical health and suicide is well documented, and more severe physical conditions, like being diagnosed as terminally ill, are also relevant for suicide.

Terminal Illness

Although terminal illness is somewhat inconsistently defined in the literature (Hui et al., 2014), scholars generally agree that it involves an irreversibility component such that the patient's medical professional/s believe, with some amount of certainty, their health cannot be restored (e.g., Lamont, 2006). Definitions vary in specifying a duration for this terminal stage, ranging from days to two years or less (Hui et al., 2014). Most commonly though, terminal illness refers to a medical condition that is expected to cause death within the next six months (e.g., Breitbart et al., 2000). This specific duration is consistent with common admission criteria for hospice care (e.g., Lamont, 2005) as well as PAD criteria (e.g., Al Rabadi et al., 2019). Regardless of definitional differences, terminal illnesses are stigmatized, often involve end-of-life care, and are a focal point of conversations related to dying with dignity.

Stigma of the Dying

Stigma also applies to individuals who are dying, despite relatively few people having regular contact with dying individuals (e.g., Kang, 2021). As evidence of this, people tend to have more negative attitudes toward the dying compared to people who are healthy or people who are ill, especially when the dying person is older (Epley & McCaghy, 1978). Specifically, dying individuals are often stereotyped with beliefs of them being worthless, unpleasant, and lonely. This stigma seems to manifest even in relation to decision-making about end-of-life care. For instance, perhaps as evidence of Western medicine's focus on curing illnesses (e.g., Lamont, 2006), people with terminal cancer are stereotyped more negatively when they opt for palliative care over chemotherapy, which can manifest in being less likely to use palliative care for oneself or family

members in the (hypothetical) future (Shen & Wellman, 2019). Taken together, stigma directed toward the dying and norms or expectations regarding healthcare may work together to inform perceptions of other's end-of-life decisions.

End-of-Life Care

There is good consensus that end-of-life care is important (Singer et al., 1999) and also that this care should differ from care provided during other time periods in people's lives (Lamont, 2006). Traditional Western medicine often has curative goals that may involve aggressive, life-extending approaches whereas the superordinate goal of end-of-life care is alleviating patients' symptoms with minimally invasive methods (Lamont, 2006). From patients' perspectives, quality end-of-life care involves five themes: appropriate symptom management, not prolonging death, autonomy, minimizing burden, and fostering relationships with loved ones (Singer et al., 1999). These patterns are consistent with first-person perspectives on what contributes to a "good death": symptom management, awareness of death, dignity, familial presence and support, as well as communication among all parties (Granda-Cameron & Houldin, 2012). For some, suicide may be an outlet to achieve a good death at the end of life, consistent with wanting control over death being associated with desires for hastened death (e.g., Wiebe et al., 2018).

Suicide & Terminal Illness

Given that physical health can be a contributing factor to suicide (e.g., Ahmedani, 2017), it follows that more extreme physical health conditions, like terminal illness, are associated with increased suicidality (e.g., Hooley et al., 2014). Earlier research suggested that the prevalence of terminal illness in completed suicides seems to be relatively low (Clark & Horton-Deutsch, 1992), but these statistics may be underreported, especially if the cause of death documentation reflects the terminal illness rather than suicide. More recent statistics, specifically data tracked by PAD

legislation, suggest medical aid in dying is becoming increasingly common for people with terminal illnesses over the last 30 years (Al Rabadi et al., 2019).

Research has examined third-person perceptions of suicide and how its acceptability may vary as a function of situational factors. Perhaps as evidence of the importance of considering physical health in relation to suicide perceptions, various health issues (e.g., needing in-home assistance) are perceived as more acceptable suicide precipitators compared to interpersonal (e.g., family issues) or impersonal (e.g., financial troubles) issues (Winterrowd et al., 2015). Specifically, suicide is considered more justified when people have health conditions that are incurable and/or have a greater frequency of being fatal (e.g., cancer, AIDS) compared to other health conditions (e.g., chronic depression, schizophrenia; e.g., Deluty, 1989; Singh et al., 1986). In other words, physical health, especially more severe health states, is an important factor in relation to the acceptability of suicide.

More recently, Schiffer and Saucier (2024) examined this social phenomenon, finding generally favorable attitudes toward people with terminal illnesses who die by suicide, including evidence that people believe suicide by people with terminal illnesses is different from suicide by people without terminal illnesses. These perceptions were sometimes moderated by demographic factors of the person with a terminal illness dying by suicide such that participants reported more favorable attitudes toward older adults (90s) and women, compared to other age groups (e.g., 40s) or men. Taken together, despite both suicide and terminal illness being stigmatized independently, their combination is generally perceived positively, but this research is often limited to one specific suicide method, PAD, so it is important to consider other possible suicide methods.

Suicide Methods

Many factors influence which suicide method someone uses, namely physical availability and sociocultural acceptability (e.g., Cantor & Baume, 1998). The former seems like a practical application of the interpersonal theory of suicide's capability component (e.g., Van Orden et al., 2010) in that the method of suicide one uses depends on its accessibility (e.g., gun suicides cannot happen without access to a gun). Consistently, when access to a specific method is restricted, there tends to be a subsequent decrease in the frequency of suicides using that method (e.g., Perry, 2016). The latter, sociocultural acceptability, refers to how cultural norms influence someone's suicide method choice (e.g., popularity; Cantor & Baume, 1998; Kanchan et al., 2009). For instance, the most common suicide methods in the US among the general public are, in order, suicide by gun, hanging, and overdose ([CDC | Suicide Data & Statistics](#)). Of course, these methods may be used by people with terminal illnesses (see Chung & Lin, 2010), but this population may have access to additional medical routes to hasten death. Accordingly, this research was designed to examine how perceptions of people with terminal illnesses' suicides vary depending on suicide method, with manipulations that include medical methods, like Voluntarily Stopping Eating and Drinking (VSED), palliative sedation, and PAD, as well as traditional methods, like overdose, hanging, and gun.

Voluntarily Stopping Eating & Drinking (VSED)

VSED refers to someone choosing to “refuse all food and liquids, including those taken through a feeding tube, with the understanding that doing so will hasten death” ([Alternative Options to Hasten Death](#)). On average, it takes 7-10 days to die after VSED (e.g., Bolt et al., 2015; [Alternative Options to Hasten Death](#)), with most dying within 15 days (Ganzini et al., 2003). VSED is said to be generally pain free (e.g., Pope & Anderson, 2011), with most people not

experiencing hunger or thirst sensations after the initial couple days (e.g., Crowther, 1982). In terms of who uses VSED, most tend to be older (80+ years of age) with severe disease that are dependent upon others for daily care (Bolt et al., 2015). Perhaps accordingly, people tend to use VSED due to poor quality of life (Ganzini et al., 2003), which often includes somatic issues, existential concerns, and dependence on others (Bolt et al., 2015).

Interestingly, the role of medical staff during VSED is perhaps misunderstood. In theory, VSED does not require medical staff assistance, but in reality, clinicians are involved in assessment (e.g., decision-making capacity), with hospice care being recommended (Quill et al., 2018). From medical staff perspectives, VSED is perceived as a “good” and “natural” death by hospice nurses (Ganzini et al., 2003) and nursing home supervisors (Stängle et al., 2020). Additionally, VSED has the support of many palliative care clinicians generally (Schwartz, 2011) as well as relative to PAD (Schwarz, 2007). Ultimately, VSED seems to be more of suicide by omission (i.e., inaction; e.g., not consuming food) rather than action and is, subsequently, a very accessible suicide method, especially compared to other alternatives (e.g., Miller & Meier, 1998; Quill et al., 2018).

Palliative Sedation

Despite varying definitions, palliative sedation, or terminal sedation, refers to administering sedatives until death (e.g., Gilbertson et al., 2022) to alleviate symptoms by reducing a person’s consciousness (e.g., Morita et al., 2001). There is debate about when to start terminal sedation and how it should progress until death, but standard terminal sedation uses sedative doses that are proportional to the person’s symptom severity (e.g., Gilbertson et al., 2022; Riisfeldt, 2023). In other words, worsening symptoms are matched with increased sedatives, which can

result in unconsciousness in one's final days. Similar to VSED, the average time until death was about a week using this method, according to Claessens et al.'s (2008) review.

Given the emphasis on symptom management, palliative sedation is commonly used when death is imminent and the person's symptoms are unmanageable (e.g., Gilbertson et al., 2022), in which case palliative sedation allows the person to be "comfortable and continuously unconscious, thereby free of the excruciating pain and related symptoms they were experiencing," ([Alternative Options to Hasten Death](#)). Because palliative sedation requires constant monitoring of sedation levels, this option is often provided in inpatient facilities, like skilled nursing or hospice ([Alternative Options to Hasten Death](#)). With respect to people with terminal illnesses, Garetto et al. (2018) estimate that 25-33% use palliative sedation, with 25% needing deep sedation. Ultimately, palliative sedation is categorically different from other medical suicide methods (e.g., Garetto et al., 2018; Riisfeldt, 2023) and may be an intermediate option between VSED and PAD.

Physician-Assisted Death (PAD)

A lot of research on people with terminal illnesses who die by suicide focuses on PAD, which refers to the intentional ending of someone's life who is terminally ill using a medication prescribed by a physician for this purpose (e.g., VandeKieft, 2020; Wilson et al., 2000). PAD was passed into law with the Oregon Death With Dignity Act in 1994 (see Purvis, 2012). Currently, PAD is legal in 10 states and the District of Columbia for adults who satisfy the following criteria: 1) a terminal diagnosis, confirmed by two physicians, 2) healthcare decision-making capability,¹ and 3) ability to ingest medication without assistance ([Death With Dignity, Glossary of Terms](#)).

¹ Patients may be referred to a psychiatrist to determine their competency as needed. In Al Rabadi et al.'s (2019) sample of 2,558 patients using Medical Aid in Dying between 1998-2017, only 4% were referred to psychiatrists for examination.

After a patient requests PAD and their physician agrees, two physicians confirm the patient's eligibility and then the primary physician prescribes the lethal medication that the patient would be able to take at their own discretion. The estimated median time between taking the medication and death is 25 minutes (Al Rabadi et al., 2019; Blanke et al., 2017).

According to archival data of 2,558 people who used PAD between 1998-2017 in Oregon and Washington (Al Rabadi et al., 2019; Blanke et al., 2017), the gender composition was essentially evenly split between men and women, with most being White, older (65+) and college-educated. Cancer was, by far, the most frequent precipitating illness. Beyond demographic identities, people who request PAD tend to have greater levels of depression, hopelessness, and independence, but lower levels of spirituality (e.g., Smith et al., 2015). Motivations for PAD were multifaceted with loss of autonomy and dignity as well as poor quality of life being the most common reasons (Al Rabadi et al., 2019).

These various experiences and motivations have been central in the (medical) ethics debate of PAD. Arguments against PAD reflect themes of threatened doctor-patient relationships (e.g., violations of doctors' Hippocratic oath), beliefs that medicine can reduce pain in the terminal stage, and fears of a slippery slope in being used beyond terminal illnesses and/or abusively (e.g., Strinic, 2015; Verbakel & Jaspers, 2010). Arguments in favor of PAD reflect themes of patients' autonomy and not prolonging suffering, both of which may offer psychological reassurance to patients (e.g., Purvis, 2012; Strinic, 2015).

Closer to the time of its inception, public perceptions seemed to follow the "Rule of Thirds," such that a third of Americans supported PAD, a third of Americans opposed PAD, and the remaining third of Americans supported PAD in certain circumstances (Emanuel, 2002). More recently, a systematic review of attitudes toward PAD and related concepts found the most

consistent demographic predictors of PAD endorsement were younger age, lower religiosity, as well as higher education and socioeconomic status (Castelli Dransart et al., 2021). Additionally, Schiffer and Saucier (under review) found people have favorable attitudes toward PAD and people who use it. Moreover, they found evidence for the idea that PAD differs from traditional suicide, with PAD being more understandable, more autonomous, and less stigmatizing. Overall, PAD may be an increasingly common method for people with terminal illnesses.

Overdose

Similar to PAD is overdose, which is a common suicide method in the general population and does not require medical staff assistance to complete. Overdosing refers to taking an excessive and, therefore, dangerous amount of a drug. The most frequent drugs used to die by suicide via overdose include common pain relievers (e.g., acetaminophen, ibuprofen) as well as antidepressants (e.g., sertraline, fluoxetine; Farah et al., 2023). Relatedly, opioids, or “narcotics” (e.g., oxycodone, hydrocodone, codeine, morphine; [FAQs About Opioids | National Institute on Drug Abuse](#)), used for pain relief, are the most common category of drug in accidental overdose deaths (e.g., 75% of overdoses in 2020; [CDC | Drug Overdose Deaths](#)). Given that many factors affect overdoses (e.g., dosage, age, weight, tolerance) and the fact that overdose deaths often occur outside of medical settings, it is difficult to estimate the average time it takes to die since ingesting the drug, with some suggesting one to three hours pass between ingesting the drug and dying from it ([Silver Pines Treatment Center](#)).

It is important to note that it may be difficult to disentangle accidental overdose deaths from intentional overdose suicides (e.g., Bohnert et al., 2013), although desires to die are not uncommon among people who overdose (about 45%; Connery et al., 2022). In any case, suicide by overdose was the third most common method in the US as of late ([CDC | Suicide Data &](#)

[Statistics](#)), with women being more likely than men to die by suicide overdose (Callanan & Davis, 2012; [CDC | Suicide Data & Statistics](#)). Moreover, overdose suicides may be rising for several demographic groups (e.g., younger adults, Black women; Han et al., 2022). Interestingly, some research suggests fatal opioid overdoses are more stigmatized than suicide (Kheibari et al., 2022). Ultimately, overdoses are considered a nonviolent suicide method (Chung & Lin, 2010) that is likely accessible to people with terminal illnesses.

Hanging

Hanging refers to someone using an anchor point above the head (e.g., ceiling fan or beam), fixing a ligature around the neck (i.e., a noose; e.g., rope, bedsheet), and then suspending their body in the air, collapsing the ligature around the neck and restricting oxygen to the brain (i.e., cerebral hypoxia; Aufderheide et al., 1994). Again, it is difficult to estimate how long it takes someone to die using this method because it is often performed in isolation and depends on several factors (e.g., security of anchor point and noose, body weight). However, according to some case studies and/or filmed hangings, most hanging deaths occur within a couple minutes (e.g., Gilbert et al., 2008; Sauvageau, 2014).

In 2021, hanging was the second most common suicide method in the US ([CDC | Suicide Data & Statistics](#)). In terms of demographic factors, hanging is historically used more by men than women (Callanan & Davis, 2012), but these genders had relatively similar rates in 2021 ([CDC | Suicide Data & Statistics](#)). From 2000-2010, hanging suicides increased substantially for adults aged 45-59 (Baker et al., 2013). According to qualitative data from people who had attempted suicide by hanging, they chose this method because it was perceived as quick, easy, and accessible (Biddle et al., 2018). However, previous research classifies hanging as a violent suicide method (Chung & Lin, 2010). To my knowledge, not much research has examined third-person

perceptions of suicide by hanging, with the current research potentially providing that initial insight as well as allowing for comparisons across methods.

Gun

In 2021, suicide by firearm was the most commonly used suicide method in the US, accounting for over half of all suicides ([CDC | Suicide Data & Statistics](#)). Guns tend to be a more lethal suicide method compared to hanging or overdose (e.g., Card, 1974), with gunshots to the head, specifically the right temple, being most common (Eisele et al., 1981). It is important to acknowledge that, of traditional suicide methods, this particular suicide method depends on one's access to a firearm, which is a key factor in contributing to suicidal behavior as proposed by the interpersonal theory of suicide (e.g., Van Orden et al., 2010).

Consistently, gun ownership is positively associated with suicide rates (e.g., Miller et al., 2013). However, it is not the case that increased exposure to guns causes suicide but rather that it increases the likelihood of suicide among individuals who are already suicidal (Anestis & Capron, 2018). Perhaps due to men being more likely to own firearms (e.g., Wolfson et al., 2020), men tend to complete suicide by firearm more frequently than women (e.g., Anestis et al., 2017). Further, consistent with women 1) being concerned with (facial) disfigurement in their suicides and 2) using less lethal means, men are far more likely than women to shoot themselves in the head compared to the body (Stack & Wasserman, 2009). Ultimately, suicide by gun is considered a violent suicide method (Chung & Lin, 2010) and is one that is very common in the US, especially among men.

Suicide Motives

Suicide motives are highly variable and multifaceted. In any case, suicide is often precipitated by psychosocial stressors (e.g., Paykel, 1976), like poor mental health (e.g.,

depression; Holma et al., 2014), interpersonal issues (e.g., divorce), and/or personal issues (e.g., financial troubles; e.g., Winterrowd et al., 2015). Additionally, the interpersonal theory of suicide identifies lack of belonging and perceived burdensomeness as two crucial precipitators that help explain why suicide occurs (Van Orden et al., 2010). It is important to note though that people with terminal illnesses have additional, physical stressors that may motivate suicide, given the well-documented relationship between poorer physical health and increased suicide rates (e.g., Ahmedani, 2017). As such, part of this research is designed to assess perceptions of people with terminal illnesses' suicides as a function of their primary motive: physical health issues, mental health issues, burdensomeness, or autonomy.

Physical Health

Beyond physical health issues being associated with higher suicide rates (e.g., Ahmedani, 2017), terminal illness diagnoses, specifically, tend to also be positively associated with suicidality (e.g., Hooley et al., 2014). In fact, reasons for desiring PAD often are related to one's illness-related experiences (e.g., fatigue, functional losses; e.g., Pearlman et al., 2005). Although there is symptom variability across health conditions, some common experiences associated with terminal illnesses include lowered mobility or independence as well as pain (e.g., Emanuel et al., 2000; Wilson et al., 2000). Interestingly, PAD research has yielded inconsistent results on the role of pain, specifically, in desiring or executing PAD. On one hand, some research reports that disease severity, symptom intensity, and pain are generally unrelated to attitudes toward PAD (e.g., Rosenfeld, 2000; Suarez-Almazor et al., 2002). On the other hand, numerous samples of people with terminal illnesses suggest pain, specifically uncontrollable and/or inadequate pain control, is associated with more favorable attitudes toward PAD policies (e.g., Blanke et al., 2017; Wilson et

al., 2000). Regardless, it is understandable that pain may be a motivator for people with terminal illnesses to desire suicide.

Mental Health

Terminal diagnoses can take severe mental tolls (e.g., Steinhauser et al., 2000), with psychological symptoms potentially being just as salient as physical symptoms (e.g., Wilson et al., 2000). Of Brown et al.'s (1986) sample of people with terminal illnesses, 23% suffered from clinical depression and desired hastened death. Breitbart et al.'s (2000) sample of terminal cancer patients had, on average, moderate scores of depressive symptoms, with 17% meeting DSM-IV criteria for a major depressive episode. It is important to note, though, that estimates in this population may be underreported because their hopelessness may be perceived by physicians as a realistic appraisal of their situation (e.g., Block, 2000). As such, it is not uncommon for physicians to not recognize depression in their patients, meaning it may often go untreated (Kleespies et al., 2000).

Again, there are inconsistent findings on the role of depression in suicide among people with terminal illnesses, with some research suggesting depression is a strong predictor of desiring hastened death (e.g., Breitbart et al., 2000) and other research reporting that no patients planning to use PAD were depressed (e.g., Pearlman et al., 2005). Interestingly, Chochinov et al. (1998) suggest a related affective experience, namely hopelessness, may be a better predictor of suicidal ideation than depression among people with terminal illnesses. Taken together, the emotional experiences of people with terminal illnesses should not be underestimated in one's desire for suicide amid a major physical health condition.

Burdensomeness

Perhaps related to mental health, perceived burdensomeness is a key affective experience that helps explain why suicide occurs according to the interpersonal theory of suicide (Van Orden et al., 2010). Feelings of burdensomeness are not uncommon among people with terminal illnesses (e.g., Chochinov et al., 2002) and are associated with a lower will to live (Chochinov et al., 2005) as well as more support for PAD (Suarez-Almazor et al., 2002). These patterns are further corroborated by psychological autopsies performed on people with terminal cancer who died by suicide that highlight burdensomeness as a key suicide precipitator (Filiberti et al., 2001). Feelings of burdensomeness may stem from the person's dependency on others due to their physical decline, and feelings of dependency among dying individuals are associated with thinking an earlier death is better (Seale & Addington-Hall, 1994). Overall, perceived burdensomeness is an important emotional experience in understanding suicide for both the general population and perhaps especially in the terminally ill population.

Autonomy

While the previous motives are largely escape-oriented or avoidant in nature, a more approach-oriented suicide motive for people with terminal illnesses may be autonomy, or the idea of self-governance. Considering the potential reality of people with terminal illnesses' physical decline (e.g., Pearlman et al., 2005), mental health concerns (e.g., Steinhauser et al., 2000), and burden on others (e.g., Chochinov et al., 2002), autonomy and/or dignity loss are not uncommon among people with terminal illnesses and can contribute to desires of hastened death (e.g., Blanke et al., 2017). Thus, suicide may provide people with terminal illnesses autonomy and control over their death (Hannig, 2019), which can be empowering at the end of life (e.g., Horgan, 1991; Werth & Cobia, 1995). Accordingly, this research investigated how this more approach-oriented and

empowering motive affects perceptions of people with terminal illnesses' suicides in comparison to potentially more negatively-valenced (e.g., mental health) and traditional (e.g., burdensomeness) suicide motives.

Individual Differences

In addition to manipulating situational aspects of people with terminal illnesses' suicides (e.g., method, motive), this research additionally examined how various individual differences may affect perceptions of this phenomenon. Earlier research in this area examined how sociodemographic factors (e.g., gender, religiosity) are associated with first-person attitudes toward PAD among people with terminal illnesses (e.g., Breitbart et al., 2000; Suarez-Almazor et al., 2002). Interestingly, third-person perspectives seem to corroborate the patterns of first-person perspectives in terms of how sociodemographic factors relate to perceptions of PAD (e.g., Schiffer & Saucier, under review). Beyond sociodemographic factors, more enduring beliefs also matter, as evidenced by Schiffer and Saucier's (2024; under review) recent work. Consistently, this research measured Masculine Honor Beliefs (MHB), Free Will Beliefs (FWB), Fear of Death (FOD), and Suicide Acceptability.

Masculine Honor Beliefs (MHB)

MHB refer to beliefs that aggression is sometimes justifiable, especially in response to provocation or in the protection of others (e.g., Saucier et al., 2016) and are derived from honor cultures, which prioritize the management and protection of one's reputation as tough (e.g., Cohen & Nisbett, 1994). Moreover, men in honor cultures are expected to earn, display, and maintain their manhood at all costs (e.g., Cohen & Nisbett, 1994), consistent with manhood being precarious in nature (Vandello & Bosson, 2013) and higher levels of MHB being associated with perceiving

the questioning of one's masculinity as particularly insulting (Saucier et al., 2015). As such, honor ideology, including MHB, have important implications for health-related attitudes and behaviors.

MHB & Health

With respect to mental health, despite honor ideology being associated with more negative attitudes toward mental health issues, it is associated with worse mental health. For instance, in terms of attitudes, higher levels of MHB are associated with greater mental health stigma (Schiffer & Saucier, 2023) as well as less suicide acceptability (Schiffer & Saucier, 2024; under review). At the state-level, honor states tend to invest less in mental healthcare (e.g., number of facilities; e.g., Brown et al., 2014a), have lower rates of people seeking mental health treatment (e.g., Foster et al., 2021a; Gul et al., 2021), and have lower antidepressant prescription rates (Crowder & Kemmelmeier, 2014; Osterman & Brown, 2011) compared to nonhonor states. Moreover, higher levels of MHB are associated with more favorable attitudes toward coping with one's mental health situation privately and independently, compared to publicly (Lawless et al., in preparation).

In terms of actual mental health, honor states tend to have higher rates of depression and suicide (e.g., Osterman & Brown, 2011). Further, suicide by gun is especially common in honor states (Brown et al., 2014b) which may be due to the increased prevalence of firearms (e.g., gun ownership), making it an accessible suicide method (Bock et al., 2021; Osterman & Brown, 2011). This discrepancy between negative attitudes toward mental health despite worse mental health may be attributed to honor ideology's values of masculinity (e.g., toughness, self-sufficiency, emotional suppression) in one's social reputation (e.g., Brown, 2016; Crowder & Kemmelmeier, 2017; Foster et al., 2024; Gul et al., 2021).

With respect to physical health, honor ideology is associated with reluctance to seek and/or use health services for gender-related conditions. For instance, greater honor endorsement is

associated with being less likely to have one's daughters get screened for HPV due to beliefs that this vaccine implies subsequent sexual promiscuity (Foster et al., 2021b). Similarly, greater honor endorsement in men is associated with being less likely to seek and/or use erectile dysfunction medication due to perceptions of it being emasculating (Foster et al., 2022). When considering how these honor ideology findings related to both mental and physical health may work together, it is clear that honor ideology, including individual differences in MHB, are important for understanding health-related attitudes and situations, including PAD and suicide among people with terminal illnesses.

MHB & Suicide by People With Terminal Illnesses

My most recent research has explored how MHB relate to perceptions of suicide among people with terminal illnesses, including PAD. Higher MHB were associated with less favorable attitudes toward people with terminal illnesses dying by suicide (including via PAD) and more frequent reports for "suicide" to be listed as their cause of death, rather than their terminal illness or some other alternative (Schiffer & Saucier, 2024; under review). Moreover, higher MHB were associated with thinking various factors (e.g., physical health issues) are less likely to contribute to one's decision to die by PAD (Schiffer & Saucier, under review). There are several potential explanations for these findings, like MHB being negatively associated with suicide acceptability (Schiffer & Saucier, 2024; under review). It is also possible that these suicides are conflated with mental health issues and honor ideology, including MHB, has well-documented relationships with mental health stigma (e.g., Schiffer & Saucier, 2023). Moreover, given that terminal illnesses are associated with dignity loss (e.g., Blanke et al., 2017), people higher in MHB may view this as a threat to one's social reputation. In any case, MHB are clearly relevant to perceptions of suicide

by people with terminal illnesses, which may be further qualified by the suicide method and/or motive.

Free Will Beliefs (FWB)

Philosophers have debated the existence of free will for centuries, and psychology does not claim to answer this major existential question, but individuals' conceptualizations of free will have implications for their affect, behavior, and cognition (Baumeister, 2008). In general, lay people conceptualize free will as meaning one has the capacity to make their own decisions, free from constraint (e.g., peer pressure; Monroe & Malle, 2010). In other words, FWB refer to beliefs that one is the causal agent of their own actions (Paulhus & Carey, 2011). As such, increased FWB are associated with stronger desires to hold others morally responsible for their actions (e.g., Clark et al., 2014). Given that FWB pertain to moral responsibility and agency (e.g., Clark et al., 2014), FWB are related to perceptions of health-related behaviors, including suicide.

FWB & Health

With respect to physical health, free will research seems to focus on addictive conditions that are typically stigmatized as being choice behaviors (i.e., resulting from a lack of willpower; e.g., Baumeister & Brewer, 2012). For instance, alcoholism (e.g., Valverde, 1997), substance abuse (e.g., Ozkok et al., 2022), and smoking (Baumeister, 2017) seem to be perceived as more voluntary behaviors than medical conditions by the general public. With respect to mental health, greater FWB are associated with attributing more blame on individuals with mental health issues (Chandrashekar, 2020) as well as greater suicide stigma (Ozkok et al., 2022). As such, it follows that FWB are related to perceptions of suicide among people with terminal illnesses.

FWB & Suicide by People With Terminal Illnesses

Schiffer and Saucier (2024; under review) also examined the role of individual differences in FWB in relation to third-person perceptions of suicide by people with terminal illnesses. Greater FWB are associated with less favorable attitudes toward suicide by people with terminal illnesses, including PAD, consistent with FWB being negatively associated with suicide acceptability (Schiffer & Saucier, 2024; under review). Additionally, greater FWB are associated with more stigmatizing perceptions of people with terminal illnesses who die by suicide or PAD (e.g., thinking they are weak and miserable) as well as with greater reports for “suicide” to be listed as the cause of death on the death certificate, rather than the terminal illness (Schiffer & Saucier, 2024; under review). Moreover, greater FWB were associated with thinking mental health issues are a stronger motivator for people with terminal illnesses to use PAD (Schiffer & Saucier, under review), consistent with FWB being positively associated with mental health stigma (e.g., Chandrashekar, 2020). Overall, FWB pertaining to agency in the world has implications for perceptions of this social phenomenon.

Fear of Death (FOD)

There are also more domain-specific constructs, like FOD, that are relevant to the current research. FOD is a relevant individual difference to examine given that people differ in the meanings they ascribe to death and how they emotionally interpret death (e.g., Lonetto & Templer, 1986). FOD refers to preoccupations with the various unknowns surrounding death and dying in relation to both the self and others (e.g., Lester & Abdel-Khalek, 2003). Anxiety and/or fear related to death are quite common, but FOD’s relationship with aging is inconsistent, with some finding less FOD (e.g., Kastenbaum, 1992) and others finding greater FOD (e.g., Viney, 1984) in older adults. Taken together, it follows that FOD are related to numerous health-related attitudes.

FOD & Health

Greater FOD is associated with less perceived control over health issues among elderly individuals in long-term care facilities (e.g., Cataldo, 1994) as well as greater concern about end-of-life treatment issues (e.g., Lockhart et al., 2001). Although poorer mental health (e.g., depression) is associated with greater FOD (Cataldo, 1994; Lockhart et al., 2001), FOD may actually serve as a barrier to suicidal behavior (Sims et al., 2023) likely because it is incompatible with the capability component (e.g., fearlessness about death) of the interpersonal theory of suicide (Joiner, 2005; Van Orden et al., 2010). For instance, greater anxiety about death is associated with greater rescue potential in suicide attempts perhaps due to hesitancy and/or lower suicide intent (Sims et al., 2023). Importantly, these first-person perceptions of one's own health and death also manifest in third-person perceptions of suicide among people with terminal illnesses.

