Religion, human rights and matters of life and death: Exploring attitude toward abortion and euthanasia among adolescents in England and Wales

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Abstract

This study explores the association between attitude toward euthanasia and both religious practices (personal prayer and worship attendance) and self-assigned religious affiliation (Protestant, Catholic, Muslim, and non-religious) among a sample of 966 students between the ages of 14 and 18 years in England and Wales, after taking into account personal factors (age and sex) and psychological factors (extraversion, neuroticism, and psychoticism). The data demonstrate that religiously inclined students are less accepting of euthanasia and abortion. Religious practice is one key indicator with a significant negative correlation between prayer frequency and acceptance of euthanasia and abortion. In addition to prayer frequency, religious identity is a second key indicator. Muslim students and Catholic students are less accepting of euthanasia and abortion than Protestant students and non-religious students.

Keywords: Religion, human rights, adolescents, personality, euthanasia, abortion

1. Introduction

1.1 The right to life

The right to life is fundamental to the spirit of Human Rights. According to the Universal Declaration of Human Rights (1948), all human beings are born free and equal in dignity and rights (article 1) and everyone has the right to life, liberty and security of person (article 3). According to the European Convention for the Protection of Human Rights and Fundamental Freedoms (1950), everyone's right to life shall be protected by law (article 2). According to the International Convention on Civil and Political Rights (1966), everyone has the inherent right to life, and that right to life shall be protected by law. In line with this human rights emphasis on the right to life, the Rome Statute of the International Criminal Court (1998) places under the jurisdiction of the criminal court the violation of human life, either by direct means (murder) or by indirect means (depravation of essential support for life).

This firm commitment to the right to life, however, is not unproblematic and is not without potential conflict with other notions of human rights. Two classic issues on which the right to life comes into conflict with other notions of human rights concern euthanasia and abortion. Issues of Euthanasia and abortion are often the subject of heated international debate. A number of writers discuss the arguments for and against both euthanasia and abortion from moral, social and political perspectives (Dworkin, 1993; Weisstub & Pintos, 2008; Toebes, Hartlev, Hendriks, & Hermann, 2012; Cook, Erdman, & Dickens, 2014). A brief examination of legal cases and challenges in this area are explored.

1.2 Human rights and euthanasia

Euthanasia is a complex issue centred on questions regarding the role of government and the rights of individual citizens. Those who support euthanasia hold to the right of individuals to autonomy, and the belief that choosing where and when to die belongs to the

individual as a human right. In contrast, arguments against euthanasia highlight the undesirability of any government supporting acts which violate the right to life of its citizens. The contrasting arguments appealing to human autonomy and civic duty of governments to protect the life of their citizens over euthanasia highlight a deeper ethical dilemma (individual ethics versus social or public ethics) within the wider narrative of secular modernity. It is these ethical ambiguities that appear to be shaping legal and political discussions over such issues.

While in the UK there may be a right to die, in that the Suicide Act (1961) made it legal for people to take their own lives, the Act also made actively taking action to end another's life illegal, even with consent. Though medically assisted suicide is legal in some European countries, including Belgium, the Netherlands and Luxembourg, a parallel right to die implied by the right to life is not recognised in UK law. However, as an outcome of the Bland ruling (1993), when the UK High Court ruled in favour of Tony Bland's doctors disconnecting the feeding tubes keeping him alive, 'assisted suicides', which involve 'omissions' that are principally the removal of life-saving care, are not illegal (BBC, 1992).

During 2003-2006 Lord Joffe campaigned for an Assisted Dying Bill in the UK but this was rejected by the House of Lords in May 2006. Lord Joffe's bill would have given doctors the right to prescribe drugs that terminally ill patients could use to end their own life (BBC, 2006). A further Assisted Dying Bill proposed by Lord Falconer was debated in the UK House of Commons in September 2015 with MPs voting overwhelmingly against doctors being allowed to help terminally ill people end their own life (Mason, 2015).

Within the European Convention on Human Rights (ECHR) requests for recognition of a right to die through euthanasia or assisted suicide have been formulated mainly on the basis of article 2 (right to life), article 3 (that the denial of a right to release oneself from unbearable pain amounts to inhuman and degrading treatment), and article 8 (the protection

of private and family life). The cases of Pretty v Director of Public Prosecutions (DPP), and Purdy v Director of Public Prosecutions (DPP) are two of the most famous in relation to this issue.

In 2001, Pretty lost her case in the UK High Court (2001) for the right to die. Pretty argued that the government's decision not to allow her to die breached article 3 of the UK Human Rights Act (1998), that no-one shall be subjected to torture or inhuman or degrading treatment or punishment. The case also challenged the DPP refusal to rule out a criminal prosecution if Pretty's husband helped her to die (Ashraf, 2001). In 2002, Pretty then took her case to the European Court of Human Rights (ECtHR) but was again unsuccessful. Under article 2 (the right to life) Pretty argued that this right extended to a right to control the manner of her death, and therefore a right to commit suicide. The ECtHR held that this article imposed a duty on the state to protect life, but not a right to die. Under article 3 (the right not to suffer torture or inhuman and degrading treatment) Pretty argued that not allowing her husband to perform assisted suicide was inhuman treatment. The ECtHR held that even if the condition that she was suffering was inhuman, it was not the result of treatment by the state or inflicted by the state.

