

Religion and Suicide: New Findings

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Abstract Suicide rates and risk and protective factors vary across religions. There has been a significant increase in research in the area of religion and suicide since the article, “Religion and Suicide,” reviewed these issues in 2009. This current article provides an updated review of the research since the original article was published. PsycINFO, MEDLINE, SocINDEX, and CINAHL databases were searched for articles on religion and suicide published between 2008 and 2017. Epidemiological data on suicidality and risk and protective factors across religions are explored. Updated general practice guidelines are provided, and areas for future research are identified.

Keywords Religion · Suicide · Christianity · Hinduism · Islam · Judaism · Protective factor · Risk factor

Introduction

Across history, religions have incorporated elements of life and death, and have exerted an influence on their followers understanding, perceptions, and behaviors related to suicide. In 1897, Emile Durkheim proposed that spiritual commitment and religious connection may contribute to emotional well-being, as it provides a source of meaning and order in the world (Durkheim 1951). Throughout the literature examining the relationship between religion and suicide, terms such as religiosity and religion are often used interchangeably with the words spiritual and spirituality. Spirituality tends to refer to personal views or beliefs of the presence or existence of something greater than the self. However, there remains no universally accepted definition of spirituality, few standardized measures of

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spirituality have been examined for reliability and validity, and the majority of extant literature focuses on the formal concept of religion. This review will focus on the more generally studied and formally defined concept of religion and, in particular, religious commitment operationalized in the literature as degree of level of adherence to the practices, beliefs, and attitudes of an organized faith community.

Research establishing a relationship between high levels of religiosity and decreased suicide risk dates back over 50 years (Kranitz et al. 1968). Empirical evidence consistently indicates that the rate of suicide varies across religions. This review represents an extension and update of our original study published approximately 10 years ago (Gearing and Lizardi 2009) and focuses on the current state of empirical knowledge regarding the relationship between religion and suicide across four dominant world religions of Christianity, Hinduism, Islam, and Judaism. However, it is important to recognize that these dominant religions are not homogenous groups, but comprise a multitude of sects and subgroups, each with some shared central tenets but also with distinct interpretations and unique and differing religious customs.

Higher levels of religiosity across these major denominations have historically been associated with decreased suicide risk (Dervic et al. 2004; Martin 1984; Stack and Kposowa 2011b). Further, research suggests that religious attendance may be an independent protective factor against suicide attempt (Rasic et al. 2011), which is consistent with earlier research that identified that individuals who attend church more frequently were four times less likely to complete commit suicide than those who never attend religious services (Martin 1984). Stack and Kposowa (2011a, b) further found that individuals residing in nations with relatively high levels of religiosity, who are affiliated with one of four major faiths, are religiously committed, and are engaged with a religious network have lower rates of suicide acceptability.

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. In addition, assessing religiosity may also identify potential areas that treatment could target and enhance life-affirming beliefs and expectations. Some research has found that religious beliefs, religious support from congregants, and the ministry of clergy played an important role in the bereavement process of suicide attempt survivors (Vandercreek and Mottram 2009). While further research in this area is required, their findings suggest the importance of religion for survivors and that religious clergy and leaders may be integral to postvention survivor treatment.

Method

PsycINFO, MEDLINE, SocINDEX, and CINAHL databases were searched for peer-reviewed published articles on religion and suicide between 2008 and 2017. The boolean search strategy and keywords included: religion, Christianity, Christian, Catholic, Catholicism, Judaism, Islam, Muslim, Hindu, or Hinduism; and attempted suicide, suicide, suicide prevention, or suicide risk and related mapped terms. Searches were limited to English language journal articles. Across the four electronic databases, 1745 articles were yielded; after removing 472 duplicates, results totaled 1273 articles. The authors reviewed the abstracts and rejected 1192 articles including: letters to the editor, editorials, book

reviews, articles that were not a research study; and, articles that did not meet the eligibility criteria and did not include data on suicide and religion, resulting in a final total of 81 articles included in the review. Research studies and review articles focusing on the relationship between religion and suicide were included in this review. The reference sections of these articles were also examined for other relevant articles. This review focuses on suicide rates and risk and protective factors for suicide across the following four religions: Christianity, Hinduism, Islam, and Judaism (Fig. 1).

Results

Religion and Suicide Across Sociodemographic and Clinical Groups

The influence of religiosity on suicide appears to vary by gender. For example, in one study of over 28,000 males and females, higher suicide rates are associated with lower levels of religious belief and religious attendance among males; whereas this relationship was not demonstrated among females (Neeleman et al. 1997). Similarly, other research has also identified that individuals with lower religious orientation compared to those individuals with versus higher religious orientation may be at increased suicide risk, but this finding was also restricted to males (Ozdel et al. 2009).

In terms of religious attendance as opposed to religious orientation, religious attendance among women historically has been shown to be negatively associated with suicide rates (Neeleman et al. 1997). Recently, VanderWeele et al. (2016) similarly found that those women who attend religious services at least once per week have an approximately fivefold lower rate of suicide compared with those women never attend religious services (VanderWeele et al. 2016).

In terms of religion as a protective factor across genders, a recent study by Kralovec et al. (2017) found that women experience a stronger protective effect of religion than men

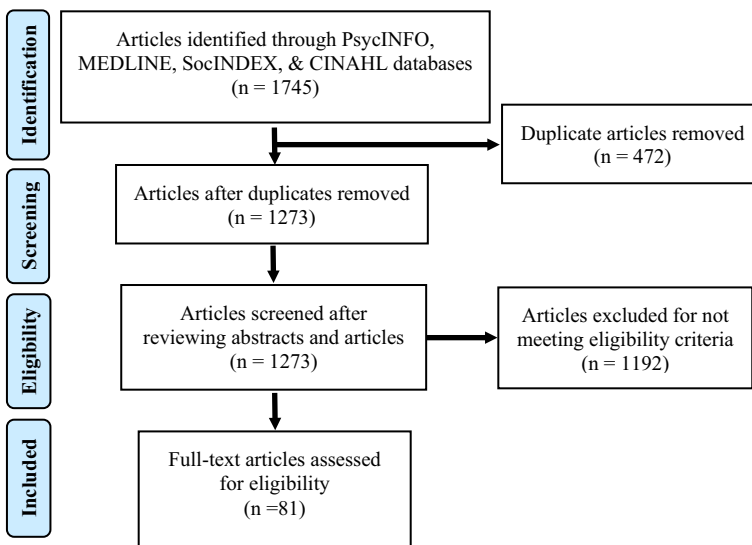


Fig. 1 PRISMA

among psychiatric inpatients (Kralovec et al. 2017), which is consistent with prior research (Colucci and Martin 2008; Rasic et al. 2011). Their results found that female suicide risk may not predominantly be affected by attendance to religious services, but a wider range of religious dimensions, such as beliefs, religious experience, and prayer (Kralovec et al. 2017). Another preliminary study seeking to identify the risk of suicidal behavior in high-risk pregnant women found that religion can serve as a protective factor against suicidal behavior by providing a social support network, giving purpose to life, self-esteem and coping strategies during a crisis (Benute et al. 2011).

The relationship between religion and suicide further appears to be differentiated by ethnicity. Research indicates the protective effect of religiosity may be influenced by cultural pressures (Al-Sharifi et al. 2015). Further, among Latinos in the USA, research has found that religious contextual variables greatly impact Latino suicide rates. For example, US-born Latinos benefit from religious communities, regardless of denomination, whereas foreign-born Latinos appear to dominantly benefit from Catholic adherents and religious homogeneity (Barranco 2016).

According to Assari (2012), religious beliefs among Blacks may serve as a buffer against the increased effect of psychiatric disorders on suicidal thoughts, specifically Blacks who are less religious and suffer from psychiatric disorders are at the highest risk for early suicidal ideation. However, in a follow-up study, the protective effect of religious beliefs on suicide was present mainly in African-American males with psychiatric disorders rather than females or Caribbean Black adults (Assari 2015).

Further, among African Americans and Caribbean Blacks, research demonstrates that frequency of interaction with church members is positively associated with suicide attempts, while subjective closeness to church members is negatively associated with suicide ideation (Chatters et al. 2011). Additionally, emotional support, service attendance, and negative interaction with church members have been found to be unrelated to both suicide ideation and attempts (Chatters et al. 2011). Other research has found that the relationship between religiousness and reasons for living is stronger for African Americans, whereas the relationship between social support and reasons for living is stronger for European Americans (June et al. 2009). While religion has been identified as a protective factor among African-American, research has been largely restricted to investigations in the USA. However, Stack and Kposowa (2011a, b) examined this phenomenon across ten nations. They found the association between religiosity and suicide across ten different nations, where the higher the religiosity of black males, the lower their suicide acceptability (Stack and Kposowa 2011a).

Research has also examined the relationship between religion and both psychiatric disorders and suicidality across ethnicities and has found associations between religious attendance and mood, anxiety and substance use disorders, as well as between suicidal ideation and attempts. For example, in a large epidemiological study of over 20,000 US adults, Robinson et al. (2012) found that infrequent religious attendance was associated with substance use disorders in Whites and African Americans only, and with anxiety and suicidal ideation in Whites and Hispanics only. Further, Asians were the only group in which religious attendance was associated with mood disorders (Robinson et al. 2012).