FOD & Suicide by People With Terminal Illnesses

It is not surprising that FOD is related to third-person perceptions of suicide by people with terminal illnesses, including PAD. However, these relationships may be more ambiguous than expected in yielding not overwhelmingly positive or negative attitudes toward this phenomenon. Most consistently, FOD is positively associated with perceiving these suicides as having negative effects on loved ones (e.g., Schiffer & Saucier, 2024; under review). In terms of motivating factors, greater FOD is associated with greater beliefs that fear of the future, time left to live, and not wanting loved ones to see them suffer are stronger motivators for suicide among people with terminal illnesses (e.g., PAD; Schiffer & Saucier, under review). FOD inconsistently relates to person perceptions, with greater perceptions that people who die by PAD are miserable (Schiffer & Saucier, under review) but also less stigmatizing attitudes toward people with terminal illnesses who die by suicide (Schiffer & Saucier, 2024).

Perhaps as evidence of this individual difference being more domain-specific than MHB or FWB, greater FOD is associated with perceiving more of a difference between suicide in the general population compared to suicide among people with terminal illnesses, with more favorable attitudes toward the latter (e.g., Schiffer & Saucier, under review). Interestingly, this effect was stronger for perceptions of men with terminal illnesses' suicides compared to women's (Schiffer & Saucier, 2024). Despite these potentially ambivalent attitudes toward people with terminal illnesses dying by suicide, these findings are consistent with the anxiety-prone nature of FOD (Lester & Abdel-Khalek, 2003) and may also vary depending on the method and/or motive of the suicide.

Suicide Acceptability

Although there may be situational differences in the perceived acceptability of suicide, Suicide Acceptability can also exist at the individual level (Hoelter, 1979). Suicide tends to be considered more acceptable by men (e.g., Deluty, 1989; Phillips & Luth, 2020, Winterrowd et al., 2015) and people who are less religious (e.g., Hoelter, 1979), more educated, and more committed to freedom of expression (e.g., Singh, 1986). Consistent with the interpersonal theory of suicide's capability component (e.g., Joiner, 2005; Van Orden et al., 2010), greater fears of various aspects related to death are associated with less Suicide Acceptability (Hoelter, 1979). Suicide Acceptability, to my knowledge, has not been examined alongside attitudes or behaviors related to health, but it is relevant for perceptions of suicide among people with terminal illnesses.

Suicide Acceptability & Suicide by People With Terminal Illnesses

Perhaps the most domain-specific individual difference related to perceptions of suicide among people with terminal illnesses is Suicide Acceptability. Greater Suicide Acceptability is associated with more favorable attitudes toward suicide among people with terminal illnesses

(Schiffer & Saucier, 2024; under review). Higher levels of Suicide Acceptability are associated with thinking several factors were motivators for suicide (e.g., physical health issues, poor quality of life, acceptance of fate; Schiffer & Saucier, 2024; under review). Moreover, greater Suicide Acceptability is associated with perceiving more of a difference between suicide among the general population versus among the terminally ill population, with more favorable attitudes toward the latter (Schiffer & Saucier, 2024; under review). Accordingly, higher levels of Suicide Acceptability were associated with more frequent reports for “terminal illness” to be listed as one’s cause of death, rather than “suicide.” Overall, Suicide Acceptability is associated with more favorable attitudes toward people with terminal illnesses’ suicides, regardless of various demographic manipulations (e.g., age, gender) and may also vary as a function of suicide method and/or motive.

Religiosity & Political Orientation

Sociodemographic ideologies are also relevant for the current research, namely religiosity and political orientation. Oftentimes, religiosity and conservatism, specifically, are positively correlated, perhaps depending on one’s level of engagement with political discourse (Malka et al., 2012). In any case, these variables often predict similar attitudes toward social phenomena. For instance, higher self-reported levels of religiosity and conservatism tend to be associated with placing more value on loyalty to people and groups, respect for authority, and purity (e.g., Graham et al., 2009; Krull et al., 2016). These ideologies and subsequent moral attitudes also manifest in health-related attitudes and behaviors.

Religiosity, Political Orientation, & Health

Religiosity is typically positively associated with better mental and physical health outcomes (e.g., Aukst-Margetić & Margetić, 2005), including recovery and longevity (e.g., Alves

et al., 2010). One potential explanation for this relationship is that religiosity helps reduce stress by way of trusting, or surrendering to, God, thereby mitigating negative, stress-related health effects (Clements & Ermakova, 2012). With respect to political orientation, compared to democrats, conservatives tend to report better mental well-being (e.g., Schlenker et al., 2012) but also engaging in fewer health-promoting behaviors (e.g., Kannan & Veazie, 2018). More conservative political parties and religious ideologies are associated with more restrictive opinions on body autonomy issues, like abortion (Osborne et al., 2022). As such, it follows that these sociodemographic ideologies are also related to perceptions of suicide among people with terminal illnesses.

Religiosity, Political Orientation, & Suicide by People With Terminal Illnesses

As previously stated, religiosity is associated with first-person perceptions of PAD, with lower religiosity being associated with greater support for PAD (Suarez-Almazor et al., 2002). Moreover, PAD seems to be more common among liberals than conservatives (Al Rabadi et al., 2019, Blanke et al., 2017). In fact, Suarez-Almazor et al. (2002) suggest sociodemographic factors are more influential than symptom severity in people with terminal illnesses' attitudes toward PAD. These patterns are present in third-person perceptions as well, according to Schiffer and Saucier (2024; under review). Specifically, greater religiosity and spirituality as well as greater conservatism are associated with less favorable attitudes toward suicide among people with terminal illnesses (e.g., greater stigmatizing attitudes; Schiffer & Saucier, 2024; under review). Moreover, these more sociodemographic variables are associated with thinking mental health issues are more likely to motivate people with terminal illnesses to die by PAD (Schiffer & Saucier, under review). Additionally, greater religiosity and spirituality, but not political orientation, are associated with thinking "suicide" should be identified as the cause of death on the death

certificate, more so than “terminal illness” (Schiffer & Saucier, 2024). Taken together, these more sociodemographic ideologies are relevant for attitude toward this social phenomenon which may further be qualified by one’s suicide method and/or motive.

Current Studies Overview

This program of research quantitatively examined how third-person perceptions of suicide among people with terminal illnesses differ as a function of various aspects of the suicide and individual differences. My three research questions are as follows: 1) How do situational factors, like suicide method and motive, influence perceptions of people with terminal illnesses’ suicides?, 2) How do individual differences related to pride and existential considerations influence perceptions of people with terminal illnesses’ suicides?, and 3) How do situational factors and individual differences interact to inform perceptions of people with terminal illnesses’ suicides?

Studies used vignettes in a between-groups designs to experimentally test the effects of the suicide method (Study 1) and motive (Study 2) on various outcomes. Specifically, vignettes described a White man in his 70s named Mike learning he is terminally ill with his doctor informing him of common experiences of others in similar situations. Vignettes state that Mike notices his symptoms worsening and concludes with a statement that he decides to die by suicide. Consistent with related research (e.g., Schiffer & Saucier, 2024), outcome variables included general perceptions (e.g., acceptability, effects on loved ones), person perceptions (i.e., of the target; e.g., stigma), comparisons to traditional suicide, and reports for what should be listed as the cause of death on the target’s death certificate. Given that sociodemographic factors (e.g., religiosity; Suarez-Almazor et al., 2002) and individual differences (e.g., Schiffer & Saucier, under review) relate to perceptions of PAD, these studies additionally assessed individual differences related to pride and existential considerations for further insight. Taken together, the objective of

this research is to examine how these perceptions differ in relation to situational factors of the suicide, specifically its method (Study 1) and motive (Study 2), as well as the role of perceivers' individual differences.

With this research focusing on the “how” and “why” of suicide among people with terminal illnesses, it addresses several unexplored, important questions in the literature. First, research on suicide among people with terminal illnesses often focuses on PAD specifically (e.g., Al Rabadi et al., 2019). Study 1 examines several suicide methods for people with terminal illnesses, including PAD, as well as the possibility that traditional methods are also used by this population, consistent with Chung and Lin (2010). Second, the interpersonal theory of suicide proposes that interpersonal stressors (i.e., lack of belonging, burdensomeness) are the primary precipitators of suicidal ideation and subsequent behavior. Study 2 examines interpersonal stressors (namely burdensomeness) in addition to other stressors that are more health-related (both physical and mental) plus autonomous reasons for dying by suicide. See Figure 1.2 for a conceptual model of how each study exists in relation to the interpersonal theory of suicide framework. Taken together, this research has important interdisciplinary implications for various areas within psychology (e.g., social-personality, health) as well as suicidology and moral philosophy.

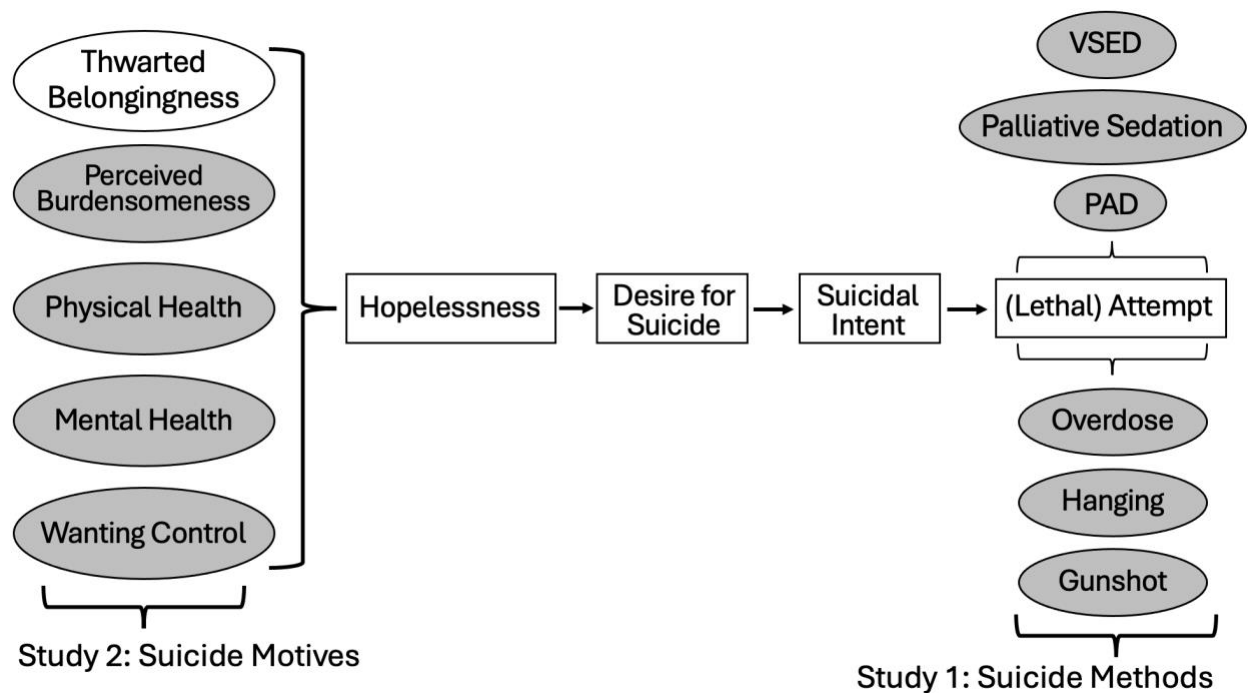


Figure 1.2. The image above displays a simplified version of Van Orden et al.’s (2010) interpersonal theory of suicide alongside the two situational factors examined by this research. Given the chronological order of transitioning from suicidal ideation to behavior, Study 1’s focus on various suicide methods for people with terminal illnesses is represented on the right side of the figure, branching off the last portion of the theory, the suicide attempt/behavior. Study 2’s focus on various suicide motives for people with terminal illnesses is represented on the left side of the figure, including the theory’s original burdensomeness component as well as three additional motives. The shaded grey circles reflect conditional manipulations examined in the present research.

Chapter 2 - Study 1

Given that people with terminal illnesses may have access to medical routes (e.g., PAD) for suicide in addition to traditional methods (i.e., those used by the general public; e.g., overdose), Study 1 examined how perceptions of the suicide and target differ as a function of the suicide method. Specifically, Study 1 vignettes stated that the target dies by suicide using one of six suicide methods. Three of the methods are medical in nature: VSED, palliative sedation, and PAD. The other three methods reflect traditional suicide methods: overdose, hanging, and gun. Together, these six suicide methods represent a comprehensive look at potential method options for suicide among people with terminal illnesses.

Broadly, I expect less negative perceptions of the suicide and target, less perceived similarity with traditional suicide, and more reports for the terminal illness being the cause of death when the target uses the medical methods (e.g., palliative sedation) compared to the more traditional methods (e.g., hanging). This would be consistent with gun and hanging deaths being considered violent suicide methods whereas overdoses are considered a nonviolent suicide method (Chung & Lin, 2010). Moreover, moral perceptions differ depending on if harm is caused by action versus omission (e.g., Cushman et al., 2006), which may imply more violent and/or active methods (e.g., gun, overdose) would be perceived more negatively than more passive methods (e.g., VSED, palliative sedation). Additionally, it is possible that greater acceptability of health conditions as precipitators of suicide (Winterrowd et al., 2015) extends to more favorable perceptions of medical suicide methods (e.g., VSED, palliative sedation, PAD) compared to traditional suicide methods (e.g., overdose, hanging, gun).

With respect to the individual differences, I expect main effects to emerge such that MHB and FWB are associated with more negative attitudes toward this phenomenon as well as FOD and

Suicide Acceptability to be associated with more positive attitudes toward this phenomenon, consistent with Schiffer and Saucier (2024; under review). I expected MHB to interact with the conditional manipulation such that higher levels of MHB would be associated with less negative perceptions when the target died by gun suicide due to honor ideology's relationship with guns (e.g., Bock et al., 2021; Brown et al., 2014b; Osterman & Brown, 2011) and this being potentially a more masculine suicide method. Additionally, I expected greater FOD to be associated with less negative attitudes when the suicide is pill-related (e.g., overdose, PAD) compared to other methods (e.g., gun, hanging) because these may be less violent (Chung & Lin, 2010) while still offering control. Although I did not expect FWB or Suicide Acceptability to interact with the conditional manipulation, I tested this possibility exploratorily.

Study 1 Method

Participants

Participants were recruited via Prolific, an online data collection platform. According to Douglas et al.'s (2023) comparison of multiple online data collection platforms (e.g., Amazon Mechanical Turk, Qualtrics, SONA [i.e., internal university student sample]), Prolific was one of the higher-quality options, meaning these participants were more likely to provide meaningful data, pass attention checks, follow instructions, and complete studies within a reasonable timeframe. Additionally, Prolific has strict pay standards that tend to be higher than other common platforms at a rate of \$8 per hour. The median time to complete the study was around 17 minutes, meaning the minimum pay to meet Prolific's \$8/hr standard was about \$2.33 per participant. Common inclusion criteria were used (e.g., 18 years of age, fluent in English). The only exclusion criterion used did not allow participants from previously completed studies on related topics to participate in this study. Data collection began and completed on June 21st, 2024.

Although my inclusion criteria were based on age of consent as well as comprehending the language used in the survey, online data collection platforms often yield Western, educated, industrialized, rich, and democratic (WEIRD; Henrich et al., 2010) samples (e.g., Chapkovski et al., 2024). Importantly, this sample is likely appropriate for the current research because, according to archival data of people who use PAD, their demographics are often WEIRD (e.g., Al Rabadi et al., 2019, Blanke et al., 2017).

Data Cleaning

359 people accessed this survey, but several were excluded for various reasons. Two participants did not consent to participate. Of those who did consent to participate, several were excluded from data analysis for failing one or more attention checks in the individual difference scales ($n = 14$) and/or failing an attention check regarding which condition of vignettes they read ($n = 17$). Several participants were also omitted for completing any of the three longer (i.e., 20+ items) individual difference scales at a rate of less than one second per item ($n = 6$). These data cleaning procedures left 320 participants for data analysis. According to a sensitivity analysis for multiple linear regressions with 35 predictors (6-level categorical conditional manipulation, five individual differences, and their two-way interactions), this sample size allowed for detection of small-to-medium effect sizes ($f^2 = .089$; Cohen, 1992) with .80 power at $\alpha = .05$.

Participant Demographics

On average, participants were 39.91 years old ($SD = 13.52$), with 73% identifying as women and 23% identifying as men. Most participants were White (69%) and heterosexual (76%). Participants' political orientation breakdown is as follows: 51% liberal, 30% middle of the road, and 19% conservative. On a scale from 1 (*Not At All*) to 9 (*Very Much*), the average combined religiosity and spirituality was just below the midpoint of the scale ($M = 4.36$, $SD = 2.41$; see Table

1). Most participants reported their education level as completing high school (or an equivalent; 38%) or completing a bachelor's degree (31%). In terms of socioeconomic status, most participants reported themselves as middle class (41%) or lower-middle class (30%), with most reporting annual household income as \$20,000-\$40,000 (21%), \$40,000-\$60,000 (24%), or above \$100,000 (23%). In terms of employment status, 61% of participants reported working, either full-time or part-time. Common occupational groups within the Bureau of Labor Statistics' categorizations included office and administrative support (12%), healthcare practitioners (10%), as well as educational instruction and library (9%).²

When asked if they had been affected by suicide in any capacity, 59% said yes and 36% said no. When asked if they had been affected by terminal illness in any capacity, 49% said yes and 51% said no. On a scale from 1 (*Definitely No*) to 9 (*Definitely Yes*), participants reported generally good healthcare, on average, in terms of quality, affordability, and sufficient insurance (see Table 1).

Materials

Unless otherwise stated, all items were completed on 1 (*Strongly Disagree*) to 9 (*Strongly Agree*) Likert-type scales. When applicable, composite scores were created such that higher scores

² For additional insight into the role of occupational group on the outcomes of interest, we used ANOVAs with condensed occupational groups (from over 20 down to 5). Most models were nonsignificant: Painless, $F(4, 309) = 1.03, p = .391$; Do You Consider Mike's Death to be Suicide, $F(4, 288) = 1.57, p = .182$; Perceived Difference Between Terminal Illness Suicide & Traditional Suicide, $F(4, 311) = 0.78, p = .540$; Terminal Illness Suicide is Better Than Traditional Suicide, $F(4, 312) = 1.04, p = .386$; and Cause of Death on the Death Certificate, $F(4, 280) = 1.16, p = .331$. See Supplementary Table A.1 in Appendix A for the estimated marginal means and Tukey's HSD results for the models that were significant.

indicate greater levels of a given construct, after antithetical items were reverse-scored when necessary.

Vignettes

Vignettes were used in a between-groups design to manipulate the suicide method (see Appendix B). Regardless of condition, vignettes described a target, specifically a White man named Mike in his 70s, learning that he has been diagnosed as terminally ill. The target's doctor shares common experiences that the target can expect in his remaining time. Then, the vignette states that because of this, the target decides to die by suicide, after which the last sentence started as follows, "To do this, Mike..." Here, participants were randomly assigned to read one of six Suicide Method conditions using plain language: 1) VSED, 2) palliative sedation, 3) PAD, 4) overdose, 5) hanging, or 6) gunshot.

Attention Check. After reading one vignette, participants correctly responded to an attention check regarding the condition they were in (i.e., how Mike died by suicide).

Manipulation Perceptions. After reading one vignette and passing its attention check, participants were presented with nine adjectives to use in response to the following question on 1 (*Not At All*) to 9 (*Very Much*) Likert-type scale: "How ____ is Mike's method of suicide?" We used an exploratory factor analysis using oblimin rotation to help reduce the number of items for analysis. This yielded two factors, Quick, eigenvalue = 1.65, 23% of variance, loadings = |.43| - |.71|; and Painless, eigenvalue = 2.09, 24% of variance, loadings = |.64| - |.86|. Although there was some cross-loading, it was all below .42. We used ANOVAs to test for differences across

conditions for each of these two manipulation perception composites, which reflected consistent patterns with the information provided in vignettes.³

Vignette Response Items

In response to vignettes, participants completed four types of outcome variable measures, consistent with Schiffer and Saucier (2024; under review). See Appendix C.

General Perceptions. First, participants rated their agreement with 20 general perception items related to the acceptability of the target's suicide (10 items; e.g., *Mike should be allowed to choose when and how he dies*) as well as its positive and negative effects on loved ones (5 items each; e.g., *Mike's death by suicide steals time away from loved ones*). Given that these

³ Suicide Method Condition was a significant predictor of Quick, $F(5, 142) = 113.00, p < .001$. The estimated marginal means for each Suicide Method's from most Quick to least Quick are as follows: gunshot ($M = 7.62, SE = 0.11$), hanging ($M = 6.39, SE = .13$), overdose ($M = 5.47, SE = 0.12$), PAD ($M = 5.04, SE = 0.13$), palliative sedation ($M = 4.04, SE = 0.18$), and VSED ($M = 3.67, SE = 0.19$). According to a Tukey's HSD test, gunshot was perceived as significantly Quicker than all other methods: hanging, $t(312) = 6.37, p < .001$; overdose, $t(312) = 11.01, p < .001$; PAD, $t(312) = 13.28, p < .001$; palliative sedation, $t(312) = 17.14, p < .001$; and VSED, $t(312) = 20.21, p < .001$. Hanging was perceived as significantly Quicker than overdose, $t(312) = 4.68, p < .001$; PAD, $t(312) = 6.91, p < .001$; palliative sedation, $t(312) = 11.21, p < .001$; and VSED, $t(312) = 13.84, p < .001$. Overdose and PAD did not significantly differ in Quickness, $t(312) = 2.20, p = .243$. Overdose was perceived as significantly Quicker than palliative sedation, $t(312) = 6.79, p < .001$; and VSED, $t(312) = 9.09, p < .001$. Palliative sedation and VSED did not significantly differ in perceived Quickness, $t(312) = 1.71, p = .523$.

Suicide Method Condition was a significant predictor of Painless, $F(5, 142) = 46.60, p < .001$. The estimated marginal means for each Suicide Method's from most Painless to least Painless are as follows: PAD ($M = 7.05, SE = 0.21$), overdose ($M = 5.98, SE = 0.24$), palliative sedation ($M = 5.76, SE = 0.31$), gunshot ($M = 4.52, SE = 0.28$), hanging ($M = 3.49, SE = 0.21$), and VSED ($M = 3.36, SE = 0.21$). According to a Tukey's HSD test, PAD was perceived as significantly more Painless than all other methods: overdose, $t(311) = 3.20, p = .019$; palliative sedation, $t(311) = 3.65, p = .004$; gunshot, $t(311) = 7.66, p < .001$; hanging, $t(311) = 10.73, p < .001$; and VSED, $t(311) = 11.08, p < .001$. Overdose was perceived as significantly more Painless than gunshot, $t(311) = 4.35, p < .001$; hanging, $t(311) = 7.40, p < .001$; and VSED, $t(311) = 7.76, p < .001$; but not palliative sedation, $t(311) = 0.62, p = .990$. Gunshot was perceived significantly more Painless than hanging, $t(311) = 3.11, p = .025$; and VSED, $t(311) = 3.50, p = .007$. Hanging and VSED did not significantly differ in perceived Painlessness, $t(311) = 0.40, p = .999$.

subcomponents are often strongly correlated (r 's $> .74$, p 's $< .001$), all items were aggregated into one composite, Positive General Perceptions, to simplify the number of necessary analyses.

Person Perceptions. Second, participants rated their agreement with 20 items about the target specifically, using an adapted version of Batterham et al.'s (2013) Stigma of Suicide Scale. Specifically, all items used the root, *Mike is...* followed by adjectives or phrases. Schiffer and Saucier (2024) have previously used the following composites for this outcome: Weak (5 items; e.g., *pathetic*), Miserable (5 items; e.g., *depressed*), Egotistical (5 items; e.g., *selfish*), and Brave (5 items; e.g., *strong*). Again, to simplify the number of necessary analyses and because these composites are strongly correlated (r 's $> .41$, p 's $< .001$), all items were aggregated into one composite, Stigmatizing Person Perceptions.

Comparisons to Traditional Suicide. Third, participants were asked to make both broad and specific comparisons between the target's suicide and traditional suicide. In terms of broad comparisons, we asked participants two questions. First, we asked, *Do you consider Mike's death to be suicide?* to which participants selected one of the following response options: yes, no, or I don't know. Second, we asked a related but distinct question, *Do you think there is a difference between Mike dying by suicide versus someone WITHOUT a terminal illness dying by suicide?* to which participants responded using a 1 (*Definitely No*) to 9 (*Definitely Yes*) Likert-type scale.

The specific comparisons involved 15 items using the root, *Which suicide is more...?* on -4 (*Suicide by Someone WITHOUT a Terminal Illness*) to 0 (*They Are Not Different*) to +4 (*Mike's Suicide*) Likert-type scales. Schiffer and Saucier (2024) have previously used the following composites for this outcome: Understandable (5 items; e.g., *acceptable*), Empowering (5 items; e.g., *liberating*), and Stigmatizing (e.g., *shameful*). Like the other outcomes, all items were

aggregated into one composite due to strong intercorrelations (r 's $> .60$, p 's $< .001$), Terminal Illness Suicide Is Better Than Traditional Suicide.

Cause of Death on Death Certificate. Finally, participants were asked, *What do you think should be listed as the cause of death on Mike's death certificate?* Participants selected one of three options: *the terminal illness*, *suicide*, or *other* (with an opportunity to write in a free-response answer). For further insight, I included a follow up question: *What was the primary reason for your previous answer?* If *terminal illness* is selected, participants selected one of three options: *Although suicide is what literally caused the death, the illness was the reason for the suicide*; *Suicide as the cause of death can be a stigmatizing label*; or *Other* (with an opportunity to write in a free-response answer). If *suicide* is selected, participants selected one of three options: *Although the illness was the reason for the suicide, suicide is what literally caused the death*; *Suicide as the cause of death can be empowering in that the person did not succumb to the illness*; or *Other* (with an opportunity to write in a free-response answer).

Individual Difference Measures

See Supplementary Table A.2 in Appendix A for the correlations among all individual difference measures and subscales described below. See Supplementary Table A.3 in Appendix A for the individual difference measures' subscales means, standard deviations, one sample t -tests from the midpoint of the scale, and their correlations with the outcome variables.

MHB. To measure MHB, participants completed Saucier et al.'s (2016) 35-item Masculine Honor Beliefs Scale (MHBS; see Appendix D). The MHBS' scale development process demonstrated internal consistency and test-retest reliability over a four- to six-week period as well as predictive validity beyond sex and trait aggression when predicting honor-related provocation (see Saucier et al., 2016). Moreover, this scale has been shown to mediate regional differences in

honor (Saucier et al., 2018a), underscoring its value as an individual difference construct and measure.

The MHBS has seven subscales with five items each: Masculine Courage (e.g., *It is important for a man to be courageous*), Pride in Manhood (e.g., *A man should be embarrassed if someone calls him a wimp*), Virtue (e.g., *It is morally wrong for a man to walk away from a fight*), Protection (e.g., *It is a male's responsibility to protect his family*), Provocation/Insult (e.g., *If a man is insulted, his manhood is insulted*), Socialization (e.g., *If your son got into a fight, you would be proud that he stood up for himself*), and Family & Community Bonds (e.g., *A man's family should be his number one priority*). Participants' responses to the 35 items were aggregated to create an overall MHB composite score for each participant.

FWB. To measure FWB, participants completed Paulhus and Carey's (2011) 27-item Free Will and Determinism Plus scale (see Appendix E). The Free Will and Determinism Plus identified its four subscales as representing distinct (i.e., orthogonal) constructs: Unpredictability (8 items; e.g., *No one can predict what will happen in this world*), Scientific Determinism (7 items; e.g., *People's biological makeup determines their talents and personality*), and Fatalistic Determinism (5 items; e.g., *Fate already has a plan for everyone*). Only the Free Will Beliefs subscale (7 items; e.g., *People have complete control over the decisions they make*) was examined for theoretical importance in this program of research. The scale demonstrates construct validity of each subscale in relation to locus of control and personality measures, specifically the Big Five, as well as reliability across student and community samples.

FOD. To measure FOD, participants completed Lester and Abdel-Khalek's (2003) 28-item Revised Collett-Lester Fear of Death scale using a 1 (*Not At All*) to 9 (*Very Much*) Likert-type scale (see Appendix F). This scale has undergone several iterations, with the first revision

addressing issues with the original scale, like unequal numbers of items in each subscale and inconsistent factor structures. The first revision of the scale demonstrated test-retest reliability as well as construct validity (e.g., correlating with neuroticism, death anxiety; Lester, 1990). The second revision to this scale, which is used in the current research, further refined the items by omitting those with poor factor loadings.

This scale uses the root question, *How disturbed or made anxious are you by the following aspects of death and dying?* with four subscales composed of seven items each: Your Own Death (e.g., *missing out on so much after you die*), Your Own Dying (e.g., *the pain involved in dying*), Death of Others (e.g., *losing someone close to you*), and Dying of Others (e.g., *watching the person suffer from pain*). Given the nature of these data reflecting third-person perceptions of people with terminal illnesses' suicides, we combined FOD's four subscales into two composites, FOD-Self and FOD-Other, and tested both as unique predictors. According to a paired samples *t*-test, participants reported significantly higher FOD in relation to others' death and dying ($M = 6.57$, $SE = 0.08$) compared to their own death and dying ($M = 5.80$, $SE = 0.08$), $t(319) = 9.53$, $p < .001$.

