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Religion and Suicide

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Abstract Religion impacts suicidality. One's degree of religiosity can potentially serve as a protective factor against suicidal behavior. To accurately assess risk of suicide, it is imperative to understand the role of religion in suicidality. PsycINFO and MEDLINE databases were searched for published articles on religion and suicide between 1980 and 2008. Epidemiological data on suicidality across four religions, and the influence of religion on suicidality are presented. Practice guidelines are presented for incorporating religiosity into suicide risk assessment. Suicide rates and risk and protective factors for suicide vary across religions. It is essential to assess for degree of religious commitment and involvement to accurately identify suicide risk.

Keywords Religion · Suicide · Judaism · Christianity · Hinduism · Islam

Introduction

Empirical evidence indicates that the rate of suicide varies across religions. This article focuses on four major religions in the United States. Among the most common religious groups in the United States, Protestants have the highest suicide rate followed by Roman Catholics. Jewish individuals have the lowest rates of suicide (Maris et al. 2000). There are lower recorded rates of suicidal behavior found among Muslims when compared to other religions, such as Christianity or Hinduism (Abdel-Khalek 2004; Ineichen, 1998). However, across religious denominations a higher degree of religiosity is associated with decreased suicide risk (Dervic et al. 2004; Martin 1984).

In 1897, Durkheim was the first to propose that spiritual commitment may contribute to emotional well-being, as it provides a source of meaning and order in the world (Durkheim 1951). Research establishing a relationship between high levels of religiosity and decreased suicide risk dates back over 40 years (Kranitz et al. 1968). Individuals who attend church more frequently are four times less likely to commit suicide than those who

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never attend (Martin 1984). The relationship between religiosity and suicide appears to vary by gender. Among males, higher male suicide rates are associated with lower levels of religious belief and religious attendance. This relationship has not been demonstrated among females (Neeleman et al. 1997).

Given the potential protective impact of religious affiliation and commitment against suicide risk, it is essential to include an evaluation of religion in any psychosocial assessment, particularly with suicidal clients. An accurate understanding of a client's religious faith and participation may indicate potential suicide risk. It may also help to identify potential areas that treatment may target to enhance life-affirming beliefs and expectations. While it is recognized that a number of factors are inter-related with one's religiosity such as gender, age, ethnicity, and/or culture, this review critically focuses on the key risk and protective factors of four dominant U.S. religions as they relate to suicide.

Method

The PsycINFO and MEDLINE databases were used to search for published articles between 1980 and 2008 using keywords of religion, Christianity, Catholic, Judaism, Islam, Muslim, Hindu, attempted suicide, suicide, suicide prevention, and related mapped terms were searched. The search was limited to English language journal articles. Research studies and review articles focusing on the relationship between religion and suicide were included in this review. Bibliographies of key articles were also included. This review focuses on suicide rates and risk and protective factors for suicide across Christianity, Hinduism, Islam, and Judaism.

Results

Religion as a Protective Factor Against Suicide

Religiosity has been shown to be associated with reduced risk of suicidality (Dervic et al. 2004; Lizardi et al. 2007; Stack 1983). For example, suicide rates in religious countries are lower than suicide rates in secular countries (Breault 1993; Dervic et al. 2004; Stack 1983). Furthermore, intensity of religious commitment has been shown to be related to suicidal behaviors (Nelson 1977). These findings are not specific to particular religious denominations (Dervic et al. 2004; Lizardi et al. 2007; Stack 1983).

Moral and religious objections to suicide have a unique association with suicidal behavior. The life-saving beliefs associated with religious commitment may protect against suicide (Dervic et al. 2004; Lizardi et al. 2007; Koenig et al. 2001; Neeleman et al. 1997; Stack 1983). Studies indicate that individuals with low moral and religious objections to suicide are more likely to have a lifetime history of suicide attempt (Dervic et al. 2004; Lizardi et al., 2007; Neeleman et al. 1997; Stack 1983). Individuals with higher moral and religious objections to suicide perceive more reasons for living.