The risk or protective nature of religiosity also varies by age. Research has identified that religion as a protective factor against suicide may exert more influence with older populations than younger populations (Wu et al. 2015). Among older adults, research has found that older adults reporting a greater negative impact of recent life events and high intrinsic religiosity report greater death ideation (Jahn et al. 2012). It has been suggested that these findings may be due to reduced fear of death in intrinsically religious older adults

(Jahn et al. 2012). Rushing et al. (2013) also examined the relationship between religion and suicidality among older adults aged 59 and older. Results indicated that church attendance was associated with less suicidal ideation. This relationship was only partially mediated by degree of perceived social support. Additionally, results indicated that church attendance (above and beyond the importance of religion, private religious practices, and social support) has the strongest relationship to current suicidal ideation among older adults (Rushing et al. 2013). Other researchers have also identified religiosity and religious practices as important elements of meaning and comfort in the lives of older adults that can assist in overcoming suicidal ideation and suicide attempts (Figueiredo et al. 2015; Huang et al. 2017).

Among youth who report a history of suicide within the last year, research has shown that religious participation related to the youth's suicidality in several ways including: (1) religious community members acting as a bridge to mental health services; (2) religious discourses were provided during services; and (3) many youths reported changes in the degree of their religious beliefs in the year before their suicide attempt (Bullock et al. 2012). Also among adolescents, private religious practices and organized practice have both been found to be associated with lower rates of suicidal ideation (Cole-Lewis et al. 2016). Further, Nkansah-Amankra et al. (2012) found that participation in religious activities is associated with reduced suicidal behaviors among adolescents, but that this effect declines during emerging adulthood (Nkansah-Amankra et al. 2012).

Research also demonstrates that religiosity varies by mental health diagnostic category. For example, among depressed individuals, those reporting negative religion also report higher suicidal ideation; however, this occurs through its association with affective liability (Baetz and Bowen 2011). Further, Lizardi et al. (2008) found that depressed inpatients reporting lower moral objections to suicide had significantly more lifetime suicide attempts and were more often without religious affiliation. In a study investigating religion among inpatients with depression intrinsic religiosity was found to be associated with resilience, quality of life, and fewer previous suicide attempts (Mosqueiro et al. 2015). Other research examining depressed individuals has found that endorsing positive religio-spirituality, defined as religious service attendance as well as the idea of comfort, strength, support, and guidance from a higher power, reduces suicidal thoughts (Baetz and Bowen 2011).

However, research regarding the role of religion as a protective factor against suicide among depressed individuals is not consistent. Some research has demonstrated that, among depressed patients, past suicide attempts are more commonly reported by those who report a religious affiliation and that suicide ideation is greater among those who considered religion more important and who attended services more frequently (Lawrence et al. 2016a).

Others have demonstrated that negative religio-spirituality, defined as having anger toward or questioning of God, as well as feelings of being punished or abandoned by God, is associated with increased suicidal ideation among depressed individuals (Baetz and Bowen 2011). Further, another study examining the role of religious beliefs in the prevention of suicide risk among depressive women found that self-reported religiosity had neither a risk nor protective effect and rather was non-significantly associated with suicidality (Florenzano et al. 2014).

Among those depressed individuals within the bipolar spectrum, high religious affiliation has been found to be associated with increased risk of suicidal behavior (Azorin et al. 2013; Caribé et al. 2015; Dervic et al. 2011). For example, Azorin et al. (2013) found that individuals with bipolar spectrum disorders, high religious involvement associated with mixed features may increase the risk of suicidal behavior, despite the existence of religious

affiliation. Further, Dervic et al. (2011) found that moral or religious objections to suicide mediated the effects of religious affiliation on suicidal behavior among individuals with bipolar disorder.

In a systematic review on the association of religion with delusions and hallucinations in the context of schizophrenia, Gearing et al. (2011) found that religion frequently has a positive influence on suicidality of individuals with schizophrenia (e.g., increased coping mechanisms, instilled hope, purpose, meaning in life, increased social integration, lessened psychotic and general symptoms, reduced substance use and risk of suicide attempts, fostered adherence to psychiatric treatment religious condemnation of suicide), but can also have a negative influence (e.g., spiritual despair, increased psychotic symptoms, social isolation) (Gearing et al. 2011). Similarly, Koenig (2009) found that religiosity can represent powerful sources of comfort, hope, and meaning, but can become intricately entangled with psychotic disorders making it difficult to determine whether it is a resource or a liability. In another review, Grover et al. (2014) found that religion serves as an effective method of coping with schizophrenia and influences treatment compliance (Grover et al. 2014). Among those with psychotic spectrum disorders, negative religious coping (spiritual struggle) was found to be associated with substantially greater frequency and intensity of suicidal ideation; however, positive religious coping was not found to be associated with suicidal ideation (Rosmarin et al. 2013).

Research has found that religion may mediate suicide among individuals diagnosed with cancer. One study found that having no religion was associated with suicidality in cancer patients (Shim and Park 2012). These findings suggest a need for careful monitoring of these factors and enhanced comprehensive care addressing both the physical and psychosocial functioning of patients with cancer in suicide prevention efforts. Another study found that religious beliefs and involvement in practices was related to fewer depressive symptoms and less suicidal ideation in cancer patients (Shaheen Al Ahwal et al. 2016).

Religion as a Protective Factor Against Suicide

Religiosity has most often been shown to be associated with reduced risk of suicidality (Caribé et al. 2012; Carli et al. 2014; Colucci and Martin 2008; Dervic et al. 2004, 2011; Kleiman and Liu 2014; Koenig 2009; Kralovec et al. 2014; Lawrence et al. 2016a, b; Lizardi et al. 2007; Mandhouj et al. 2016; Rasic et al.; Spoerri et al. 2010; Stack 1983; Wu et al. 2015). However, it is important to note that empirical evidence is somewhat inconsistent, with some studies reporting religiosity to risk factor (Colucci and Martin 2008; Jia and Zhang 2012; Zhao et al. 2012), and still others reporting it unrelated to suicide risk (Colucci and Martin 2008; Sisask et al. 2010). This may be due, in part, to a lack of universality in how religiosity is defined and operationalized across studies with some measuring degree of affiliation and others including measures of level of participation and adherence to doctrine. Overall, suicide rates in religious countries are lower than suicide rates in secular countries (Breault 1993; Colucci and Martin 2008; Dervic et al. 2004). Furthermore, intensity of religious commitment and beliefs has been shown to be related to suicidal behaviors (Caribé et al. 2012; Chen et al. 2014; Nelson 1977). These findings are not specific to particular religious denominations (Dervic et al. 2004; Lizardi et al. 2007; Stack 1983). A recent cross-national analysis of religion and suicide found that individuals who are religiously committed, engaged within their religious community network, and residing in countries with high levels of religiosity are found to be lower in suicide acceptability (Steven Stack and Kposowa 2011b). Further, one study of approximately 5000 individuals found that while rates of suicidal ideation were similar across

secular, partially observant, and religious participants (9.4, 6.7, and 6.2%, respectively), rates of suicide attempts were significantly lower among religious subjects (2.4, 2.5, and 0.4% for secular, partially observant, and religious, respectively) (Burshtein et al. 2016). Others have also found that increased religious attendance is associated with decreased risk suicidal attempt (Price and Callahan 2017; Rasic et al. 2009). Further, research found that among religious affiliated patients there were fewer suicides in first-degree relatives (Dervic et al. 2011).

Moral and religious objections to suicide have a unique association with suicidal behavior. The life-saving beliefs associated with religious commitment may serve to protect against suicide (Dervic et al. 2004; Koenig et al. 2001; Lizardi et al. 2007; 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. Another study examining religious faith as a reason for living found that, among students with serious suicidal ideation and/or a previous suicide attempt, the strongest predictor for students' reasons for living was strength of religious faith (Rieger et al. 2015). Yet another study of undergraduates found that involvement in public, but not private, religious practices was associated with lower levels of both suicidal ideation and history of suicide attempts and that social support mediated these relationships, but religious beliefs did not (Robins and Fiske 2009).

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. Further, it has been suggested that all major religions discourage violence of any kind, which would include suicide, and promote peace and unity which can be considered life-affirming values, thereby protecting against suicide (Agoramoorthy and Hsu 2017). 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 (Benute et al. 2011; Caribé et al. 2012; 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 consistently been shown to be related to suicidal behavior. Additionally, many religions proscribe illicit behaviors such as substance abuse (Hilton et al. 2002) and smoking (Martin et al. 2003), which also 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 self-esteem and the decision to live (Benute et al. 2011; Pinto et al. 1998). Further studies with more comprehensive assessment and definition of religiosity are needed to clarify the relationship between suicidality and religiosity.

Challenges to Religion as a Protective Factor for Suicide

Recent research has found that the protective nature of religion may vary by dimension of suicidality being examined (ideation, behaviors, completion). For example, a systematic review seeking to identify the specific dimensions of religion (participation, affiliation, doctrine) that are associated with specific aspects of suicide (ideation, attempt, completion) found that religious affiliation does not necessarily protect against suicidal ideation, but does protect against suicide attempts. It further found that religious service attendance is not protective against suicidal ideation, but does protect against suicide attempts, and may also have a protective effect against completed suicide (Lawrence et al. 2016a). Similarly, Price and Callahan (2017) found that the protective effects of religious attendance against suicide ideation did not remain significant once social support was accounted for.