Suicide Acceptability. To measure Suicide Acceptability, participants completed Hoelter's (1979) 6-item Suicide Acceptability Scale (see Appendix G). Due to the low number of items, a factor structure has not been explored for this construct. However, multiple studies show sufficient reliability coefficients or measures of internal consistency (i.e., $> .70$; e.g., Hoelter, 1979; Schiffer & Saucier, 2024). Participants' responses to all items (e.g., *Suicide is immoral* [reverse-scored]) were aggregated to create an overall Suicide Acceptability composite score for each participant.

Procedure

After receiving IRB approval, this study was preregistered on the Open Science Framework (OSF; <https://doi.org/10.17605/OSF.IO/8H73Q>). Participants signed up for this study on Prolific and completed the survey via Qualtrics. First, participants provided informed consent and demographic information. Second, in a counterbalanced order, participants completed the vignette (and its response items) and (randomized) individual difference measures. Finally, participants were debriefed, thanked, and compensated.

Study 1 Results

Descriptive Statistics

Table 1 includes the means, standard deviations, and one sample *t*-tests against the midpoint of the scale for relevant continuous variables. Participants' average level of Positive General Perceptions was significantly *above* the midpoint of scale whereas their average level of Stigmatizing Person Perceptions was significantly *below* the midpoint of the scale, consistent with my hypotheses and past research (e.g., Schiffer & Saucier, 2024). In terms of comparisons to traditional suicide, when asked, "Do you consider Mike's death to be suicide?", 89% of participants said yes ($n = 262$) and 11% of participants said no ($n = 33$). This could be a product of the study materials using the term "suicide" or reflective of true beliefs that this is suicide. Additionally, and consistent with hypotheses, when asked on a 1 (*Definitely No*) to 9 (*Definitely Yes*) Likert-type scale if there was difference between the target's suicide and traditional suicide, participants' average response was significantly above the midpoint of the scale. Moreover, participants' average level of Terminal Illness Suicide is Better than Traditional Suicide (e.g., more understandable, more empowering, less stigmatizing) was also significantly above the midpoint of the scale (i.e., 1 [*Suicide by Someone WITHOUT a Terminal Illness*] to 9 [*Mike's Suicide*]). Taken

together, these findings suggest that while participants generally consider the target's death to be suicide, they view it as a distinct form of suicide that is less stigmatizing than traditional suicide.

In response to the question regarding what should be listed as the cause of death on the death certificate, 52% said suicide ($n = 165$), 38% said the terminal illness ($n = 123$), and 10% said other and wrote in a response ($n = 32$). Write-in responses often suggested some label that mentions *both* suicide and terminal illness or some label that is more method-specific (e.g., malnutrition, euthanasia). Of the 165 participants who selected “suicide”, 99% attributed their response to suicide being the literal cause of death ($n = 163$) whereas one participant attributed their response to suicide being more empowering than dying from the illness. One participant selected “other” and wrote in that this cause of the death was the truth. Of the 123 participants who selected “the terminal illness”, 89% attributed their response to the terminal illness being the reason for the suicide ($n = 109$) whereas 10% attributed their response to suicide being a stigmatizing label ($n = 12$). Two participants selected “other”; one mentioned that both of our provided reasons were correct and the other noted that listing “suicide” may influence life insurance payouts.

Table 1*Study 1 Means, Standard Deviations, & One Sample t-tests Against the Midpoint of the Scale*

	<i>M</i>	<i>SD</i>	Range	<i>t</i>	<i>p</i>	<i>d</i>
1. Masculine Honor Beliefs	5.02	1.37	1.74, 8.63	0.21	.832	0.01
2. Free Will Beliefs	6.13	1.39	1.29, 9	14.61	<.001	0.81
3. Fear of Death - Self	5.80	1.89	1, 9	7.59	<.001	0.42
4. Fear of Death - Others	6.57	1.52	1.57, 9	18.50	<.001	1.03
5. Suicide Acceptability	4.62	2.01	1, 9	-3.35	.001	-0.19
8. Religiosity & Spirituality	4.36	2.41	1, 9	-4.72	<.001	-0.27
9. Political Orientation	1.68	0.78	1, 3	-7.26	<.001	-0.41
10. Quality Healthcare	7.04	2.15	1, 9	17.02	<.001	0.95
11. Affordable Healthcare	6.48	2.29	1, 9	11.51	<.001	0.65
12. Sufficient Health Insurance	6.50	2.59	1, 9	10.38	<.001	0.58
13. Experience with Suicide?	0.62	0.49	0, 1	4.42	<.001	0.24
14. Experience with TI?	0.49	0.50	0, 1	-0.28	.780	-0.02
15. Manipulation Perception: Quick	5.45	1.70	1.17, 9	4.72	<.001	0.26
16. Manipulation Perception: Painless	5.00	2.21	1, 9	0.03	.973	0.00
15. Positive General Perceptions	5.74	1.87	1.15, 9	7.08	<.001	0.40
16. Stigmatizing Person Perceptions	3.68	1.44	1, 8.60	-16.45	<.001	-0.92
17. Is It Suicide?	0.88	0.32	0, 1	21.10	<.001	1.19
18. Diff b/w TI Suicide & Trad Suicide	6.82	2.14	1, 9	15.20	<.001	0.85
19. TI Suicide > Traditional Suicide	6.25	1.10	2.20, 9	20.35	<.001	1.14
20. Cause of Death on Death Certificate	0.43	0.50	0, 1	-2.50	.013	-0.14

Note: Most variables were completed on 1 to 9 Likert-type scales, with various anchor labels. Political Orientation was coded as follows: 1 = liberal, 2 = middle of the road, and 3 = conservative. Is It Suicide? coded “no” as 0 and “yes” as 1. Cause of Death on Death Certificate coded “suicide” as 0 and “their terminal illness” as 1, while treating “other” as missing values.

Correlations

Theoretically consistent relationships emerged among the death materials (see Table 2), consistent with my hypotheses and past research (e.g., Schiffer & Saucier, 2024). For instance, there were positive correlations between the more favorable outcomes (e.g., Positive General Perceptions, Terminal Illness Suicide Is Better than Traditional Suicide) and negative correlations between the more favorable outcomes and Stigmatizing Person Perceptions. Additionally, the more favorable outcomes were associated with a greater likelihood of reporting “terminal illness” as the cause of death on the death certificate whereas greater Stigmatizing Person Perceptions were associated with a greater likelihood of reporting “suicide” as the cause of death on the death certificate. In terms of manipulation perceptions, perceived Quickness did not significantly correlate with any of the death materials. However, perceived Painlessness was associated with more favorable outcomes (e.g., more Positive General Perceptions, Terminal Illness Suicide Is Better than Traditional Suicide; less Stigmatizing Person Perceptions).

Table 2

Correlations Among Study 1 Variables

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1. Masc Honor Beliefs	(.95)																							
2. Free Will Beliefs	.48	(.81)																						
3. Fear of Death - Self	.04	-.02	(.92)																					
4. Fear of Death - Others	.15	-.00	.67	(.89)																				
5. Suicide Acceptability	-.31	-.33	.04	.01	(.83)																			
6. Age	.02	.11	-.18	-.25	-.04	-																		
7. Gender	.21	-.04	-.21	-.14	.03	-.05	-																	
8. Race	-.24	-.09	-.00	-.06	.14	.23	-.01	-																
9. Education	-.15	-.21	.01	-.02	-.08	.10	-.04	.03	-															
10. SES	.01	.00	.03	-.02	-.21	.06	-.00	.08	.40	-														
11. Religiosity & Spirit	.36	.33	.05	.10	-.45	.20	-.09	-.05	.00	.05	(.74)													
12. Political Orientation	.39	.34	-.05	-.08	-.37	.26	-.01	.04	-.15	.04	.45	-												
13. Quality Healthcare	.10	.12	-.03	-.03	-.21	.22	-.05	.13	.12	.32	.08	.07	-											
14. Affordable Healthcare	.11	.12	.03	.02	-.13	.21	-.10	.04	.02	.18	.10	.05	.72	-										
15. Sufficient Health Insur	.05	.07	.02	-.00	-.13	.13	-.04	.15	.10	.27	.09	.00	.75	.82	-									
16. Exp w/ suicide	-.03	-.09	.06	.08	.29	-.09	-.06	.01	-.18	-.20	-.06	-.11	-.16	-.08	-.10	-								
17. Exp w/ TI	-.03	.04	-.05	-.09	.06	.22	-.08	.17	-.04	.03	.05	.06	.14	.03	.05	.09	-							
18. MP – Quick	-.01	-.10	.04	.02	.02	-.02	-.05	-.03	.04	.02	.06	-.00	.05	.12	.07	-.03	-.02	(.72)						
19. MP – Painless	-.15	-.16	-.04	-.05	.29	.14	-.02	.18	.01	-.05	-.09	-.14	-.07	-.10	-.07	.09	.02	-.02	(.77)					
20. Positive General Perc	-.35	-.29	-.01	-.09	.68	.12	.01	.19	-.06	-.12	-.41	-.34	-.06	-.07	-.04	.19	.14	-.05	.49	(.95)				
21. Stigmatizing Person	.37	.25	-.07	.02	-.56	-.07	.10	-.18	.02	.07	.32	.28	.07	.06	.04	-.11	-.18	.03	-.37	-.79	(.92)			
22. Is It Suicide?	.08	-.03	-.03	.05	-.04	-.17	.05	-.05	.02	.00	.01	-.02	.01	.06	-.00	.04	-.04	.05	-.28	-.30	.32	-		
23. Diff?: TI v Trad Sui	-.02	-.08	.11	.04	.26	-.04	.02	.12	-.10	-.07	-.17	-.12	.09	-.00	.05	.03	.02	-.02	.20	.39	-.35	-.16	-	
24. TI > Trad Suicide	.02	-.02	.13	.13	.22	.09	.04	.13	-.02	.08	-.11	-.11	.05	-.01	.02	.05	.10	-.02	.38	.46	-.40	-.30	.56	(.92)
25. Death Certificate	-.10	-.12	.14	.07	.14	.07	-.10	.18	.09	.04	-.11	-.12	.09	-.02	.05	-.04	.09	-.11	.28	.40	-.42	-.34	.32	.33

Note: $p < .05$ are bolded. Alphas are provided along the diagonal. Gender was coded women as 0 and men as 1, excluding participants who identified differently. Race was coded nonwhite individuals as 0 and white individuals as 1. Education was coded as follows: 0 = some high school or less, 1 = high school or equivalent, 2 = associate’s degree, 3 = bachelor’s degree, 4 = master’s degree, 5 = doctorate. SES was coded as follows: 0 = lower class, 1 = lower-middle class, 2 = middle class, and 3 = upper-middle class. Is It Suicide? coded “no” as 0 and “yes” as 1. Cause of Death on Death Certificate coded “suicide” as 0 and “their terminal illness” as 1, while treating “other” as missing values.

Individual Differences

Higher MHB were associated with less Positive General Perceptions and more Stigmatizing Person Perceptions, consistent with my hypotheses as well as Schiffer and Saucier (2024; under review). This pattern may be attributed to terminal illnesses often being accompanied by dignity loss (Blanke et al., 2017; Chochinov et al., 2002) and stigma (e.g., Epley & McCaghy, 1978), which may be perceived by individuals higher in honor ideology as weakening one's reputation. Inconsistent with my hypotheses, MHB were unassociated with comparisons to traditional suicide and the Cause of Death on the Death Certificate question. Additionally, higher MHB were associated with lower perceived Painlessness of the suicide method (across conditions), which may be consistent with MHB being positively associated with FOD directed toward others.

Similarly, higher FWB were also associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, as well as more frequent reports for "suicide" to be listed as the Cause of Death on the Death Certificate, consistent with my hypotheses as well as Schiffer and Saucier (2024; under review) generally. These patterns may be consistent with FWB's positive relationships with mental health stigma (e.g., Chandrashekar, 2020) and negative correlation with Suicide Acceptability. Additionally, higher FWB were associated with lower perceived Painlessness of the suicide method (across conditions). Inconsistent with my hypotheses, FWB were unassociated with comparisons to traditional suicide.

The FOD variables did not significantly correlate with general or person perceptions, but both greater FOD-Self and FOD-Other were associated with greater agreement that Terminal Illness Suicide is Better than Traditional Suicide. Greater FOD-Self was additionally associated with more frequent reports for "terminal illness" to be listed as the Cause of Death on the Death Certificate. These findings are consistent with my hypotheses for the overall FOD construct, which

were derived from the fact that unknowns surrounding death (e.g., Lester & Abdel-Khalek, 2003) and perceptions that fear may motivate PAD (Schiffer & Saucier, under review) are salient for greater FOD.

Greater Suicide Acceptability was associated with more Positive General Perceptions, less Stigmatizing Person Perceptions, perceiving more of a difference between suicide by people with versus without terminal illnesses, thinking Terminal Illness Suicide is Better than Traditional Suicide, and more frequent reports for “terminal illness” to be listed as the Cause of Death on the Death Certificate, consistent with my hypotheses as well as Schiffer and Saucier (2024; under review). Additionally, greater Suicide Acceptability was associated with greater perceived Painlessness of the suicide method (across conditions).

Demographics

As age increased, so did the likelihood of participants being White (compared to nonwhite). Age was also positively associated with Religiosity & Spirituality, political conservatism, satisfactory access to healthcare, and experience with terminal illness. Moreover, as age increased, FOD, for both the self and others, tended to decrease, consistent with Kastenbaum (1992). Perhaps relatedly, as age increased, participants tended to report greater perceived Painlessness of the suicide method (across conditions), greater Positive General Perceptions, and more frequent reports for “no” in response to the question Do You Consider Mike’s Death to be Suicide? In terms of gender, identifying as a man (compared to a woman) was associated with greater MHB and less FOD, both toward the self and others. This pattern for MHB is consistent with the socialization of gender norms and honor values (e.g., Schiffer et al., in preparation). Although some research suggests there may be no gender differences in FOD (e.g., Conte et al., 1982), our finding is consistent with Davis et al. (1983).

In terms of race, identifying as White (compared to nonwhite) was associated with more satisfactory healthcare, greater experience with terminal illness, lower MHB, greater Suicide Acceptability. With respect to the study outcomes, identifying as White was associated with greater perceived Painlessness (of the suicide methods), more Positive General Perceptions, less Stigmatizing Person Perceptions, perceiving more of a Difference Between Terminal Illness Suicide & Traditional Suicide, more agreement with Terminal Illness Suicide is Better Than Traditional Suicide, and more frequent reports for the “terminal illness” to be listed as the Cause of Death on the Death Certificate.

In terms of education, higher levels of education were associated with greater socioeconomic status, being more politically liberal, greater access to quality healthcare, and less experience with suicide. With respect to the individual differences, higher levels of education were also associated with lower MHB and FWB. In terms of socioeconomic status, greater socioeconomic status was associated with more satisfactory access to healthcare, less experience with suicide, less Suicide Acceptability, and less Positive General Perceptions.

There was a positive correlation between Religiosity and Spirituality political orientation (meaning political conservatism), yielding similar relationships with the other variables. Specifically, both were positively associated with MHB and FWB but negatively associated with Suicide Acceptability. With respect to study outcomes, both were associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, perceiving less of a difference between suicide by people with versus without terminal illnesses, and less agreement with Terminal Illness Suicide is Better than Traditional Suicide. Greater conservatism (but not Religiosity & Spirituality) was additionally associated with less perceived Painlessness of the

suicide methods as well as more frequent reports for “suicide” to be listed as the Cause of Death on the Death Certificate.

There were positive correlations among the various access to healthcare items. However, only access to quality healthcare, specifically, was negatively associated with experience with suicide and positively associated with experience with terminal illness. Quality healthcare was also associated with greater FWB and less Suicide Acceptability. Affordable healthcare was positively associated with MHB and FWB, but negatively associated with Suicide Acceptability. Greater self-reported affordability of healthcare was also associated with perceiving the various suicide methods are more Quick. Sufficiency of health insurance was also negatively associated with Suicide Acceptability. Experience with suicide was positively associated with Suicide Acceptability and Positive General Perceptions. Greater experience with terminal illness was associated with more Positive General Perceptions and less Stigmatizing Person Perceptions.

Regressions

To test the predictive effects of key variables on perceptions of the target’s suicide, we used both simultaneous multiple linear regressions and logistic regressions for specific outcomes. Predictors were the same in all models: Suicide Method (6-level categorical variable),⁴ MHB, FWB, FOD-Self, FOD-Others, Suicide Acceptability, MHB x Suicide Method, FWB x Suicide Method, FOD-Self x Suicide Method, FOD-Other x Suicide Method, and Suicide Acceptability x Suicide Method. Due to the volume of predictors and the lack of theoretical value in understanding the interactions between individual differences, I did not examine the full factorials. Simultaneous

⁴ Participants were divided between the six conditions via Qualtrics’ random assignment. Specifically, there were 57 participants in the gunshot condition, 56 participants in the hanging condition, 56 participants in the PAD condition, 54 participants in the overdose condition, 54 participants in the VSED condition, and 43 participants in the palliative sedation condition.

linear regression models were used to predict the four continuous outcome variables: Positive General Perceptions, Stigmatizing Person Perceptions, Different From Traditional Suicide, and Terminal Illness Suicide Is Comparatively Better Than Traditional Suicide. A logistic regression was used to predict the two binomial outcome variables: Do You Consider Mike's Death to be Suicide (yes/no) and Cause of Death on the Death Certificate (suicide/terminal illness).

Together, these predictors yielded significant models for all simultaneous regression models, accounting for 58% of variance in Positive General Perceptions, $F(35, 284) = 11.29, p < .001$; 44% of variance in Stigmatizing Person Perceptions, $F(35, 284) = 6.28, p < .001$; 18% of variance in Perceived Difference Between Terminal Illness Suicide and Traditional Suicide, $F(35, 284) = 1.82, p = .005$; and 22% of variance in Terminal Illness Suicide is Better Than Traditional Suicide, $F(35, 284) = 2.27, p < .001$. See Table 3. Similarly, the omnibus tests for both binomial outcomes were significant: Do You Consider Mike's Death to be Suicide, $\chi^2(35, N = 295) = 75.60, p < .001$ (including 262 who said "yes" and 33 who said "no"), and Cause of Death on the Death Certificate, $\chi^2(35, N = 288) = 96.50, p < .001$ (including 165 who said "suicide" and 123 who said "terminal illness"; excluding 32 participants who selected "other"). See Table 4.

Table 3*Study 1 Simultaneous Linear Regressions: Fixed Effects & Parameter Estimates*

<u>Positive General Perceptions</u>								<u>Stigmatizing Person Perceptions</u>							
$R^2 = .58, F(35, 284) = 11.29, p < .001$								$R^2 = .44, F(35, 284) = 6.28, p < .001$							
	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>		<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Intercept	-	-	0.00	5.80	0.07	78.34	<.001		-	-	0.00	3.63	0.07	54.97	<.001
Suicide Method [gunshot]	6.40	<.001	-0.05	-0.10	0.25	-0.40	.687		3.08	.010	-0.03	-0.05	0.22	-0.23	.822
MHB	8.97	.003	-0.14	-0.20	0.07	-3.00	.003		15.54	<.001	0.22	0.23	0.06	3.94	<.001
FWB	0.02	.887	0.01	0.01	0.07	0.14	.887		0.44	.507	-0.04	-0.04	0.06	-0.66	.507
FOD-Self	0.11	.737	0.02	0.02	0.05	0.34	.737		1.31	.254	-0.07	-0.06	0.05	-1.14	.254
FOD-Other	3.47	.064	-0.10	-0.13	0.07	-1.86	.064		0.56	.456	0.05	0.05	0.06	0.75	.456
Suicide Acceptability	209.62	<.001	0.63	0.58	0.04	14.48	<.001		93.02	<.001	-0.48	-0.35	0.04	-9.64	<.001
MHB x Suicide Method	1.13	.346	0.04	0.06	0.21	0.27	.789		0.54	.745	-0.08	-0.09	0.18	-0.48	.630
FWB x Suicide Method	1.08	.373	-0.19	-0.25	0.20	-1.27	.204		0.95	.451	0.18	0.19	0.18	1.08	.283
FOD-S x Suicide Method	0.78	.568	0.23	0.22	0.20	1.12	.263		0.77	.575	-0.34	-0.25	0.18	-1.44	.152
FOD-O x Suicide Method	1.64	.148	0.09	0.11	0.26	0.40	.689		0.97	.436	-0.01	-0.01	0.24	-0.06	.952
SA x Suicide Method	0.34	.890	0.14	0.13	0.14	0.92	.357		0.28	.921	-0.12	-0.08	0.12	-0.68	.497
<u>Diff b/w Terminal Illness Suicide & Traditional Suicide</u>								<u>Terminal Illness Suicide Better Than Traditional Suicide</u>							
$R^2 = .18, F(35, 284) = 1.82, p = .005$								$R^2 = .22, F(35, 284) = 2.27, p < .001$							
	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>		<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Intercept	-	-	0.00	6.90	0.12	58.12	<.001		-	-	0.00	6.28	0.06	105.52	<.001
Suicide Method [gunshot]	0.90	.484	-0.20	-0.44	0.40	-1.09	.276		3.70	.003	-0.27	-0.30	0.20	-1.48	.139
MHB	1.12	.290	0.07	0.11	0.11	1.06	.290		0.81	.369	0.06	0.05	0.05	0.90	.369
FWB	0.68	.410	-0.06	-0.09	0.11	-0.82	.410		0.22	.643	0.03	0.02	0.05	0.46	.643
FOD-Self	3.02	.083	0.13	0.15	0.09	1.74	.083		0.83	.363	0.07	0.04	0.04	0.91	.363
FOD-Other	1.04	.308	-0.08	-0.11	0.11	-1.02	.308		0.48	.488	0.05	0.04	0.06	0.69	.488
Suicide Acceptability	15.87	<.001	0.24	0.26	0.06	3.98	<.001		16.35	<.001	0.24	0.13	0.03	4.04	<.001
MHB x Suicide Method	1.09	.368	-0.11	-0.16	0.34	-0.49	.624		1.58	.165	0.12	0.10	0.17	0.60	.550
FWB x Suicide Method	1.66	.144	-0.44	-0.67	0.32	-2.12	.035		2.50	.031	-0.35	-0.28	0.16	-1.77	.078
FOD-S x Suicide Method	1.66	.143	0.43	0.48	0.32	1.51	.131		0.37	.868	0.09	0.05	0.16	0.34	.736
FOD-O x Suicide Method	2.20	.055	-0.07	-0.11	0.42	-0.25	.804		1.61	.157	0.49	0.36	0.21	1.67	.095
SA x Suicide Method	0.30	.912	0.01	0.01	0.22	0.03	.978		0.43	.828	0.05	0.02	0.11	0.22	.824

Note: Both standardized beta weights (β) and unstandardized estimates (*b*) are provided.

Table 4*Study 1 Logistic Regressions: Likelihood Ratio Tests & Model Coefficients*

	<u>Do You Consider Mike's Death to be Suicide?</u>						<u>Cause of Death on Death Certificate</u>					
	$X^2(35, N = 295) = 75.60, p < .001$						$X^2(35, N = 288) = 96.50, p < .001$					
	X^2	p	b	SE	Z	p	X^2	p	b	SE	Z	p
Intercept	-	-	-4.28	4.37	-0.98	.328	-	-	.121	2.72	0.45	.656
Suicide Method [gunshot]	19.32	.002	-86.08	6.05e-5	-1.42e-4	1.00	2.82	.809	-3.57	3.76	-0.95	.341
MHB	3.25	.071	0.90	0.53	1.68	.093	7.10	.008	-1.00	0.44	-2.25	.024
FWB	2.43	.119	-0.65	0.47	-1.37	.169	0.86	.353	0.25	0.27	0.91	.361
FOD-Self	0.94	.333	-0.49	0.53	-0.93	.355	3.27	.071	0.65	0.38	1.69	.091
FOD-Other	5.64	.018	1.74	0.93	1.86	.063	3.09	.079	-0.81	0.48	-1.70	.089
Suicide Acceptability	0.70	.401	-0.31	0.37	-0.83	.409	4.23	.040	0.48	0.25	1.93	.054
MHB x Suicide Method	10.93	.053	-17.31	5.73e-4	-3.02e-4	1.00	9.26	.099	0.96	0.53	1.82	.069
FWB x Suicide Method	23.77	<.001	24.12	3.04e-4	7.93e-4	.999	2.73	.741	-0.28	0.39	-0.72	.047
FOD-S x Suicide Method	9.54	.089	19.25	2.69e-4	7.17e-4	.999	4.74	.448	-0.27	0.50	-0.55	.582
FOD-O x Suicide Method	15.59	.008	11.34	1.71e-4	6.63e-4	.999	9.80	.081	0.50	0.59	0.84	.400
SA x Suicide Method	2.64	.756	-7.81	1.69e-4	-4.62e-4	1.00	14.72	.012	-0.16	0.31	-0.51	.608

Note: Do You Consider Mike's Death to be Suicide? coded "no" ($n = 33$) as 0 and "yes" ($n = 262$) as 1. Cause of Death on Death Certificate coded "suicide" ($n = 165$) as 0 and "terminal illness" ($n = 123$) as 1. These analyses exclude participants who did not respond using these binomial outcomes.

Given that Suicide Method Condition also yielded significant differences in both manipulation perception variables (as described in the Study 1 Method section), it is possible that any unique effects emerging in these various regression models may be mediated by the manipulation perception variables, Quick and Painless. These variables may serve as viable mediators because they temporally preceded the outcome variables (e.g., Quick and Painless ratings were completed before Positive General Perceptions). Moreover, we expected the Suicide Method condition to influence the manipulation perception variables (given their phrasing directly pertained to participants' perspectives on the specified suicide method) and that these, in turn, would influence the broader outcome variables which were less condition-specific (e.g., Positive General Perceptions). We believe this order of mediation makes more temporal and logical sense compared to the alternative (i.e., outcome variables influencing the manipulation perception variables). As such, for any significant main effect⁵ of an individual difference variable, we tested mediation models; for any significant interaction effect, we tested moderated mediation models such that the individual difference's effect on the outcome is mediated by perceived Quick and/or Painless at different levels of the Suicide Method Condition (i.e., moderator).

Suicide Method Condition

Suicide Method Condition uniquely predicted most of the continuous outcomes: Positive General Perceptions, $F(5, 284) = 6.40, p < .001$; Stigmatizing Person Perceptions, $F(5, 284) = 3.08, p = .010$; and Terminal Illness Suicide is Better Than Traditional Suicide, $F(5, 284) = 3.70, p = .003$. Additionally, Suicide Method Condition uniquely predicted one binomial outcome: Do You Consider Mike's Death to be Suicide, $L-R \chi^2(5, N = 295) = 19.32, p = .002$.

⁵ There are other approaches to mediation that do not require a significant direct relationship between variables, but the current research will follow that of Baron and Kenny (1986).

Positive General Perceptions. The estimated marginal means for each Suicide Method's from most to least Positive General Perceptions are as follows: PAD ($M = 6.51$, $SE = 0.17$), palliative sedation ($M = 6.22$, $SE = 0.21$), VSED ($M = 5.62$, $SE = 0.18$), overdose ($M = 5.57$, $SE = 0.18$), gunshot ($M = 5.49$, $SE = 0.18$), and hanging ($M = 5.39$, $SE = 0.18$). According to a Tukey's HSD test, PAD had significantly more Positive General Perceptions than VSED, $t(284) = 3.54$, $p = .006$; overdose, $t(284) = 3.76$, $p = .003$; gunshot, $t(284) = 4.12$, $p < .001$; and hanging, $t(284) = 4.53$, $p < .001$. Additionally, palliative sedation had significantly more Positive General Perceptions than hanging, $t(284) = 3.09$, $p = .027$. These patterns are somewhat consistent with my hypotheses, with medical methods (e.g., PAD, palliative sedation) receiving more favorable perceptions than the three traditional methods. The exception to this is VSED, which was perceived less favorably than expected.

Stigmatizing Person Perceptions. The estimated marginal means for each Suicide Method are as follows from most to least Stigmatizing Person Perceptions: VSED ($M = 3.91$, $SE = 0.16$), gunshot ($M = 3.83$, $SE = 0.16$), hanging ($M = 3.78$, $SE = 0.16$), overdose ($M = 3.70$, $SE = 0.16$), palliative sedation ($M = 3.39$, $SE = 0.18$), and PAD ($M = 3.19$, $SE = 0.15$). According to a Tukey's HSD test, PAD had significantly less Stigmatizing Perceptions than gunshot, $t(284) = 2.88$, $p = .045$, and VSED, $t(284) = 3.22$, $p = .018$. Again, these patterns are mostly consistent with my hypotheses, except for VSED, and the patterns that emerged in the Positive General Perceptions model.

Terminal Illness Suicide is Better Than Traditional Suicide. The estimated marginal means for each Suicide Method are as follows from most to least Terminal Illness Suicide is Better Than Traditional Suicide: PAD ($M = 6.75$, $SE = 0.14$), palliative sedation ($M = 6.41$, $SE = 0.17$), gunshot ($M = 6.29$, $SE = 0.14$), VSED ($M = 6.15$, $SE = 0.14$), overdose ($M = 6.11$, $SE = 0.14$), and

hanging ($M = 5.99$, $SE = 0.14$). According to a Tukey's HSD test, PAD had significantly more Terminal Illness Suicide is Better Than Traditional Suicide than VSED, $t(284) = 3.00$, $p = .035$; overdose, $t(284) = 3.23$, $p = .017$; and hanging, $t(284) = 3.83$, $p = .002$. See Figure 3. This is consistent with the patterns emerging in the previous two models.