As a result Harmon and Sethi (2011) reflect that, while Pretty failed in what she sought to achieve in terms of the route to death she desired, the case broke new legal ground. While under articles 2 and 3 she had no right to die, article 8 was in some way supported as the Court accepted that respecting autonomy does include respecting one's decisions about dying (it was this that set a precedent). Similarly, in the case of Purdy v DPP (2009) interpretation of article 8 by the House of Lords led the DPP to produce a list of public factors that would be taken into account in cases of assisted suicide. Despite this move to a recognition of autonomy, the ECtHR supported the House of Lords in its refusal to agree with both Pretty and Purdy's requests: 'article 8 didn't overwrite article 2' (Harmon & Sethi, 2011,

p. 358). Hence, while a right to die is recognised by the ECHR, English and International courts have concluded that the right to life does not give any right to self-determination over life and death, since the provisions of the ECHR were designed for protecting and preserving life.

More recently, according to Puppinck and La Hougue (2014), the ECtHR seems to be progressively outlining a right to assisted suicide, which would fall in the scope of the right to private life and the right to respect for personal autonomy (article 8) claiming that through the judgement in the case of Haas v Switzerland (2011), the ECtHR went from assisted suicide as a quality of personal freedom to that of a conventional right. In contrast, Harmon and Sethi (2011, p. 359-60) claim that Haas sought more than Pretty and achieved less. Unlike Pretty, Haas wanted not just decisional scope to end his life but the state to facilitate that right (letting a physician issue a prescription to cause death). The ECtHR ruled that the existence of the right to make decisions concerning one's own death did not, and could not, impose an obligation on the state to assist in that death. As in the case of Pretty the ECtHR agreed with the right to respect private life and that time and circumstances of dying are protected under article 8 but that in cases where life was in the balance, as with Haas, article 2 which affirms the right to life and the states obligation to protect vulnerable individuals must be considered and must colour the interpretation and scope of article 8.

In a similar case, English (2015) reports on Lambert and Others v France (2014) with the Grand Chamber of the Strasbourg Court allowing the argument that the state's obligation to protect life also involves a duty to respect people's rights to exit life with dignity. It is an important step away from Pretty v DPP upholding that there would be no violation of article 2 (right to life) of the ECHR if artificial nutrition and hydration were to be withdrawn from a patient in a persistent vegetative state. English views this decision as an important step towards refining the Convention as a guardian of autonomy rather than the conservative

position of defending life preservation above all other interests. It was not, however, a unanimous decision within the Court and a number of judges publicly disagreed with the decision. They used the case of Pretty v UK (2002) to insist that article 2 protects the right to life but not the right to die. Likewise, article 3 guarantees a right not to be subjected to ill-treatment, but no 'right' whatsoever to waive this right and to be, for example, beaten, tortured or starved to death (English, 2015).

1.3 Human rights and abortion

At the international level recognition has been given of choice about child bearing being a basic human right. Finer and Fine (2013) assert that there has been a global trend toward the liberalisation of abortion laws. This trend reflects the recognition of women's access to legal abortion services as a matter of women's rights and self-determination and an understanding of the distressing public health implications of criminalising abortion. Likewise, according to Cook and Dickens (2003), the following factors require that women's choices for self-determination be legally respected and not criminalised: recognition that resort to safe and dignified healthcare is a major human right; respect for women's reproductive self-determination; and recognition of a women's rights to equal citizenship with men. According to Ireland (2013), pro-choice advocates assert that pregnancy and the decision either to continue or to end a pregnancy are private matters, which women should be able to decide for themselves without government intervention. Hence, the USA recognised abortion as part of the right to privacy in the case of Roe v Wade (1973) (Ireland, 2013, p. 655).

The Universal Declaration on Human Rights (UDHR) (1948) gives recognition to the child before birth, including from the moment of conception. For Cook and Dickens (1999), legal recognition that human life begins at conception does not resolve conflicts between respect due to women's reproductive self-determination and respect due to prenatal life.

Indeed, as outlined by Ireland (2013) in terms of article 2 (the right to life), "the ECtHR has not decided whether a foetus fits under Article 2's definition of a 'person'" (Ireland, 2013, p. 668). On this issue Rothbard (2012) examines the arguments invoked by debates about when life starts and proposes that a foetus younger than 24 weeks is not a human life (when cerebral brain wave activity is detected) in the moral sense, and hence has no right to life (though it may have potential for human life). He concludes that abortion up to 24 weeks does not involve the violation of any human rights and a woman's right of self-ownership to abort a foetus should be supported.

National and international tribunals are increasingly called upon to resolve conflicts between state enforcement of continuation of pregnancy against women's wishes and women's reproductive choices. Many of the cases relate to challenges in countries where the influence of religion and the Catholic Church is strong such as Ireland and Poland. As Ireland (2013) points out, Ireland is the only country among those that recognise the ECHR that does not recognise a woman's right to terminate her pregnancy. Poland is somewhere in the middle, in that it does not automatically grant women the right to terminate a pregnancy though Polish law does permit it in certain circumstances (Ireland, 2013, pp. 655-656).