Another hindrance to the potential protective effect of religious affiliation against suicide is that a large proportion of clergy tend to report feeling ill-equipped to deal with parishioners experiencing suicidality. Specifically, a qualitative study on clergy and suicide identified that clergy reported having low confidence in their ability to identify and assess for suicidal risk (Mason et al. 2011). Further, it has been found that 25–30% of clergy members interviewed reported a suicide in their congregation in the past year, and only one-third reported having received adequate training in suicide intervention strategies (Hedman 2016; Mason et al. 2011). The majority (85%) reported they felt that it was their role to provide education on suicide and mental health to their congregations; however, 32% reported no or low ability to do so. Most clergy interviewed (70%) stated, if concerned about a parishioner's mental health, they would ask about the presence of suicidal thoughts, but fewer (59%) stated they would specifically ask about suicidal intent (Hedman 2016). One study found that only 10% of clergy subsequently referred help-seekers with suicidal issues to mental health providers (Mason et al. 2011).

Suicide Across Religious Denominations

Among the most common religious groups in the USA, Protestants have the highest suicide rate followed by Roman Catholics, whereas Jewish individuals have the lowest rates of suicide (Maris et al. 2000). Lower rates of suicidal behavior have also been found for Muslims when compared to other religions, such as Christianity, Hinduism, or Judaism (Abdel-Khalek 2004; Cooper-Kazaz 2013; Ineichen 1998; Central Bureau of Statistics 2010). A review of research regarding suicide in each of these four dominant world religion follows.

Christianity and Suicide

Historical Perspective

There are 2.3 billion Christians worldwide (Hackett and McClendon 2017). Christianity's historical perspective and attitude toward suicide has remained consistent since the fifth century (Phipps 1985), when suicide was conceptualized by St. Augustine as a violation of the sixth commandment (Thou shall not kill) (Kennedy 2000; Maris et al. 2000; Phipps 1985; Retterstol 1993). This position on suicide was later expanded by St. Thomas Aquinas, who described suicide is a sin against self, neighbor and God (Gearing and Lizardi 2009; Kennedy 2000; Phipps 1985).

The current view of suicide across Christian denominations (e.g., Catholics, Baptists, Protestants) remains consistent with the historical perspective that regards suicide as a sin. Suicide is equated with other sins resulting in the taking life, such as murder and abortion (Maris et al. 2000; Wogaman 1990). However, according to the Catechism of the Catholic Church (1994), an individual has to be mentally competent in order for the act in which he/she partakes to be deemed a sin. Therefore, if one considers suicide an act of the mentally ill, it may mitigate the interpretation of this act as a sin (Gearing and Lizardi 2009). For example, one study of clergy from various Christian denominations found that a compassionate response to suicide was commonly held by clergy who most often attributed the act to mental illness (Leavey et al. 2011).

According to Christian doctrine, when an individual dies, s/he faces judgment by God and only God can decide if the individual will enter heaven or will go to 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 less practiced custom within Catholicism. More common today is, during funeral services, forgiveness is asked for the deceased and comfort for the survivors (Gearing and Lizardi 2009; Turner 1998).

Research Findings

Among the dominant Christian denominations (Catholics, Baptists, and Protestants), the highest suicide rates are found among those endorsing Protestant faith and the lowest rate of suicide is found among Catholics and evangelical Baptists (Panczak et al. 2013; Pescosolido and Georgianna 1989). Similar results have been found on a national level with Catholic countries reporting lower suicide rates than Protestant ones. Further, within Protestant countries, areas with a preponderance of Catholics have lower suicide rates (Gearing and Lizardi 2009; 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 and Amanullah 2007; Spoerri et al. 2010).

Research has demonstrated that Catholics and Baptists have higher levels of religious participation and are more likely to be actively involved in church activities (Pescosolido and Georgianna 1989). They may, therefore, benefit more from expanded social support networks as a result of their higher level of participation (Pescosolido and Georgianna 1989). However, others have found lower rates of suicide among Catholics as compared to Protestants even after controlling for quantity and quality of social and religious networks (Torgler and Schaltegger 2014). Still others propose that the lower rates of suicide found among conservative Catholics may be due to their lower rates of alcohol consumption and engagement in other risk behaviors (Rosato and O'Reilly 2015).

In a prospective study examining suicide risk by Christian religious affiliation, approximately 1,106,104 individuals aged 16–74 years in the UK were followed for 9 years and compared for level of religious activity and degree of commitment. It was hypothesized that if church attendance is most important, risk would be lowest for Roman Catholics and highest for those with no religion. Conversely, if religiosity is most important, then “conservative” Christians would present as at lowest risk. Results indicated that Roman Catholics, Protestants, and those professing no religion recorded similar risks. However, the risk associated with conservative Christians was lower than that for Catholics (Rosato and O'Reilly 2015).

Interestingly, research has found that suicide rates decrease approaching Christmas, only to return to normal levels in the New Year (Plöderl et al. 2015). This may speak to the

importance of religious participation rather than degree of adherence to religious doctrine, as Christmas is a widely practiced holiday across levels of religiously committed individuals.

Overall, research over the last decade continues to demonstrate great variance in suicide rates across Christian denominations. Further research is needed examining the role of religious participation as compared to adherence to religious doctrine in order to better understand the discrepancy in rates across these groups. In addition, more nuanced research on how protective factors identified with Christianity influence various individuals, groups, and areas, and their intersection with mental illness and stigma is warranted.

Hinduism and Suicide

Historical Perspective

There are an estimated 1.1 billion Hindus in the world (Hackett and McClendon 2017), predominantly in the Indian subcontinent. Unlike the other dominant religions, Hindu scriptures are less resolute on the issue of suicide as an unacceptable act (Ineichen 1998). The Sanskrit term for suicide refers to the words *Pranatyaga* or *Atmahatya* that indicate an abandoning life force, which is discouraged in Hindu faith (Agoramoorthy and Hsu 2017). According to the Hindu philosophies of reincarnation and karma, life does not end at one's death; rather death will lead to one's rebirth (Hassan 1983; Ineichen 1998). This reincarnation tenet has led some scholars to suggest that while discouraged, there may be more tolerance to suicide within the Hindu religion (Agoramoorthy and Hsu 2017; Gearing and Lizardi 2009; Hassan 1983; Ineichen 1998; Kamal and Loewenthal 2002).

Research Findings

There has been limited research conducted on suicidality and Hindus (Gearing and Lizardi 2009); this body of work has not increased significantly in the past decade. Earlier research identified a higher rate of suicide among Hindus than Muslims (Ineichen 1998). This finding was supported by another study of Hindus and Muslims that found Hindus having less strongly endorsed moral objections and survival-and-coping reasons for living than Muslims (Kamal and Loewenthal 2002). Two newer studies replicated similar findings. One survey study investigating the influence of religion on attitudes toward suicide found higher rates of suicidal attempts and suicidal thoughts among family members of Hindus than among Muslim participants (Thimmaiah et al. 2016). Another study conducted by Maniam et al. (2013) found that suicide ideation was higher among Indians in Malaysia with Hindu faith compared to other religious faiths (e.g., Christian, Buddhism, Islam) (Maniam et al. 2013).

In terms of sociodemographic and clinical characteristics associated with suicide among Hindus, research indicates that males have higher rates of suicide than females (Latha et al. 1996). Research also demonstrates that the majority of suicide attempters studied had a psychiatric diagnosis (Latha et al. 1996).

It is also important to recognize the centuries' old Hindu practice of *Sati*, the ritual act of suicide in which widows self-immolate on the funeral pyre of their husbands. Currently illegal this ritual nonetheless continues to be practiced in some areas of the Indian subcontinent (Kumar 2003; Roye 2011). Instances of *sati* are not considered to be religiously driven or related to a psychiatric illness; rather this form of suicide appears more related to social, gender, and cultural factors (Bhugra 2005). More recently, Roye (2011) has

questioned whether the focus should simply center on whether sati is just painful female victimization or if it may also reflect powerful female agency and the power of devotion. Future research in this area may offer further insight into this phenomenon. Overall, the past decade has resulted in minimal new research in the area of suicidality and the Hindu religion or its practitioners. More targeted research in this area is recommended, as the influence of religiosity on suicidality as a protective and risk factor emerges.

Islam and Suicide

Historical Perspective

For the 1.8 billion Muslims (Hackett and McClendon 2017), the Holy Qu'ran expressly forbids suicide in Surah 4, verses 29 and 30, which state, "do not kill or destroy yourself." The Quran refers to suicide as self-murder (*qatl-al-nafs*) and strongly prohibits it; even wishing for death is explicitly rejected (Shah and Chandia 2010). Life should not only be life valued (Shomali 2008), but the prophetic teachings within Islam forbid suicide and subsequently condemn the individual who suicides to an eternal retribution of constant repetitions of the suicidal act (Al-Harrasi et al. 2016).

The Qu'ran, similar to the Christian Bible, is interpreted differently across various predominantly Islamic countries, regions, and religious sects (Pritchard and Amanullah 2007). Furthermore, many Islamic countries have incorporated Sharia (Islamic law) into their legal system, such as in Saudi Arabia, Pakistan, or Kuwait, where suicide and suicide attempts remain criminal offenses (Al-Jahdali et al. 2004; Khan and Hyder 2006; Sarfraz and Castle 2002; Suleiman et al. 1989). While limited, research has consistently found lower rates of suicide associated with the Islamic faith.

Research Findings

Research into Muslim suicidality remains limited not only in overall 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). While research on suicidality and Islam may be under-investigated, studies have identified that Islam religion is often associated with lower suicide acceptability and that low prevalence rates may be attributed to the more religiously oriented lifestyle of Muslims (Stack and Kposowa 2011b).