Do You Consider Mike's Death to be Suicide? The probability of participants selecting "yes" in response to the question, Do You Consider Mike's Death to be Suicide? is as follows in descending order: hanging (probability = 1.00, $SE = 1.70e-11$, 95CI [2.22e-16, 1.00]), overdose (probability = 1.00, $SE = 2.67e-11$, 95CI [2.22-e16, 1.00]), gunshot (probability = 0.97, $SE = 0.03$, 95CI [0.83, 0.96]), VSED (probability = 0.94, $SE = 0.04$, 95CI [0.79, 0.98]), palliative sedation (probability = 0.87, $SE = 0.07$, 95CI [0.66, 0.96]), and PAD (probability = 0.80, $SE = 0.06$, 95CI [0.65, 0.89]). Although I did not originally offer formal hypotheses for this outcome, it follows that the methods with the highest probabilities of receiving "yes" as the answer to Do You Consider Mike's Death to be Suicide are those that are methods traditionally used by the general population, meaning these may be scripts or heuristics for suicide. Extending this, PAD received the most reports for not being considered suicide, perhaps because logistically someone else with authority is helping.

MHB

MHB uniquely predicted Positive General Perceptions, $F(1, 284) = 8.97$, $p = .003$, and Stigmatizing Person Perceptions, $F(1, 284) = 15.54$, $p < .001$. Specifically, higher MHB were associated with less Positive General Perceptions, $\beta = -0.14$, $b = -0.20$, $SE = 0.07$, $p = .003$, and greater Stigmatizing Person Perceptions, $\beta = 0.22$, $b = 0.23$, $SE = 0.06$, $p < .001$. Additionally, MHB served as a unique predictor of the binomial outcome, Cause of Death on the Death Certificate, L-R $\chi^2(1, N = 288) = 7.10$, $p = .008$, such that higher MHB were associated with a

lower likelihood of selecting “terminal illness” (as opposed to “suicide”) as the cause of death, $b = -1.00$, $SE = 0.44$, $Z = -2.25$, $p = .024$. The MHB effects that emerged were consistent with my hypotheses, but MHB did not interact with Suicide Method, contrary to my hypotheses.

Mediation of MHB’s Effects. The mediation analyses for MHB’s main effects on the outcomes are provided in Table 5. Quick did not serve as a significant mediator with any of MHB’s main effects, which is likely because the relationship between MHB and perceived Quickness was negligible. However, Painless partially mediated MHB’s effects on Positive General Perceptions and Stigmatizing Person Perceptions, but not Cause of Death on the Death Certificate. Specifically, higher MHB were associated with lower perceived Painlessness, lessening the positive effect of perceived Painlessness on Positive General Perceptions and strengthening the negative effect of perceived Painlessness on Stigmatizing Person Perceptions. The idea that higher MHB were associated with perceiving suicide (regardless of type of method) as more painful seems contrary to the nature of MHB as valuing a tough and dominant social reputation (Saucier et al., 2016; 2018), but nonetheless seems to exacerbate negative attitudes toward people with terminal illnesses’ suicides.

Table 5

Study 1 Mediation Effects & Path Estimates for Significant MHB Main Effects with Quick & Painless as Mediators

Positive General Perceptions	Estimate	<u>Quick</u>			Estimate	<u>Painless</u>		
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	3.92e-4	0.01	0.07	.944	-0.09	0.04	-2.40	.016
a) MHB → Mediator	-0.01	0.07	-0.10	.921	-0.23	0.09	-2.55	.011
b) Mediator → Outcome	-0.06	0.06	-0.96	.337	0.38	0.04	9.60	<.001
Direct (c: MHB → Outcome)	-0.47	0.07	-6.72	<.001	-0.38	0.06	-6.43	<.001
Total (c + a x b)	-0.47	0.07	-6.73	<.001	-0.47	0.07	-6.89	<.001
Stigmatizing Person Perceptions	Estimate	<u>Quick</u>			Estimate	<u>Painless</u>		
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	-1.94e-4	0.00	-0.05	.959	0.05	0.02	2.46	.014
a) MHB → Mediator	-0.01	0.07	-0.10	.919	-0.23	0.09	-2.62	.009
b) Mediator → Outcome	0.03	0.04	0.66	.507	-0.21	0.03	-7.03	<.001
Direct (c: MHB → Outcome)	0.39	0.06	6.75	<.001	0.34	0.05	6.56	<.001
Total (c + a x b)	0.39	0.06	6.75	<.001	0.39	0.06	7.00	<.001
COD on Death Certificate	Estimate	<u>Quick</u>			Estimate	<u>Painless</u>		
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	3.15e-4	0.00	0.12	.906	-0.01	0.01	-1.70	.090
a) MHB → Mediator	-0.01	0.07	-0.14	.892	-0.17	0.09	-1.85	.064
b) Mediator → Outcome	-0.03	0.02	-1.96	.050	0.06	0.01	4.63	<.001
Direct (c: MHB → Outcome)	-0.03	0.02	-1.60	.110	-0.02	0.02	-1.07	.285
Total (c + a x b)	-0.03	0.02	-1.58	.113	-0.03	0.02	-1.50	.135

Note: These mediation analyses are based on 1,000 bootstrap samples. “MHB” refers to Masculine Honor Beliefs. Cause of Death on Death Certificate was coded as “suicide” = 0 and “terminal illness” = 1, while treating “other” as missing.

FWB

Contrary to my hypotheses, FWB interacted with Suicide Method Condition in predicting two outcomes: Terminal Illness Suicide is Better Than Traditional Suicide, $F(5, 284) = 2.50, p = .031$, and Do You Consider Mike's Death to be Suicide, $\chi^2(5, N = 295) = 23.77, p < .001$. With respect to Terminal Illness Suicide is Better Than Traditional Suicide, simple effects analyses suggest FWB interacted significantly with the gunshot, $F(1, 284) = 4.05, p = .045$, and VSED, $F(1, 284) = 5.38, p = .021$, conditions. Specifically, greater FWB were associated with *more* agreement with Terminal Illness Suicide is Better Than Traditional Suicide when the target died by *gunshot* ($\beta = 0.28, b = 0.22, SE = 0.11, t[284] = 2.01, p = .045$) and *less* agreement with Terminal Illness Suicide is Better Than Traditional Suicide when the target died by *VSED* ($\beta = -0.42, b = -0.33, SE = 0.14, t[284] = -2.32, p = .021$). This finding can likely be attributed to suicide by gunshot serving as a more agentic death whereas VSED may be viewed as a prolonging or drawn-out method of suicide.

With respect to Do You Consider Mike's Death to be Suicide, there was no variation in the hanging and overdose conditions (i.e., all participants selected "yes"), so I will forego further discussion of those two conditions. It is important to note that all other conditions had probabilities of selecting "yes" that were over .50. As FWB increased, the probability of selecting "yes" *decreased* in the gunshot condition ($M-1SD = .97, SE = 0.02; M = .97, SE = 0.03; M+1SD = .93, SE = 0.07$), in the PAD condition ($M-1SD = .82, SE = 0.08; M = .80, SE = 0.06; M+1SD = .77, SE = 0.10$), and especially in the palliative sedation condition ($M-1SD = .98, SE = 0.03; M = .87, SE = 0.07; M+1SD = .52, SE = 0.15$). Also, as FWB increased, the probability of selecting "yes" *increased* in the VSED condition ($M-1SD = .74, SE = 0.14; M = .94, SE = 0.04; M+1SD = .99, SE = 0.02$). Related to the Terminal Illness Suicide is Better Than Traditional Suicide findings, these

patterns are likely reflective of perceived peacefulness of death when deciding if one considers it to be suicide or not.

Moderated Mediation of FWB's Effects. Given FWB's significant interaction effects with Suicide Method when predicting Terminal Illness is Better than Traditional Suicide (see Table 6) and Do You Consider Mike's Death to be Suicide (see Table 7), we tested their moderated mediation models. The moderated mediation model with perceived Quickness as a mediator and Suicide Method Condition as a moderator did not yield any significant indirect effects when predicting Terminal Illness is Better than Traditional Suicide. However, the moderated mediation model with perceived Painlessness as a mediator and Suicide Method Condition as a moderator yielded one significant indirect effect of VSED when predicting Terminal Illness is Better than Traditional Suicide. Specifically, in the VSED condition, greater FWB were associated with lower perceived Painlessness, buffering the positive relationship between Painlessness and Terminal Illness is Better than Traditional Suicide. In other words, greater FWB were associated with perceiving VSED as more painful suicide method which contributes to lower beliefs that Terminal Illness is Better than Traditional Suicide. All other levels of Suicide Method condition in this moderated mediation model were nonsignificant.

The moderated mediation model with perceived Quickness as a mediator and Suicide Method Condition as a moderator did not yield any significant indirect effects when predicting Do You Consider Mike's Death to be Suicide. The moderated mediation model with perceived Painlessness as a mediator and Suicide Method Condition as a moderator did not yield any significant indirect effects any specific condition when predicting Do You Consider Mike's Death to be Suicide. In other words, these lack of significant moderated mediation models means FWB's interaction with Suicide Method when predicting participants' responses to Do You Consider

Mike's Death to be Suicide was not a product of participants' perceived Quickness or Painlessness in relation to any specific condition.

Table 6

Study 1 Moderated Mediation: Free Will Beliefs Predicting Terminal Illness Suicide is Better Than Traditional Suicide with Quick & Painless as Mediators

Average	<u>Quick</u>					<u>Painless</u>				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.01	-0.00	-0.74	.458	-0.04	0.02	-0.05	-2.36	.018
a) FWB → Mediator	-0.08	0.04	-0.06	1.81	.070	-0.19	0.07	-0.12	-2.55	.011
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849
Gunshot	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.00	-0.44	.660	-0.05	0.03	-0.07	-1.69	.091
a) FWB → Mediator	-0.05	0.09	-0.04	-0.52	.601	-0.26	0.15	-0.16	-1.76	.079
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849
Hanging	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-7.35e-4	0.00	-9.27e-4	-0.17	.868	-0.01	0.03	-0.01	-0.28	.780
a) FWB → Mediator	-0.02	0.09	-0.01	-0.17	.865	-0.04	0.15	-0.03	-0.28	.780
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849
Overdose	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	8.18e-4	0.01	0.00	0.16	.871	-0.04	0.04	-0.05	-1.04	.297
a) FWB → Mediator	0.02	0.10	0.01	0.17	.868	-0.19	0.18	-0.12	-1.06	.290
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849

PAD	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.01	-0.00	-0.41	.679	-0.04	0.03	-0.05	-1.12	.265
a) FWB → Mediator	-0.04	0.09	-0.04	-0.48	.630	-0.18	0.16	-0.11	-1.13	.257
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849
Palliative Sedation	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.01	0.01	-0.01	-0.66	.513	-0.01	0.05	-0.02	-0.29	.775
a) FWB → Mediator	-0.16	0.15	-0.13	-1.10	.271	-0.07	0.25	-0.04	-0.29	.775
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849
VSED	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.01	0.01	-0.01	-0.76	.450	-0.08	0.04	-0.10	-1.99	.046
a) FWB → Mediator	-0.22	0.11	-0.18	-2.02	.044	-0.40	0.19	-0.25	-2.10	.036
b) Mediator → Outcome	0.05	0.06	0.07	0.81	.415	0.21	0.03	0.42	6.28	<.001
Direct (c)	-0.01	0.04	-0.01	-0.16	.877	0.02	0.04	0.03	0.56	.577
Total (c + a x b)	-0.01	0.04	-0.01	-0.19	.849	-0.01	0.04	-0.01	-0.19	.849

Table 7

Study 1 Moderated Mediation: Free Will Beliefs Predicting Do You Consider Mike's Death to be Suicide with Quick & Painless as Mediators

Average	Quick					Painless				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.00	0.00	0.01	1.13	.260	0.01	0.00	0.04	2.15	.032
a) FWB → Mediator	-0.10	0.05	-0.08	-2.14	.033	-0.19	0.08	-0.12	-2.50	.012
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720
Gunshot	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	9.73e-4	0.00	0.00	0.45	.651	0.01	0.01	0.05	1.58	.113
a) FWB → Mediator	-0.04	0.09	-0.03	-0.48	.631	-0.26	0.15	-0.16	-1.71	.087
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720
Hanging	Estimate	SE	B	z	p	Estimate	SE	β	z	p
Indirect (a x b)	7.36e-4	0.00	0.00	0.33	.742	5.06e-4	0.01	0.00	0.08	.940
a) FWB → Mediator	-0.03	0.09	-0.03	-0.34	.733	-0.01	0.16	-0.01	-0.08	.940
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720
Overdose	Estimate	SE	B	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-2.03e-4	0.00	-9.01e-4	-0.08	.933	0.01	0.01	0.03	0.92	.358
a) FWB → Mediator	0.01	0.11	0.01	0.08	.933	-0.17	0.18	-0.11	-0.94	.347
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720
PAD	Estimate	SE	B	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.00	0.000	0.01	0.66	.508	0.01	0.01	0.03	1.04	.297
a) FWB → Mediator	-0.08	0.10	-0.06	-0.76	.445	-0.18	0.17	-0.11	-1.08	.282
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720

Palliative Sedation	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.00	0.00	0.02	0.92	.356	0.00	0.01	0.02	0.42	.671
a) FWB → Mediator	-0.20	0.16	-0.16	-1.28	.199	-0.11	0.26	-0.07	-0.43	.669
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720
VSED	Estimate	SE	B	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.01	0.00	0.02	1.12	.261	0.02	0.01	0.08	1.95	.052
a) FWB → Mediator	-0.25	0.12	-0.20	-2.12	.034	-0.43	0.20	-0.27	-2.20	.028
b) Mediator → Outcome	-0.02	0.02	-0.12	-1.33	.185	-0.04	0.01	-0.06	-4.19	<.001
Direct (c)	-0.01	0.01	-0.03	-0.46	.643	-0.01	0.01	-0.06	-1.00	.319
Total (c + a x b)	-0.00	0.01	-0.02	-0.36	.720	-0.00	0.01	-0.02	-0.36	.720

Note: Responses to Do You Consider Mike's Death to be Suicide were coded as "yes" = 1 and "no" = 0.

FOD-Other

FOD-Other uniquely predicted the binomial outcome, Do You Consider Mike's Death to be Suicide, $L-R \chi^2(1, N = 295) = 5.64, p = .018$. Although the likelihood ratio test was significant, its model coefficient did not reach significance. Specifically, FOD directed toward others trended toward being associated with a greater likelihood of reporting that the target's death is suicide (as opposed to not), $b = 1.74, SE = 0.93, Z = 1.86, p = .063$.

This relationship was further qualified by an interaction between FOD-Other and Suicide Method in the same model, $L-R \chi^2(5, N = 295) = 15.59, p = .008$. Again, all participants selected "yes" to Do You Consider Mike's Death to be Suicide in the hanging and overdose conditions, so I will forego further discussion. As FOD-Other increased, the probability of selecting "yes" increased in the gunshot condition ($M-1SD = .69, SE = 0.25; M = .97, SE = 0.03; M+1SD = .99, SE = 0.00$), but remained relatively stable in the other conditions: PAD ($M-1SD = .79, SE = 0.11; M = .80, SE = 0.06; M+1SD = .80, SE = 0.11$), palliative sedation ($M-1SD = .85, SE = 0.09; M = .87, SE = 0.07; M+1SD = .88, SE = 0.11$), and VSED ($M-1SD = .94, SE = 0.06; M = .94, SE = 0.04; M+1SD = .93, SE = 0.07$). This effect for gunshot is likely a function of it being a violent method of suicide (Chung & Lin, 2010), which may be of concern for individuals higher in FOD broadly.

(Moderated) Mediation of FOD-O's Effects. FOD-Other's relationship with Do You Consider Mike's Death to be Suicide was not significantly mediated by perceived Quickness or perceived Painless (see Table 8). The moderated mediation analyses for FOD-Other's interaction effect are provided in Table 9. Perceived Quickness did not serve as a significant mediator at any level of Suicide Method Condition when predicting Do You Consider Mike's Death to be Suicide. However, perceived Painlessness yielded a significant indirect effect as a moderator of the

mediated relationship between FOD-Other and with Do You Consider Mike's Death to be Suicide at the gunshot level of Suicide Method Condition. Specifically, in the gunshot condition, higher FOD-O was associated with lower perceived Painlessness which, in turn is associated with a lower likelihood of "yes" responses to Do You Consider Mike's Death to be Suicide. In other words, greater FOD directed toward others was associated with perceiving suicide by gunshot as more painful, buffering the relationship between greater perceived Painlessness and a greater likelihood of not believing this was suicide. All other levels of Suicide Method condition in this moderated mediation model were nonsignificant. It is also worth noting that almost all participants responded "yes" to Do You Consider Mike's Death to be Suicide, so these findings should be interpreted with caution.

Table 8

Study 1 Mediation Effects & Estimates: Quick & Painless as Mediators of FOD-Other's Relationship with Do You Consider Mike's Death to be Suicide?

	<u>Quick</u>				<u>Painless</u>			
	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	3.21e-4	9.34e-4	0.34	.731	0.00	0.00	0.44	.661
a) FOD-O → Mediator	0.03	0.06	0.54	.592	-0.03	0.08	-0.44	.659
b) Mediator → Outcome	0.01	0.01	1.03	.301	-0.04	0.01	-4.19	<.001
Direct (c)	0.01	0.01	0.83	.410	0.01	0.01	0.78	.433
Total (c + a x b)	0.01	0.01	0.86	.390	0.01	0.01	0.85	.397

Note: These mediation analyses are based on 1,000 bootstrap samples. Do You Consider Mike's Death to be Suicide? was coded as "no" = 0 and "yes" = 1.

Table 9*Study 1 Moderated Mediation: FOD-O Predicting Do You Consider Mike's Death Suicide with Quick & Painless as Mediators*

Average	Quick					Painless				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-6.76e-4	0.00	-0.00	-0.38	.706	0.00	0.00	0.02	1.54	.123
a) FOD-O → Mediator	-0.02	0.04	-0.01	-0.39	.698	-0.11	0.07	-0.08	-1.67	.095
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
Gunshot	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.01	-0.01	-0.36	.718	0.02	0.01	0.11	2.44	.015
a) FOD-O → Mediator	-0.04	0.12	-0.04	-0.37	.711	-0.62	0.20	-0.42	-3.08	.002
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
Hanging	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.01	-0.70	.486	0.01	0.01	0.04	1.39	.166
a) FOD-O → Mediator	-0.07	0.09	-0.06	-0.77	.440	-0.22	0.15	-0.15	-1.48	.140
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
Overdose	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	5.91e-4	0.00	-0.00	-0.15	.878	-0.01	0.01	-0.03	-0.84	.404
a) FOD-O → Mediator	-0.01	0.09	-0.01	-0.15	.877	0.13	0.15	0.09	0.85	.394
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
PAD	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.01	0.01	0.02	1.05	.295	-0.00	0.01	-0.02	-0.53	.595
a) FOD-O → Mediator	0.13	0.09	0.11	1.37	.170	0.08	0.16	0.06	0.54	.592
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
Palliative Sedation	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.00	-0.34	.731	0.00	0.01	0.01	0.21	.834
a) FOD-O → Mediator	-0.03	0.10	-0.03	-0.35	.725	-0.03	0.17	-0.02	-0.21	.834
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346
VSED	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.01	-0.58	.564	0.00	0.01	0.01	0.17	.867
a) FOD-O → Mediator	-0.06	0.10	-0.06	-0.62	.537	-0.03	0.17	-0.02	-0.17	.867
b) Mediator → Outcome	0.04	0.03	0.15	1.62	.104	-0.04	0.01	-0.28	-4.03	<.001
Direct (c: FOD-O → Outcome)	0.03	0.02	0.08	1.50	.135	0.01	0.01	0.04	0.70	.487
Total (c + a x b)	0.03	0.02	0.09	1.57	.116	0.01	0.01	0.05	0.94	.346

Note: Do You Consider Mike's Death to be Suicide? was coded as "no" = 0 and "yes" = 1.

Suicide Acceptability

Suicide Acceptability uniquely predicted all four continuous outcomes: Positive General Perceptions, $F(1, 284) = 209.62, p < .001$; Stigmatizing Person Perceptions, $F(1, 284) = 93.02, p < .001$; Perceived Difference Between Terminal Illness Suicide and Traditional Suicide, $F(1, 284) = 15.87, p < .001$; and Terminal Illness Suicide is Better Than Traditional Suicide, $F(1, 284) = 16.35, p < .001$. Specifically, greater Suicide Acceptability was associated with more Positive General Perceptions, $\beta = 0.63, b = 0.58, SE = 0.04, p < .001$; less Stigmatizing Person Perceptions, $\beta = -0.48, b = -0.35, SE = 0.04, p < .001$; greater Perceived Difference Between Terminal Illness Suicide and Traditional Suicide, $\beta = 0.24, b = 0.26, SE = 0.06, p < .001$; and greater Terminal Illness Suicide is Better Than Traditional Suicide, $\beta = 0.24, b = 0.13, SE = 0.03, p < .001$.

Additionally, Suicide Acceptability served as a unique predictor of the binomial outcome, Cause of Death on the Death Certificate, L-R $\chi^2(1, N = 288) = 4.23, p = .040$. Although the likelihood ratio test was significant, its model coefficient trended toward significance, such that greater Suicide Acceptability was associated with a greater likelihood of selecting “terminal illness” (as opposed to suicide) as the cause of death, $b = 0.48, SE = 0.25, Z = 1.93, p = .054$. This relationship was further qualified by an interaction effect between Suicide Acceptability and Suicide Method Condition, L-R $\chi^2(5, N = 288) = 14.72, p = .012$. It is important to note that the probability of selecting “terminal illness” was quite variable across conditions, with several being below .50 and several being above .50. As Suicide Acceptability increased, the probability of selecting “terminal illness” *increased* in the gunshot ($M-1SD = .07, SE = 0.06; M = .17, SE = 0.07; M+1SD = .36, SE = 0.12$), hanging ($M-1SD = .14, SE = 0.07; M = .24, SE = 0.07; M+1SD = .38, SE = 0.11$), PAD ($M-1SD = .55, SE = 0.12; M = .70, SE = 0.07; M+1SD = .81, SE = 0.08$), and palliative sedation ($M-1SD = .68, SE = 0.13; M = .82, SE = 0.08; M+1SD = .90, SE = 0.07$)

conditions, but *decreased* in the VSED condition ($M-1SD = .54$, $SE = 0.13$; $M = .32$, $SE = 0.07$; $M+1SD = .16$, $SE = 0.08$). The probability of selecting “terminal illness” remained somewhat stable in the overdose ($M-1SD = .33$, $SE = 0.10$; $M = .36$, $SE = 0.07$; $M+1SD = .39$, $SE = 0.11$) condition across different levels of Suicide Acceptability. Although the main effects of Suicide Acceptability were generally consistent with my hypotheses, the interaction effect was unexpected and reveals further nuance of this individual difference variable in perceptions of people with terminal illnesses’ suicide depending on the suicide method used.

(Moderated) Mediation of Suicide Acceptability’s Effects. The mediation analyses for Suicide Acceptability’s main effects are provided in Table 10. Perceived Quickness did not significantly mediate any of Suicide Acceptability’s relationships, perhaps because their correlational relationship was functionally zero. Perceived Painlessness partially mediated Suicide Acceptability’s relationships with Positive General Perceptions, Stigmatizing Person Perceptions, Difference Between Terminal Illness Suicide and Traditional Suicide, as well as Terminal Illness Suicide is Better Than Traditional Suicide. Additionally, perceived Painlessness fully mediated Suicide Acceptability’s relationship with Cause of Death on the Death Certificate. Greater Suicide Acceptability was associated with greater perceived Painlessness which, in turn, was 1) *positively* associated with Positive General Perceptions, Difference Between Terminal Illness Suicide and Traditional Suicide, Terminal Illness Suicide is Better Than Traditional Suicide, and selecting “terminal illness” as the Cause of Death on the Death Certificate, as well as 2) *negatively* associated with Stigmatizing Person Perceptions.

Table 10*Study 1 Mediation: Suicide Acceptability with 5 outcomes with Quick & Painless as Mediators*

Positive General Perceptions	Estimate	Quick			Estimate	Painless		
		SE	Z	p		SE	Z	p
Indirect (a x b)	-0.00	0.00	-0.32	.746	0.09	0.02	4.38	<.001
a) SA → Mediator	0.02	0.05	0.39	.694	0.32	0.06	5.34	<.001
b) Mediator → Outcome	-0.07	0.05	-1.56	.120	0.27	0.04	7.35	<.001
Direct (c: SA → Outcome)	0.64	0.04	17.34	<.001	0.55	0.04	14.55	<.001
Total (c + a x b)	0.64	0.04	17.41	<.001	0.63	0.04	17.06	<.001
Stigmatizing Person Perceptions	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	7.16e-4	0.00	0.24	.815	-0.05	0.01	-3.67	<.001
a) SA → Mediator	0.02	0.05	0.37	.709	0.32	0.06	5.09	<.001
b) Mediator → Outcome	0.04	0.04	0.93	.352	-0.15	0.03	-4.76	<.001
Direct (c: SA → Outcome)	-0.41	0.04	-11.78	<.001	-0.36	0.04	-9.81	<.001
Total (c + a x b)	-0.41	0.03	-11.82	<.001	-0.40	0.04	-11.50	<.001
Diff b/w TI Suicide & Trad Suicide	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	-7.89e-4	0.00	-0.19	.849	0.04	0.02	2.13	.033
a) SA → Mediator	0.02	0.05	0.48	.633	0.32	0.06	5.13	<.001
b) Mediator → Outcome	-0.03	0.07	-0.48	.632	0.13	0.06	2.27	.023
Direct (c: SA → Outcome)	0.29	0.07	4.37	<.001	0.24	0.07	3.73	<.001
Total (c + a x b)	0.29	0.07	4.36	<.001	0.28	0.07	4.25	<.001
TI Suicide Is Better Than Trad Suicide	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	-3.08e-4	0.00	-0.15	.877	0.05	0.01	4.16	<.001
a) SA → Mediator	0.02	0.05	0.39	.696	0.32	0.06	5.17	<.001
b) Mediator → Outcome	-0.02	0.03	-0.46	.644	0.17	0.03	5.96	<.001
Direct (c: SA → Outcome)	0.13	0.03	4.95	<.001	0.07	0.03	2.22	.027
Total (c + a x b)	0.13	0.03	4.96	<.001	0.12	0.03	4.34	<.001
Cause of Death on Death Certificate	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	8.39e-5	0.00	0.04	.964	0.02	0.01	3.52	<.001
a) SA → Mediator	-0.00	0.05	-0.05	.962	0.32	0.06	5.10	<.001
b) Mediator → Outcome	-0.03	0.02	-2.00	.046	0.06	0.01	4.39	<.001
Direct (c: SA → Outcome)	0.03	0.01	2.59	.010	0.01	0.01	1.01	.314
Total (c + a x b)	0.03	0.01	2.58	.010	0.03	0.01	2.36	.018

Note: These mediation analyses are based on 1,000 bootstrap samples. Cause of Death on Death Certificate was coded as “suicide” = 0 and “terminal illness” = 1, while treating “other” as missing.

Finally, we tested the moderation mediation model for Suicide Acceptability's interaction effects with Suicide Method Condition when predicting Cause of Death on the Death Certificate (see Table 11). The moderated mediation model with perceived Quickness as a mediator and Suicide Method Condition as a moderator did not yield any significant indirect effects. Similarly, the moderated mediation model with perceived Painlessness as a mediator and Suicide Method Condition as a moderator did not yield any significant indirect effects. These lack of significant moderated mediation models means Suicide Acceptability's interaction with Suicide Method when predicting participants' responses to Cause of Death on the Death Certificate was not a product of participants' perceived Quickness or Painlessness in any specific condition.

Table 11

Study 1 Moderated Mediation: Suicide Acceptability Predicting Cause of Death on the Death Certificate with Quick & Painless as Mediators

Average	<u>Quick</u>					<u>Painless</u>				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-4.45e-4	0.00	-0.00	-0.33	.741	0.01	0.01	0.03	1.52	.129
a) SA → Mediator	-0.01	0.03	-0.01	-0.34	.736	0.32	0.05	0.30	6.99	<.001
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012
Gunshot	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.00	0.00	0.02	1.01	.313	0.02	0.01	0.07	1.50	.134
a) SA → Mediator	0.10	0.08	0.12	1.24	.214	0.69	0.13	0.64	5.50	<.001
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012

Hanging	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-7.88e-4	0.00	-0.00	-0.28	.780	-7.06e-4	0.00	-0.00	-0.28	.781
a) SA → Mediator	-0.02	0.06	-0.02	-0.28	.777	-0.03	0.10	-0.03	-0.28	.778
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012
Overdose	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.02	-1.08	.282	0.01	0.01	0.04	1.43	.154
a) SA → Mediator	-0.10	0.07	-0.12	-1.37	.170	0.40	0.11	0.37	3.57	<.001
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012
PAD	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.01	-0.57	.567	0.01	0.01	0.05	1.46	.145
a) SA → Mediator	-0.04	0.07	-0.05	-0.61	.544	0.45	0.11	0.41	4.18	<.001
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012
Palliative Sedation	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.01	0.01	0.04	1.40	.163	0.01	0.01	0.03	1.31	.189
a) SA → Mediator	0.19	0.08	0.22	2.37	.018	0.29	0.12	0.27	2.45	.014
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012
VSED	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.01	0.01	-0.04	1.46	.145	0.00	0.00	0.01	0.90	.366
a) SA → Mediator	-0.19	0.07	-0.22	-2.71	.007	0.12	0.11	0.11	1.11	.267
b) Mediator → Outcome	0.05	0.03	0.16	1.73	.084	0.03	0.02	0.11	1.56	.120
Direct (c)	0.04	0.01	0.15	2.81	.005	0.02	0.01	0.10	1.75	.080
Total (c + a x b)	0.03	0.01	0.14	2.52	.012	0.03	0.01	0.14	2.52	.012

Note: Responses to the Cause of Death on the Death Certificate were coded as “the terminal illness” = 1 and “suicide” = 0.