According to Weinstein (2012), article 8 of the ECHR guarantees the right to privacy, which the ECtHR has held to encompass, among other rights, the right to health and wellbeing. Weinstein reflects on the violation of the ECHR by Ireland's abortion law in the case of A.B.C. v Ireland (2010). Under article 8 European law guarantees women a fundamental right to abortion whereas in Ireland there is prohibition on abortion in all circumstances, except where there is a real and substantial risk to a woman's life. In this case the ECtHR had the opportunity to declare that article 8, the right to privacy, guarantees women a fundamental right to abortion. The court failed to do so and instead declared that

Ireland did not violate the applicant's rights, even though their health and wellbeing - rights protected as part of the fundamental right to privacy - were at risk:

> The court concluded that the prohibition in Ireland on abortions sought for reasons of health and wellbeing does not exceed the state's margin of appreciation.... By finding that Ireland's restrictive abortion laws successfully balance Ireland's aim of protecting public morals and women's right to health and wellbeing the Court improperly deferred to Ireland's domestic legislation by granting Ireland a broad margin of appreciation – the ability to regulate a fundamental right guaranteed under the ECHR. (Weinstein, 2012, pp. 394-395)

However, as Ireland (2013, p. 677) points out, in the case of A.B.C. v Ireland (2010) the ECtHR did declare Irish abortion practice to be problematic, since the country does not appropriately allow for abortions when women's lives are in danger – even though the law explicitly protects women in such circumstances. In a similar case, Amnesty International (2016) reported on the situation of Irish woman Amanda Mellet (2011) who had to travel to the UK for an abortion when she discovered the foetus had a fatal impairment. The UN committee found Ireland's abortion laws in violation of articles 7 and 26 of the International Convention on Civil and Political Rights (ICCPR) by subjecting her to cruel, inhuman and degrading treatment and also violating article 17 on the right to privacy.

According to Ireland (2013), while the case of A.B.C. v Ireland (2010) was unsuccessful, the case of R.R. v Poland (2011) illustrates how the ECtHR continues to expand the scope of rights available to women in asserting their reproductive freedoms. Discussing the ECtHR ruling in the case of R.R. v Poland in the context of international reproductive rights and domestic abortion laws, Ireland (2013) argues that rather than use article 8 advocates should use article 3 (no-one shall be subjected to torture or inhuman or degrading treatment or punishment) when pushing for greater reproductive freedoms. Hence,

in the case of R.R. v Poland (2011), R.R. succeeded on a claim that she received insufficient medical treatment. The ECtHR concluded that her suffering reached the minimum threshold of severity meaning that her article 3 rights were violated.

In some ways all these cases illustrate two core conclusions: the difficulty of using human rights arguments for resolving disputes around issues of euthanasia and abortion which involve conflicting rights, and the central place of religion in studying the debates.

1.4 Theological perspectives

Not surprisingly euthanasia and abortion are issues that have come under close scrutiny within religious traditions. Christian theology and Islamic theology all have insight to offer on these issues. In the Christian tradition the first clear teaching on the subject of abortion comes from the second century *Didache* which condemns the practice (2:2). Christian theologians and Church Councils have usually taken the same view. However, as Astley (2000) points out, Augustine made a distinction between abortions taking place before, and those administered after the 'animation' of the foetus when it received its soul (variously estimated at 40, 60 or 80 days). Aquinas held that the foetus cannot have a human soul until it develops a recognisably human shape, a view affirmed by the Council of Vienne (1311-1312).

In the Christian tradition the subject of euthanasia is often linked with the discussion of suicide. As in the case of abortion, with respect to both suicide and euthanasia Christian teaching appeals to the notion that life is a sacred gift from God. Thus suicide, and therefore voluntary euthanasia, becomes a deliberate rejection of the creative gift of life. This is regarded as an act of rebellious disobedience that precludes repentance.

While there are clear variations in teaching on abortion and euthanasia among the different streams within the Christian tradition, one clear strand of teaching is provided by the

Catholic Church. The *Catechism of the Catholic Church* provides a core resource for formal Catholic teaching on both euthanasia and abortion. The Catechism declares that:

> Human life must be respected and protected absolutely from the moment of conception. From the first moment of his existence, a human being must be recognised as having the rights of a person – among which is the inviolable right of every innocent being to life. (*Catechism* no 2270)

A fuller discussion is provided in *Donum Vitae* (10 March 1987). This document argues that:

> From the moment of conception, the life of every human being is to be respected in an absolute way because man is the only creature on earth that God has 'wished for himself' and the spiritual soul of each man is 'immediately created' by God; his whole being bears the image of the Creator. Human life is sacred because from its beginning it involves 'the creative action of God' and it remains forever in a special relationship with the Creator, who is its sole end. God alone is the Lord of life from its beginning until its end: no one can, in any circumstance, claim for himself the right to destroy directly an innocent human being. (*Donum Vitae*, 1987, Par 5)

The *Catechism of the Catholic Church* also holds a clear line on euthanasia, but in doing so makes a clear distinction between direct euthanasia and indirect euthanasia. Direct euthanasia is always unacceptable. Acts to eliminate suffering that cause death are regarded as murder. Indirect euthanasia recognises the limitations of medical procedures and interventions to prevent death. Thus, 'discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate… Here one does not will to cause death; one's inability to impede it is merely accepted' (*Catechism* no 2278). Within this context, palliative care is acceptable: 'painkillers to alleviate the suffering of the dying, even at the risk of shortening their days, can be morally in

conformity with human dignity if death is not willed as either an end or a means, but only foreseen and tolerated as inevitable' (*Catechism* no 2279).