It has been posited that the scarcity of research about suicide in the Islamic world has limited our knowledge of predisposing and precipitating risk factors (Al-Harrasi et al. 2016; Morad et al. 2005). Nevertheless, one study found that the number of suicide attempts was higher on religious feast days, which may be associated with changes to the daily rhythm and increases in family interactions and confrontations (Akkaya-Kalayci et al. 2015). Another study by Shaheen Al Ahwal et al. (2016) examined the role of religiosity as a predictor of depression and suicide ideation. Among a sample of Muslim cancer patients, results indicated that those patients who reported a greater degree of religious affiliation (as measured by level of engagement in prayer, times recited the Qur'an, fasting during Ramadan, and the degree to which the individual's approach to life was religiously motivated, etc.) reported fewer depressive symptoms and less suicide ideation. Further, according to Pritchard and Amanullah's (2007) analysis comparing suicide and

undetermined deaths in 17 Islamic countries, patterns of suicide similar to those in Western countries were found (e.g., increased risk with age).

Protective factors have more often been identified in research on suicidality and Islam, specifically intrinsic religiousness within Islam has been demonstrated to be a protective role against suicide attempts (Akbari et al. 2015). Further, research has demonstrated that endorsing strong religious beliefs is a protective factor even when the individual is experiencing a high number of stressful life events and severe psychiatric symptoms; especially when they report having strong family support and good problem-solving skills (Baneshi et al. 2017). However, 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; Lester 2006).

Some research has indicated an increasing suicide trend in Islamic countries (Al-Jahdali et al. 2004; Cosar et al. 1997; Khan 2007; Khan and Hyder 2006; Khan and Reza 2000; Khokher and Khan 2005). Other research in Iran has examined the association between female suicide rates and the social control of women, with rates expected to be higher in areas with greater social regulation over the lives of women and those holding stronger traditional tribal cultures (Aliverdinia and Pridemore 2009). Results of this study demonstrated that provinces in which females had lower levels of education, labor force participation, and urbanization have higher rates of female suicide. Another study also indicated that within predominantly Islamic Middle Eastern countries suicide rates are increasing among young females (Rezaeian 2010). Some have suggested that the rising rates of suicide may be due in part to the process of modernization that can lead to less religious adherence and weakening faith (Shah and Chandia 2010). This research has found significant negative correlations between general population suicide rates and the percentage of people adherent to Islam in males and females, even while controlling for socioeconomic status and income inequality (Shah and Chandia 2010).

Research suggests that among certain subcultures of Muslim populations, suicide may be considered to be an honorable act in specific situations. For example, women who are raped or are in a situation where they believe that rape is impending sometimes opt to kill themselves rather than to subject themselves and their families to the dishonor and shame associated with this act (Aijaz and Ambareen 2014).

It has been identified in the literature that suicide is notably under-reported in Islamic countries (Al-Harrasi et al. 2016). The strong Islamic condemnation of suicide as culturally unacceptable often leads families of individuals of the deceased not to report the death as a suicide, but rather as an accident to avoid shame and stigma (Al-Harrasi et al. 2016; Pritchard and Amanullah 2007). Individuals who have attempted suicide and their families will generally avoid going to public hospitals whenever possible due to fear that the hospital will report the event as a crime to the police (Khan 2007; Khan and Hyder 2006). Surviving family members from traditional Muslim communities often find themselves stigmatized (Rassool 2015; Sarfraz and Castle 2002). They are further ostracized following the suicide of a loved one as Muslim graveyards are often reluctant to bury an individual after a suicide, which is considered a haram or forbidden death (Sarfraz and Castle 2002). Also, 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). Given these factors, some have suggested that Muslim suicide may not actually be so low and the proposed rareness of the event may reflect the under-reporting of such events due to social stigma (Gearing and Lizardi 2009; Lester and Akande 1994; Sarfraz and Castle 2002).

While research examining the intersection between suicidality and Islam has increased over the last decade, providing an increasingly a more nuance understanding of the phenomenon, the existing data are limited. Studies continue to find Islam a very strong protective factor against suicide; the influence does not appear uniform populations, demographics, an individual's level of religiosity, and health and mental health conditions. Research has advanced in investigating specific protective factors, the potential effect of stigma warrants further scientific attention. Also, future research is needed to more fully understand the unique protective role that Islam provides against suicide across the wide range of practicing individuals.

Judaism and Suicide

Historical Perspective

Across the world, 15 million people identify themselves as Jewish. Judaism strictly sanctions against murder, and perceives suicide as self-murder, which is a criminal act. Jewish doctrine condemns suicide as 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). In contrast to historical Catholic doctrine, Jewish law does not consider the fifth commandment of "Thou shall not kill" as applying to suicide; however, the opposition to suicide is derived more from the preservation of human life above all else (Jacobs 1995).

However, Judaism contains examples of suicide that have been recognized and revered, although often explained as an acceptable act focused on the greater good. For example, Samson has often been interpreted as a heroic figure exemplifying the ultimate Jewish hero who killed himself to help his people (Shoenfeld and Strous 2008). Additionally, the historical Battle of Masada between the Jews and the Romans culminated in the mass suicide of hundreds of Jewish men, women, and children, known as the Zealots, and is said to represent the ongoing Jewish fight for freedom, as they chose to complete suicide rather than be captured and enslaved by the Romans (Ngo 2014).

Further, Judaic principles ascribe a spiritual consequence to suicide. When an individual commits suicide, the soul enters into a state of limbo, which is very painful because it has no place to be (Kaplan and Schoenberg 1988). The soul cannot return to the body, as it has been destroyed; however, it cannot enter into any of the soul worlds, as its time has not come. Thus, an individual who perceives suicide as an escape may in reality be trapped in a far worse situation. Accordingly in this world where problems can be resolved in this world, after death, there are no more opportunities, only consequences. In 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).

Research Findings

Suicide rates among Jewish individuals in the USA and Israel have historically been found to be low (Dublin 1963; Levav and Aisenberg 1989; Miller 1976) with suicide rates in Israel being lower than in the USA (Levav and Aisenberg 1989). However, Jewish suicide rates have been found to be lower when compared to Christians and Protestants prevalence rates in the USA (Maris et al. 2000). Among Jewish adolescents in the USA, level of religiosity has been found to be inversely associated with self-injurious thoughts and behaviors, decreasing the likelihood of occurrence by 55%. These findings hold even after adjusting for depression and sociodemographic characteristics (Amit et al. 2014).

The overall suicide rates in Israel for Jewish population are among the lowest in the world (Kohn et al. 1997), but are higher for Jewish individuals than for Muslims (Levav and Aisenberg 1989; Lubin et al. 2001). Suicide rates are higher for Jewish males than for females, and suicide prevalence rates increase with age (Lubin et al. 2001; Nachman et al. 2002). Research has further demonstrated that certain subpopulations of Israeli Jews there may be at greater risk than others. For example, an elevated suicidal risk has been found among male Israeli soldiers, immigrants from the former USSR and Ethiopia, adolescent immigrants, elderly Holocaust survivors, and young Israeli-Arab women (Witztum and Stein 2012). Research has found that although religion creates a buffer to suicide, in Israel the degree of religiosity had a relatively low impact on coping and study participants reported that it was difficult to access their religiosity during harsh life situations (Band et al. 2011).

Overall, research over the last decade regarding Judaism and suicidality has not grown significantly with existing data supporting lower rates of suicide associated with this religion as compared to others. Future research is needed to better understand the unique protective role that Judaism exerts against suicide, specifically as it may be moderated by demographic characteristics (e.g., gender, age, and belonging to specific subgroups) and degree of religiosity (e.g., participation in religious activities).

Recommended Clinical Guidelines

The relationship between an individual's religiosity and suicidality is often minimized or ignored in clinical assessments. Despite the increase in attention that the role of religiosity has received over the last decade as a risk and/or protective factor for suicide, formal guidelines for including religious information in a suicide risk assessment have yet to be established.

Nevertheless, research has demonstrated that clinicians and therapists are open to discussing spiritual and religious topics with their clients, especially clients who want to discuss these matters during treatment (Post and Wade 2009). Also, most mental health disciplines have formally acknowledged the importance of including religion and spirituality in training (Moreira-Almeida et al. 2014), formalized evidence-based religious and spiritual competencies and methods to assess them remain undeveloped (Schafer et al. 2011). Further, research to date has not established that including religious practices in clinical treatment (i.e., prayer during sessions, referring to religious texts, directing clients to pray) is an effective clinical tool (Rassool 2015; Vieten et al. 2013).

The literature has suggested that the same criteria applied to including multicultural competencies in clinical practice can be extended to including cultural differences involving religion and spirituality (Vieten et al. 2013), often referred to as "spiritual competence" (Hodge 2004). The fundamental activities of multicultural and spiritual competence are characterized by a dynamic process comprised of three interrelated domains: (1) awareness of one's personal worldview along with its associated assumptions, limitations, biases; (2) an empathic, strengths-based understanding of the client's spiritual worldview; and (3) the ability to develop and utilize intervention approaches that are sensitive to the client's spiritual worldview (Hodge 2004; Vieten et al. 2013).

Moreira-Almeida et al. (2014) conducted a systematic review of the literature examining the incorporation of religion and spirituality in mental health treatment. Their recommendations include the following research-based general principles for mental health

clinicians: (1) maintain ethical boundaries, recognizing that incorporating religion into treatment should be patient-centered and not prescribing, imposing, or proselytizing; (2) maintain a person-centered approach; (3) be attentive to countertransference, acknowledging that the clinician's own values, beliefs, and history may raise important issues and influence practice (i.e., having a strong reaction to religious topics, avoiding religious issues, or stressing them too much); (4) remain open-minded while expressing genuine interest in and respect for the patient's beliefs, values, and experiences; (5) avoid self-disclosure of one's own religious beliefs as it may lead to disagreement, conflict, or avoidance (Moreira-Almeida et al. 2014).