Study 1 Summary

Study 1 examined perceptions of a hypothetical suicide by someone with a terminal illness as a function of the suicide method used and various individual differences. My hypotheses related to the averages for composites and the correlational relationships were largely supported and consistent with my past research (Schiffer & Saucier, 2024; under review). My hypotheses regarding the effects of Suicide Method condition were mostly supported in that there were more favorable perceptions of medical suicide methods, specifically PAD and palliative sedation, compared to traditional suicide methods, specifically overdose, hanging, and gun. However, VSED, a medical method was consistently perceived the least favorably across the outcomes. This finding can likely be attributed to VSED being perceived as the least Quick and least Painless method on average, despite VSED reportedly being a “good” or “natural” death (e.g., Ganzini et al., 2003; Stängle et al., 2020).

The individual difference main effects that emerged were largely consistent with my hypotheses, like higher MHB being associated with less favorable attitudes and higher Suicide Acceptability being associated with more favorable attitudes. Additionally, a couple interaction effects emerged that were unexpected, like for FWB. Of the tested mediators, perceived Painlessness had many more contributions to explaining existing effects compared to perceived Quickness. Together, Study 1’s design, analyses, and findings extend our theoretical understanding of an understudied social phenomenon in relation to 1) the suicide method used and 2) relevant individual differences. Study 2 assessed a related but independent aspect of the suicide, its motive.

Chapter 3 - Study 2

Suicide motives are multifaceted in the general population and there may be more specific or unique motives among people with terminal illnesses. As such, Study 2 examined how perceptions of the suicide and target differ as a function of the primary suicide motive. Specifically, Study 2 vignettes stated that the target decides to die by suicide because of one of four primary reasons: avoiding physical pain, avoiding mental and emotional distress, avoiding burdening loved ones, or wanting control over death. Together, these motives are consistent with the interpersonal theory of suicide (e.g., Van Orden et al., 2010) but also account for unique reasons that may pertain more directly to people with dire physical health conditions.

Broadly, I expect less negative perceptions of the suicide and target, less similarity with traditional suicide, and more frequent reports for the terminal illness being listed as the cause of death on the death certificate when the target dies by suicide because they want control over death followed by wanting to avoid physical health concerns followed by not wanting to be a burden followed by wanting to avoid mental health concerns. This pattern would be consistent with suicide for autonomous reasons may be viewed as empowering (e.g., Horgan, 1991; Werth & Cobia, 1995) as well as physical conditions being more acceptable reasons for suicide compared to other issues (e.g., Winterrowd et al., 2015). Moreover, burdensomeness is a key factor according to the interpersonal theory of suicide (Van Orden et al., 2010) and with this being a relatively other-oriented motive, I expected it to be met with less favorable perceptions. Relatedly, mental health issues are subjected to stigma (e.g., Vogt et al., 2014), hence their lower expected perceptions.

With respect to individual differences, I expect to replicate any main effects that emerge in Study 1, namely MHB and FWB being associated with more negative attitudes toward this phenomenon but FOD and Suicide Acceptability being associated with more positive attitudes. I

expected several interactions between the individual difference variables and the conditional manipulation. I hypothesized higher MHB and FWB to predict more negative perceptions when the suicide is motivated by wanting to avoid mental and emotional distress compared to when the suicide is motivated by wanting control over death, avoiding physical pain, or avoiding burdensomeness. This would be consistent with MHB being positively associated with mental health stigma (e.g., Schiffer & Saucier, 2023) and FWB being positively associated with suicide stigma (Ozkok et al., 2022). I also expected higher FOD to predict less negative attitudes when the suicide is motivated by wanting control over death compared to other motives, consistent with FOD being rooted in anxiety over the unknowns surrounding death and perceived lack of control over one's health (e.g., Cataldo, 1994). I tested the interaction with Suicide Acceptability and the conditional manipulation exploratorily.

Study 2 Method

Participants

The same recruitment techniques as in Study 1 were employed for Study 2 (see Study 1 Participants Section). Data collection began on July 28th, 2024 and completed on July 29th, 2024.

Data Cleaning

315 people accessed this survey, but several were excluded for various reasons, like failing attention checks in the individual difference scales ($n = 8$) or regarding which condition of vignettes they read ($n = 39$). Several participants were also omitted for completing any of the three longer (i.e., 20+ items) individual difference scales at a rate of less than one second per item ($n = 2$). These data cleaning procedures left 265 participants for data analysis. According to a sensitivity analysis for multiple linear regressions with 23 predictors (4-level categorical conditional

manipulation, five individual differences, and their two-way interactions), this sample size allowed for detection of small-to-medium effect sizes ($f^2 = .090$; Cohen, 1992) with .80 power at $\alpha = .05$.

Participant Demographics

On average, participants were 38.40 years old ($SD = 13.70$), with 62% identifying as women and 34% identifying as men. Most participants were White (62%) and heterosexual (75%). Participants' political orientation breakdown is as follows: 47% liberal, 34% middle of the road, and 19% conservative. On a scale from 1 (*Not At All*) to 9 (*Very Much*), the average combined religiosity and spirituality was just below the midpoint of the scale (see Table 1). Most participants reported their education level as completing either high school (or an equivalent; 31%) or a bachelor's degree (30%). In terms of socioeconomic status, most participants reported themselves as either middle class (44%) or lower-middle class (29%), with half reporting an annual household income of either \$40,000-\$60,000 (27%) or above \$100,000 (27%). In terms of employment status, 69% of participants reported working, either full-time or part-time. Common occupational groups within the Bureau of Labor Statistics' categorizations included sales (10%), office and administrative support (9%), and healthcare practitioners (9%).⁶

When asked if they had been affected by suicide in any capacity, 38% said no. When asked if they had been affected by terminal illness in any capacity, 56% said no. On a scale from 1

⁶ According to ANOVAs, the broader occupational groups did not serve as a significant predictor of any manipulation perception variable or outcome: Avoidant, $F(4, 258) = 0.99, p = .413$; Proactive, $F(4, 257) = 0.47, p = .754$; Positive General Perceptions, $F(4, 260) = 1.65, p = .162$; Stigmatizing Person Perceptions, $F(4, 260) = 1.02, p = .399$; Do You Consider Mike's Death to be Suicide, $F(4, 233) = 2.17, p = .073$; Perceived Difference Between Terminal Illness Suicide & Traditional Suicide, $F(4, 259) = 1.49, p = .206$; Terminal Illness Suicide is Better Than Traditional Suicide, $F(4, 260) = 0.28, p = .893$; and Cause of Death on the Death Certificate, $F(4, 236) = 0.54, p = .704$.

(*Definitely No*) to 9 (*Definitely Yes*), participants reported generally good healthcare, on average, in terms of quality, affordability, and sufficient health insurance (see Table 1).

Materials & Procedure

As in Study 1, all items were completed on 1 (*Strongly Disagree*) to 9 (*Strongly Agree*) Likert-type scales, unless otherwise stated. Again, participants completed the same outcome variables in response to vignettes (see Appendix C)⁷ and individual difference measures (see Appendices D-G).⁸ For individual difference measures' subscale descriptive statistics and correlations, see Supplementary Tables A.4 and A.5 in Appendix A. As in Study 1, composites were created such that higher scores reflect a greater presence of the construct. The Study 2 Procedure followed that of Study 1's (see Study 1 Procedure Section; preregistered on OSF: <https://doi.org/10.17605/OSF.IO/EFZQ7>).

Vignettes

To understand how perceptions of suicide among people with terminal illnesses may be perceived differently as a function of the person's motive for the suicide, I used vignettes in a between-groups design to manipulate the target's primary motive (see Appendix H). Vignettes provided similar descriptions and information as in Study 1 regarding target information (e.g., terminal illness, demographics) and expectations of the situation worsening. The last sentence of vignettes stated, *Because of the expected suffering, Mike decides to die by suicide primarily to...*

⁷ The outcome variables were again consolidated into broader composites due to high correlations among subcomponents: Positive General Perceptions (r 's among Acceptability & Effects on Loved Ones > .58, p 's < .001), Stigmatizing Person Perceptions (r 's among Weak, Miserable, Egotistical, & Brave > .36, p 's < .001), & Terminal Illness Suicide is Better Than Traditional Suicide (r 's among Understandable, Empowering, & Stigmatizing > .55, p 's < .001).

⁸ According to a paired samples t -test, other-directed FOD ($M = 6.45$, $SD = 1.58$) was significantly higher than self-directed FOD ($M = 5.93$, $SD = 1.89$), $t(256) = 8.80$, $p < .001$.

Here, participants were randomly assigned to read one of four Suicide Motive conditions: 1) avoid physical pain, 2) avoid mental and emotional distress, 3) avoid burdening loved ones, or 4) have control over death. After reading one vignette, participants responded to an attention check regarding the condition they were in (i.e., why Mike decided to die by suicide). Participants were excluded from data analysis for providing the incorrect response for their condition or selecting the “I don’t know” option.

Manipulation Perceptions. Similar to Study 1, after reading one vignette and passing its attention check (but prior to completing the vignette response items), participants were presented with four adjectives to use in response to the following question on 1 (*Not At All*) to 9 (*Very Much*) Likert-type scale: “How ____ is Mike’s motive for suicide?” We used an exploratory factor analysis using oblimin rotation to help reduce the number of items for analysis. This yielded one factor, Proactive (i.e., proactive, realistic, & impulsive [reverse-scored]), eigenvalue = 1.22, 31% of variance, loadings = $|.52| - |.69|$. Given that the remaining adjective, “avoidant”, did not load onto this factor but still may be relevant for subsequent perceptions of the vignettes, it was retained as a single item for later mediation analyses. We used ANOVAs to test for differences across conditions for each of these two manipulation perception composites, which did not yield any significant differences.⁹

Study 2 Results

Descriptive Statistics

Table 12 provides the means, standard deviations, and one-sample *t*-tests for all variables. With respect to the Study 2 manipulation perceptions regarding Mike’s suicide motive, participants

⁹ Suicide Motive Condition was not a significant predictor of either Avoidant, $F(3, 259) = 1.16, p = .324$, or Proactive, $F(3, 258) = 2.05, p = .107$.

beliefs about the motive as being Avoidant did not significantly differ from the midpoint of the scale, but participants reported greater average agreement with the motive being Proactive.

Similar to Study 1, on average, participants reported greater agreement with Positive General Perceptions and less agreement with Stigmatizing Person Perceptions, consistent with my hypotheses and past research. In terms of comparisons to traditional suicide, when asked, “Do you consider Mike’s death to be suicide?”, 87% of participants said yes ($n = 206$) and 13% of participants said no ($n = 32$). Additionally, and consistent with hypotheses, when asked on a 1 (*Definitely No*) to 9 (*Definitely Yes*) Likert-type scale if there was difference between the target’s suicide and traditional suicide, participants’ average response was significantly above the midpoint of the scale. Moreover, Terminal Illness Suicide is Better than Traditional Suicide was also significantly above the midpoint of the scale.

In response to the question regarding what should be listed as the cause of death on the death certificate, 49% said suicide ($n = 129$), 42% said the terminal illness ($n = 112$), and 9% said other and wrote in a response ($n = 24$). Write-in responses typically recommended the cause of death reflect *both* suicide *and* terminal illness. Of the 129 participants who selected “suicide”, 98% attributed their response to suicide being the literal cause of death ($n = 127$) whereas two participants attributed their response to suicide being more empowering than dying from the illness. Of the 112 participants who selected “the terminal illness”, 87% attributed their response to the terminal illness being the reason for the suicide ($n = 97$) whereas 13% attributed their response to suicide being a stigmatizing label ($n = 14$). One participant selected “other” and mentioned that they agreed with both of the options listed but also by listing the cause of death as suicide it may affect life insurance payouts. Overall, these descriptives corroborate Study 1 findings as well as my other previous research (e.g., Schiffer & Saucier, 2024), while reiterating

that the target's death is generally considered to be suicide, but perhaps a less stigmatizing form of it.

Table 12

Study 2 Means, Standard Deviations, & One Sample t-tests Against the Midpoint of the Scale

	<i>M</i>	<i>SD</i>	Range	<i>t</i>	<i>p</i>	<i>d</i>
1. Masculine Honor Beliefs	5.15	1.39	1.60, 8.71	1.80	.074	0.11
2. Free Will Beliefs	6.23	1.39	1.43, 9	14.40	<.001	0.88
3. Fear of Death - Self	5.69	1.87	1, 9	5.95	<.001	0.37
4. Fear of Death - Others	6.44	1.58	1, 9	14.70	<.001	0.92
5. Suicide Acceptability	4.25	2.02	1, 8.83	-6.10	<.001	-0.37
8. Religiosity & Spirituality	4.58	2.50	1, 9	-2.71	.007	-0.17
9. Political Orientation	1.72	0.76	1, 3	-5.97	<.001	-0.37
10. Quality Healthcare	7.31	1.90	1, 9	19.83	<.001	1.22
11. Affordable Healthcare	6.45	2.46	1, 9	9.63	<.001	0.59
12. Sufficient Health Insurance	6.73	2.46	1, 9	11.44	<.001	0.70
13. Experience with Suicide?	0.61	0.49	0, 1	3.56	<.001	0.22
14. Experience with TI?	0.44	0.50	0, 1	-2.12	.035	-0.13
15. Manipulation Perception: Avoidant	5.25	2.77	1, 9	1.45	.149	0.09
16. Manipulation Perception: Proactive	6.52	1.68	1, 9	14.67	<.001	0.91
15. Positive General Perceptions	5.57	1.78	1, 9	5.25	<.001	0.32
16. Stigmatizing Person Perceptions	3.77	1.51	1, 9	-13.22	<.001	-0.81
17. Is It Suicide?	0.87	0.34	0, 1	16.50	<.001	1.07
18. Diff b/w TI Suicide & Trad Suicide	7.03	2.09	1, 9	15.79	<.001	0.97
19. TI Suicide > Traditional Suicide	6.29	1.20	3.27, 9	17.47	<.001	1.07
20. Cause of Death on Death Certificate	0.47	0.50	0, 1	-1.10	.274	-0.07

Note: Most variables were completed on 1 to 9 Likert-type scales, with various anchor labels. Political Orientation was coded as follows: 1 = liberal, 2 = middle of the road, and 3 = conservative. Is It Suicide? coded "no" as 0 and "yes" as 1. Cause of Death on Death Certificate coded "suicide" as 0 and "their terminal illness" as 1, while treating "other" as missing values.

Correlations

The correlational relationships among the outcomes were consistent with Study 1 (see Table 13). For example, more Positive General Perceptions were associated with less Stigmatizing Person Perceptions, more frequent reports for “no” in response to “Do you consider Mike’s death to be suicide?”, perceiving more of Difference Between Traditional Suicide and Terminal Illness Suicide, greater beliefs that Terminal Illness Suicide is Better than Traditional Suicide, and more frequent reports for the “terminal illness” to be listed as the cause of death on the death certificate. The manipulation perception variables, Avoidant and Proactive, were negatively correlated, with Avoidant correlating negatively with the more supportive outcomes (e.g., Positive General Perceptions) and Proactive correlating positively with the same outcomes.

Table 13*Correlations Among Study 2 Variables*

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
1. Masc Honor Beliefs	(.95)																							
2. Free Will Beliefs	.44	(.79)																						
3. Fear of Death - Self	.12	.01	(.91)																					
4. Fear of Death - Others	.22	.11	.70	(.90)																				
5. Suicide Acceptability	-.33	-.34	-.04	.01	(.83)																			
6. Age	-.07	-.06	-.04	-.08	-.10	-																		
7. Gender	.26	.08	-.11	-.10	-.14	-.13	-																	
8. Race	-.17	-.20	-.06	-.10	.12	.18	-.05	-																
9. Education	.01	-.13	-.03	-.02	-.10	.07	.05	-.10	-															
10. SES	.10	.06	-.07	-.09	-.18	.12	.02	-.10	.39	-														
11. Religiosity & Spirit	.37	.31	.02	.10	-.42	.13	-.16	-.22	.07	.17	(.79)													
12. Political Orientation	.41	.31	-.07	.05	-.27	.06	.07	.14	-.00	.12	.38	-												
13. Quality Healthcare	.05	.13	-.06	-.03	-.14	.23	-.05	-.05	.25	.35	.09	.00	-											
14. Affordable Healthcare	.12	.08	.03	-.01	-.08	.20	.00	-.12	.16	.21	.03	-.01	.73	-										
15. Sufficient Health Insur	.07	.08	.03	.00	-.12	.10	.01	-.08	.25	.34	.02	-.04	.76	.78	-									
16. Exp w/ suicide	-.03	-.06	.02	.03	.40	-.06	-.03	.06	-.04	-.22	-.17	-.12	-.18	-.15	-.18	-								
17. Exp w/ TI	.09	.11	.10	.16	-.02	.12	-.05	.01	.03	-.03	.10	.16	-.00	-.09	-.12	.12	-							
18. MP – Avoidant	.08	-.03	.07	.08	-.14	-.09	.17	-.00	.19	.04	.03	.06	.02	.05	.09	-.11	-.07	-						
19. MP – Proactive	-.22	-.20	.10	-.06	.44	.18	-.01	.11	.01	-.03	-.28	-.22	.04	.01	.01	.15	.06	-.16	(.65)					
20. Positive General Perc	-.32	-.27	-.02	-.15	.63	.06	-.02	.23	-.05	-.12	-.48	-.30	.01	-.00	-.01	.21	.02	-.20	.72	(.95)				
21. Stigmatizing Person	.38	.24	.00	.12	-.52	-.03	.13	-.22	.13	.15	.40	.27	-.01	.07	.04	-.11	-.01	.25	-.60	-.79	(.92)			
22. Is It Suicide?	.03	-.03	-.05	-.02	-.13	-.18	-.13	-.05	.03	.04	.10	-.00	-.05	-.12	-.08	.01	.08	.13	-.19	-.21	.19	-		
23. Diff?: TI v Trad Sui	.05	-.08	.27	.13	.09	.07	.06	.06	.11	.11	-.15	-.03	.05	.06	.04	.05	.04	-.08	.29	.26	-.19	-.23	-	
24. TI > Trad Suicide	-.04	-.03	.09	.02	.14	.05	-.05	.09	.14	.10	-.20	-.08	.09	-.00	.07	.03	.02	-.04	.36	.42	-.35	-.12	.40	(.92)
25. Death Certificate	-.23	-.22	-.01	-.04	.27	.18	-.02	.13	.11	.03	-.27	-.15	.01	.00	.03	.12	.02	-.20	.36	.47	-.42	-.32	.15	.31

Note: $p < .05$ are bolded. Alphas are provided along the diagonal. Gender was coded women as 0 and men as 1, excluding participants who identified differently. Race was coded nonwhite individuals as 0 and white individuals as 1. Education was coded as follows: 0 = some high school or less, 1 = high school or equivalent, 2 = associate's degree, 3 = bachelor's degree, 4 = master's degree, 5 = doctorate. SES was coded as follows: 0 = lower class, 1 = lower-middle class, 2 = middle class, and 3 = upper-middle class.

Individual Differences

The correlational relationships between each individual difference with the death materials were consistent with Study 1, my hypotheses, and past research (e.g., Schiffer & Saucier, 2024). Both higher MHB and FWB were associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, more frequent reports for “suicide” to be listed as the cause of death on the death certificate, as well as lower perceptions of the Suicide Motive as Proactive. Greater self-directed FOD was associated with perceiving more of a Difference Between Traditional Suicide and Terminal Illness Suicide. Slightly different from Study 1, greater other-directed FOD was associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, but also perceiving more of a Difference Between Traditional Suicide and Terminal Illness Suicide. Again, greater Suicide Acceptability was associated with more Positive General Perceptions, less Stigmatizing Person Perceptions, greater beliefs that Terminal Illness Suicide is Better than Traditional Suicide, and more frequent reports for the “terminal illness” to be listed as the cause of death on the death certificate. With respect to the manipulation perception variables, greater Suicide Acceptability was associated with thinking the target’s suicide motive was less Avoidant and more Proactive.

Demographics

As age increased, so did the likelihood of participants identifying as a woman and White (compared to identifying as a man or nonwhite). Age was also positively correlated with Religiosity & Spirituality, having quality and affordable healthcare, as well as more frequent reports for experience with terminal illness. In terms of outcomes, older age was associated with more frequent reports for “no” in response to “Do you consider Mike’s death to be suicide?”, more frequent reports for “terminal illness” to be listed as the cause of death on the death certificate, as

well as greater beliefs that the suicide motive was Proactive. These patterns generally reflect those that emerged for age in Study 1.

In terms of gender, identifying as a man (compared to a woman) was associated with lower Religiosity & Spirituality as well as greater MHB. With respect to the outcomes, identifying as a man (compared to a woman) was associated with more Stigmatizing Person Perceptions, more frequent reports for “no” in response to Do You Consider Mike’s Death to be Suicide, and greater beliefs that the suicide motive was Avoidant. Although the demographic relationships were consistent with Study 1, the findings related to the outcomes are unique to Study 2.

In terms of race, identifying as White (compared to nonwhite) was associated with lower Religiosity & Spirituality, greater political conservatism, lower MHB, and lower FWB. With respect to the outcomes, identifying as White (compared to nonwhite) was associated with more Positive General Perceptions, less Stigmatizing Person Perceptions, and more frequent reports for the “terminal illness” to be listed as the Cause of Death on the Death Certificate. In terms of education, higher levels of education were associated with greater socioeconomic status, better healthcare overall, and lower FWB. With respect to the outcomes, higher levels of education were associated with more Stigmatizing Person Perceptions, greater beliefs that Terminal Illness Suicide is Better than Traditional Suicide, and greater perceptions of the suicide motive as Avoidant.

In terms of socioeconomic status, greater socioeconomic status was associated with greater Religiosity & Spirituality, greater political conservatism, better healthcare overall, less experience with suicide, and lower Suicide Acceptability. With respect to the outcomes, higher socioeconomic status was associated with more Stigmatizing Person Perceptions. In terms of Religiosity & Spirituality, greater Religiosity & Spirituality was associated with greater political conservatism, less experience with suicide, greater MHB, greater FWB, and lower Suicide Acceptability. With

respect to the outcomes, greater Religiosity & Spirituality was associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, perceiving less of a Difference Between Traditional Suicide and Terminal Illness Suicide, lower beliefs that Terminal Illness Suicide is Better than Traditional Suicide, more frequent reports for the “suicide” to be listed as the cause of death on the death certificate, and perceiving the suicide motive as less Proactive.

In terms of political orientation, greater political conservatism was associated with greater experience with terminal illness, greater MHB, greater FWB, and lower Suicide Acceptability. Greater conservatism was associated with less Positive General Perceptions, more Stigmatizing Person Perceptions, more frequent reports for the “suicide” to be listed as the cause of death on the death certificate, and perceiving the suicide motive as less Proactive. The various healthcare items were all positively correlated, all of which were associated with less experience with suicide. Greater quality healthcare was associated with greater FWB and lower Suicide Acceptability. Greater access to affordable healthcare was associated with greater MHB. None of the healthcare items correlated with any of the outcomes, consistent with Study 1. Greater experience with suicide was associated with greater Suicide Acceptability, more Positive General Perceptions, and thinking the suicide motive was more Proactive. Greater experience with terminal illness was associated with greater other-directed FOD.

Regressions

As in Study 1, we tested the predictive effects of key variables on the various perceptions of the target’s suicide, using both simultaneous multiple linear regressions and logistic regressions.

Predictors were the same in all models: Suicide Motive (4-level categorical variable),¹⁰ MHB, FWB, FOD-Self, FOD-Others, Suicide Acceptability, MHB x Suicide Motive, FWB x Suicide Motive, FOD-Self x Suicide Motive, FOD-Other x Suicide Motive, and Suicide Acceptability x Suicide Motive. Together, these predictors yielded significant models for most simultaneous regression models, accounting for 48% of variance in Positive General Perceptions, $F(23, 233) = 9.27, p < .001$; 41% of variance in Stigmatizing Person Perceptions, $F(23, 233) = 6.92, p < .001$; and 15% of variance in Perceived Difference Between Terminal Illness Suicide and Traditional Suicide, $F(23, 233) = 1.78, p = .018$. The model predicting Terminal Illness Suicide is Better Than Traditional Suicide was not significant, 7% of variance, $F(23, 233) = 0.80, p = .731$, so specific effects will not be further discussed. See Table 14. The omnibus test was significant for both binomial outcomes: Do You Consider Mike's Death to be Suicide, $X^2(23, N = 238) = 35.90, p = .042$ (including 206 participants who said "yes" and 32 who said "no") and Cause of Death on the Death Certificate, $X^2(23, N = 241) = 51.70, p < .001$ (including 129 participants who said "suicide" and 112 who said "terminal illness"). However, the latter did not yield any significant unique main effects or interaction effects, so this outcome will not be further discussed. See Table 15.

¹⁰ Participants were divided between the four conditions via Qualtrics' random assignment: 72 participants in the avoid burden condition, 74 participants in the want control condition, 48 participants in the avoid mental health issues condition, and 71 participants in the avoid physical pain condition.

Table 14*Study 2 Simultaneous Regressions: Fixed Effects & Parameter Estimates*

<u>Positive General Perceptions</u> $R^2 = .48, F(23, 233) = 9.27, p < .001$								<u>Stigmatizing Person Perceptions</u> $R^2 = .41, F(23, 233) = 6.92, p < .001$						
	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Intercept	-	-	0.00	5.57	0.09	62.31	<.001	-	-	0.00	3.80	0.08	46.80	<.001
Suicide Motive [burden]	1.78	.152	-0.01	-0.02	0.24	-0.08	.933	1.28	.282	0.04	0.07	0.21	0.31	.760
MHB	3.01	.084	-0.10	-0.13	0.08	-1.73	.084	15.96	<.001	0.25	0.27	0.07	4.00	<.001
FWB	0.01	.940	0.00	0.01	0.07	0.08	.940	1.00	.319	-0.06	-0.07	0.07	-1.00	.319
FOD-Self	11.97	<.001	0.25	0.23	0.07	3.46	<.001	8.60	.004	-0.22	-0.18	0.06	-2.93	.004
FOD-Other	15.37	<.001	-0.28	-0.32	0.08	-3.92	<.001	7.19	.008	0.21	0.20	0.07	2.68	.008
Suicide Acceptability	115.49	<.001	0.61	0.54	0.05	10.75	<.001	60.71	<.001	-0.47	-0.35	0.05	-7.79	<.001
MHB x Suicide Motive	0.56	.644	-0.13	-0.16	0.20	-0.78	.435	1.61	.188	0.29	0.31	0.19	1.70	.091
FWB x Suicide Motive	0.41	.745	-0.09	-0.11	0.21	-0.52	.602	0.77	.514	0.07	0.08	0.20	0.40	.686
FOD-S x Suicide Motive	0.05	.987	0.01	0.01	0.16	0.07	.943	0.36	.786	-0.07	-0.05	0.15	-0.37	.712
FOD-O x Suicide Motive	0.40	.752	-0.05	-0.06	0.20	-0.29	.771	0.90	.440	0.06	0.06	0.18	0.34	.738
SA x Suicide Motive	0.97	.408	0.15	0.13	0.13	1.02	.309	1.64	.180	-0.14	-0.11	0.12	-0.91	.362
<u>Diff b/w Terminal Illness Suicide & Traditional Suicide</u> $R^2 = .15, F(23, 233) = 1.78, p = .018$								<u>Terminal Illness Suicide Better Than Traditional Suicide</u> $R^2 = .07, F(23, 233) = 0.80, p = .731$						
	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>	<i>F</i>	<i>p</i>	β	<i>b</i>	<i>SE</i>	<i>t</i>	<i>p</i>
Intercept	-	-	0.00	7.04	0.13	52.34	<.001	-	-	0.00	6.32	0.08	77.89	<.001
Suicide Motive [burden]	0.57	.635	-0.21	-0.44	0.36	-1.24	.218	0.94	.420	-0.12	-0.14	0.21	-0.65	.514
MHB	2.40	.122	0.12	0.18	0.11	1.55	.122	0.07	.793	0.02	0.02	0.07	0.26	.793
FWB	1.92	.167	-0.10	-0.15	0.11	-1.39	.167	0.06	.812	0.02	0.02	0.07	0.24	.812
FOD-Self	11.94	<.001	0.31	0.35	0.10	3.46	<.001	2.73	.100	0.16	0.10	0.06	1.65	.100
FOD-Other	1.42	.235	-0.11	-0.14	0.12	-1.19	.235	1.05	.306	-0.10	-0.08	0.07	-1.03	.306
Suicide Acceptability	2.06	.153	0.10	0.11	0.08	1.43	.153	4.26	.040	0.16	0.09	0.05	2.06	.040
MHB x Suicide Motive	0.49	.689	0.15	0.23	0.31	0.73	.465	0.33	.805	-0.03	-0.03	0.19	-0.15	.881
FWB x Suicide Motive	0.04	.989	-0.03	-0.05	0.32	-0.15	.885	0.89	.446	-0.09	-0.08	0.20	-0.42	.672
FOD-S x Suicide Motive	1.45	.228	0.37	0.41	0.24	1.69	.093	0.50	.685	0.21	0.14	0.15	0.93	.351
FOD-O x Suicide Motive	1.06	.365	-0.31	-0.42	0.30	-1.39	.166	0.71	.549	-0.26	-0.20	0.18	-1.10	.271
SA x Suicide Motive	1.52	.211	0.29	0.30	0.20	1.51	.133	0.06	.982	0.01	0.00	0.12	0.03	.974

Note: Both standardized beta weights (β) and unstandardized estimates (*b*) are provided.