The *Declaration on Euthanasia* published by the Vatican Congregation of Faith (5 May 1980) defines euthanasia as follows:

> By euthanasia is understood an action or an omission which of itself or by intention causes death, in order that all suffering may in this way be eliminated. Euthanasia's terms of reference, therefore, are to be found in the intention of the will and in the methods used. (Chapter 2)

The *Declaration on Euthanasia* argues that the killing of an innocent life is not permissible 'whether a foetus or an embryo, an infant or an adult, an old person, or one suffering from an incurable disease, or a person who is dying.' Such an action is 'the violation of the divine law, an offense against the dignity of the human person, a crime against life, and an attack on humanity' (Chapter 2).

In his encyclical *Evangelicum Vitae* (1995) Pope John Paul II argued that 'extraordinary' care or medical treatment to prolong life need not be continued if it is futile, dangerous or burdensome to the patient, family or society. The administering of drugs such as morphine with the intention to prevent pain, even when they hasten death, was also accepted by the Pope in some circumstances, by appeal to the doctrine of double effect. The concern throughout is that there should be no *direct* attack on human life.

A good and detailed overview of Islamic teaching on abortion and euthanasia is provided by the essays edited by Brockopp (2003) in *Islamic ethics of life: Abortion, wars and euthanasia.* According to Islamic teachings, expressed within the Qur'an and the prophetic traditions, life is a Divine gift and therefore Islamic ethics is embedded in the fundamental principle affirming sanctity of all life. Moreover, Islam is often depicted as a 'rights'- based faith as the rights of humans *(huquq alebad*) and the Creator (*huquq alAllah*)

are explicitly recognised. According to this, while God, as the giver of the gift life, has the right to be acknowledged, humans have the right to protect their dignity (*karama*). Classical Muslim scholars by working within the framework of this distinctive notion of human rights in Islam, which predates the modern secular-humanist notion of human rights, have identified the following five rights that they suggested to be summarising the ultimate ethos of Islamic ethics and law: right to protect life, family (progeny), property, religion and reason (human sanity) (Sahin, 2011). As such the majority of Muslim theological and legal schools of thought agree that euthanasia is not allowed in Islam. This view is justified by the following reasons: The Qur'an explicitly forbids 'taking any human life that God has made sacred' (17:33) and the voluntary act of taking one's life, suicide (4.29). Furthermore, based on the Qur'anic verses (16:61/ 3:145), the mainstream Islamic theology asserts that the length of human life is decided by God. And finally, in Islamic Law euthanasia and suicide are not included among the reasons allowed for killing.

The Qur'an does not explicitly mention abortion. As such, the sanctity of life principle shapes Muslim theological and legal perspectives toward abortion which is seen to be wrong and forbidden. However, a majority of Muslim scholars accept that abortion may be permitted in certain cases invoking the well established legal maxim in Islamic law suggesting that sometimes 'necessities in life renders the unlawful lawful'. For example, abortion is permitted if continuing the pregnancy would put the mother's life in real danger. There are different scholarly opinions regarding the timing of the permitted abortion; some argue in the first 16 weeks of pregnancy, while others only permit it in the first 7 weeks. What is beyond dispute is the fact that in Islam a mother's life and well-being are taken seriously when considering the permissibility of abortion. In Islamic Law abortion is generally seen as a serious moral wrong but not a directly punishable act. Muslim jurists agree that after the foetus is completely formed and if the continuation of the pregnancy will

not constitute a real danger to mother's life, abortion becomes a punishable crime because it constitutes an offense against a complete, living human being. Muslim jurists often insist that the payment of blood money (*diya*) becomes incumbent if the baby is aborted alive and then died.

1.5 Empirical studies

Several strands of empirical research have mapped the connection between religiosity and attitudes toward abortion and euthanasia. One of these strands has focused on the connection between frequency of church attendance and levels of agreement with survey questions. In an early study of *The Religious factor in Australian Life*, Bouma and Dixon (1986) reported a strong association between frequency of church attendance and agreement with the statement that abortion is *never* justified: 17% of non-attenders, 26% of those who attend rarely, 26% of those who attend occasionally, and 51% of those who attend at least monthly. A similar pattern emerged in agreement with the statement that euthanasia is *never* justified: 17% of non-attenders, 16% of those who attend rarely, 17% of those who attend occasionally, and 43% of those who attend at least monthly. In his study of *Churchgoing and Christian Ethics*, Gill (1999), using British Social Attitudes Survey data, also recorded connections between frequency of churchgoing and attitudes to abortion and euthanasia. Also drawing on the British Social Attitudes Survey data, Curtice and Gallagher (1990) found that 25% of weekly attenders agreed that abortion should not be allowed in cases where there is a strong chance of defect in the baby, compared with 6% of those who attended less that twice a year. Donnison and Bryson (1996) constructed a scale to measure pro-euthanasia attitudes. They found significantly less acceptance of euthanasia among weekly attendees. Heath, Martin, and Elgenias (2007) examined the changing association between frequency of church attendance and attitudes toward abortion between 1984 and 2005. They found that the view that a woman should not be allowed an abortion if she did not want the child declined from

77% to 51% among churchgoers and from 67% to 32% among those who had a religious identity but did not attend church. Clery, McLean, and Phillips (2007) created a scale of acceptance of euthanasia. They found higher acceptance among non-churchgoers than among churchgoers.

In the Teenage Religion and Values Survey, conducted among nearly 34,000 young people between the ages of 13 and 15 years, Francis (2001a) included the item, 'Abortion is wrong'. In an analysis crosstabulated against frequency of church attendance this study found agreement with this item among 47% of weekly churchgoers, compared with 33% of those who attend church less than weekly and 34% of those who never attend church.