The following expanded general practice recommendations may further guide clinicians in assessing and understanding the influence and impact of clients' religiosity on their suicide risk (Gearing and Lizardi 2009):

1. Assess the importance of religion to the client. Evaluation in this area should include the importance of religion in the life of the client, specifically, what is the client's degree of religious affiliation (e.g., how often do they attend services? Engage in religious rites, like prayer or reading of religious texts?)? Do they socialize with members of their religious community?
2. Assess the importance of religion to the client's family/significant others. Family and support networks often exert a significant influence on the health, mental health, ability to access care, and support ongoing treatment engagement. This influence can be positive by facilitating engagement in treatment, or negative, serving as a barrier to treatment, being ostracizing and stigmatizing. Evaluation in this area should include the importance of religion in the lives of the client's parents, partners, and friends, and how religion may facilitate or limit support and treatment.
3. Assess the importance of religion to the client's identity. Evaluation in this area should consider how strongly does the client identify with their religion's tenets? Has degree of their religious commitment recently changed? How does this aspect of the client's identity interconnect with their ideas of suicide or mental illness?
4. 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 acceptable act? Are there varying interpretations of suicidality within the religion? Does this stance serve as a represent a conflict with the client's personal beliefs? If so, how do they address this conflict and its impact on their faith?
5. 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 or has it contributed to her/his level of distress? Has the client's religiosity served to neither positively nor negatively influence his/her 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?
6. Assess the value of strengthening the client's religiosity and participation in their religion. For some clients, increasing their religiosity may play a key part of treatment seeking to increase the client's protective factors against suicide. 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 across major religions. In addition, each major religion provides a series of effective coping strategies (e.g., prayer, rituals, religious services, social networks) to support an individual managing difficulties, such as suicide. Research over the last decade has expanded our understanding of the complicated relationship between religiosity and suicidality. While it is now generally accepted that religion most often serves as a protective factor against suicide across religious denominations, there are aspects of religion that are now recognized as potentially representing a risk factor for increased suicide risk for some followers. Further research is warranted in the area of religion and suicidality to better understand the relationship between religiosity and gender, age, culture, and ethnicity. Also, the influence of religion on the various groups within the dominant religions remains under-investigated. The recommended general clinical guidelines serve as an aid to clinicians for assessing the role that religion plays in the lives of clients and for integrating this information into suicide risk assessment protocols.

Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Informed Consent Not applicable as this was a systematic review.

References

- Abdel-Khalek, A. (2004). Neither altruistic suicide, nor terrorism but martyrdom: A Muslim perspective. *Archives of Suicide Research*, 8(1), 99–113.
- Agoramoorthy, G., & Hsu, M. J. (2017). The suicide paradigm: Insights from ancient Hindu scriptures. *Journal of Religion and Health*, 56(3), 807–816. <https://doi.org/10.1007/s10943-015-0178-3>.
- Aijaz, A., & Ambareen, U. (2014). Depression in a Pakistani woman. *The American Journal of Psychiatry*, 171(7), 729–731. <https://doi.org/10.1176/appi.ajp.2013.13111548>.
- Akbari, M., Haghdoost, A.-A., Nakhaee, N., Bahramnejad, A., Baneshi, M. R., & Zolala, F. (2015). Risk and protective factor for suicide attempt in Iran: a matched case–control study. *Archives of Iranian Medicine*, 18(11), 747–752.
- Akkaya-Kalayci, T., Popow, C., Waldhör, T., & Özlü-Erkilic, Z. (2015). Impact of religious feast days on youth suicide attempts in Istanbul, Turkey. *Neuropsychiatrie: Klinik, Diagnostik, Therapie Und Rehabilitation: Organ Der Gesellschaft Österreichischer Nervenärzte Und Psychiater*, 29(3), 120–124. <https://doi.org/10.1007/s40211-015-0147-9>.
- Al-Harrasi, A., Al Maqbali, M., & Al-Sinawi, H. (2016). Surviving a suicide attempt. *Oman Medical Journal*, 31(5), 378–380.
- Aliverdinia, A., & Pridemore, W. A. (2009). Women's fatalistic suicide in Iran: A partial test of Durkheim in an Islamic Republic. *Violence Against Women*, 15(3), 307–320.
- Al-Jahdali, H., Al-Johani, A., Al-Hakawi, A., Arabi, Y., Ahmed, Q. A., Altowirky, J., et al. (2004). Pattern and risk factors for intentional drug overdose in Saudi Arabia. *Canadian Journal of Psychiatry*, 49(5), 331–334.
- Al-Sharifi, A., Krynicki, C. R., & Uptegrove, R. (2015). Self-harm and ethnicity: A systematic review. *The International Journal of Social Psychiatry*, 61(6), 600–612. <https://doi.org/10.1177/0020764015573085>.
- Amit, B. H., Krivoy, A., Mansbach-Kleinfeld, I., Zalsman, G., Ponizovsky, A. M., Hoshen, M., et al. (2014). Religiosity is a protective factor against self-injurious thoughts and behaviors in Jewish adolescents:

- Findings from a nationally representative survey. *European Psychiatry: The Journal of the Association of European Psychiatrists*, 29(8), 509–513. <https://doi.org/10.1016/j.eurpsy.2014.04.005>.
- Assari, S. (2015). Ethnic and gender differences in additive effects of socio-economics, psychiatric disorders, and subjective religiosity on suicidal ideation among blacks. *International Journal of Preventive Medicine*, 6, 53. <https://doi.org/10.4103/2008-7802.158913>.
- Assari, S., Lankarani, M. M., & Moazen, B. (2012). Religious beliefs may reduce the negative effect of psychiatric disorders on age of onset of suicidal ideation among Blacks in the United States. *International Journal of Preventive Medicine*, 3(5), 358–364.
- Azarin, J. M., Kaladjian, A., Fakra, E., Adida, M., Belzeaux, R., Hantouche, E., et al. (2013). Religious involvement in major depression: Protective or risky behavior? The relevance of bipolar spectrum. *Journal of Affective Disorders*, 150(3), 753–759. <https://doi.org/10.1016/j.jad.2013.02.034>.
- Baetz, M., & Bowen, R. (2011). Suicidal ideation, affective lability, and religion in depressed adults. *Mental Health, Religion & Culture*, 14(7), 633–641. <https://doi.org/10.1080/13674676.2010.504202>.
- Bailey, W. T., & Stein, L. B. (1995). Jewish affiliation in relation to suicide rates. *Psychological Reports*, 76(2), 561–562.
- Band, M., Dein, S., & Loewenthal, K. M. (2011). Religiosity, coping, and suicidality within the religious Zionist community of Israel: A thematic qualitative analysis. *Mental Health, Religion & Culture*, 14(10), 1031–1047. <https://doi.org/10.1080/13674676.2010.548059>.
- Baneshi, M. R., Haghdoust, A. A., Zolala, F., Nakhaee, N., Jalali, M., Tabrizi, R., et al. (2017). Can religious beliefs be a protective factor for suicidal behavior? A decision tree analysis in a mid-sized city in Iran, 2013. *Journal of Religion and Health*, 56(2), 428–436. <https://doi.org/10.1007/s10943-016-0215-x>.
- Barranco, R. E. (2016). Suicide, religion, and Latinos: A macrolevel study of US Latino suicide rates. *The Sociological Quarterly*, 57(2), 256–281. <https://doi.org/10.1111/tsq.12110>.
- Benute, G. R. G., Nomura, R. M. Y., Jorge, V. M. F., Nonnenmacher, D., Fráguas Junior, R., Lucia, M. C. S. D., et al. (2011). Risk of suicide in high risk pregnancy: An exploratory study. *Revista Da Associacao Medica Brasileira (1992)*, 57(5), 583–587.
- Bhugra, D. (2005). Sati: A type of nonpsychiatric suicide. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, 26(2), 73–77.
- Breault, K. D. (1993). Suicide in America: A test of Durkheim's theory of religious family integration, 1933–1980. *American Journal of Sociology*, 92, 628–656.
- Bullock, M., Nadeau, L., & Renaud, J. (2012). Spirituality and religion in youth suicide attempters' trajectories of mental health service utilization: The year before a suicide attempt. *Journal of the Canadian Academy of Child and Adolescent Psychiatry = Journal De L'academie Canadienne De Psychiatrie De L'enfant Et De L'adolescent*, 21(3), 186–193.
- Burshtein, S., Dohrenwend, B. P., Levav, I., Werbeloff, N., Davidson, M., & Weiser, M. (2016). Religiosity as a protective factor against suicidal behaviour. *Acta Psychiatrica Scandinavica*, 133(6), 481–488. <https://doi.org/10.1111/acps.12555>.
- Caribé, A. C., Nunez, R., Montal, D., Ribeiro, L., Sarmento, S., Quarantini, L. C., et al. (2012). Religiosity as a protective factor in suicidal behavior: A case-control study. *The Journal of Nervous and Mental Disease*, 200(10), 863–867. <https://doi.org/10.1097/NMD.0b013e31826b6d05>.
- Caribé, A. C., Studart, P., Bezerra-Filho, S., Brietzke, E., Nunes Noto, M., Vianna-Sulzbach, M., et al. (2015). Is religiosity a protective factor against suicidal behavior in bipolar I outpatients? *Journal of Affective Disorders*, 186, 156–161. <https://doi.org/10.1016/j.jad.2015.07.024>.
- Carli, V., Mandelli, L., Zaninotto, L., Iosue, M., Hadlaczky, G., Wasserman, D., et al. (2014). Serious suicidal behaviors: Socio-demographic and clinical features in a multinational, multicenter sample. *Nordic Journal of Psychiatry*, 68(1), 44–52. <https://doi.org/10.3109/08039488.2013.767934>.
- Catholic Church. (1994). United States of America: United States Catholic conference. Inc-Libreria Editrice Vaticana.
- Central Bureau of Statistics. (2010). Statistical Abstract of Israel, No. 61. Retrieved April 20, 2017 from http://cbs.gov.il/reader/shnaton/shnatone_new.htm?CYear=2010&Vol=61&CSubject=12.
- Chatters, L. M., Taylor, R. J., Lincoln, K. D., Nguyen, A., & Joe, S. (2011). Church-based social support and suicidality among African Americans and Black Caribbeans. *Archives of Suicide Research: Official Journal of the International Academy For Suicide Research*, 15(4), 337–353. <https://doi.org/10.1080/13811118.2011.615703>.
- Chen, Y.-J., Tsai, Y.-F., Lee, S.-H., & Lee, H.-L. (2014). Protective factors against suicide among young-old Chinese outpatients. *BMC Public Health*, 14, 372. <https://doi.org/10.1186/1471-2458-14-372>.
- Cheng, A., Chen, T., Chen, C., & Jenkins, R. (2000). Psychosocial and psychiatric risk factors for suicide: Case-control psychological autopsy study. *British Journal of Psychiatry*, 177, 360–365.