Table 15*Study 2 Logistic Regressions: Likelihood Ratio Tests & Model Coefficients*

	<u>Do You Consider Mike's Death to be Suicide?</u>						<u>Cause of Death on Death Certificate</u>					
	$X^2(23, N = 238) = 35.90, p = .042$						$X^2(23, N = 241) = 51.70, p < .001$					
	X^2	p	b	SE	Z	p	X^2	p	b	SE	Z	p
Intercept	-	-	0.18	3.00	0.06	.952	-	-	2.38	2.05	1.16	.247
Suicide Motive [burden]	9.81	.020	3.51	4.14	0.85	.396	2.03	.566	0.39	3.16	0.12	.901
MHB	0.03	.865	-0.05	0.32	-0.17	.866	0.18	.675	-0.09	0.21	-0.42	.676
FWB	1.02	.313	0.33	0.34	0.99	.322	1.58	.209	-0.28	0.23	-1.24	.215
FOD-Self	0.01	.915	0.03	0.28	0.11	.915	1.21	.272	0.21	0.19	1.07	.282
FOD-Other	0.43	.513	-0.24	0.36	-0.66	.512	0.42	.516	-0.15	0.24	-0.65	.519
Suicide Acceptability	1.62	.203	0.28	0.23	1.20	.229	0.01	.943	0.01	0.14	0.07	.943
MHB x Suicide Motive	1.50	.682	0.51	0.50	1.02	.307	2.31	.510	-0.47	0.37	-1.28	.201
FWB x Suicide Motive	11.04	.011	-0.25	0.48	-0.52	.607	1.39	.708	0.13	0.37	0.35	.723
FOD-S x Suicide Motive	2.76	.431	-0.25	0.42	-0.60	.547	1.14	.767	-0.13	0.28	-0.48	.632
FOD-O x Suicide Motive	1.83	.608	0.20	0.49	0.42	.677	2.34	.505	0.01	0.34	0.04	.970
SA x Suicide Motive	9.88	.020	-0.94	0.37	-2.56	.011	3.56	.313	0.33	0.22	1.49	.137

Note: Do You Consider Mike's Death to be Suicide? coded "no" ($n = 32$) as 0 and "yes" ($n = 206$) as 1. Cause of Death on Death Certificate coded "suicide" ($n = 129$) as 0 and "terminal illness" ($n = 112$) as 1. These analyses exclude participants who did not respond using these binomial outcomes.

Suicide Motive Condition

Contrary to my hypotheses, Suicide Motive Condition did not uniquely predict any of the continuous outcomes. I expected more favorable perceptions when the target was motivated to have control over death, followed by avoiding physical health concerns followed by not wanting to be a burden followed by avoiding mental health concerns. The lack of differences across these Suicide Motive Conditions may suggest the broader situational context of having a progressive terminal illness was sufficient enough for participants perceptions of the situation. In other words, the bigger picture of the target's health being dire was more salient and informative for perceptions than a specific motive.

Suicide Motive Condition did uniquely predict one binomial outcome: Do You Consider Mike's Death to be Suicide, L-R $\chi^2(3, N = 238) = 9.81, p = .020$. The probability of participants selecting "yes" in response to the question, Do You Consider Mike's Death to be Suicide? is as follows in descending order: avoid mental and emotional distress (probability = 0.97, $SE = 0.03$, 95CI [0.79, 1.00]), avoid physical pain (probability = 0.92, $SE = 0.04$, 95CI [0.79, 0.97]), wanting control over death (probability = 0.91, $SE = 0.05$, 95CI [0.77, 0.97]), and avoid burdening others (probability = 0.86, $SE = 0.05$, 95CI [0.72, 0.94]). This pattern is generally consistent with my broader hypothesis that mental health motives would be perceived the least favorably (i.e., most aligned with beliefs of this as suicide), but inconsistent with my similar expectation for burdening others to be viewed less favorably.

MHB

MHB uniquely predicted Stigmatizing Person Perceptions, $F(1, 233) = 15.96, p < .001$. Specifically, higher MHB were associated with greater Stigmatizing Person Perceptions, $\beta = 0.25$, $b = 0.27, SE = 0.07, p < .001$. This effect was consistent with my hypotheses, Study 1, and my

previous research (e.g., Schiffer & Saucier, 2024). However, several other hypothesized effects did not emerge, namely interactions with Suicide Motive Condition.

Mediation of MHB's Effect. MHB's relationship with Stigmatizing Person Perceptions was not mediated by perceptions of the motive as Avoidant, but it was partially mediated by perceptions of the motive as Proactive (see Table 16). Specifically, higher levels of MHB were associated with lower perceived Proactiveness of the suicide motive, which, in turn, was negatively associated with Stigmatizing Person Perceptions. This finding may be consistent with MHB being consistently negatively correlated with Suicide Acceptability, reflecting in beliefs about the immorality of suicide rather than beliefs about the logistical benefits of being proactive in end-of-life decision-making.

Table 16

Study 2 Mediation Effects & Estimates: Avoidant & Proactive as Mediators of MHB's Relationship with Stigmatizing Person Perceptions

	<u>Avoidant</u>				<u>Proactive</u>			
	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	0.02	0.02	1.15	.249	0.13	0.04	3.22	.001
a) MHB → Mediator	0.15	0.12	1.24	.213	-0.27	0.08	-3.47	<.001
b) Mediator → Outcome	0.12	0.03	3.86	<.001	-0.49	0.05	-9.56	<.001
Direct (c)	0.39	0.06	6.03	<.001	0.28	0.06	4.86	<.001
Total (c + a x b)	0.40	0.06	6.04	<.001	0.41	0.07	5.98	<.001

Note: These mediation analyses are based on 1,000 bootstrap samples.

FWB

Somewhat similar to Study 1, the only effect that emerged for FWB was an interaction with Suicide Motive Condition predicting Do You Consider Mike's Death to be Suicide. As FWB increased, the probability of selecting "yes" *increased* in the avoid burdening loved ones condition ($M-1SD = .80$, $SE = 0.10$; $M = .86$, $SE = 0.05$; $M+1SD = .91$, $SE = 0.06$) and remained relatively stable in the wanting control over death condition ($M-1SD = .90$, $SE = 0.06$; $M = .91$, $SE = 0.05$;

$M+1SD = .92, SE = 0.06$). In contrast, as FWB increased, the probability of selecting “yes” *decreased* in both the avoid mental and emotional distress condition ($M-1SD = 1.00, SE = 0.00; M = .97, SE = 0.03; M+1SD = .76, SE = 0.14$) and avoid physical pain condition ($M-1SD = 0.95, SE = 0.04; M = .92, SE = 0.04; M+1SD = .87, SE = 0.08$). It is important to note that in all conditions, the probability of selecting “yes” is well over 50%. Taken together, it seems as though individuals higher in FWB may view social aspects (e.g., loved ones’ thoughts and feelings) as not true reflections of autonomy whereas making this decision due to personal, health-related concerns is.

Moderated Mediation of FWB’s Effects. Table 17 provides the moderated mediation analyses for FWB’s interaction effect. Avoidant did not serve as a significant mediator, but perceived Proactiveness fully mediated the relationship between FWB and Do You Consider Mike’s Death to be Suicide on average. Of the four levels of Suicide Motive Condition, the indirect effect was significant only in the wanting control over death condition. Specifically, greater FWB were associated with less perceived Proactiveness of the wanting control over death as a motive, weakening the negative effect of perceived Proactiveness on the likelihood of selecting “yes” in response to Do You Consider Mike’s Death to be Suicide. The fact that the negative relationship between FWB and Proactiveness seems to drive FWB’s relationship with perceiving Mike’s death more frequently as suicide when it is motivated by wanting control seems contrary to the autonomous and agentic nature of FWB.

Table 17

Study 2 Moderated Mediation: Free Will Beliefs Predicting Do You Consider Mike's Death to be Suicide with Avoidant & Proactive as Mediators

Average	Avoidant					Proactive				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-6.76e-4	0.00	-0.00	-0.33	.738	0.01	0.00	0.05	2.38	.017
a) FWB → Mediator	-0.04	0.13	-0.2	-0.34	.734	-0.26	0.08	-0.22	-3.43	<.001
b) Mediator → Outcome	0.02	0.01	0.13	1.94	.052	-0.04	0.01	-0.22	-3.31	<.001
Direct (c)	-0.00	0.02	-0.02	-0.30	.767	-0.02	0.02	-0.07	-1.06	.291
Total (c + a x b)	-0.01	0.02	-0.02	-0.3	.739	-0.01	0.02	-0.02	-0.33	.739
Burden	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	0.00	0.00	0.02	0.88	.380	-0.00	0.01	-0.00	-0.18	.855
a) FWB → Mediator	0.25	0.25	0.13	0.98	.325	0.03	0.15	0.02	0.18	.855
b) Mediator → Outcome	0.02	0.01	0.13	1.94	.052	-0.04	0.01	-0.22	-3.31	<.001
Direct (c)	-0.00	0.02	-0.02	-0.30	.767	-0.02	0.02	-0.07	-1.06	.291
Total (c + a x b)	-0.01	0.02	-0.02	-0.3	.739	-0.01	0.02	-0.02	-0.33	.739
Control	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	8.62e-4	0.00	0.00	0.21	.830	0.02	0.01	0.09	2.37	.018
a) FWB → Mediator	0.06	0.26	0.03	0.22	.829	-0.51	0.15	-0.43	-3.38	<.001
b) Mediator → Outcome	0.02	0.01	0.13	1.94	.052	-0.04	0.01	-0.22	-3.31	<.001
Direct (c)	-0.00	0.02	-0.02	-0.30	.767	-0.02	0.02	-0.07	-1.06	.291
Total (c + a x b)	-0.01	0.02	-0.02	-0.3	.739	-0.01	0.02	-0.02	-0.33	.739
Mental	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-1.55e-4	0.00	-6.38e-4	-0.04	.970	0.01	0.01	0.06	1.80	.072
a) FWB → Mediator	-0.01	0.26	-0.01	-0.04	.970	-0.33	0.15	-0.28	-2.14	.032
b) Mediator → Outcome	0.02	0.01	0.13	1.94	.052	-0.04	0.01	-0.22	-3.31	<.001
Direct (c)	-0.00	0.02	-0.02	-0.30	.767	-0.02	0.02	-0.07	-1.06	.291
Total (c + a x b)	-0.01	0.02	-0.02	-0.3	.739	-0.01	0.02	-0.02	-0.33	.739
Physical	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.01	0.01	-0.03	-1.34	.179	0.01	0.01	0.04	1.35	.177
a) FWB → Mediator	-0.47	0.25	-0.24	-1.86	.063	-0.22	0.15	-0.18	-1.48	.139
b) Mediator → Outcome	0.02	0.01	0.13	1.94	.052	-0.04	0.01	-0.22	-3.31	<.001
Direct (c)	-0.00	0.02	-0.02	-0.30	.767	-0.02	0.02	-0.07	-1.06	.291
Total (c + a x b)	-0.01	0.02	-0.02	-0.3	.739	-0.01	0.02	-0.02	-0.33	.739

Note: Responses to this outcome coded “yes” as 1 and “no” as 0.

FOD – Self

Self-directed FOD was a unique predictor of Positive General Perceptions, $F(1, 233) = 11.97, p < .001$; Stigmatizing Person Perceptions, $F(1, 233) = 8.60, p = .004$; and Perceived Difference Between Traditional & Terminal Illness Suicide, $F(1, 233) = 11.94, p < .001$. Specifically, greater self-directed FOD was associated with greater Positive General Perceptions, $\beta = 0.25, b = 0.23, SE = 0.07, p < .001$; less Stigmatizing Person Perceptions, $\beta = -0.22, b = -0.18, SE = 0.06, p = .004$; and greater Perceived Difference Between Traditional & Terminal Illness Suicide, $\beta = 0.31, b = 0.35, SE = 0.10, p < .001$. Consistent with my FOD hypotheses, these patterns may suggest that the more one fears their own death, the more empathetic perspectives they have toward someone with a terminal illness dying by suicide.

Mediation of FOD-Self's Effects. FOD-Self's effects were not significantly mediated by perceptions of the suicide motive as either avoidant or proactive (see Table 18). The lack of effects implies the relationships between self-directed FOD and perceptions of people with terminal illnesses' suicides are not dependent on perceived avoidance or proactiveness of the suicide motive.

Table 18

Study 2: Mediation Effects & Path Estimates for Significant Fear of Death - Self Main Effects with Avoidant & Proactive as Mediators

Positive General Perceptions	<u>Avoidant</u>				<u>Proactive</u>			
	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	-0.01	0.01	-1.01	.314	0.07	0.05	1.38	.167
a) FOD-S → Mediator	0.10	0.09	1.09	.277	0.08	0.06	1.37	.170
b) Mediator → Outcome	-0.13	0.04	-3.04	.002	0.80	0.05	16.61	<.001
Direct (c: FOD-S → Outcome)	0.00	0.06	0.02	.983	-0.08	0.04	-1.89	.058
Total (c + a x b)	-0.01	0.06	-0.19	.850	-0.01	0.06	-0.18	.855
Stigmatizing Person Perceptions	Estimate	SE	Z	p	Estimate	SE	Z	p
	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	0.01	0.01	1.02	.310	-0.05	0.03	-1.36	.173
a) FOD-S → Mediator	0.10	0.09	1.06	.289	0.08	0.06	1.38	.168
b) Mediator → Outcome	0.14	0.04	3.84	<.001	-0.55	0.05	-10.54	<.001
Direct (c: FOD-S → Outcome)	-0.01	0.05	-0.21	.834	0.05	0.04	1.18	.239
Total (c + a x b)	0.00	0.05	0.06	.952	0.00	0.05	0.07	.942
Difference b/w Traditional & TI Suicide	Estimate	SE	Z	p	Estimate	SE	Z	p
	Estimate	SE	Z	p	Estimate	SE	Z	p
Indirect (a x b)	-0.01	0.01	-0.86	.391	0.03	0.02	1.28	.201
a) FOD-S → Mediator	0.10	0.09	1.08	.278	0.09	0.06	1.35	.177
b) Mediator → Outcome	-0.09	0.05	-1.80	.072	0.37	0.09	4.27	<.001
Direct (c: FOD-S → Outcome)	0.30	0.07	4.34	<.001	0.27	0.07	4.03	<.001
Total (c + a x b)	0.29	0.07	4.27	<.001	0.30	0.07	4.34	<.001

Note: These mediation analyses are based on 1,000 bootstrap samples.

FOD – Other

Other-directed FOD was a unique predictor of Positive General Perceptions, $F(1, 233) = 15.37, p < .001$, and Stigmatizing Person Perceptions, $F(1, 233) = 7.19, p = .008$. Specifically, greater other-directed FOD was associated with less Positive General Perceptions, $\beta = -0.28, b = -0.32, SE = 0.08, p < .001$, and more Stigmatizing Person Perceptions, $\beta = 0.21, b = 0.20, SE = 0.07, p = .008$. Contrary to the patterns that emerged for self-directed FOD, these effects for other-directed FOD may imply that the more anxiety one feels about other people dying, the less supportive they are of people with terminal illnesses dying by suicide.

Mediation of FOD-Other's Effects. FOD-Other's effects were not significantly mediated by perceptions of the suicide motive as either avoidant or proactive (see Table 19). Similar to self-directed FOD, other-directed FOD was relatively unassociated with perceived avoidance and proactiveness.

Table 19

Study 2: Mediation Effects & Path Estimates for Significant Fear of Death - Other Main Effects with Avoidant & Proactive as Mediators

Positive General Perceptions	Estimate	<u>Avoidant</u>			<i>p</i>	Estimate	<u>Proactive</u>			<i>p</i>
		<i>SE</i>	<i>Z</i>				<i>SE</i>	<i>Z</i>		
Indirect (a x b)	-0.02	0.02	-1.06	.291		-0.05	0.06	-0.77	.441	
a) FOD-O → Mediator	0.14	0.11	1.21	.227		-0.06	0.08	-0.78	.433	
b) Mediator → Outcome	-0.13	0.04	-3.04	.002		0.76	0.05	16.37	<.001	
Direct (c: FOD-O → Outcome)	-0.15	0.07	-1.98	.048		-0.12	0.05	-2.02	.028	
Total (c + a x b)	-0.16	0.08	-2.14	.033		-0.16	0.08	-2.11	.035	
Stigmatizing Person Perceptions	Estimate				<i>p</i>	Estimate				<i>p</i>
		<i>SE</i>	<i>Z</i>				<i>SE</i>	<i>Z</i>		
Indirect (a x b)	0.02	0.02	1.09	.275		0.03	0.04	0.76	.446	
a) FOD-O → Mediator	0.14	0.12	1.18	.238		-0.06	0.08	-0.77	.439	
b) Mediator → Outcome	0.13	0.04	3.55	<.001		-0.53	0.05	-10.16	<.001	
Direct (c: FOD-O → Outcome)	0.10	0.06	1.70	.090		0.09	0.05	1.71	.088	
Total (c + a x b)	0.12	0.06	1.95	.051		0.13	0.06	1.96	.050	

Note: These mediation analyses are based on 1,000 bootstrap samples.

Suicide Acceptability

Suicide Acceptability unique predicted Positive General Perceptions, $F(1, 233) = 115.49$, $p < .001$; Stigmatizing Person Perceptions, $F(1, 233) = 60.71$, $p < .001$; and Terminal Illness Suicide is Better Than Traditional Suicide, $F(1, 233) = 4.26$, $p = .040$. Specifically, greater Suicide Acceptability was associated with more Positive General Perceptions, $\beta = 0.61$, $b = 0.54$, $SE = 0.05$, $p < .001$, less Stigmatizing Person Perceptions, $\beta = -0.47$, $b = -0.35$, $SE = 0.05$, $p < .001$; and greater beliefs that Terminal Illness Suicide is Better Than Traditional Suicide, $\beta = 0.16$, $b = 0.09$, $SE = 0.0$, $p = .040$. These findings are consistent with my hypotheses, past research (Schiffer & Saucier, 2024), and the nature of Suicide Acceptability (Hoelter, 1979).

Suicide Acceptability interacted with Suicide Motive condition when predicting Do You Consider Mike's Death to be Suicide. As Suicide Acceptability increased, the probability of selecting "yes" *increased* in the avoid burdening loved ones condition ($M-1SD = .78$, $SE = 0.09$; $M = .86$, $SE = 0.05$; $M+1SD = .92$, $SE = 0.06$). Additionally, as Suicide Acceptability increased, the probability of selecting "yes" *decreased* in the wanting control over death condition ($M-1SD = 0.98$, $SE = 0.02$; $M = .91$, $SE = 0.05$; $M+1SD = .72$, $SE = 0.11$), the avoid mental and emotional distress condition ($M-1SD = 0.99$, $SE = 0.01$; $M = .97$, $SE = 0.03$; $M+1SD = .92$, $SE = 0.09$), and avoid physical pain condition ($M-1SD = 0.96$, $SE = 0.04$; $M = .92$, $SE = 0.04$; $M+1SD = .86$, $SE = 0.06$).

Although I did not expect Suicide Acceptability to interact with the conditional manipulation, these patterns seem to extend the earlier finding of greater Suicide Acceptability being associated with seeing more nuances in suicide (e.g., greater Terminal Illness Suicide is Better Than Traditional Suicide) in that greater Suicide Acceptability tended to be associated with a lower frequency of perceiving the death as suicide across conditions. The exception to this was

the burden condition which perhaps most accurately maps onto a major tenet of the interpersonal theory of suicide (Van Orden et al., 2010), perhaps making this condition a more accurate representation of traditional suicide.

(Moderated) Mediation of Suicide Acceptability's Effects. The mediation analyses for Suicide Acceptability's main effects are provided in Table 20. Avoidant did not serve as a significant mediator for any outcome, but Proactive partially mediated Suicide Acceptability's relationships with all three outcomes. Specifically, greater Suicide Acceptability was associated with greater perceptions of the suicide motive as Proactive, and greater perceptions of the suicide motive as Proactive was associated with more Positive General Perceptions, less Stigmatizing Person Perceptions, and greater beliefs that Terminal Illness Suicide is Better Than Traditional Suicide. It is worth noting that the Positive General Perceptions and Stigmatizing Person Perceptions models were partially mediated whereas the Terminal Illness Suicide is Better Than Traditional Suicide model was fully mediated. These findings reiterate the nuances of Suicide Acceptability's relationships with our outcomes such that Suicide Acceptability is generally associated with greater beliefs that people with terminal illnesses' suicides are more proactive and this is especially true relative to traditional suicide by people in the general population (i.e., without terminal illnesses).

Table 20

Study 2: Mediation Effects & Path Estimates for Significant Suicide Acceptability's Main Effects with Avoidant & Proactive as Mediators

Positive General Perceptions	Estimate	<u>Avoidant</u>			Estimate	<u>Proactive</u>		
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	0.01	0.01	1.46	.144	0.22	0.04	6.09	<.001
a) SA → Mediator	-0.19	0.09	-2.06	.039	0.36	0.05	7.46	<.001
b) Mediator → Outcome	-0.07	0.03	-2.45	.014	0.59	0.05	11.52	<.001
Direct (c: SA → Outcome)	0.54	0.04	12.77	<.001	0.34	0.04	7.88	<.001
Total (c + a x b)	0.55	0.04	13.10	<.001	0.55	0.04	12.57	<.001
Stigmatizing Person Perceptions	Estimate				Estimate			
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	-0.02	0.01	-1.64	.101	-0.15	0.03	-5.07	<.001
a) SA → Mediator	-0.19	0.09	-2.12	.034	0.36	0.05	7.77	<.001
b) Mediator → Outcome	0.10	0.03	3.29	<.001	-0.41	0.05	-7.70	<.001
Direct (c: SA → Outcome)	-0.37	0.04	-9.96	<.001	-0.24	0.04	-6.50	<.001
Total (c + a x b)	-0.39	0.04	-10.15	<.001	-0.39	0.04	-10.22	<.001
Terminal Illness Suicide Better Than Traditional Suicide	Estimate				Estimate			
		<i>SE</i>	<i>Z</i>	<i>p</i>		<i>SE</i>	<i>Z</i>	<i>p</i>
Indirect (a x b)	0.00	0.01	0.29	.771	0.10	0.02	4.07	<.001
a) SA → Mediator	-0.19	0.09	-2.18	.029	0.36	0.05	7.41	<.001
b) Mediator → Outcome	-0.01	0.03	-0.32	.748	0.27	0.05	5.13	<.001
Direct (c: SA → Outcome)	0.08	0.04	2.28	.023	-0.01	0.4	-0.35	.724
Total (c + a x b)	0.08	0.04	2.35	.019	0.08	0.03	2.44	.015

Note: These mediation analyses are based on 1,000 bootstrap samples.

The moderated mediation analysis of Suicide predicting Do You Consider Mike's Death to be Suicide is provided in Table 21. Again, Avoidant did not serve as a significant mediator for any outcome, but Proactive mediated the effect on Do You Consider Mike's Death to be Suicide in all conditions except for burdening others. Specifically, greater Suicide Acceptability was associated with greater reported Proactiveness when the motive was wanting control over death, mental health issues, and physical health issues, all of which were associated with a lower probability of selecting "yes" to Do You Consider Mike's Death to be Suicide. It is somewhat interesting that this effect did not emerge in the burdensomeness condition, which aligns with the interpersonal theory of suicide and is also the only other-oriented suicide motive. Regardless, this is a binomial outcome with not much variability so these results should be interpreted with caution.

Table 21

Study 2 Moderated Mediation: Suicide Acceptability Predicting Do You Consider Mike's Death to be Suicide with Avoidant & Proactive as Mediators

Average	Avoidant					Proactive				
	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.02	-1.38	.169	-0.01	0.01	-0.08	-2.39	.017
a) SA → Mediator	-0.22	0.09	-0.16	-2.47	.014	0.38	0.05	0.45	7.63	<.001
b) Mediator → Outcome	0.01	0.01	0.11	1.66	.098	-0.04	0.01	-0.18	-2.51	.012
Direct (c)	-0.02	0.01	-0.12	-1.75	.080	-0.01	0.01	-0.05	-0.75	.453
Total (c + a x b)	-0.02	0.01	-0.14	-2.08	.038	-0.02	0.01	-0.14	-2.08	.038
Burden	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.03	-1.28	.199	-0.01	0.00	-0.05	-1.71	.087
a) SA → Mediator	-0.34	0.17	-0.25	-2.03	.042	0.22	0.09	0.26	2.34	.019
b) Mediator → Outcome	0.01	0.01	0.11	1.66	.098	-0.04	0.01	-0.18	-2.51	.012
Direct (c)	-0.02	0.01	-0.12	-1.75	.080	-0.01	0.01	-0.05	-0.75	.453
Total (c + a x b)	-0.02	0.01	-0.14	-2.08	.038	-0.02	0.01	-0.14	-2.08	.038
Control	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.01	0.00	-0.04	-1.44	.151	-0.02	0.01	-0.09	-2.17	.030
a) SA → Mediator	-0.51	0.18	-0.37	-2.87	.004	0.42	0.10	0.51	4.31	<.001
b) Mediator → Outcome	0.01	0.01	0.11	1.66	.098	-0.04	0.01	-0.18	-2.51	.012
Direct (c)	-0.02	0.01	-0.12	-1.75	.080	-0.01	0.01	-0.05	-0.75	.453
Total (c + a x b)	-0.02	0.01	-0.14	-2.08	.038	-0.02	0.01	-0.14	-2.08	.038
Mental	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	-0.00	0.00	-0.01	-0.48	.633	-0.02	0.01	-0.10	-2.19	.029
a) SA → Mediator	-0.10	0.19	-0.07	-0.50	.617	0.48	0.11	0.57	4.44	<.001
b) Mediator → Outcome	0.01	0.01	0.11	1.66	.098	-0.04	0.01	-0.18	-2.51	.012
Direct (c)	-0.02	0.01	-0.12	-1.75	.080	-0.01	0.01	-0.05	-0.75	.453
Total (c + a x b)	-0.02	0.01	-0.14	-2.08	.038	-0.02	0.01	-0.14	-2.08	.038
Physical	Estimate	SE	β	z	p	Estimate	SE	β	z	p
Indirect (a x b)	9.15e-4	0.00	0.01	0.39	.699	-0.01	0.01	-0.08	-2.14	.033
a) SA → Mediator	0.07	0.17	0.05	0.40	.691	0.39	0.01	0.47	4.07	<.001
b) Mediator → Outcome	0.01	0.01	0.11	1.66	.098	-0.04	0.01	-0.18	-2.51	.012
Direct (c)	-0.02	0.01	-0.12	-1.75	.080	-0.01	0.01	-0.05	-0.75	.453
Total (c + a x b)	-0.02	0.01	-0.14	-2.08	.038	-0.02	0.01	-0.14	-2.08	.038

Note: Responses to this outcome coded “yes” as 1 and “no” as 0.

Study 2 Summary

Study 2 examined perceptions of a hypothetical suicide by someone with a terminal illness as a function of the suicide motive and various individual differences. My hypotheses related to the averages for composites and the correlational relationships were largely supported and consistent with both Study 1 and my past research (e.g., Schiffer & Saucier, 2024). However, my hypotheses regarding Suicide Motive were largely unsupported, with minimal effects emerging. Although the levels of Suicide Motive condition were representative of common and/or theory-driven motives, it seems like the broader context of terminal illness may wash out nuanced motives for suicide. Other possible explanations for this lack of effect are discussed in the Discussion section.

The individual difference effects were largely consistent with my hypotheses, Study 1, and my past research, but again several hypothesized effects did not emerge, and a couple interaction effects emerged that were unexpected, namely for FWB and Suicide Acceptability, which is consistent with Study 1. Of the tested mediators, perceived Proactiveness of the suicide motive had many more contributions to explaining existing effects compared to perceived Avoidance. Together, Study 2's design, analyses, and findings extend our theoretical understanding of an understudied social phenomenon in relation to 1) the suicide motive and 2) relevant individual differences.

Chapter 4 - Discussion

This research quantitatively investigated third-person perceptions of suicide among people with terminal illnesses as a function of the suicide's method ("How?"; Study 1) and motive ("Why?"; Study 2). This is a particularly important topic given the increasing support and/or demand for legislation related to body autonomy in the US (e.g., PAD, abortion). This research demonstrates a novel appreciation of the uniqueness of people with terminal illnesses' situation in relation to suicide as an end-of-life decision. Manipulations in the present research were informed by incorporating traditional aspects of suicide as used by the general public and more unique aspects of suicide pertaining to people with terminal illnesses, all of which were informed by data (e.g., CDC) and/or theory (e.g., the interpersonal theory of suicide; Van Orden et al., 2010). Given that psychosocial variables (e.g., religiosity; Suarez-Almazor et al., 2002) and individual differences (e.g., Schiffer & Saucier, 2024; under review) relate to attitudes toward suicide in this population and/or PAD, we measured how individual differences in MHB, FWB, FOD, and Suicide Acceptability relate to and/or predict various perceptions of this understudied social phenomenon. As such, the current research contributes to the extant literature in three ways, namely by 1) expanding beyond the examination of suicide methods in isolation (for people with terminal illnesses), 2) acknowledging how suicide motive may affect perceptions of suicide, and 3) assessing the role of relevant individual differences.