A second strand of research has focused on the connection between self-assigned religious affiliation and attitudes toward abortion and euthanasia. Once again the British Social Attitudes Survey data has provided a useful source of data. For example, using their scale of acceptance of euthanasia, Clery, McLean and Phillips (2007) found highest acceptance among those who reported no religion, followed by Anglicans, Roman Catholics, other Christians, and non-Christian religious groups. Park and Rhead (2013), drawing on the 2012 British Social Attitudes Survey data, found that self-assigned religious affiliation continued to be closely associated with attitudes toward abortion. In 2012 Catholics were the least accepting, with 39% agreeing that abortion should be allowed when the woman does not wish to have the child, compared with 56% of Anglicans and 73% of non-affiliates. Park and Rhead (2013) also chart the growing acceptance of abortion among the religiously affiliated since the first British Social Attitudes Survey in 1983. For example, while in 1983 34% of Anglicans supported abortion when the woman does not want to have the child, the proportions rose to 54% in 1994 and to 56% in 2012.

The importance of self-assigned religious affiliation in shaping attitudes toward abortion has been explored by a series of studies drawing on the Teenage Religion and

Values data (2001a). In the first of these studies, Francis (2001b) explored responses to the item ‘abortion is wrong’ through a sequence of analyses that gradually refined the notion of self-assigned religious affiliation. The first step dichotomised the participants into two groups, those who belonged to a faith group and those who did not: 38% of those who belonged to a faith group agreed that abortion is wrong, compared with 33% of those who did not belong to a faith group. The second step further dichotomised those who belonged to faith groups into Christian and other faiths: 38% of those who belonged to a Christian group agreed that abortion is wrong, compared with 46% of those who belonged to other faith groups. The third step distinguished among the non-Christian faith groups: 27% of Jews, 31% of Hindus, 40% of Sikhs, and 58% of Muslims agreed that abortion is wrong. The fourth step distinguished among different streams within the Christian tradition: 31% of Anglicans, 38% of Protestants, 50% of Catholics and 65% of those who belonged to the smaller Christian sects agreed that abortion is wrong. In the second of these studies, Francis (2008a) took a more detailed view on the ways in which young females affiliated with different Christian denominations responded to the item ‘abortion is wrong’. This analysis found that the view that abortion is wrong was endorsed by 34% of Anglicans, 36% of Presbyterians, 37% of Methodists, 45% of Baptists, 53% of Roman Catholics, 68% of Protestants, and 82% of Jehovah’s Witnesses. In the third study, Francis (2008b) also focused on young females, but compared the responses of those affiliated with different faith groups. The analysis found that the view that abortion is wrong was endorsed by 34% of Hindus, 40% of Christians, 43% of Sikhs, and 58% of Muslims, compared with 38% of non-affiliates.

Within the studies published on data generated by the International Empirical Research Programme Religion and Human Rights 1.0, van der Ven (2016) compared attitude toward euthanasia among Christians, Muslims, and non-religious across six nations (Belgium, England/Wales, Germany, Netherlands, Norway, and Sweden). The same pattern

emerged in all six nations, with non-religious more supportive of euthanasia than Christians, and with Christians more supportive of euthanasia than Muslims.

A third strand of research has recognised the multidimensional nature of religiosity, within the context of the social scientific study of religion and set out to explore the contribution of different aspects of religiosity to explaining individual differences in attitude toward abortion. For example, a series of studies conducted in the USA, drawing on the General Social Survey's database have examined the religious, social (and sometimes psychological) predictors of individual differences in attitude toward abortion, including work reported by Emerson (1996), Sullins (1999), and Petersen (2001). One interesting example of the approach within the UK is provided by Francis (2004), again drawing on the Teenage Religion and Values data. After controlling for individual differences in sex, age and personality (extraversion, neuroticism, and psychoticism), Francis (2004) employed measures of church attendance, personal prayer, religious experience, belief in God, creationism, punitive God image, and denominational affiliation. Among these variables considered simultaneously, the strongest beta weight was associated with creationism ($\beta = .11$), followed by Catholic affiliation ($\beta = .09$) and a punitive God image ($\beta = .07$).

Within the studies published on data generated by the International Empirical Research Programme Religion and Human Rights 1.0, two studies employed a scale designed to measure attitudes toward permissions to lift the right to life as the dependent measure alongside multiple indices of religiosity. In the first of these two studies, conducted in Turkey, Ok and Eren (2013) created a nine-item scale that embraced the following themes and generated an alpha coefficient of .82:

- It should be possible for a pregnant woman to obtain a legal abortion:
    - if economically she cannot afford any more children;
    - if psychologically she cannot afford any more children

    - if there is a strong chance of serious defect in the baby;
    - if the woman's own health is seriously endangered by the pregnancy.
- A woman in the final stages of an incurable disease wants to end her life:
    - the doctor is allowed to do this;
    - the doctor is allowed to do this only if palliative care is exhausted.
- In regard to abortion politicians should take decisions independently of religious leaders.
- In regard to euthanasia politicians should decide irrespective of any religious leaders' will.
- Any form of sexual relations between adults should be their individual choice.

In their study designed to replicate Ok and Eren's (2013) study in England and Wales, Francis and Robbins (2016) argued that the last item listed in the original scale was problematic to locate within the theme concerned with permission to lift the right to life. Thus, they worked with an eight-item scale, generating an alpha coefficient of .76.