- Cole-Lewis, Y. C., Gipson, P. Y., Opperman, K. J., Arango, A., & King, C. A. (2016). Protective role of religious involvement against depression and suicidal ideation among youth with interpersonal problems. *Journal of Religion and Health, 55*(4), 1172–1188. <https://doi.org/10.1007/s10943-016-0194-y>.
- Colucci, E., & Martin, G. (2008). Religion and spirituality along the suicidal path. *Suicide and Life-Threatening Behavior, 38*, 229–244.
- Cooper-Kazaz, R. (2013). Psychiatric consultation of all suicide-attempt patients during a one year period in a tertiary hospital. *The Israel Medical Association Journal: IMAJ, 15*(8), 424–429.
- Cosar, B., Kocal, N., Arikan, Z., & Isik, E. (1997). Suicide attempts among Turkish psychiatric patients. *Canadian Journal of Psychiatry, 42*, 1072–1075.
- Dervic, K., Carballo, J. J., Baca-Garcia, E., Galfalvy, H. C., Mann, J. J., Brent, D. A., et al. (2011). Moral or religious objections to suicide may protect against suicidal behavior in bipolar disorder. *The Journal of Clinical Psychiatry, 72*(10), 1390–1396. <https://doi.org/10.4088/JCP.09m05910gre>.
- Dervic, K., Oquendo, M. A., Grunebaum, M. F., Ellis, S., Burke, A. K., & Mann, J. J. (2004). Religious affiliation and suicide attempt. *American Journal of Psychiatry, 161*(12), 2303–2308.
- Dublin, L. I. (1963). Suicide in Jewish history. In *Suicide: A sociological and statistical study*. New York: The Ronald Press Co.
- Durkheim, E. (1951). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). New York: Free Press.
- Figueiredo, A. E. B., da Silva, R. M., Vieira, L. J. E. S., Mangas, R. M. D. N., de Sousa, G. S., Freitas, J. S., et al. (2015). Is it possible to overcome suicidal ideation and suicide attempts? A study of the elderly. *Ciencia & Saude Coletiva, 20*(6), 1711–1719. <https://doi.org/10.1590/1413-81232015206.02102015>.
- Florenzano, R., Rodríguez, J., Sieverson, C., Cataldo, E., Pastorino, S., & Fernández, L. (2014). Suicidal risk, depression, and religiosity: A study of women in a general hospital in Santiago de Chile. *Asia-Pacific Psychiatry: Official Journal of the Pacific Rim College of Psychiatrists, 6*(1), 23–27. <https://doi.org/10.1111/appy.12102>.
- Gearing, R. E., Alonzo, D., Smolak, A., McHuge, K., Harmon, S., & Baldwin, S. (2011). Association of religion with delusions and hallucinations in the context of schizophrenia: Implications for engagement and adherence. *Schizophrenia Research, 126*, 150–163.
- Gearing, R. E., & Lizardi, D. (2009). Religion and suicide. *Journal of Religion and Health, 48*(3), 332–341. <https://doi.org/10.1007/s10943-008-9181-2>.
- Gould, M. S., Fisher, P., Parides, M., Flory, M., & Shaffer, D. (1996). Psychosocial risk factors of child and adolescent completed suicides. *Archives of General Psychiatry, 53*, 1155–1162.
- Greening, L., & Stoppelbein, L. (2002). Religiosity, attributional style, and social support as psychosocial buffers for African American and white adolescents' perceived risk for suicide. *Suicide & Life-Threatening Behavior, 32*, 404–417.
- Grover, S., Davuluri, T., & Chakrabarti, S. (2014). Religion, spirituality, and schizophrenia: A review. *Indian Journal of Psychological Medicine, 36*(2), 119–124. <https://doi.org/10.4103/0253-7176.130962>.
- Hackett, C., & McClendon, D. (2017). *Christians remain world's largest religious group, but they are declining in Europe*. Retrieved April 27, 2017 from <http://www.pewresearch.org/fact-tank/2017/04/05/christians-remain-worlds-largest-religious-group-but-they-are-declining-in-europe/>.
- Hassan, R. (1983). *A way of dying: Suicide in Singapore*. Kuala Lumpur: Oxford University Press.
- Hedman, A. S. (2016). Minnesota clergy's attitudes on suicide prevention and likelihood to inquire about suicidal thoughts and intent. *Mental Health, Religion & Culture, 19*(6), 565–573. <https://doi.org/10.1080/13674676.2016.1216531>.
- Hilton, S. C., Fellingham, G. W., & Lyon, J. L. (2002). Suicide rates and religious commitment in young adult males in Utah. *Journal of Epidemiology and Community Health, 155*(5), 413–419.
- Hodge, D. R. (2004). Spirituality and people with mental illness: Developing spiritual competency in assessment and intervention. *Families in Society, 85*(1), 36–44.
- Hood-Williams, J. (1996). Studying suicide. *Health & Place, 2*(3), 167–177.
- Huang, L. B., Tsai, Y. F., Liu, C. Y., & Chen, Y. J. (2017). Influencing and protective factors of suicidal ideation among older adults. *International Journal of Mental Health Nursing, 26*(2), 191–199. <https://doi.org/10.1111/inm.12247>.
- Ineichen, B. (1998). The influence of religion on the suicide rate: Islam and Hinduism compared. *Mental Health, Religion and Culture, 1*, 31–36.
- Jacobs, L. (1995). *The Jewish religion: A companion*. Oxford: Oxford University Press.
- Jahn, D. R., Poindexter, E. K., Graham, R. D., & Cukrowicz, K. C. (2012). The moderating effect of the negative impact of recent life events on the relation between intrinsic religiosity and death ideation in older adults. *Suicide and Life-Threatening Behavior, 42*(6), 589–601. <https://doi.org/10.1111/j.1943-278X.2012.00114.x>.