The protective role of religiosity includes a number of mechanisms. Most religions have strong sanctions against suicide; thus, those individuals who report stronger commitment to those religions would be less likely to resort to suicide. In addition to condoning suicide, involvement in organized religions provides the opportunity to develop an extended support network in congregation members and clergy, which has been shown to be a protective factor against suicidality (Cheng et al. 2000; Gould et al.1996; Greening and Stoppelbein

2002; Koenig et al. 2001; Mann 2002; Szanto et al. 2003). Religiosity has also been shown to be associated with lower levels of aggression and hostility (Koenig et al. 2001; Malone et al. 1995; Mann et al. 2005; Oquendo et al. 2000) which have been consistently shown to be related to suicidal behavior. Additionally, many religions proscribe elicit behaviors such as substance abuse (Hilton et al. 2002) and smoking (Martin et al. 2003) which have an established relationship to suicide. Thus, high levels of religiosity could have an indirect protective effect on suicide via the prohibition of substance use (Hilton et al. 2002). Further, the motivation to commit suicide involves considerable ambivalence, and suicidal individuals often experience an internal struggle between wanting to live and wanting to die (Shneidman and Farberow 1957). Given that the moral objections to suicide are founded in traditional religious beliefs (Linehan et al. 1983), religious values and optimism may be important considerations for many individuals contemplating suicide (Linehan et al. 1983) and may serve to positively influence the decision to live (Pinto et al. 1998). Further studies with more comprehensive assessment of religiosity are needed to clarify the relationship between suicidality and religiosity.

Christianity and Suicide

The word suicide does not appear in the Bible; however, there are several examples of individuals committing suicide, such as, Judas, King Saul, Samson (Maris et al. 2000; Phipps 1985). Biblical writers neither condemn nor praise those whom they recorded as having taken their own lives. The Christian perspective on suicide has remained relatively stable since the fifth century (Phipps 1985). St. Augustine argued in the fifth century that suicide was a violation of the sixth commandment, "Thou shall not kill" (Kennedy 2000; Maris et al. 2000; Phipps 1985; Retterstol 1993). He argued that this applied to one's own life as well as the lives of others and all life should be preserved (Kennedy 2000; Phipps 1985; Retterstol 1993). St. Thomas Aquinas, Catholic theologian, expanded on Augustine's perspective and described suicide is a sin against self, neighbor and God (Aquinas 1225–1274). St. Aquinas claimed that every living organism naturally desires to preserve its life, thus suicide is against nature. St. Thomas Aquinas also claimed that suicide is contrary to religious rights, in that only God has the right to decide when a person will live or die. Further, St. Aquinas believed that confession of sins must be made prior to departing from the world to enter Heaven. Consequently, suicide is one of the most serious of all sins because the individual who completes suicide is unable to confess to the act and repent (Kennedy 2000; Phipps 1985).

The view of suicide as a sin dominates current Christian attitudes across the various denominations (e.g., Catholics, Baptists, and Protestants). The sin of suicide is equated with other forms of taking life such as abortion and murder (Maris et al. 2000; Wogaman 1990). According to the Catechism of the Catholic Church (1994), one has to be mentally competent to understand that the act in which he/she partakes is a sin. Thus, if one considers suicide an act of the mentally ill, it cannot simultaneously be viewed a sin. When an individual dies, s/he faces judgment by God, and only God can decide if the individual will go to heaven, hell, or purgatory (Catholic Church 1994). Historically, those who committed the suicide were unable to be buried in Catholic cemeteries (Phipps 1985); however, this is now a rarely practiced custom within Catholicism. During funeral services, forgiveness is asked for the deceased and comfort, for the survivors (Turner 1998).