The original study in Turkey by Ok and Eren (2013) employed three measures of religiosity: a three-item scale of religious salience ($\alpha = .80$), a six-item scale of religious openness ($\alpha = .79$), and a six-item scale of religious stress ($\alpha = .87$). They also included three population characteristics in the model: sex, age and political preference. These data found positive associations between permissions to lift the right to life and both religious openness ($\beta = .16$) and religious stress ($\beta = .27$) and a negative association between permission to lift the right to life and religious saliency ($\beta = -.19$). The replication study in England and Wales by Francis and Robbins (2016) also employed three measures of religiosity: a four-item scale of religious saliency ($\alpha = .87$), a six-item scale of interreligious openness ($\alpha = .83$) and self-assigned religious affiliation, distinguishing between non-affiliates, Christians and Muslims. They also included in the model two personal variables (sex and age), three psychological

variables (extraversion, neuroticism, and psychoticism) and a five-point measure of political preference (left, centre left, centre, centre right, and right). These data found a positive association between permissions to lift the right to life and interreligious openness (β = .19), and negative association between permissions to lift the right to life and religious saliency (β = - .15) and religious affiliation as Christian (β = - .15) and as Muslim (β = - .19).

1.6 Research question

Against this background the aims of the present study drew on data generated by the International Empirical Research Programme in Religion and Human Rights 2.0 among young people in England and Wales in order to construct and to test a scale of attitude toward euthanasia and abortion and to test the general hypothesis that religiosity functions as a significant predictor among young people of individual differences in attitude toward matters of life and death. Within this general hypothesis the study is designed to differentiate between the effects of religious practice (personal prayer and worship attendance) and religious affiliation (Protestant, Catholic, and Muslim). The effect of these religious factors is contextualised within the effect of personal factors (sex and age) and psychological factors (extraversion, neuroticism, and psychoticism).

Such contextualisation is important because of the place given to these factors in previous research. The two personal factors (sex and age) are recognised as key predictors of individual differences in adolescent religiosity. Research tends to show that females record higher levels of religiosity than males (Francis & Penny, 2014) and that levels of religiosity decline during adolescence (Kay & Francis, 1996). The three psychological factors proposed by Eysenck's dimensional model of personality (Eysenck & Eysenck, 1991) are also recognised as key predictors of individual differences in religiosity (Beit-Hallahmi & Argyle, 1997). Eysenck's dimensional model of personality proposes three higher order factors defined as extraversion, neuroticism, and psychoticism. Empirical studies within the

psychology of religion employing this model of personality have consistently shown an inverse association between psychoticism scores and religiosity, as crystalised by Francis (1992) and confirmed by more recent studies, including Francis, Robbins, ap Sion, Lewis, and Barnes (2007), Francis, Robbins, Santosh, and Bhanot (2008), and Francis and Hermans (2009).

2. Method

2.1 Procedure

Selected schools within England and Wales in conurbations where there was evidence of Christian, Muslim and religiously-unaffiliated students were invited to participate in the study. Within participating schools complete classes of year 11, year 12, and year 13 students (15- to 18-year-olds) were invited to complete the questionnaire within the context of a normal lesson. Students were assured of confidentiality and anonymity. Although all students were given the choice not to present their questionnaire for analysis very few decided not to submit their response.

2.2 Measures

Attitude toward euthanasia and abortion was assessed by a newly constructed scale comprising three items about euthanasia and seven items about abortion. Each item was rated on a five-point Likert scale: disagree strongly (1), disagree (2), not certain (3), agree (4), and agree strongly (5).

Personal factors were assessed by two variables: sex, male (1) and female (2); and school year, year 11 (1), year 12 (2) and year 13 (3).

Psychological factors were assessed by the abbreviated form of the Eysenck Personality Questionnaire Revised (EPQR-A) as developed originally by Francis, Brown, and Philipchalk (1992) and further modified by Francis, Robbins, Louden, and Haley (2001). This

instrument comprised three six-item measures for extraversion, neuroticism and psychoticism. Each item is rated on a two-point scale: yes (1), and no (0).

Religious practice was assessed by two items. Frequency of worship attendance was assessed by the question 'How often do you take part in religious services at a church or mosque or another place?' rated on a six-point scale: never (1), hardly ever (2), a few times a year (3), one to three times a month (4), once a week (5), and more than once a week (6). Frequency of personal prayer was assessed by the question 'How often do you pray?' rated on an eight-point scale: never (1), hardly ever (2), a few times a year (3), one to three times a month (4), once a week (5), more than once a week (6), once a day (7), and several times a day (8).

Religious affiliation was assessed by the question 'Do you belong to a religious community or would you describe yourself as non-religious?' followed by a checklist of religious groups and the final category 'non-religious'.

2.3 Participants

The analyses reported in this paper were conducted on the 966 students who self-assigned as Catholic, as Protestant, as Muslim, or as non-religious. This group comprised 370 males and 596 females, 360 students from year 11, 383 students from year 12, and 223 students from year 13; 101 Catholics, 145 Protestants, 35 Muslims, and 685 non-religious students.