- Jia, C. X., & Zhang, J. (2012). Global functioning and suicide among Chinese rural population aged 15–34 years: A psychological autopsy case–control study. *Journal of Forensic Sciences*, *57*(2), 391–397. <https://doi.org/10.1111/j.1556-4029.2011.01978.x>.
- June, A., Segal, D. L., Coolidge, F. L., & Klebe, K. (2009). Religiousness, social support and reasons for living in African American and European American older adults: An exploratory study. *Aging & Mental Health*, *13*(5), 753–760. <https://doi.org/10.1080/13607860902918215>.
- Kamal, Z., & Loewenthal, K. M. (2002). Suicide beliefs and behaviour among young Muslims and Hindus in the UK. *Mental Health, Religion & Culture*, *5*(2), 111–118.
- Kaplan, S. J., & Schoenberg, L. A. (1988). Defining suicide: Importance and implications for Judaism. *Journal of Religion and Health*, *27*(2), 154–156.
- Kennedy, T. D. (2000). Suicide and the silence of scripture. *Christianity Today*.
- Khan, M. M. (2007). Suicide prevention in Pakistan: An impossible challenge? *Journal of Pakistan Medical Association*, *57*(10), 478–480.
- Khan, M. M., & Hyder, A. A. (2006). Suicides in the developing world: Case study from Pakistan. *Suicide and Life-Threatening Behavior*, *36*(1), 76–81.
- Khan, M. M., & Reza, H. (2000). The pattern of suicide in Pakistan. *Crisis*, *21*(1), 31–35.
- Khokher, S., & Khan, M. M. (2005). Suicidal ideation in Pakistani college students. *Crisis*, *26*(3), 125–127.
- Kleiman, E. M., & Liu, R. T. (2014). Prospective prediction of suicide in a nationally representative sample: Religious service attendance as a protective factor. *The British Journal of Psychiatry: The Journal of Mental Science*, *204*, 262–266. <https://doi.org/10.1192/bjp.bp.113.128900>.
- Koenig, H. G. (2009). Research on religion, spirituality, and mental health: A review. *Canadian Journal of Psychiatry. Revue Canadienne De Psychiatrie*, *54*(5), 283–291.
- Koenig, H. G., McCullough, M. E., & Larson, D. B. (2001). *Handbook of religion and health*. New York: Oxford University Press.
- Kohn, R., Levav, I., Chang, B., Halperin, B., & Zadka, P. (1997). Epidemiology of youth in Israel. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(11), 1537–1542.
- Kralovec, K., Fartacek, C., Fartacek, R., & Plöderl, M. (2014). Religion and suicide risk in lesbian, gay and bisexual Austrians. *Journal of Religion and Health*, *53*(2), 413–423. <https://doi.org/10.1007/s10943-012-9645-2>.
- Kralovec, K., Kunrath, S., Fartacek, C., Pichler, E. M., & Plöderl, M. (2017). The gender-specific associations between religion/spirituality and suicide risk in a sample of Austrian psychiatric inpatients. *Suicide and Life-Threatening Behavior*. <https://doi.org/10.1111/sltb.12349>.
- Kranitz, L., Abrahams, J., Spiegel, D., & Keith-Spiegel, P. (1968). Religious beliefs of suicidal patients. *Psychological Reports*, *22*, 936.
- Kumar, V. (2003). Burnt wives—A study of suicides. *Burns*, *29*(1), 31–51.
- Latha, K. S., Bhat, S. M., & D’Souza, P. (1996). Suicide attempters in a general hospital unit in India: Their socio-demographic and clinical profile—Emphasis on cross-cultural aspects. *Acta Psychiatrica Scandinavica*, *94*(1), 26–30.
- Lawrence, R. E., Brent, D., Mann, J. J., Burke, A. K., Grunebaum, M. F., Galfalvy, H. C., et al. (2016a). Religion as a risk factor for suicide attempt and suicide ideation among depressed patients. *The Journal of Nervous and Mental Disease*, *204*(11), 845–850.
- Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016b). Religion and suicide risk: A systematic review. *Archives of Suicide Research: Official Journal of the International Academy for Suicide Research*, *20*(1), 1–21. <https://doi.org/10.1080/13811118.2015.1004494>.
- Leavey, G., Rondon, J., & McBride, P. (2011). Between compassion and condemnation: A qualitative study of clergy views on suicide in Northern Ireland. *Mental Health, Religion & Culture*, *14*(1), 65–74. <https://doi.org/10.1080/13674676.2010.502523>.
- Lester, D. (2006). Suicide and Islam. *Archives of Suicide Research*, *10*, 77–97.
- Lester, D., & Akande, A. (1994). Attitudes about suicide among the Yoruba of Nigeria. *The Journal of Social Psychology*, *134*, 851–853.
- Levav, I., & Aisenberg, E. (1989). Suicide in Israel: Crossnational comparisons. *Acta Psychiatrica Scandinavica*, *79*(5), 468–473.
- Linehan, M. M., Goodstein, J. L., Nielsen, S. L., & Chiles, J. A. (1983). Reasons for staying alive when you are thinking of killing yourself: The reasons for living inventory. *Journal of Consulting and Clinical Psychology*, *51*, 276–286.
- Lizardi, D., Currier, D., Galfalvy, H., Sher, L., Burke, A., Mann, J. J., et al. (2007). Perceived reasons for living and index hospitalization and future suicide attempt. *Journal of Nervous and Mental Disease*, *195*(5), 451–455.

- Lizardi, D., Dervic, K., Grunebaum, M. F., Burke, A., Mann, J. J., & Oquendo, M. A. (2008). The role of moral objections to suicide in the assessment of suicidal patients. *Journal of Psychiatric Research, 42*(10), 815–821.
- Lubin, G., Glasser, S., Boyko, V., & Barell, V. (2001). Epidemiology of suicide in Israel: A nationwide population study. *Social Psychiatry and Psychiatric Epidemiology, 36*(3), 123–127.
- Malone, K. M., Haas, G. L., Sweeny, J. A., & Mann, J. J. (1995). Major depression and the risk of attempted suicide. *Journal of Affective Disorders, 34*, 173–185.
- Mandhouj, O., Perroud, N., Hasler, R., Younes, N., & Huguélet, P. (2016). Characteristics of spirituality and religion among suicide attempters. *The Journal of Nervous and Mental Disease, 204*(11), 861–867.
- Maniam, T., Chinna, K., Lim, C. H., Kadir, A. B., Nurashikin, I., Salina, A. A., et al. (2013). Suicide prevention program for at-risk groups: Pointers from an epidemiological study. *Preventive Medicine, 57*(Suppl), S45–S46. <https://doi.org/10.1016/j.ypmed.2013.02.022>.
- Mann, J. J. (2002). A current perspective of suicide and attempted suicide. *Annals of Internal Medicine, 136*, 302–311.
- Mann, J. J., Bortinger, J., Oquendo, M. A., Currier, D., Li, S., & Brent, D. A. (2005). Family history of suicidal behavior and mood disorders in probands with mood disorders. *American Journal of Psychiatry, 162*(9), 1672–1679.
- Maris, R. W., Berman, A. L., & Silverman, M. M. (2000). *Comprehensive textbook of suicidology*. New York: Guilford Press.
- Martin, W. T. (1984). Religiosity and United States suicide rates, 1972–1978. *Journal of Clinical Psychology, 40*, 1166–1169.
- Martin, T., Kirkcaldy, B., & Siefen, G. (2003). Antecedents of adult wellbeing: Adolescent religiosity and health. *Journal of Managerial Psychology, 18*(5), 453–470.
- Mason, K. E., Polischuk, P., Pendleton, R., Bousa, E., Good, R., & Wines, J. D., Jr. (2011). Clergy referral of suicidal individuals: A qualitative study. *The Journal of Pastoral Care & Counseling: JPCC, 65*(3–4), 1–11.
- Miller, L. (1976). Some data on suicide and attempted suicide of the Jewish population in Israel. *Mental Health and Society, 3*, 178–181.
- Morad, M., Merrick, E., Schwarz, A., & Merric, J. (2005). A review of suicide behavior among Arab adolescents. *The Scientific World Journal, 5*, 674–679.
- Moreira-Almeida, A., Koenig, H. G., & Lucchetti, G. (2014). Clinical implications of spirituality to mental health: Review of evidence and practical guidelines. *Revista Brasileira de Psiquiatria, 36*(2), 176–182.
- Mosqueiro, B. P., da Rocha, N. S., & de Almeida Fleck, M. P. (2015). Intrinsic religiosity, resilience, quality of life, and suicide risk in depressed inpatients. *Journal of Affective Disorders, 179*, 128–133. <https://doi.org/10.1016/j.jad.2015.03.022>.
- Nachman, R., Yanai, O., Goldin, L., Swartz, M., Barak, Y., & Hiss, J. (2002). Suicide in Israel: 1985–1997. *Journal of Psychiatry and Neuroscience, 27*(6), 423–428.
- Neeleman, J., Halpern, D., Leon, D., & Lewis, G. T. (1997). Tolerance of suicide, religion, and suicide rates: An ecological and individual study in 19 Western countries. *Psychological Medicine, 27*, 1165–1171.
- Nelson, F. L. (1977). Religiosity and self-destructive crises in the institutionalized elderly. *Suicide & Life-Threatening Behavior, 7*, 67–74.
- Ngo, R. (2014). *The Masada siege: The Roman assault on Herod's desert fortress*. Retrieved April 27, 2017 from <https://www.biblicalarchaeology.org/daily/biblical-sites-places/biblical-archaeology-sites/the-masada-siege/>.
- Nkansah-Amankra, S., Diedhiou, A., Agbanu, S. K., Agbanu, H. L., Opoku-Adomako, N. S., & Twumasi-Ankrah, P. (2012). A longitudinal evaluation of religiosity and psychosocial determinants of suicidal behaviors among a population-based sample in the United States. *Journal of Affective Disorders, 139*(1), 40–51. <https://doi.org/10.1016/j.jad.2011.12.027>.
- Oquendo, M., Waternaux, C., Brodsky, B., Parsons, B., Haas, G. L., Malone, K. M., et al. (2000). Suicidal behavior in bipolar mood disorder: Clinical characteristics of attempters and non-attempters. *Journal of Affective Disorders, 59*, 107–117.
- Ozdel, O., Varma, G., Atesci, F. C., Oguzhanoglu, N. K., Karadag, F., & Amuk, T. (2009). Characteristics of suicidal behavior in a Turkish sample. *Crisis, 30*(2), 90–93. <https://doi.org/10.1027/0227-5910.30.2.90>.
- Panczak, R., Spoerri, A., Zwahlen, M., Bopp, M., Gutzwiller, F., & Egger, M. (2013). Religion and suicide in patients with mental illness or cancer. *Suicide & Life-Threatening Behavior, 43*(2), 213–222. <https://doi.org/10.1111/sltb.12009>.
- Pescosolido, B. A., & Georgianna, S. (1989). Durkheim, suicide, and religion: Toward a network theory of suicide. *American Sociological Review, 54*(1), 33–48.
- Phipps, W. (1985). Christian perspectives on suicide. *The Christian Century*, pp. 970–972.