"How?": Beyond PAD

As previously stated, most of the research examining the intersection of suicide and terminal illness focuses on PAD. Further, this research often tracks archival data via legislation (e.g., Al Rabadi et al., 2019; Blanke et al., 2017) and/or has a medical focus (e.g., experiences of people with terminal illnesses; e.g., Suarez-Almazor et al., 2002). Additionally, access and/or

capability to complete suicide matters in one's suicide decision-making and behavior (e.g., Cantor & Baume, 1998; Van Orden et al., 2010), and PAD has limited accessibility in that it is only legal in select states with varying criteria ([Death With Dignity](#)). Given that people with terminal illnesses may use medical or traditional suicide methods (Chung & Lin, 2010), Study 1 manipulated the suicide method used by a hypothetical person with a terminal illness via VSED, palliative sedation, PAD, overdose, hanging, or gunshot.

My hypotheses were largely based on differences in methods traditionally used by the general populations versus those more unique to the terminally ill population, divisions between violent and non-violent suicide methods made in previous literature (Chung & Lin, 2010), as well as differences in perceived morality of harm caused by act versus omission (Cushman et al., 2006). Broadly, my hypothesis that medical methods would be perceived more favorably than traditional methods was mostly supported. The exception to this was for VSED, which was consistently perceived the least favorably across conditions.

Although VSED may represent an omission (rather than an action), this method was perceived as the least Quick and the least Painless, according to our manipulation perception variables. The perceived quickness accurately reflected information presented in vignettes with VSED taking multiple days to complete compared to other methods occurring within hours usually. The perceived painfulness of VSED contradicts existing literature suggesting it is relatively pain free (e.g., Pope & Anderson, 2011) and represents good death, according to medical staff (Ganzini et al., 2003; Stängle et al., 2020). This discrepancy could be attributed to participants not being as familiar with VSED and/or people who have used it. Furthermore, VSED may be unique in relation to the other medical methods tested in having less involvement from medical staff to execute compared to palliative sedation or PAD. Thus, although the taxonomy for medical

versus traditional is straightforward, there is further nuance in the level of medical staff involvement, which may have helped informed participant perceptions.

Although I expected PAD to be perceived similarly to overdose and be more middle-of-the-road in terms of various perceptions across conditions, PAD was consistently perceived the most favorably across outcomes. These generally favorable attitudes are consistent with Schiffer and Saucier (under review) who used similar outcomes in their examination of PAD perceptions only. Relative to other conditions though, PAD was perceived as the most Painless method. The perceived painlessness may be attributable to PAD having the greatest involvement of medical staff in its process, perhaps suggesting safety, regulation, and beneficence, compared to the other medical methods and certainly the traditional methods. Additionally, this increased level of involvement from a physician may serve as social permission to die by suicide, given that doctors are perceived as authority figures (e.g., Staum & Larsen, 2006).

The overwhelmingly positive perceptions of PAD, especially compared to other suicide methods, should encourage further expansion of PAD legislation to more states in the US. Given that PAD is a bureaucratic process, revision and streamlining its implementation, if possible, may also help its accessibility and efficiency for people at the end of life, minimizing the number of people who may change their mind due to other interventions (Ganzini et al., 2000). Although the purpose of Study 1 was to explore perceptions of various suicide methods as a way to recognize other options, our findings demonstrate strong and consistent support for PAD as an end-of-life option for people with terminal illnesses.

“Why?”: Varied Motivations

Suicide motives are often multifaceted, but there are some commonalities in the general population. According to the interpersonal theory of suicide, suicidal ideation stems from a lack

of belonging coupled with feelings of burdensomeness, with suicidal behavior actually occurring when the person believes themselves to be capable of doing so (e.g., access to guns; Van Orden et al., 2010). Perhaps related to belongingness and burdensomeness, suicidal behavior is often precipitated by mental health issues (e.g., Holma et al., 2014). However, the role of one's physical health must not be overlooked considering it is an additional factor associated with increased suicide rates (e.g., Ahmedani, 2017). Moreover, there may be other suicide motives that are more unique to people nearing the end of life, like autonomy over death (e.g., Hannig, 2019; Werth & Cobia, 1995), which can provide simultaneous comfort and dignity for someone approaching the end of life (e.g., Hyde, 2001; Lester, 2006). As such, Study 2 was designed to account for traditional motives (e.g., burdensomeness, mental health) that are also present in the population of people with terminal illnesses (e.g., Chochinov et al., 2002) but also physical health and wanting control over death.

Contrary to my hypotheses, I did not find many effects related to suicide motive in relation to Study 2 outcomes or manipulation perception variables. One possible explanation for this is a weak manipulation, in that the conditions were not salient enough and/or were not (perceived as) categorically distinct, but I do not believe either of these to be the case. My data cleaning procedures required participants to know which condition they were in. Specifically, in order to be included in this sample, participants had to correctly identify which condition they were in via an attention check, meaning participants were aware of Mike's primary motive for the suicide. However, because I used a between-groups design, participants only read one condition of the vignettes. This is consistent with existing research which has demonstrated differences in perceptions of social phenomena as a function of mental versus physical health issues (e.g., Schiffer & Saucier, 2023), despite mental and physical health issues often co-occurring (e.g.,

Hynes et al., 2021). A within-subjects design (in which all participants saw all levels of the manipulation) may provide a more powerful test of how these various motivates compare in terms of perceptions of end-of-life decisions.

A more probable explanation is that these null findings reflect a true lack of difference in perceptions across the four suicide motive conditions. It is possible the bigger picture context of the situation, with the hypothetical person being terminally ill which may have rendered their specific motive a moot point. The lack of differences is perhaps consistent with Winterrowd et al.'s (2015) finding that health issues (e.g., terminal illness) are perceived as more acceptable precipitators of suicide compared to interpersonal issues (e.g., a breakup, family discord) or impersonal issues (e.g., financial or legal troubles) in the context of my vignettes being terminal illness, despite providing more nuanced motives. Additionally, because suicide motives are often multifaceted (e.g., Van Orden et al., 2010), they are not necessarily independent of one another. Perhaps as evidence of this, Schiffer and Saucier (under review) find that participants often tend to agree (more than disagree) on average that many factors likely contribute to people with terminal illnesses decision to die by PAD, like acceptance of finality of their diagnosis, access to quality care, and fear of the future. Moreover, vignettes stated that Mike noticed various symptoms worsening, potentially fueling beliefs that there was more than one contributing factor or motive in his decision to die by suicide. Ultimately, despite the inclusion of common and/or theory-driven motives, the “why” behind suicide for people with terminal illnesses was not very salient for informing participants’ perceptions.

Individual Differences

This program of research also advances personality research by examining individual differences in relation to third-person perceptions of suicide among people with terminal illnesses.

Consistent with the general lack of social-personality psychological research on this topic, previous research has primarily only measured sociodemographic (e.g., gender, religiosity) variables in relation to this phenomenon (e.g., Suarez-Almazor et al., 2002), except for my most recent research (see Schiffer & Saucier, 2024). As such, this research offers important contributions to further understanding the nomological networks of MHB, FWB, FOD, and Suicide Acceptability by unpacking their relationships with perceptions of suicide among people with terminal illnesses, including as a function of important situational factors, like its method and/or motive.

Masculine Honor Beliefs (MHB)

The MHB main effects that emerged were consistent with my hypotheses, with greater MHB being associated with more Stigmatizing Person Perceptions in both studies. Study 1 saw additional effects with greater MHB being associated with less Positive General Perceptions and a lower likelihood of selecting “terminal illness” (as opposed to “suicide”) as the Cause of Death on the Death Certificate. These patterns are consistent with my previous research (e.g., Schiffer & Saucier, 2024; under review) and may also serve as an extension of mental health stigma (as shown by Schiffer & Saucier, 2023) to people with terminal illnesses’ suicides.

Some of these effects were mediated by the manipulation perception variables. In Study 1, MHB’s effects on Positive General Perceptions and Stigmatizing Person Perceptions were partially mediated by lower perceived Painlessness of the suicide method. In Study 2, MHB’s effect on Stigmatizing Person Perceptions was partially mediated by lower perceived Proactiveness of the suicide motive. Although some of these findings may seem contrary to MHB’s mentality of toughness and agentic values (Saucier et al., 2016), they could be manifestations of MHB’s

positive relationship with other-directed FOD and negative relationship with Suicide Acceptability.

Inconsistent with my hypotheses, MHB did not interact with either study's manipulation. I expected MHB to be associated with less negative attitudes toward suicides completed by gun (Study 1) due to honor ideology's relationships with guns (e.g., Bock et al., 2021; Brown et al., 2014b; Osterman & Brown, 2011) and more negative attitudes toward suicide that is motivated by mental health concerns (Study 2) due to honor ideology's positive relationship with mental health stigma (e.g., Schiffer & Saucier, 2023). The lack of interactions is likely not attributable to weak manipulations for previously discussed reasons, but rather demonstrates the strength of MHB's effects on perceptions of people with terminal illnesses' suicides, regardless of their "how" (i.e., method) or "why" (i.e., motive).

Free Will Beliefs (FWB)

My hypotheses regarding the predictive effects of FWB were largely unsupported. I did not expect an interaction between FWB and Suicide Method (Study 1), but greater FWB was associated with more favorable attitudes toward gunshot suicide compared to VSED suicide (e.g., in terms of Terminal Illness Suicide is Better Than Traditional Suicide & Do You Consider Mike's Death to be Suicide). Although this may seem contrary to FWB being positively associated with stigma directed toward choice behaviors that lack willpower (e.g., Baumeister & Brewer, 2012) and VSED being approximately a week-long test of willpower and commitment, this finding may be partially attributed to VSED being perceived as more painful by people reporting greater levels of FWB.

In Study 2, I hypothesized FWB would be associated with more positive perceptions of dying by suicide to have control over death (Study 2), due to autonomy during death being

empowering (e.g., Horgan, 1991; Werth & Cobia, 1995) and the nature of this construct valuing one's agency (Paulhus & Carey, 2011). FWB did not interact with Suicide Motive Condition when predicting any continuous outcome, but did again predict Do You Consider Mike's Death to be Suicide, similar to Study 1. Specifically, as FWB increased, burdening loved ones had more reports for being classified as suicide whereas reports were lower for mental health and physical pain. This seems to suggest that other-oriented motives, like considering loved ones' thoughts and feelings about their death, closely align with conceptualizations of suicide for people reporting greater levels of FWB. Interestingly, the wanting control over death motive remained relatively stable in terms of responses to Do You Consider Mike's Death to be Suicide across levels of FWB, perhaps because this condition was mediated by lower perceived Proactiveness.

This latter finding seems contrary to the idea that suicide is the epitome of autonomous action (Sanati, 2009). If lay conceptualizations of free will refer to the capacity to make one's own decisions as their own causal agent (e.g., Monroe & Malle, 2010; Paulhus & Carey, 2011), the consistently negative attitudes of people with greater levels of FWB toward this phenomenon (Schiffer & Saucier, 2024; under review) perhaps imply almost a disagreement with the decision to die by suicide. This explanation would be consistent with FWB's positive relationship with suicide stigma (Ozkok et al., 2022) and negative relationship with Suicide Acceptability as shown in both studies as well as by Schiffer and Saucier (2024, under review).

Fear of Death (FOD): Self-Directed & Other-Directed

Although previous research in this area used FOD as a singular construct (see Schiffer & Saucier, 2024; under review), the present research examined self-directed and other-directed FOD separately. The primary reason for this was to better more accurately account for third-person perceptions of others' deaths, which is the stimulus of this research. In both studies, other-directed

FOD was significantly greater than self-directed FOD. Interestingly, these yielded different effects across studies. Self-directed FOD predicted several outcomes in Study 2, but not Study 1. Specifically, greater self-directed FOD was associated with greater Positive General Perceptions, less Stigmatizing Person Perceptions, and greater Perceived Difference Between Traditional & Terminal Illness Suicide. Consistent with my FOD hypotheses, this could be evidence that anxiety about death and dying (e.g., Lester & Abdel-Khalek, 2003), especially one's own, may manifest in more empathetic perspectives toward people with terminal illnesses dying by suicide.

Despite their positive correlation, other-directed FOD yielded many more effects across studies, often in the opposite direction compared to self-directed FOD. In Study 1, higher levels of FOD-Other were associated with more frequent reports of this as suicide in the gunshot condition compared to the other levels of Suicide Method Condition. This could be attributable to gun suicides being more violent in nature (e.g., Chung & Lin, 2010) and/or perhaps more prototypical of suicide given that it is one of the most commonly used methods in the US ([CDC Suicide Data & Statistics](#)), either of which may be of concern for individuals higher in FOD directed toward others. Supporting either explanation, the moderated mediation of this effect reinforced the idea that suicide by gun may be a more painful suicide method which contributed to more negative attitudes. In Study 2, greater other-directed FOD was associated with less Positive General Perceptions and more Stigmatizing Person Perceptions, inconsistent with my broader FOD hypotheses. However, this may be further evidence of FOD's relationship with concerns about end-of-life treatment issues (e.g., Lockhart et al., 2001).

Taken together, the separation of self-directed versus other-directed FOD was useful in understanding more nuanced views of third-person perceptions of people with terminal illnesses' suicides. In fact, the discrepancy between these two constructs may provide insight on the

complicated patterns that emerged for FOD as a singular construct in other research, like greater perceptions that people who die by PAD are miserable (Schiffer & Saucier, under review) but also less stigmatizing attitudes toward people with terminal illnesses who die by suicide (Schiffer & Saucier, 2024). Given these contradictory patterns, future research should continue to examine different perspectives on FOD simultaneously, especially when measuring third-person perceptions of a situation.

Suicide Acceptability

The effects of Suicide Acceptability were consistent with my past research (Schiffer & Saucier, 2024; under review) and my hypothesis that it would be positively associated with favorable attitudes toward suicide among people with terminal illnesses. Specifically, greater Suicide Acceptability was associated with more Positive General Perceptions, less Stigmatizing Person Perceptions, and greater Terminal Illness Suicide is Better Than Traditional Suicide in both studies, as well as greater Perceived Difference Between Terminal Illness Suicide and Traditional Suicide in Study 1. Interestingly, these effects were mediated by increased perceived painlessness of the suicide method (Study 1) and increased perceived proactiveness of the suicide motive (Study 2). Together, these effects suggest that, consistent with the nature of the construct, Suicide Acceptability is associated with more favorable attitudes toward people with terminal illnesses' suicides, but also a certain sensitivity to nuance regarding this particular end-of-life situation in perceiving methods as less painful and motives as more proactive.

As further evidence of Suicide Acceptability being key to understanding complexities of this social phenomenon, Suicide Acceptability interacted with conditional manipulations in both studies, contrary to my hypotheses. In Study 1, higher levels of Suicide Acceptability were associated with more frequent reports for "terminal illness" to be listed as the Cause of Death on

the Death Certificate in most conditions, except for VSED. This finding is interesting because VSED represents essentially death by omission, compared to the other suicide methods, meaning it would most closely reflect death by terminal illness compared to suicide. Moreover, this effect was not mediated by either manipulation perception variable, despite VSED being perceived as one of the more painful methods. With this binomial outcome having little variation in responses, caution should be used in further interpreting this effect. In Study 2, higher levels of Suicide Acceptability were associated with more frequent identifications of the death as suicide when the target was motivated to avoid burdening loved ones, but less so in the other conditions. This could be attributed to the burdensomeness condition being the only other-oriented suicide motive (with the other conditions being more self-oriented) and/or this being major tenet of the interpersonal theory of suicide (Van Orden et al., 2010) which could then be perceived as more reflective of suicide.

Taken together, these findings provide evidence for variability in Suicide Acceptability as an individual difference construct, plus that higher levels are associated with perceiving people with terminal illnesses' suicides more favorably, consistent with the nature of the construct (Hoelter, 1979). Moreover, the effects that emerged in terms of main effects (e.g., Terminal Illness Suicide is Better Than Traditional Suicide) and the mere presence of interaction effects highlight the idea that beliefs about the acceptability of suicide may be associated with more complex/nuanced perceptions of suicide. Overall, this research emphasizes the importance of not only understanding situational differences in perceptions of suicide (Winterrowd et al., 2015) but also allowing for individual variability in the perceived acceptability of suicide.

Limitations

Given that this research was conducted using online data collection tools, the samples were Western, educated, industrialized, rich, and democratic (WEIRD; Henrich et al., 2010) in nature, which may affect the generalizability of these findings. At the same time, when examining archival data of people who use PAD, their demographics are often WEIRD as well, in being predominantly White, educated, and liberal (e.g., Al Rabadi et al., 2019, Blanke et al., 2017). Related to being WEIRD, it is important to note the potential for self-selection biases in participants' decisions to engage with this research. Both studies were advertised on Prolific as "Perceptions of End-of-Life Decisions" with appropriate content notices on the study information page and in the informed consent. Nonetheless, certain people, perhaps those with more experience with these topics and/or those with more passionate beliefs about these topics, may have been more likely to participate in these studies compared to others.

Generalizability is also limited by the ecological validity of the vignettes used in this research. In terms of demographics, vignettes are limited to specifying a White man in his 70s, which is consistent with racial, gender, and age demographics that are associated with higher suicide rates (e.g., [CDC Suicide Data & Statistics](#)). The common experiences of what the target can expect were derived from first-person perspectives from people with terminal illnesses (e.g., Breitbart et al., 2000; Chochinov et al., 2002; Emanuel et al., 2000; Suarez-Almazor et al., 2002; Wilson et al., 2000). Thus, although the vignettes may lack ecological validity, their included identifiers and manipulations reflect real world data and experiences.

With respect to the outcome variables measured, there is an important distinction to be made related to the cause of death outcome. On death certificates, the cause of death is very specific to what literally caused the death in the last minutes of life, like a complication of a heart

attack (e.g., rupture of myocardium), while the underlying condition may also be identified as appropriate (e.g., heart disease). Therefore, in our studies, what would actually be identified as the cause of death on the death certificate would depend on the suicide method used, which was only (broadly) specified in Study 1 vignettes. Importantly, there is often minimal subjectivity in specifying cause of death information, even when examining the coexistence of suicide and terminal illness. For example, under Oregon's Death With Dignity Act, someone who died using physician-assisted death would have their terminal illness identified as their cause of death and "natural" identified as their manner of death. In other words, our inclusion of this question may imply an illusion of choice, when there really is not one.

Moreover, how this outcome was phrased (i.e., "cause of death") may be misleading in technical terms given that the response options more accurately reflect the hypothetical person's manner of death (i.e., the circumstances leading to the death) by asking participants to report their perceptions as to if this death resulted from natural causes (e.g., the terminal illness) or from suicide. Both the phrasing of the question (as "cause of death") and the breadth of the response options were intended to allow for simplicity and understanding of participants. We acknowledge the response options do not directly reflect how cause of death would be represented on a true death certificate, but nonetheless believe this outcome provides a creative assessment of participant perceptions, which may have interesting practical implications (as discussed later).

Although Study 1 involves several different suicide methods, it does not encapsulate all possible suicide methods. Nonetheless, those that are included represent a wide variety that range from passive to violent with some being more medical routes and others being more traditional routes. Moreover, some of the suicide methods may not necessarily be accessible to all individuals with terminal illnesses (e.g., owning a gun, being a resident of a state in which PAD is legal), and

one's illness may limit their access to said methods (e.g., Kleespies et al., 2000). As such, participants may have made inferences about the target depending on their chosen suicide method. Similarly, Study 2 focused on four specific motivations for suicide which do not reflect all possible motives, nor the possibility of motives coexisting. However, the motives included in Study 2 were informed by common precipitators for suicide in the general population (e.g., mental health; Holma et al., 2014) and theory-driven reasons (e.g., burdensomeness; Van Orden et al., 2010) as well as some that may be more unique to people with terminal illnesses (e.g., physical health issues, wanting control; Horgan, 1991; Werth & Cobia, 1995).

Future Directions

To expand on the sample limitations of this research, future research could target different age groups to better reflect the population of people most likely to be experience terminal illness and/or use medical aid in dying. In addition, given the lack of effects across suicide motives, future research should consider using a true control condition (i.e., not specify a specific motive), having participants provide the motive they attribute to the suicide, or allowing for multiple motives to be present (see Schiffer & Saucier, 2024; under review). Perhaps relatedly, a within-groups design in which participants view all conditions rather than just one, would allow for more nuanced comparisons across methods and motives relative to one another.

Incorporating more moral psychology, future research could explore how various approaches to decision-making (e.g., utilitarianism, deontology) may affect perceptions of the suicide. In this case, it may be worthwhile to take Conway and Gawronskis' (2013) process-dissociation approach to allow for the coexistence of multiple decision-making strategies. Participant perceptions of this situation may also differ depending on if the vignette is written in third-person (e.g., about Mike) versus first-person (e.g., imagine you learn you are terminally ill).

Further, third-person perceptions may also vary on if the target in the vignette is a stranger (like Mike) or a loved one (e.g., imagine a loved one of yours learns they are terminally ill). Regardless of specific conditions, research manipulating the perspective of this situation should measure participants' level of empathy, which likely will serve as an important moderator.

One of the more fruitful opportunities for future research should examine how the health condition itself may affect perceptions of the person's suicide, namely because stigma is condition-specific (e.g., Link & Phelan, 2006). In particular, of people who use PAD, conditions vary from cancer being the most common to heart disease to HIV (Blanke et al., 2017). Moreover, physical conditions are stigmatized based on various factors (e.g., visibility, disruptiveness; Livneh et al., 2014), with the condition's origin perhaps being especially relevant to terminal illness. Condition origin is usually categorized as either adventitious, meaning the person is personally responsible for their condition (e.g., smoking and lung cancer), or congenital, meaning the condition is hereditary. Moreover, given that suicide among people with terminal illnesses may blend physical and mental health issues, mental health conditions are similarly stigmatized as the person being responsible for having their disorder (i.e., onset responsibility; Corrigan & Kosyluk, 2014). In other words, perceptions of suicide by someone who is terminally ill with a condition that their lifestyle played a role in (e.g., lung cancer) will likely be perceived differently than someone who is terminally ill with a condition that is genetic (e.g., congenital heart disease).

Theoretical Implications

Theoretical implications of this research not only address gaps in the literature but also offer important interdisciplinary contributions. My first research question inquired about the situational factors that affect perceptions of people with terminal illnesses suicide. My previous research examined situational factors related to person variables, namely demographics like age

and gender (Schiffer & Saucier, 2024). To extend this, situational factors in the present research examined the suicide's "how" (Study 1) and "why" (Study 2), offering greater contributions to our understanding of suicide in this population as well as advances for suicide theory. Historically, research on the intersection of suicide and terminal illness focuses only on one specific method, PAD which is only legal in some states, and most of this research tracks usage trends (e.g., Al Rabadi et al., 2019). Chung and Lin (2010) tracked different types of traditional suicide methods in terminal cancer patients. Study 1 combined medical methods, including but also beyond PAD, and traditional methods, allowing for a more holistic look at this phenomenon. This has implications for social psychology and moral philosophy in identifying contextual factors related to perceptions of this phenomenon that vary in agency (e.g., VSED may represent suicide by omission rather than action) and sociality (e.g., medical methods involve assistance from medical staff).

Moreover, the interpersonal theory of suicide proposes that interpersonal stressors (i.e., lack of belonging, burdensomeness) are the primary precipitators of suicidal ideation and subsequent behavior (Van Orden et al., 2010). Importantly, many other theories exist to explain suicidal behavior, which can be most broadly differentiated as first-generation versus second-generation suicide theories (Yöyen & Keleş, 2024). First-generation suicide theories are those that were developed before the 2000s (e.g., Psychodynamic Theory, Hopelessness Theory, Escape Theory) whereas second-generation suicide theories are those that were developed after the 2000s (e.g., Interpersonal Psychological Suicide Theory, Three Stage Suicide Theory, Variable Predisposition Theory). Beyond the temporal distinction between these classes of suicide theories, second-generation theories extend upon first-generation theories by separating suicidal ideation from suicidal behavior and offering testable hypotheses regarding how thought translates into

action. Nonetheless, the majority of these second-generation theories rely on some combination of psychological pain, hopelessness, and/or a practical capability for suicidal behavior, which often only indirectly account for physical health as a contributing factor to suicidal ideation and behavior.

Study 2 essentially offered the translation of thought into action for someone with a terminal illness by manipulating a hypothetical person's primary suicide motive. This included examines interpersonal stressors (namely burdensomeness) in addition to other stressors that are more health-related (both physical and mental) plus autonomous reasons for dying by suicide. The lack of effect of suicide motive on perceptions perhaps highlights the hopelessness of the situation as informing perceptions. For example, rather than burdensomeness eliciting different perceptions than wanting control over death, a specific motive or precipitator may be moot in the context of terminal illness. In this case, hopelessness is the gatekeeper of perceptions, which is perhaps contrary to the interpersonal theory of suicide suggesting burdensomeness and lack of belonging inform hopelessness. As such, this research may encourage further expansion or broadening of experiences that contribute to suicidal ideation to include hopelessness as a primary experience, which could be informed by physical health issues.

My second research question regarding the role of individual differences in these perceptions helps advance both social and personality psychology. Outside of my research (see Schiffer & Saucier, 2024; under review), other scholars have mostly focused on sociodemographic differences in attitudes toward PAD (e.g., Suarez-Almazor et al., 2002). In examining more enduring individual differences, we can better understand belief systems that contribute to perceptions of people with terminal illnesses' suicides. I, specifically, have examined individual differences related to pride (i.e., MHB) and existential considerations (i.e., FWB, FOD, Suicide

Acceptability), meaning there are many more avenues for future research to incorporate personality traits and individual differences.

Additionally, much of the existing research in this area focuses on *first-person* perspectives on suicide, like tracking actual deaths (e.g., Al Rabadi et al., 2019; Chung & Lin, 2010) or inquiring about the terminally ill population's desires for suicide (e.g., Breitbart et al., 2000). My examination of *third-person* perceptions of suicide among people with terminal illnesses provides insight on the public stigma (or lack thereof) of this phenomenon. These relative levels of stigma can potentially inform voting behaviors related to medical aid in dying (e.g., PAD) legislation. Also, within psychology, the examination of terminal illness as well as death and dying may also help inform health psychology and lifespan development research. Beyond psychology, the overarching research questions pertain to individuals', specifically people with terminal illnesses', body autonomy which has implications for moral philosophy discussions on rights and free will. Ultimately, this research is novel in its examination of suicide by people with terminal illnesses and important situational factors, beyond those who use PAD.

Practical Implications

The theoretical implications of this research lend themselves to broader practical implications related to healthcare policy and potentially legislation. First, stigma directed toward people with terminal illnesses who die by suicide may have potential repercussions for life insurance policies. For instance, life insurance policies often do not pay out to families when the death is attributed to suicide if the policy was implemented recently (e.g., Yip et al., 2010). Thus, our examination of death certificate information, although phrased as cause of death but functionally representing manner of death (e.g., suicide versus natural causes), has implications for such life insurance policies. In other words, this research provides a critical look at factors that

may influence what is listed on the death certificate for people with terminal illnesses who die by suicide, including aspects of the suicide, most notably its method, but also aspects of perceivers.

Second, the intersection between health, psychology, and philosophy has broader implications for legislation related to body autonomy. Given recent and evolving legislation on related topics (e.g., PAD, abortion), this research gauged aggregate perceptions of body autonomy at the end of life. PAD was consistently viewed the most favorably across various suicide methods, especially compared to traditional methods used by the general population. As such, with this research providing evidence for less stigma directed toward this particular suicide method, we hope these data can serve as a call for advocacy to further expand legislation to make PAD a more accessible option for people with terminal illness. Activism toward this end may take the form of education surrounding first-person experiences with end-of-life issues and considerations, specifically targeting policymakers. In doing so, people with terminal illnesses' voices could be amplified while advocating for safe and accessible routes for maintaining body autonomy at the end-of-life.

Conclusion

This program of research examined third-person perceptions of suicide by people with terminal illnesses in relation to situational factors and individual differences. To do this, vignettes were used in between-groups designs, with outcome variables measuring general and person perceptions, comparisons to traditional suicide, and reports for the cause of death on death certificates. This research extends previous work on PAD as well as my own research that examined demographic variables as situational factors that inform third-person perceptions of people with terminal illnesses' suicides (Schiffer & Saucier, 2024). As such, this research helps advance suicide theory, stigma research, as well as several areas of psychology.

Situational factors examined include suicide method (Study 1) and motive (Study 2). The manipulations for Study 1 were chosen based on methods that are potentially available for people with terminal illnesses (e.g., PAD) as well as those that are most common in the US according to CDC data. My hypotheses were mostly supported with medical methods being perceived more favorably than traditional methods, except for VSED. The manipulations for Study 2 were chosen based on data from first-person studies on common experiences that are associated with desiring hastened death within the terminally ill population (e.g., Chochinov et al., 2002; 2005) as well as accounting for some interpersonal motives for suicide (Van Orden et al., 2010). Inconsistent with my hypotheses, there were few differences in perceptions across various suicide motives.

Individual differences examined include those relating to pride and existential considerations, and the effects that emerged were largely consistent with previous research in this area (e.g., Schiffer & Saucier, 2024). Specifically, greater MHB were associated with more stigmatizing attitudes toward this phenomenon. FWB unexpectedly interacted with conditional manipulations, but its correlations suggest stigmatizing attitudes in general. It was fruitful to separate FOD into self-directed and other-directed components, which yielded contradictory findings at times. Greater Suicide Acceptability was consistently associated with more favorable perceptions of this phenomenon. Taken together, this research quantitatively assessed third-person perceptions of people with terminal illnesses' suicides as a function of the suicide method and motive and individual differences related to pride and existential considerations. Ultimately, this research highlights the nuances of perceptions of end-of-life decisions from a social-personality psychology perspective.