3. Results and discussion

- insert table 1 about here -

The first step in data analysis examined the scale properties of the newly constructed Scale of Attitude toward Euthanasia and Abortion. The data presented in table 1 demonstrates that each of the ten items contributed to a homogeneous scale with correlations between the individual items and the sum of the other nine items ranging from .35 to .70. Overall the item

endorsements reveal a positive attitude toward both euthanasia and abortion. In the case of euthanasia, 72% of the students agree that euthanasia should be permitted in the case of unbearable and irreversible suffering, and 61% agree that euthanasia should be permitted in the case of unbearable and irreversible suffering if palliative care is exhausted. Just 11% of the students agree that euthanasia should be prohibited in all circumstances. In the case of abortion, over three quarters of the students agree that abortion should be permitted in the case of rape (77%) and that abortion should be permitted when the woman's own health is seriously endangered by the pregnancy (77%). Two thirds of the students agree that abortion should be permitted in the case of incest (68%). Over half of the students agree that abortion should be permitted when there is a strong chance of serious defect in the baby (56%) and that abortion should be permitted when the woman cannot afford more children psychologically (56%). The proportion falls slightly to 49% who agree that abortion should be permitted when the woman cannot afford more children economically.

- insert table 2 about here -

The second step in data analysis took an overview of the psychometric properties of the four scales employed in the study in terms of means, standard deviations, and alpha coefficients (Cronbach, 1951). The data presented in table 2 demonstrate that the ten-item scale concerned with attitude toward abortion and euthanasia and two of the three scales concerned with psychological factors (extraversion and neuroticism) recorded internal consistency reliability in terms of alpha coefficients in excess of the threshold of .65 commended by DeVellis (2003). The lower alpha coefficient recorded by the psychoticism scale is consistent with the known operational difficulties incurred in measuring this dimension of personality (Francis, Brown, & Philipchalk, 1992).

- insert table 3 about here -

The third step in data analysis explored the bivariate correlations between attitude toward euthanasia and abortion and the two personal factors (sex and age), the three psychological factors (extraversion, neuroticism and psychoticism), the two religious practices (personal prayer and worship attendance) and religious affiliation (Protestant, Catholic, Muslim, and non-religious). For the purpose of correlational analysis (and subsequent regression analysis) the categorical variable of religious affiliation was employed to create four dummy variables (Protestant, Catholic, Muslim, and non-religious). These correlation coefficients are presented in the first column of table 3. They demonstrate that, when each of these factors is considered in isolation, the personal factors carry little predictive power in relation to attitude toward euthanasia and abortion: there is no significant sex difference, and a slight increase in acceptance of euthanasia and abortion with age. The psychological factors also carry little predictive power in relation to attitude toward euthanasia and abortion: there is no significant correlation with either extraversion scores or psychoticism scores, and a small positive correlation with neuroticism scores. Religious practice factors carry greater predictive power: there is a significant negative correlation between attitude toward euthanasia and abortion and both frequency of personal prayer and frequency of worship attendance. Religious affiliation also carry significant predictive power: there is a positive correlation between non-religious identity and attitude toward euthanasia and abortion, and significant negative correlations between Protestant affiliation, Catholic affiliation and Muslim affiliation and attitude toward euthanasia and abortion.

In light of these multiple correlations, the fourth step in data analysis constructs a series of regression models with attitude toward euthanasia and abortion as the dependent variable and with the independent variables being added incrementally in four steps (see table 3). Model one begins by introducing the personal factors (sex and age). Model two adds the psychological factors (extraversion, neuroticism, and psychoticism). Model three adds the

religious practices factors (personal prayer and worship attendance). Finally model four adds religious affiliation. In this model religious affiliation is added as three dummy variables (Protestant, Catholic, and Muslim) with non-religious identity standing as the reference point. It is the fourth model that is of greatest interest when all the predictor factors are taken into account. In this model, the factors of core importance are religious practice and religious affiliation. In terms of personal factors, age remains statistically significant ($p < .01$) when all other variables are in the equation: year 13 students are overall more accepting of euthanasia and abortion that year 11 students. In terms of psychological factors neuroticism scores remain statistically significant ($p < .05$) when all other variables are in the equation: higher neuroticism scores are associated with an attitude more accepting of euthanasia and abortion.

In terms of religious practice factors, while the correlation coefficients suggest that both personal prayer and worship attendance are significant predictors of a less accepting attitude toward euthanasia and abortion, the regression model demonstrates that personal prayer is the strongest predictor. When personal prayer is in the equation worship attendance accounts for no additional variance. Personal prayer remains a significant predictor when all other variables are in the equation. In terms of religious affiliation, even after personal prayer and worship attendance are in the equation, identities as Catholic and as Muslim carry additional predictive power, taking the non-religious as the reference point. Identity as Protestant, however, is not significant. This finding suggests that, irrespective of individual differences in religious practice, self-understanding as Catholic and self-understanding as Muslim carries higher rejection of euthanasia and abortion

4. Conclusion

Within the wider context of the human rights legislation, debates and controversies concerning the right to life and abortion and euthanasia, the present study set out to explore the connections among adolescents in England and Wales between attitude toward abortion

and euthanasia on the one hand and religious identity and religious practice on the other hand, after taking into account personal and psychological factors. Three main conclusions emerge from this study conducted among 966 students between the ages of 14 and 18 years.

The first conclusion concerns the coherence between euthanasia and abortion within the minds of these adolescents. The development and psychometric examination of the ten-item Scale of Attitude toward Euthanasia and Abortion (SAEA) confirmed that the ten items, covering both issues, cohered to generate an homogenous scale with an alpha coefficient of .87. Acceptance and rejection of both issues concerning life and death work side-by-side in the adolescent mind.