There are 2.1 billion Christians worldwide. Among the dominant Christian denominations (Catholics Baptists and other Protestants), the lowest suicide rates are found among

Catholics and evangelical Baptists, with higher incidence occurring among other Protestant faiths (Pescosolido & Georgianna, 1989). Researchers indicate that Catholics and Baptists are more likely to be actively involved in church activities and, therefore, may benefit more from expanded social support networks (Pescosolido & Georgianna, 1989). Furthermore, Catholic countries have lower suicide rates than Protestant ones and within Protestant countries areas with a preponderance of Catholics have lower suicide rates (Hood-Williams, 1996). There are significantly higher suicide rates in men and in the elderly in Catholic and Christian orthodox countries, compared to rates in non-Catholic and orthodox countries (Pritchard & Baldwin, 2001).

Hinduism and Suicide

There are an estimated 900,000 million Hindus in the world, predominantly in the Indian subcontinent. Unlike Muslim or Christian writings, Hindu scriptures are relatively ambivalent on the issue of suicide (Ineichen 1998). Also, Hindu philosophies of reincarnation and karma mean, that for Hindus, life does not end at death, as death leads to rebirth (Hassan 1983; Ineichen 1998). Thus, it has been purported by some that Hindu religion is more tolerant toward suicide (Hassan 1983; Ineichen 1998; Kamal and Loewenthal 2002).

There is limited research on suicidality and Hindus. In a study examining suicide beliefs and behavior among Hindus and Muslims living in the UK, it was found that Hindus less strongly endorsed moral objections and survival-and-coping reasons for living than Muslims (Kamal and Loewenthal 2002). Another survey study found a higher rate of suicide among Hindus than Muslims (Ineichen 1998). Research seems to indicate that males have higher rates of suicide than females and the majority of suicide attempters studied had a psychiatric diagnosis (Latha et al. 1996).

The centuries' old Hindu practice of Sati is a ritual act of suicide in which widows self-immolate on the funeral pyre of their husbands. Although this ritual is now illegal, it continues to be practiced in some areas of the Indian subcontinent (Kumar 2003). Research has found little evidence that women who engage in Sati have a psychiatric disorder (Bhugra 2005). It is important to recognize that Sati is not a religious act nor is it related to psychiatric illness; rather this form of suicide appears more related to social, gender, and cultural factors (Bhugra 2005).

Islam and Suicide

The impact and influence of the Islamic faith on suicidality remains difficult to determine, due to the limited research in the area (Cosar et al. 1997; Khan and Reza 2000). No Middle Eastern country has reported morality data to the World Health Organization (WHO) since 1989 (Lester 2006), and very few Islamic countries record suicide or report suicide rates (Khan and Hyder 2006; Pritchard and Amanullah 2007). It is important to separate the concept of suicide from martyrdom. The focus here is on suicide, the self-inflicted intentional act designed to end one's own life, not on martyrdom, which involves using one's death in a defense of one's homeland by inflicting losses on an enemy (Abdel-Khalek 2004).

Limited research has indicated that suicide rates are lower in predominantly Islamic countries in comparison to other countries (Abdel-Khalek 2004). Similarly, there are lower recorded rates of suicidality found among the 1.5 billion Muslims when compared to other

religions, such as Christianity or Hinduism (Abdel-Khalek 2004; Ineichen 1998; Kamal and Loewenthal 2002). In studies that have focused on psychological disorders and traits such as depression, anxiety, obsessive compulsion, neuroticism, pessimism, and death obsession, samples from Islamic countries have scored higher than western samples (Abdel-Khalek 2004, Abdel-Khalek 2006; Abdel-Khalek and Lester, 1999, Abdel-Khalek and Lester 2003).

Studies examining this phenomenon of low suicide rates, but higher levels of psychological distress scores, have proposed several explanations. One, higher rates of religiosity among Muslims act as a buffer to suicidality (Thorson et al. 1997); however, religiosity is associated with lower levels of depression and anxiety (Abdel-Khalek 2007). Two, Islam is firmer in regard to the sinfulness of suicide as compared to other religions (Ineichen 1998; Lester 2006; Pritchard and Amanullah 2007). Three, the social stigma of suicidality in predominantly Islamic countries artificially lowers the reported rates (Lester and Akande 1994; Sarfraz and Castle 2002). It has been suggested that the reported rareness of Muslim suicide is a myth (Sarfraz and Castle 2002), because of the under-reporting due to social stigma (Lester and Akande, 1994; Sarfraz and Castle 2002).