- Pinto, A., Whisman, M. A., & Conwell, Y. (1998). Reasons for living in a clinical sample of adolescents. *Journal of Adolescence*, *21*, 397–405.
- Plöderl, M., Fartacek, C., Kunrath, S., Pichler, E. M., Fartacek, R., Datz, C., et al. (2015). Nothing like Christmas—Suicides during Christmas and other holidays in Austria. *European Journal of Public Health*, *25*(3), 410–413.
- Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psycho-therapy: A practice-friendly review of research. *Journal of Clinical Psychology*, *65*, 131–146.
- Price, S. D., & Callahan, J. L. (2017). Religious attendance serves as a protective variable against suicidal ideation during treatment. *Pastoral Psychology*, *66*(1), 103–115. <https://doi.org/10.1007/s11089-016-0725-1>.
- Pritchard, C., & Amanullah, S. (2007). An analysis of suicide and undetermined deaths in 17 predominantly Islamic countries contrasted with the UK. *Psychological Medicine*, *37*, 421–430.
- Rasic, D. T., Belik, S. L., Elias, B., Katz, L. Y., Enns, M., & Sareen, J. (2009). Spirituality, religion and suicidal behavior in a nationally representative sample. *Journal of Affective Disorders*, *114*(1–3), 32–40. <https://doi.org/10.1016/j.jad.2008.08.007>.
- Rasic, D., Robinson, J. A., Bolton, J., Bienvenu, O. J., & Sareen, J. (2011). Longitudinal relationships of religious worship attendance and spirituality with major depression, anxiety disorders, and suicidal ideation and attempts: Findings from the Baltimore epidemiologic catchment area study. *Journal of Psychiatric Research*, *45*(6), 848–854. <https://doi.org/10.1016/j.jpsychires.2010.11.014>.
- Rassool, G. H. (2015). Cultural competence in counseling the Muslim patient: Implications for mental health. *Archives of Psychiatric Nursing*, *29*(5), 321–325.
- Retterstol, N. (1993). *Suicide: A European perspective* (R. Williams, Trans.). Cambridge: Cambridge University Press.
- Rezaeian, M. (2010). Suicide among young Middle Eastern Muslim females: The perspective of an Iranian epidemiologist. *Crisis: The Journal of Crisis Intervention and Suicide Prevention*, *31*(1), 36–42. <https://doi.org/10.1027/0227-5910/a000005>.
- Rieger, S. J., Peter, T., & Roberts, L. W. (2015). 'Give me a reason to live!' Examining reasons for living across levels of suicidality. *Journal of Religion and Health*, *54*(6), 2005–2019. <https://doi.org/10.1007/s10943-014-9893-4>.
- Robins, A., & Fiske, A. (2009). Explaining the relation between religiousness and reduced suicidal behavior: Social support rather than specific beliefs. *Suicide & Life-Threatening Behavior*, *39*(4), 386–395. <https://doi.org/10.1521/suli.2009.39.4.386>.
- Robinson, J. A., Bolton, J. M., Rasic, D., & Sareen, J. (2012). Exploring the relationship between religious service attendance, mental disorders, and suicidality among different ethnic groups: Results from a nationally representative survey. *Depression and Anxiety*, *29*(11), 983–990. <https://doi.org/10.1002/da.21978>.
- Rosato, M., & O'Reilly, D. (2015). Religion and the risk of suicide: Longitudinal study of over 1 million people. *British Journal of Psychiatry*, *206*(6), 466–470.
- Rosmarin, D. H., Bigda-Peyton, J. S., Öngür, D., Pargament, K. I., & Björgvinsson, T. (2013). Religious coping among psychotic patients: Relevance to suicidality and treatment outcomes. *Psychiatry Research*, *210*(1), 182–187. <https://doi.org/10.1016/j.psychres.2013.03.023>.
- Roye, S. (2011). Suttie Sainthood through selflessness: Pain of repression or power of devotion? *South Asia Research*, *31*(3), 281–299.
- Rushing, N. C., Corsentino, E., Hames, J. L., Sachs-Ericsson, N., & Steffens, D. C. (2013). The relationship of religious involvement indicators and social support to current and past suicidality among depressed older adults. *Aging & Mental Health*, *17*(3), 366–374. <https://doi.org/10.1080/13607863.2012.738414>.
- Sarfraz, A., & Castle, D. J. (2002). A Muslim suicide. *Australasian Psychiatry*, *10*(1), 48–50.
- Schafer, R. M., Handal, P. J., Brawer, P. A., & Ubinger, M. (2011). Training and education in religion/spirituality within APA-accredited clinical psychology programs: 8 years later. *Journal of Religion and Health*, *50*, 232–239.
- Schwartz, M., & Kaplan, K. J. (1992). Judaism, Masada, and suicide: A critical analysis. *Journal of Death and Dying*, *25*(2), 127–132.
- Shah, A., & Chandia, M. (2010). The relationship between suicide and Islam: A cross-national study. *Journal of Injury & Violence Research*, *2*(2), 93–97. <https://doi.org/10.5249/jivr.v2i2.60>.
- Shaheen Al Ahwal, M., Al Zaben, F., Sehlo, M. G., Khalifa, D. A., & Koenig, H. G. (2016). Religious beliefs, practices, and health in colorectal cancer patients in Saudi Arabia. *Psycho-Oncology*, *25*(3), 292–299. <https://doi.org/10.1002/pon.3845>.
- Shim, E.-J., & Park, J.-H. (2012). Suicidality and its associated factors in cancer patients: Results of a multi-center study in Korea. *International Journal of Psychiatry in Medicine*, *43*(4), 381–403.

- Shneidman, E. S., & Farberow, N. L. (1957). Some comparisons between genuine and simulated suicide notes in terms of Mowrer's concepts of discomfort and relief. *Journal of General Psychology*, *56*, 251–256.
- Shoenfeld, N., & Strous, R. D. (2008). Samson's suicide: Psychopathology (Grossman) vs. heroism (Jabotinsky). *The Israel Medical Association Journal: IMAJ*, *10*(3), 196–201.
- Shomali, M. A. (2008). Islamic bioethics: A general scheme. *Journal of Medical Ethics and History of Medicine*, *1*, 1.
- Sisask, M., Varnik, A., Kolves, K., Bertolote, J. M., Bolhari, J., Botega, N. J., et al. (2010). Is religiosity a protective factor against attempted suicide: A cross-cultural case-control study. *Archives of Suicide Research*, *14*(1), 44–55.
- Spoerri, A., Zwahlen, M., Bopp, M., Gutzwiller, F., & Egger, M. (2010). Religion and assisted and non-assisted suicide in Switzerland: National Cohort Study. *International Journal of Epidemiology*, *39*(6), 1486–1494. <https://doi.org/10.1093/ije/dyq141>.
- Stack, S. (1983). The effect of religious commitment on suicide: Cross-national analysis. *Journal of Health and Social Behavior*, *24*, 362–374.
- Stack, S., & Kposowa, A. J. (2011a). The effect of survivalism–self-expressionism culture on black male suicide acceptability: A cross-national analysis. *Social Science & Medicine* (1982), *72*(7), 1211–1218. <https://doi.org/10.1016/j.socscimed.2011.01.028>.
- Stack, S., & Kposowa, A. J. (2011b). Religion and suicide acceptability: A cross-national analysis. *Journal for the Scientific Study of Religion*, *50*(2), 289–306.
- Suleiman, M. A., Moussa, M. A., & El-Islam, M. F. (1989). The profile of parasuicide repeaters in Kuwait. *International Journal of Social Psychiatry*, *235*(2), 146–155.
- Szanto, K., Mulsant, B. H., Houck, P., Dew, M. A., & Reynolds, C. F. (2003). Occurrence and course of suicidality during short-term treatment of late-life depression. *Archives of General Psychiatry*, *60*, 610–617.
- Thimmaiah, R., Poreddi, V., Ramu, R., Selvi, S., & Math, S. B. (2016). Influence of religion on attitude towards suicide: An Indian perspective. *Journal of Religion and Health*, *55*(6), 2039–2052. <https://doi.org/10.1007/s10943-016-0213-z>.
- Torgler, B., & Schaltegger, C. (2014). Suicide and religion: New evidence on the differences between Protestantism and Catholicism. *Journal for the Scientific Study of Religion*, *53*(2), 316–340. <https://doi.org/10.1111/jssr.12117>.
- Turner, P. (1998). *Suicide funerals*. Retrieved April 20, 2017 from <http://www.rpinet.com/ml/2503bi1.html>.
- Vandercreek, L., & Mottram, K. (2009). The religious life during suicide bereavement: A description. *Death Studies*, *33*(8), 741–761. <https://doi.org/10.1080/07481180903070467>.
- VanderWeele, T. J., Li, S., Tsai, A. C., & Kawachi, I. (2016). Association between religious service attendance and lower suicide rates among US women. *JAMA Psychiatry*, *73*(8), 845–851. <https://doi.org/10.1001/jamapsychiatry.2016.1243>.
- Vieten, C., Scammell, S., Pilato, R., Ammondson, I., Pargament, K. I., & Lukoff, D. (2013). Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality*, *5*(3), 129.
- Witztum, E., & Stein, D. (2012). Suicide in Judaism with a special emphasis on modern Israel. *Religions*, *3*(3), 725–738.
- Wogaman, P. J. (1990). *Ethical perspectives for the community*. England: Westminster/John Knox Press.
- Wu, A., Wang, J.-Y., & Jia, C.-X. (2015). Religion and completed suicide: A meta-analysis. *PLoS ONE*, *10*(6), e0131715. <https://doi.org/10.1371/journal.pone.0131715>.
- Zhao, J., Yang, X., Xiao, R., Zhang, X., Aguilera, D., & Zhao, J. (2012). Belief system, meaningfulness, and psychopathology associated with suicidality among Chinese college students: A cross-sectional survey. *BMC Public Health*, *12*, 668. <https://doi.org/10.1186/1471-2458-12-668>.