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Appendix A - Supplementary Tables

Supplementary Table A.1

Study 1 Estimated Marginal Means for Significant ANOVAs with Simplified Occupational Group as a Predictor of the Outcome Variables

	<u>Quick</u>		<u>Positive General Perceptions</u>		<u>Stigmatizing Person Perceptions</u>	
	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>	<i>M</i>	<i>SE</i>
Business & Administration	5.05 _a	0.16	5.43 _a	0.18	3.79 _a	0.14
STEM Related	5.75 _a	0.20	5.53 _{a,b}	0.22	3.94 _a	0.17
First Responders & Protective Services	5.52 _a	0.23	5.93 _{a,b}	0.24	3.72 _a	0.19
Manual Labor & Trades	5.63 _a	0.25	6.45 _b	0.28	3.22 _a	0.21
Other	5.71 _a	0.27	6.02 _{a,b}	0.30	3.26 _a	0.23

Note: “Business & Administration” included the following: Management Occupations, Business and Financial Operations Occupations, Sales and Related Occupations, and Office and Administrative Support Occupations ($n = 106$).

“STEM Related” included the following: Computer and Mathematical Occupation; Architecture and Engineering Occupations; Life, Physical, and Social Science Occupations; Education, Training, and Library Occupations; and Arts, Design, Entertainment, Sports, and Media Occupations ($n = 72$).

“First Responders & Protective Services” included the following: Protective Service Occupations, Healthcare Practitioners and Technical Occupations, Healthcare Support Occupations, Community and Social Service Occupations, and Legal Occupations ($n = 57$).

“Manual Labor & Trades” included the following: Food Preparation and Serving Related Occupations; Building and Grounds Cleaning and Maintenance Occupations; Personal Care and Service Occupations; Farming, Fishing, and Forestry Occupations; Construction and Extraction Occupations; Installation, Maintenance, and Repair Occupations; Production Occupations; and Transportation and Material Moving Occupations ($n = 44$).

“Other” was retained as self-identified ($n = 38$).

ANOVAs revealed significant models when predicting Quick, $F(4, 310) = 2.46, p = .045$; Positive General Perceptions, $F(4, 312) = 3.00, p = .019$; and Stigmatizing Person Perceptions, $F(4, 312) = 2.75, p = .029$. Significant differences, according to Tukey’s HSD tests, are denoted by different letter subscripts.

Supplementary Table A.2

Study 1 Correlations Among Individual Difference Variables, Including All Subscales, & Demographic Variables

	1	1a	1b	1c	1d	1e	1f	1g	2	3	4	5	6	6a	6b	6c	6d	7	8	9	10	11	12	13	14	15	16
1. Masc Honor Beliefs	(.95)																										
1a. Masc Courage	.88	(.90)																									
1b. Pride in Manhood	.89	.78	(.84)																								
1c. Socialization	.73	.59	.55	(.81)																							
1d. Virtue	.67	.55	.69	.34	(.82)																						
1e. Protection	.81	.68	.64	.62	.33	(.89)																					
1f. Provocation/Insult	.76	.56	.67	.39	.58	.46	(.93)																				
1g. Fam & Community	.63	.52	.40	.52	.14	.66	.28	(.80)																			
2. Free Will Beliefs	.48	.40	.39	.33	.24	.47	.36	.41	(.81)																		
3. Unpredictability	.16	.03	.12	.20	.17	.11	.18	.06	.11	(.78)																	
4. Scientific Determinism	.21	.15	.15	.12	.28	.09	.22	.13	.16	.18	(.69)																
5. Fatalistic Determinism	.39	.30	.42	.22	.35	.26	.43	.10	.23	.29	.27	(.85)															
6. Fear of Death	.10	-.03	.05	.12	.00	.14	.12	.14	-.01	.21	-.00	.13	(.94)														
6a. Your Death	.08	-.03	.05	.07	.06	.10	.13	.07	-.01	.15	.01	.11	.85	(.89)													
6b. Your Dying	-.02	-.14	-.07	.04	-.07	.06	.02	.09	-.03	.17	-.01	.02	.85	.67	(.87)												
6c. Others Death	.11	.02	.07	.16	-.03	.14	.10	.16	-.04	.16	-.01	.10	.81	.54	.55	(.78)											
6d. Others Dying	.17	.06	.13	.15	.03	.19	.17	.17	.03	.22	.01	.20	.85	.55	.62	.74	(.86)										
7. Suicide Acceptability	-.31	-.29	-.22	-.14	-.18	-.25	-.26	-.30	-.33	.14	.09	-.17	.03	-.05	.13	.03	-.01	(.83)									
8. Age	.02	.07	.04	-.08	.01	.03	.00	.03	.11	-.07	-.07	-.01	-.23	-.26	-.06	-.27	-.19	-.04	-								
9. Gender	.21	.25	.20	.17	.13	.17	.10	.08	-.04	.04	.13	-.08	-.20	-.19	-.20	-.14	-.12	.03	-.05	-							
10. Race	-.24	-.21	-.22	-.16	-.21	-.17	-.23	-.09	-.09	-.04	.03	-.09	-.03	-.05	.07	.00	-.11	.15	.22	.00	-						
11. Education	-.15	-.08	-.17	-.19	-.08	-.12	-.19	.04	-.21	-.11	.02	-.14	-.01	.00	.01	.02	-.05	-.08	.10	-.04	.03	-					
12. SES	.01	.03	.00	-.04	.03	-.03	-.03	.15	.00	-.15	.03	-.08	.01	.08	-.05	.02	-.05	-.21	.06	-.00	.07	.40	-				
13. Religiosity & Spirit	.36	.34	.30	.23	.15	.33	.28	.28	.33	-.05	-.06	.34	.08	.06	.04	.10	.08	-.44	.20	-.09	-.04	.00	.05	(.74)			
14. Political Orientation	.39	.37	.38	.19	.27	.32	.30	.23	.34	-.10	-.04	.16	-.07	-.04	-.07	-.09	-.06	-.37	.25	-.01	.04	-.15	.04	.45	-		
15. Quality Healthcare	.10	.05	.03	.07	.07	.07	.09	.23	.12	.03	-.04	-.00	-.03	-.05	-.01	-.02	-.03	-.21	.22	-.05	.12	.12	.32	.08	.06	-	
16. Affordable Healthcare	.11	.03	.02	.09	.11	.08	.13	.18	.12	.08	-.05	.08	.03	-.02	.09	.02	.01	-.13	.21	-.10	.04	.02	.18	.10	.05	.72	-
17. Sufficient Health Insur	.05	-.02	-.03	.04	.01	.02	.09	.15	.07	.07	-.06	.03	.01	-.00	.04	.01	-.02	-.13	.13	-.04	.14	.10	.27	.09	.00	.75	.82

Note: $p < .05$ are bolded. Alphas are provided along the diagonal. Gender was coded women as 0 and men as 1, excluding participants who identified differently. Race was coded nonwhite individuals as 0 and white individuals as 1. Education was coded as follows: 0 = some high school or less, 1 = high school or equivalent, 2 = associate's degree, 3 = bachelor's degree, 4 = master's degree, 5 = doctorate. SES was coded as follows: 0 = lower class, 1 = lower-middle class, 2 = middle class, and 3 = upper-middle class.

Supplementary Table A.3

Study 1 Means, Standard Deviations, One Sample t-tests Against Midpoint of the Scale, for the Individual Differences' Subscales, & Correlations with the Outcomes

	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	Quick	Painless	Positive General	Stigmatizing Person	Is it Suicide?	Diff in TI v Trad	TI>Trad Suicide	COD
1. Masc Honor Beliefs	5.02	1.37	0.21	.832	-.01	-.15	-.35	.37	.08	-.02	.02	-.10
1a. Masc Courage	5.09	2.02	0.78	.435	-.06	-.13	-.31	.36	.07	-.03	-.02	-.10
1b. Pride in Manhood	3.96	1.88	-9.86	<.001	.02	-.06	-.29	.35	.10	-.05	-.01	-.07
1c. Socialization	6.56	1.57	17.73	<.001	-.03	-.13	-.19	.20	.05	.06	.11	-.05
1d. Virtue	2.43	1.43	-32.22	<.001	.01	-.05	-.22	.30	.10	-.08	-.09	-.04
1e. Protection	6.49	1.82	14.62	<.001	-.06	-.16	-.31	.29	.11	-.01	.01	-.13
1f. Provocation/Insult	3.34	2.17	-13.64	<.001	.07	-.10	-.29	.31	.00	-.04	-.01	-.05
1g. Fam & Community	7.24	1.41	28.36	<.001	.01	-.17	-.23	.19	-.00	.05	.13	-.06
2. Free Will Beliefs	6.13	1.39	14.61	<.001	-.10	-.16	-.29	.25	-.03	-.08	-.02	-.12
3. Unpredictability	5.91	1.23	13.29	<.001	.05	.02	.13	-.19	-.09	.05	.11	.06
4. Scientific Determinism	4.95	1.14	-0.85	.398	.01	.07	.03	.01	-.02	-.01	-.01	-.02
5. Fatalistic Determinism	4.35	1.82	-6.37	<.001	.04	.03	-.20	.17	-.01	-.10	-.02	-.00
6. Fear of Death	6.19	1.56	13.63	<.001	.03	-.05	-.05	-.03	.01	.09	.15	.12
6a. Your Death	5.18	2.26	1.44	.150	.01	-.06	-.09	-.01	-.03	.08	.09	.16
6b. Your Dying	6.42	1.89	13.47	<.001	.07	-.01	.08	-.12	-.02	.11	.16	.09
6c. Others Death	6.65	1.53	19.25	<.001	.00	-.04	-.08	.02	.07	.02	.14	.07
6d. Others Dying	6.49	1.72	15.52	<.001	.03	-.05	-.09	.01	.04	.06	.11	.06

Note: Most variables were completed on 1 to 9 Likert-type scales, with various anchor labels. Is It Suicide? coded “no” as 0 and “yes” as 1. Cause of Death on Death Certificate coded “suicide” as 0 and “their terminal illness” as 1, while treating “other” as missing values. $p < .05$ are bolded.

Supplementary Table A.4

Study 2 Correlations Among Individual Difference Variables, Including All Subscales, & Demographic Variables

	1	1a	1b	1c	1d	1e	1f	1g	2	3	4	5	6	6a	6b	6c	6d	7	8	9	10	11	12	13	14	15	s
1. Masc Honor Beliefs	(.95)																										
1a. Masc Courage	.88	(.88)																									
1b. Pride in Manhood	.88	.80	(.83)																								
1c. Socialization	.72	.57	.51	(.78)																							
1d. Virtue	.71	.57	.69	.36	(.80)																						
1e. Protection	.82	.69	.63	.67	.37	(.89)																					
1f. Provocation/Insult	.81	.63	.72	.42	.69	.49	(.94)																				
1g. Fam & Community	.60	.45	.39	.47	.14	.67	.30	(.80)																			
2. Free Will Beliefs	.44	.36	.34	.45	.22	.47	.20	.43	(.79)																		
3. Unpredictability	.16	.04	.11	.21	.18	.11	.13	.12	.22	(.76)																	
4. Scientific Determinism	.35	.28	.39	.15	.42	.17	.33	.15	.23	.33	(.74)																
5. Fatalistic Determinism	.34	.22	.30	.24	.40	.20	.34	.15	.29	.36	.47	(.84)															
6. Fear of Death	.17	.07	.16	.08	.09	.12	.21	.21	.06	.15	.14	.15	(.94)														
6a. Your Death	.20	.09	.22	.10	.17	.13	.23	.16	.07	.13	.18	.16	.84	(.86)													
6b. Your Dying	.01	-.03	.02	-.05	-.01	-.01	.06	.10	-.03	.12	.03	.02	.84	.63	(.90)												
6c. Others Death	.15	.05	.10	.09	.04	.11	.19	.25	.07	.11	.14	.15	.84	.56	.60	(.83)											
6d. Others Dying	.22	.13	.19	.14	.09	.18	.23	.21	.11	.13	.12	.19	.84	.57	.72	(.86)											
7. Suicide Acceptability	-.33	-.34	-.31	-.16	-.17	-.29	-.23	-.29	-.34	.13	-.02	-.08	-.01	-.13	.06	.01	.03	(.83)									
8. Age	-.07	-.06	-.09	-.10	-.10	-.03	-.07	.06	-.06	-.11	-.22	-.10	-.07	-.16	.09	-.08	-.10	-.10	-								
9. Gender	.26	.29	.23	.16	.18	.21	.27	-.01	.08	.04	.11	-.09	-.11	-.07	-.12	-.14	-.05	-.14	-.13	-							
10. Race	-.17	-.18	-.10	-.12	-.15	-.11	-.14	-.13	-.20	-.17	-.16	-.23	-.09	-.12	-.01	-.07	-.10	.12	.18	-.05	-						
11. Education	.01	.07	.04	-.12	.00	-.11	.07	.05	-.13	-.06	.04	-.08	-.01	-.04	.02	.03	-.05	-.10	.07	.05	-.10	.07					
12. SES	.10	.07	.14	-.02	.14	.02	.10	.12	.06	.06	.12	.08	-.08	-.04	-.08	-.08	-.08	-.18	.12	.02	-.10	.39	-				
13. Religiosity & Spirit	.37	.33	.31	.31	.23	.37	.21	.33	.31	-.01	.00	.35	.06	.06	-.02	.08	.08	-.42	.13	-.16	-.22	.07	.17	(.79)			
14. Political Orientation	.41	.39	.42	.30	.27	.36	.23	.28	.31	-.09	-.03	.13	-.02	-.04	-.10	.04	.04	-.27	.06	.07	.14	-.00	.12	.38	-		
15. Quality Healthcare	.05	-.01	.02	.04	-.01	.02	.04	.20	.13	-.02	.02	-.03	-.05	-.10	-.00	.01	-.09	-.14	.23	-.05	-.05	.25	.35	.09	.00	-	
16. Affordable Healthcare	.12	.07	.09	.05	.12	.04	.16	.17	.08	-.01	.11	-.00	.01	-.01	.07	.01	-.04	-.08	.20	.00	-.12	.16	.21	.03	-.01	.73	-
17. Sufficient Health Insur	.07	.01	.06	.06	.04	.00	.10	.14	.08	.04	.09	-.04	.01	.00	.06	.02	-.04	-.12	.10	.01	-.08	.25	.34	.02	-.04	.76	.78

Note: $p < .05$ are bolded. Alphas are provided along the diagonal. Gender was coded women as 0 and men as 1, excluding participants who identified differently. Race was coded nonwhite individuals as 0 and white individuals as 1. Education was coded as follows: 0 = some high school or less, 1 = high school or equivalent, 2 = associate's degree, 3 = bachelor's degree, 4 = master's degree, 5 = doctorate. SES was coded as follows: 0 = lower class, 1 = lower-middle class, 2 = middle class, and 3 = upper-middle class.

Supplementary Table A.5

Study 2 Means, Standard Deviations, One Sample *t*-tests Against Midpoint of the Scale, for the Individual Differences' Subscales, & Correlations with the Outcomes

	<i>M</i>	<i>SD</i>	<i>t</i>	<i>p</i>	Avoidant	Proactive	Positive General	Stigmatizing Person	Is it Suicide?	Diff in TI v Trad	TI>Trad Suicide	COD
1. Masc Honor Beliefs	5.15	1.39	1.80	.074	.08	-.22	-.32	.38	.03	.05	-.04	-.23
1a. Masc Courage	5.29	1.98	2.35	.020	.08	-.22	-.28	.37	.03	.04	-.01	-.20
1b. Pride in Manhood	4.08	1.89	-7.97	<.001	.12	-.22	-.32	.41	.06	.07	.01	-.22
1c. Socialization	6.57	1.58	16.15	<.001	.04	-.11	-.17	.15	-.02	-.02	.01	-.17
1d. Virtue	2.52	1.45	-27.82	<.001	.09	-.14	-.21	.34	.06	.04	-.08	-.15
1e. Protection	6.74	1.81	15.63	<.001	-.01	-.18	-.27	.27	.01	-.02	-.05	-.21
1f. Provocation/Insult	3.43	2.31	-11.06	<.001	.08	-.20	-.26	.35	.02	.10	-.09	-.17
1g. Fam & Community	7.46	1.37	29.32	<.001	-.01	-.13	-.21	.11	-.03	.08	.02	-.11
2. Free Will Beliefs	6.23	1.39	14.36	<.001	-.03	-.20	-.27	.24	-.03	-.08	-.03	-.22
3. Unpredictability	5.92	1.25	12.03	<.001	.01	.07	.00	.03	-.03	.00	.04	.03
4. Scientific Determinism	4.87	1.34	-1.61	.108	.03	-.05	-.06	.18	-.07	.13	.08	-.01
5. Fatalistic Determinism	4.11	1.88	-7.66	<.001	-.02	-.20	-.22	.30	-.01	-.09	-.11	-.12
6. Fear of Death	6.08	1.60	10.98	<.001	.09	.02	-.08	.07	-.04	.22	.07	-.02
6a. Your Death	5.14	2.14	1.08	.281	.08	-.07	-.16	.12	.00	.17	.01	-.11
6b. Your Dying	6.27	2.04	10.10	<.001	.04	.23	.12	-.10	-.09	.32	.18	.10
6c. Others Death	6.49	1.68	14.37	<.001	.08	-.08	-.15	.12	.01	.08	.02	-.01
6d. Others Dying	6.41	1.75	13.17	<.001	.10	.04	-.10	.10	-.04	.16	.04	-.04

Note: Most variables were completed on 1 to 9 Likert-type scales, with various anchor labels. Is It Suicide? coded “no” as 0 and “yes” as 1. Cause of Death on Death Certificate coded “suicide” as 0 and “their terminal illness” as 1, while treating “other” as missing values. Correlations with *p* < .05 are bolded.

Appendix B - Study 1 Vignettes

Suicide Method Vignette

Mike is a White man in his 70s who was just diagnosed as terminally ill by his doctor, meaning he is expected to have 6 months left to live. The doctor informs Mike that his condition will worsen. To give Mike an idea of what to expect in his remaining time, the doctor also shares the common experiences of others who were previously in this situation. Most notably, the progression of this condition is characterized by severe pain, lowered independence and mobility, as well as emotional distress and depression. Because of the expected suffering, Mike decides to die by suicide. To do this, Mike **stops eating and drinking until he dies within a week / stops eating and drinking and requests sedation from the medical staff so he is unconscious and pain-free until he dies within a week / requests assistance from his doctor, who confirms Mike meets the legal criteria for assisted death (e.g., he is capable of healthcare decision-making) then prescribes a lethal pill that Mike later takes and dies within 30 minutes / overdoses on his medications and dies within a couple hours / hangs himself and dies within a couple of minutes / shoots himself in the head and dies instantly.**

Attention Check

Which suicide method did Mike use?

- A) Stopped eating and drinking
- B) Stopped eating and drinking plus sedation
- C) Took a lethal pill prescribed by his doctor
- D) Overdose
- E) Hanging
- F) Gunshot
- G) I don't know

Note: Participants who provide incorrect responses or select "I don't know" were excluded from data analysis.

Manipulation Perceptions

How ____ is Mike's method of suicide?

Painless

1. humane
2. practical
3. painful ***

Quick

1. quick
2. violent
3. active
4. passive ***
5. realistic
6. common

*** denotes reverse-scored items

Appendix C - Vignette Response Items

Positive General Perceptions

1 (*Strongly Disagree*) to 9 (*Strongly Agree*)

Acceptability

1. I can appreciate that suicide prevents further pain and suffering for Mike.
2. Mike should be allowed to choose when and how he dies.
3. If I were in Mike's position, I might kill myself too.
4. Mike should not feel ashamed for choosing to die by suicide.
5. If I were a loved one of Mike's, I could accept his decision.
6. It is more empowering for Mike to die by suicide rather than from his terminal illness.
7. It is just as socially acceptable for Mike to die by suicide as it would have been to die from the illness itself.
8. I am morally opposed to Mike's suicide. ***
9. If I were one of Mike's loved ones, I would have tried to change his mind. ***
10. Even though the dying process is physically and mentally difficult for Mike, he should have still avoided suicide.

Negative Effects on Loved Ones

Mike's death by suicide...

1. is embarrassing for his loved ones.
2. is a disgrace to his loved ones.
3. steals time away from loved ones.
4. is harder on his loved ones than dying from the illness itself because he died sooner than he needed to.
5. is harder on his loved ones than dying from the illness itself because he gave up.

Positive Effects on Loved Ones

Mike's death by suicide...

1. is a relief for loved ones.
2. alleviates caregiving responsibilities for loved ones.
3. offers closure for loved ones.
4. is easier on his loved ones than dying from the illness itself because he suffered less.
5. is easier on his loved ones than dying from the illness itself because he died in a way that he could plan and control.

Stigmatizing Person Perceptions

Note: The items below are largely adapted from Batterham et al.'s (2013) Stigma of Suicide Scale. Items followed by a "+" were added by Schiffer & Saucier (under review).

1 (*Strongly Disagree*) to 9 (*Strongly Agree*)

Mike is...

Weak

1. Weak
2. Pathetic
3. Cowardly
4. An embarrassment
5. Giving up +

Miserable

6. Miserable
7. Lonely
8. Depressed
9. Hopeless
10. Pessimistic +

***Egotistical* +**

11. Selfish
12. Attention-seeking
13. Arrogant
14. Egotistical +
15. Playing God +

Brave

16. Brave
17. Strong
18. Noble
19. Fearless
20. Respectable +

Comparisons to Traditional Suicide

Is it Considered Suicide?

Do you consider Mike's death to be suicide?

- a. Yes
- b. No
- c. I don't know

Different From Traditional Suicide

Do you think there is a difference between Mike dying by suicide versus someone WITHOUT a terminal illness dying by suicide?

1 (*Definitely No*) to 9 (*Definitely Yes*)

Terminal Illness Suicide Is Better Than Traditional Suicide

1 (*Suicide by Someone WITHOUT a Terminal Illness*) to 9 (*Mike's Suicide*)

Which suicide is more...

Understandable

- 1. understandable?
- 2. acceptable?
- 3. moral?
- 4. rational?
- 5. reasonable?

Empowering

- 1. empowering?
- 2. liberating?
- 3. inspiring?
- 4. honorable?
- 5. respectable?

Stigmatizing

1. stigmatizing?
2. weak?
3. pathetic?
4. shameful?
5. traumatic?

Death Certificate

What do you think should be listed as the cause of death on Mike's death certificate?

- A) the terminal illness they were diagnosed with
- B) suicide
- C) other (please specify): [opportunity to write in a response]

What was the **primary** reason for your previous answer?

[Note: The "branch logic" feature in Qualtrics differentially presented answer items depending on which answer participants selected]

A) [if terminal illness is selected]

- a. Although suicide is what literally caused the death, the illness was the reason for the suicide.
- b. Suicide as the cause of death can be a stigmatizing label.
- c. Other (please specify): [opportunity to write in a response]

B) [if suicide is selected]

- a. Although the illness was the reason for the suicide, suicide is what literally caused the death.
- b. Suicide as the cause of death can be empowering in that the person did not succumb to the illness.
- c. Other (please specify): [opportunity to write in a response]

Appendix D - Masculine Honor Beliefs Scale (Saucier et al., 2016)

1 (*Strongly Disagree*) to 9 (*Strongly Agree*)

Masculine Courage

1. It is very important for a man to act bravely.
2. A man should not be afraid to fight.
3. It is important for a man to be able to face danger.
4. It is important for a man to be able to take pain.
5. It is important for a man to be courageous.

Pride in Manhood

6. It is important for a man to be more masculine than other men.
7. A man should be embarrassed if someone calls him a wimp.
8. A man should be expected to fight for himself.
9. If a man does not defend his wife, he is not a very strong man.
10. If a man does not defend himself, he is not a very strong man.

Socialization

11. If your son got into a fight, you would be proud that he stood up for himself.
12. You would want your son to stand up to bullies.
13. As a child you were taught that boys should defend girls.
14. If your son got into a fight to defend his sister, you would be proud that he protected his sister.
15. As a child you were taught that boys should always defend themselves.

Virtue

16. You would praise a man who reacted aggressively to an insult.
17. Physical aggression is always admirable and acceptable.
18. It is morally wrong for a man to walk away from a fight.
19. "A man who doesn't take any crap from anybody" is an admirable reputation to have.
20. Physical violence is the most honorable way to defend yourself.

Protection

21. A man should do whatever it takes to protect his wife because it is the right thing to do.
22. If a man cares about his wife, he should protect her even if everyone else thinks it's wrong.
23. A man should stand up for a female who is in his family or is a close friend.
24. It is a male's responsibility to protect his family.
25. A man should protect his wife.

Provocation/Insult

- 26. If a man's wife is insulted, his manhood is insulted.
- 27. If a man's mother is insulted, his manhood is insulted.
- 28. If a man's father is insulted, his manhood is insulted.
- 29. If a man is insulted, his manhood is insulted.
- 30. If a man's brother is insulted, his manhood is insulted.

Family & Community Bonds

- 31. It is important to spend time with the members of your family.
- 32. It is important for a man to be loyal to his family.
- 33. A man's family should be his number one priority.
- 34. It is important to interact with other members of your community.
- 35. It is a man's responsibility to respect his family.

Appendix E - Free Will & Determinism Plus Scale (Paulhus & Carey, 2011)

1 (*Strongly Disagree*) to 9 (*Strongly Agree*)

Free Will

1. People have complete control over the decisions they make.
2. People must take full responsibility for any bad choices they make.
3. People can overcome any obstacles if they truly want to.
4. Criminals are totally responsible for the bad things they do.
5. People have complete free will.
6. People are always at fault for their bad behavior.
7. Strength of mind can always overcome the body's desires.

Unpredictability

8. Chance events seem to be the major cause of human history.
9. No one can predict what will happen in this world.
10. Life seems unpredictable—just like throwing dice or flipping a coin.
11. People are unpredictable.
12. Life is hard to predict because it is almost totally random.
13. Luck plays a big role in people's lives.
14. What happens to people is a matter of chance.
15. People's futures cannot be predicted.

Scientific Determinism

16. People's biological makeup determines their talents and personality.
17. Psychologists and psychiatrists will eventually figure out all human behavior.
18. Your genes determine your future.
19. Science has shown how your past environment created your current intelligence and personality.
20. As with other animals, human behavior always follows the laws of nature.
21. Parents' character will determine the character of their children.
22. Childhood environment will determine your success as an adult.

Fatalistic Determinism

23. I believe that the future has already been determined by fate.
24. No matter how hard you try, you can't change your destiny.

- 25. Fate already has a plan for everyone.
- 26. Whatever will be, will be—there's not much you can do about it.
- 27. Whether people like it or not, mysterious forces seem to move their lives.

Note: Participants completed the whole scale, but only the first subscale was examined for theoretical importance. The remaining subscales' correlations are reported exploratorily.

Appendix F - Collett-Lester Fear of Death Scale (Lester & Abdel-Khalek, 2003)

How disturbed or made anxious are you by the following aspects of death and dying?

1 (*Not At All*) to 9 (*Very Much*)

Your Own Death

1. The total isolation of death
2. The shortness of life
3. Missing out on so much after you die
4. Dying young
5. How it will feel to be dead
6. Never thinking or experiencing anything again
7. The disintegration of your body after you die

Your Own Dying

8. The physical degeneration involved
9. The pain involved in dying
10. The intellectual degeneration of old age
11. That your abilities will be limited as you lay dying
12. The uncertainty as to how bravely you will face the process of dying
13. Your lack of control over the dying process
14. The possibility of dying in a hospital away from friends and family

The Death of Others

15. Losing someone close to you
16. Having to see the person's dead body
17. Never being able to communicate with the person again
18. Regret over not being nicer to the person when they were alive
19. Growing old alone without the person
20. Feeling guilty that you are relieved that the person is dead
21. Feeling lonely without the person

The Dying of Others

22. Having to be with someone who is dying
23. Having the person want to talk about death with you
24. Watching the person suffer from pain

- 25. Seeing the physical degeneration of the person's body
- 26. Not knowing what to do about your grief at losing the person when you are with them
- 27. Watching the deterioration of the person's mental abilities
- 28. Being reminded that you are going to go through the experience also one day

Appendix G - Suicide Acceptability Scale (Hoelter, 1979)

1 (*Strongly Disagree*) to 9 (*Strongly Agree*)

1. Suicide is immoral. ***
2. If my personal problems became worse, I may decide to take my life.
3. I would never, under any conditions, kill myself. ***
4. If I were suffering from a terminal illness, I might kill myself.
5. People who kill themselves may be better off now than when they were alive.
6. If everyone I loved were gone, I would consider killing myself.

*** denotes reverse-scored items.

Appendix H - Study 2 Vignettes

Suicide Motive Vignette

Mike is a White man in his 70s who was just diagnosed as terminally ill by his doctor, meaning he is expected to have 6 months left to live. The doctor informs Mike that his condition will worsen. To give Mike an idea of what to expect in his remaining time, the doctor also shares the common experiences of others who were previously in this situation. Most notably, the progression of this condition is characterized by severe pain, lowered independence and mobility, as well as emotional distress and depression. Because of the expected suffering, Mike decides to die by suicide primarily to **have control over his death / avoid burdening his loved ones / avoid physical pain / avoid mental and emotional distress.**

Attention Check

Why did Mike decide to die by suicide?

- A) To have control over his death
- B) To avoid burdening loved ones
- C) To avoid physical pain
- D) To avoid mental and emotional distress
- E) I don't know

Note: Participants who provide the incorrect response or select "I don't know" were excluded from data analysis.

Manipulation Perceptions

How _____ is Mike's motive for suicide?

- 1. avoidant
- 2. proactive
- 3. realistic
- 4. impulsive