In the Holy Qu'ran, suicide is expressly forbidden in Surah 4, verses 29 and 30, which state "do not kill or destroy yourself", with eternal punishment for suicide resulting in the individual burning in hell. Similar to the Christian Bible, however, the Qu'ran is interpreted differently across various (Islamic) countries, regions, and sects (Pritchard and Amanullah, 2007). Furthermore, as many Islamic countries have incorporated the Sharia (Islamic law) into their legal system, such as in Saudi Arabia, Pakistan, or Kuwait, suicide and suicide attempts remain criminal offenses (Al-Jahdali et al. 2004; Khan and Hyder 2006; Sarfraz and Castle 2002; Suleiman et al. 1989).

Some research, however, has indicated an increasing suicide trend in Islamic countries (Khan 2007; Khan and Hyder 2006). For example, the suicide rates have reportedly increased in the Sindh region in Pakistan from 90 in 1987 to 360 in 1999 (Khan and Hyder 2006). Another study surveying suicide ideation among Pakistan college students found high overall rates equally in both men and women (Khokher and Khan 2005). Research investigating suicide in predominantly Islamic countries has found suicidality to be both a reality and a growing concern (Al-Jahdali et al. 2004; Cosar et al. 1997; Khan and Reza 2000). According to Pritchard and Amanullah's (2007) analysis comparing suicide and undetermined deaths in 17 Islamic countries, patterns of suicide (e.g., increased risk with age) similar to those in Western countries have been found. Suicide in Islamic countries was found to be a significant problem (Pritchard and Amanullah 2007). Nonetheless, there are few mental health or social services in predominantly Islamic countries for individuals who are suicidal and fewer for survivors and family members following a suicide (Khan and Hyder 2006; Sarfraz and Castle 2002). Often individuals who have attempted suicide and their families will avoid going to public hospitals which will report the event as a crime to the police (Khan 2007; Khan and Hyder 2006). Surviving family members are stigmatized and often ostracized in traditional Muslim communities (Sarfraz and Castle 2002). Muslim graveyards are often reluctant to bury an individual after a suicide, which is considered a *haram* or forbidden death (Sarfraz and Castle 2002).

To date, research into Muslim suicidality remains limited not only in reported data, but also across religious subgroups. Islam is not a single unified religion, rather it is comprised of many competing sects (Lester 2006). Yet, there is little investigation or empirical data across the various Islamic sects of the Sunni or Shia, or the smaller sects of the Ahmadi, Alawai, Druze, Islaili, Qadiani, Sufi, or Yezidi (Lester 2006).

Judaism and Suicide

Judaism strictly sanctions suicide and regards suicide as a criminal act. Suicide is likened to murder. According to Jewish doctrine, an individual does not have the right to wound his/her own body, let alone to take his own life (Bailey and Stein 1995; Schwartz and Kaplan 1992). Jewish law does not consider the fifth commandment of "Thou shall not kill" as applying to suicide (Jacobs 1995). However, it does value the preservation of human life above all else (Jacobs 1995), and thus condemns suicide.

According to Kaplan and Schoenberg (1988), Judaic principles ascribe a great spiritual consequence to suicide. When an individual commits suicide, the soul has nowhere to go (Kaplan and Schoenberg 1988). It cannot return to the body, because the body has been destroyed. It cannot be let in to any of the soul worlds, because its time has not come. Thus, it is in a state of limbo which is very painful. A person may commit suicide because he wants to escape, but, in reality, the result is a far worse situation. While problems have the opportunity to be resolved in this world, after death, there are no more opportunities, only consequences. According to strict Judaic belief, individuals who commit suicide are unable to receive traditional post-death rituals such as a proper burial and blessings (Kaplan and Schoenberg 1988).