The second conclusion concerns the connection between attitude toward euthanasia and abortion and personal religious practice. The correlation coefficients demonstrate significant negative associations between acceptance of euthanasia and abortion and both church attendance and prayer. The beta weights, however, demonstrate the primary role of personal prayer. After personal prayer has been taken into account no additional variance is accounted for by church attendance. This finding is consistent with the classic distinction, advanced by Allport and Ross (1967) and confirmed by Batson and Ventis (1982) and by Francis (2007), between intrinsic religious orientation and extrinsic religious orientation. Intrinsic religious orientation accesses the religion of the heart where religion is a master motivation or end in itself. Extrinsic religious orientation accesses a public face of religion where religion may serve other personal or social ends. Within this conceptual framework, personal prayer may serve as an indicator of intrinsic religiosity, less subject to social constraints, while church attendance may embrace aspects of extrinsic religiosity as well as intrinsic religiosity. In this sense, personal religiosity measured by frequency of prayer provides a sharper measure of the connection between religion and attitude toward euthanasia

and abortion than offered by personal religiosity measured by frequency of church attendance.

The third conclusion concerns the connection between self-assigned religious affiliation and attitude toward euthanasia and abortion. This finding is important for two reasons. First the simple bivariate correlation coefficients confirm that the sense of belonging to a religious tradition continues to shape the attitudes of young people to core matters of life and death. In other words, the theological and religious teachings of the traditions to which they belong carry measurable implications for their lives and values. In secular and religiously diverse societies young people affiliated with Christian and Muslim traditions actually see matters of life and death through a different lens.

Second, the multiple regression model develops this insight regarding the connection between self-assigned religious affiliation and attitude toward euthanasia and abortion persists, after taking personal prayer into account, for two of the three religious traditions but not for the third. For young Protestants, the effect of self-assigned religious affiliation is mediated entirely through personal prayer. This suggests that young Protestants who have abandoned religious practice are undifferentiated in their attitude toward euthanasia and abortion from religiously unaffiliated young people. They retain no cultural resonance from their religious tradition. However, both for young Muslims and for young Catholics, the effect of self-assigned religious affiliation persists after taking individual differences in personal prayer into account. This suggests that young Catholics and young Muslims who have abandoned religious practice nonetheless continue to be influenced by their religious cultural heritage. This finding is consistent with the theories of religious identification developed and tested by Bouma (1992) in Australia and by Bibby (1985, 1987) in Canada, and re-presented by Fane (1999) in England. For example, Bibby's theory of encasement argued that Canadian Christians were 'encased' within the Christian tradition, and that the

tradition retained an influence over both its active and latent members. The present data suggest that this remains the case for both Catholics and Muslims in England and Wales. In secular and religiously diverse societies young people who see themselves as Catholics or as Muslims continue to see matters of life and death through a different lens, even if they have abandoned the discipline of religious practice.

The weakness of the present study is that it was conducted on a small sample of only 966, among whom there were merely 101 Catholics and 35 Muslims. Further research within this tradition is needed in England and Wales among sufficiently large samples of young people that allow the smaller religious groups to become more fully visible.

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Table 1

Scale of Attitude toward Euthanasia and Abortion (SAEA): Scale properties

	r	%
Euthanasia should be prohibited in all circumstances*	.35	11
Euthanasia should be permitted in the case of unbearable and irreversible suffering	.59	72
Euthanasia should be permitted in the case of unbearable and irreversible suffering if palliative care is exhausted	.54	61
Abortion should be prohibited in all circumstances because it ends human life*	.51	13
Abortion should be permitted in the case of rape	.70	77
Abortion should be permitted in the case of incest	.67	68
Abortion should be permitted when there is a strong chance of serious defects to the baby	.63	56
Abortion should be permitted when the woman's own health is seriously endangered by the pregnancy	.68	77
Abortion should be permitted when the woman cannot afford more children economically	.58	49
Abortion should be permitted when the woman cannot afford more children psychologically	.65	56

Note: *r*, correlation between individual item and sum of other nine items

%, sum of agree strongly and agree responses

*these items were reverse coded to calculate *r* and the scale score

Table 2

Scale Properties

	N items	α	*M*	*SD*	Low	High
Euthanasia and abortion	10	.87	38.36	7.52	10	50
Extraversion	6	.79	3.98	1.96	0	6
Neuroticism	6	.72	3.86	1.78	0	6
Psychoticism	6	.47	1.02	1.18	0	6

Table 3

Regression models on attitude toward euthanasia and abortion

	r	Model 1	Model 2	Model 3	Model 4
Personal factors					
Sex	.06	.05	.02	.03	.04
Age	.08*	.07*	.07*	.09**	.10**
Psychological factors					
Extraversion	.04		.05	.04	.03
Neuroticism	.10*		.10**	.09**	.09*
Psychoticism	-.04		-.02	-.04	-.03
Religious practice					
Personal prayer	-.23***			-.21***	-.15***
Worship attendance	-.17***			-.05	-.03
Religious affiliation					
Protestant	-.09**				-.06
Catholic	-.16***				-.13***
Muslim	-.10**				-.07*
Non religious	.22***				
Total r^2		.009	.018	.076	.090

Note: $^{*}p < .05$; $^{**}p < .01$; $^{***}p < .001$

Index terms

Abortion

Anglicans

Catholic

European Court of Human Rights (ECtHR)

Euthanasia

Muslim

Personality

Protestant

Psychological factors

Religious factors

Right to die

Right to life

Women’s rights