Across the world, 14 million people identify themselves as Jewish. Suicide rates among Jewish individuals in the United States and Israel have historically been noted to be low (Dublin 1963; Levav and Aisenberg 1989; Miller 1976) with suicide rates in Israel being lower than suicide rates in the United States (Levav and Aisenberg 1989). Overall, Jewish individuals have the lowest rate of suicide in the United States as compared to Christians and Protestants (Maris et al. 2000). Several studies have reported that suicide rates are lower among Jews as compared to the general population in predominantly Protestant communities (Danto and Danto, 1983; Goss and Reed 1971; Levav et al. 1988; Williams 1997). Additionally, in a study of the United States examining the proportion of the Jewish population and corresponding suicide rates across 50 states, a significant negative correlation was found (Bailey and Stein 1995).

In Israel, suicide rates among the Jewish population are among the lowest in the world (Kohn et al. 1997), yet they are higher for Jewish individuals than for Muslims (Levav and Aisenberg 1989; Lubin et al. 2001). Among the Jewish population, suicide rates are higher for men than for women (Lubin et al. 2001). The suicide rate increases directly with age. In addition, the suicide rate for Jewish males in Israel is increasing, particularly in the 18- to 21-year-old age group. Rates of suicide are found to differ according to marital status. The highest rates were in married individuals (Nachman et al. 2002). An increase in the use of firearms has also been cited (Lubin et al. 2001).

Recommended Clinical Guidelines

The relationship between an individual's religiosity and suicidality often remains ignored in clinical assessments. Although research is increasingly recognizing the risk and protective role that religion may exert on an individual's suicide risk, specific guidelines for integrating religious information and beliefs into suicide risk assessment have yet to be established. The following general practice guidelines may aid clinicians in assessing the influence and impact of clients' religiosity on their suicide risk:

1) *Assess the importance of religion to the client and their identity*. This step can be extended to include the importance of religion in the lives of the client's significant

others, such as partners, parents, and friends. Specifically, what is the client's degree of religious affiliation? (e.g., how often do they attend services or engage in religious rites, like prayer? Do they socialize with members of their religious community?). How strongly do they identify with their religion's tenets? Has the degree of their religious commitment recently changed?

2) *Assess the role of religiosity during previous times of stress and difficulties*. Has the client's religiosity served as a source of comfort or as a coping mechanism in past difficulties? Has the client's religiosity contributed to her or his level of distress? Has the client's religiosity neither positively nor negatively influenced her or his level of distress during times of crisis? If religion has been utilized, how so (e.g. relying on religious figures as sources of guidance and support; increasing involvement in religious activities such as attendance at and participation in religious rituals). If religion has not been utilized, why?
3) *Assess how suicide is conceptualized and perceived in the client's religion*. Are there sanctions against suicide? Are there circumstances when it may be an accepted act? Are there different interpretations of suicidality within the religion? Is there conflict between their religion's viewpoint and their personal beliefs in relation to suicide? If so, how do they address this conflict and its impact on their faith?
4) *Assess the value of strengthening the client's religiosity and participation in their religion*. For some clients, increasing their religiosity may be a central protective factor. In such cases, it is important to examine: Which elements of the client's religiosity provide protection? How can the client find ways to maximize the support they receive from their religiosity? In contrast, if religion has been a source of distress or difficulty, it is important to examine: Which elements of the client's religiosity have added to her or his distress? How can the client find ways to minimize these harmful effects?

Conclusion

The act of suicide is condemned in most major religious sects. Research has established that degree of religiosity is directly related to degree of suicidality, with greater religiosity predicting decreased risk of suicidal behavior. Several mechanisms have been attributed to the protective role of religion, including a decrease of aggression and hostility and an increase in reasons for living. The protective role of religion can be found across major religious denominations; thus, assessing a client's degree of religious affiliation may serve as an effective indicator of suicide risk. The recommended clinical guidelines serve as an aid to clinicians for integrating this information into assessment protocols. Further research is warranted in the area of religion and suicidality to better understand the relationship between religiosity and gender, age, culture, and ethnicity.

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