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Religion and Suicide: Buddhism, Native American and African Religions, Atheism, and Agnosticism

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Abstract Research has repeatedly demonstrated that religiosity can potentially serve as a protective factor against suicidal behavior. A clear understanding of the influence of religion on suicidality is required to more fully assess for the risk of suicide. The databases PsycINFO and MEDLINE were used to search peer-reviewed journals prior to 2008 focusing on religion and suicide. Articles focusing on suicidality across Buddhism, Native American and African religions, as well as on the relationship among Atheism, Agnosticism, and suicide were utilized for this review. Practice recommendations are offered for conducting accurate assessment of religiosity as it relates to suicidality in these populations. Given the influence of religious beliefs on suicide, it is important to examine each major religious group for its unique conceptualization and position on suicide to accurately identify a client's suicide risk.

Keywords Religion · Suicide · Buddhism · African · Native American · Agnostic · Atheist

Introduction

Research supports the notion that suicidal behavior is influenced by one's degree of religiosity. Greater religiosity is associated with decreased risk of suicidal behavior (Gearing and Lizardi 2008; (Dervic et al. 2004; Martin 1984). In an earlier article, the authors explored the relationship between religion and suicide across four major religions in the United States (US): Christianity, Hinduism, Islam, and Judaism. That review article reported that Protestants have the highest suicide rate followed by Roman Catholics, and Jewish individuals have the lowest rates of suicide (Gearing and Lizardi 2008). Empirical evidence indicated that there are lower recorded rates of suicidal behavior among Muslims when compared to other religions, such as Christianity or Hinduism (Abdel-Khalek 2004; Ineichen 1998). Overall, however, the act of suicide is, to varying degrees, condemned

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across these four major religious traditions, and several mechanisms were explored as contributing to the protective role of these four religions, including a decrease in aggression and hostility and an increase in reasons for living (Gearing and Lizardi 2008). A client's degree of religious affiliation may serve as an effective indicator of suicide risk. Therefore, this article seeks to expand on these previous findings by exploring the relationship between suicide and religion across other prevalent world religions, specifically, Buddhism, Native American, African, as well as among Agnosticism and Atheism.

Thorough assessment of suicide risk should include an evaluation of the client's religious affiliation and commitment. Assessment of a client's religious faith and participation may indicate potential suicide risks. Such an assessment may also guide in identifying areas to target in treatment to enhance life-affirming beliefs and expectations. This review article focuses on the key risk and protective factors across other less attended to religious groups in order to inform accurate suicide risk assessment and evaluation.

Method

Peer-reviewed published articles were searched using the PsycINFO and MEDLINE databases through 2008. The keywords of religion, religious beliefs, spirituality, faith, Buddhism, Buddhist, Atheist, Atheism, Agonistic, Agnosticism, Native American, African, attempted suicide, suicide, suicide prevention, and related mapped terms were searched. The search was limited to English language journal articles. Any research studies and review articles focusing on the relationship between religion and suicide were included in this review. Bibliographies of key articles were also examined for additional articles. This review focuses on suicide rates and risk and protective factors for suicide across Buddhism, Native American, and African religions, as well as on Atheism and Agnosticism.

Results

Buddhism and Suicide

At present, Buddhism is comprised of two major communities of teachings and practices known as Theravada (or Hinayana) and Mahayana. Theravada Buddhism has been a significant religion in India, Sri Lanka, Thailand, Cambodia, Myanmar, and Laos. Mahayana Buddhism has been a major religion in China, Japan, Taiwan, Tibet, Nepal, Mongolia, Korea, and Vietnam. It is estimated that approximately 350 million individuals worldwide practice Buddhism, approximately 6% of the world population, including 2% of the United States (US) population or some 5,973,446 US residents (Kosmin et al. 2001). According to the Pew Forum's U.S. Religious Landscape Survey (2008), Buddhism is the third largest religion practiced in the United States following Christianity and Judaism.

Specific research and statistics regarding the incidence and prevalence of suicide among practicing Buddhists in the US and the world are lacking. However, the Centers for Disease Control and Prevention (CDC) (2007) report that, between 1999 and 2004, the suicide rate among the Asian American and Pacific Islander population was 5.40 per 100,000, approximately half the rate for the United States overall of 10.75 per 100,000. Furthermore, suicide was ranked as the 8th leading cause of death for all ages compared to 11th for the overall US population (CDC 2007). Elderly Asian American/Pacific Islander women have higher rates of suicide than whites or Blacks (CDC 2007). Asian American

and Pacific Islander adolescents are equally as likely as their Black, Hispanic, and White counterparts to attempt suicide (CDC 2007). While Asian Americans comprise the largest proportion of Buddhists in the US, these statistics may only provide some indications of suicide rates among US Buddhists and further research is needed to clarify this issue.

In Buddhism, life and death are a great cycle that does not end until one reaches Nirvana, the state that is characterized by the cessation of desire and suffering and epitomizes bliss and peace. Unless Nirvana is reached, death is considered just the beginning of another cycle of pain and suffering (Disayavanish and Disayavanish 2007). Buddhist doctrine teaches the Four Noble Truths, which encompass the message that life is full of dissatisfactions (Disayavanish and Disayavanish 2007). All the stages of life, birth, aging, sickness, and death are filled with want and desire, which are considered the conditions of suffering. Buddha taught that the end to a dissatisfactory life is possible only through the Noble Eightfold Path.

The teaching of the Noble Eightfold Path constitutes a process by which persons are empowered to gain control of the mind, want and desire (Keown 1998). In both Theravada and Mahayana Buddhism, the mind is considered to be the cause of both suffering and happiness. Mental states based on craving result in increased suffering and misery (Disayavanish and Disayavanish 2007). These mental states and their ensuing actions are called 'unskilful' (Dhammapada 2001). Actions that are based on contentment, termed 'skillful,' result in increased happiness (Dhammapada 2001). Accordingly, if one attempts to end suffering by taking one's life through suicide, rather than by purifying the mind through mediation and following the eightfold path, the result is rebirth into a lower level of life (Disayavanish and Disayavanish 2007) (Karmic retribution or Wheel of Suffering) and future anguish, not relief from suffering.

Furthermore, a main Buddhist principle in both the Theravada and Mahayana communities, is the principle of nonviolence, i.e., not killing or harming living beings. It is believed that Buddha was incapable of knowingly committing harm to another living being. Individuals practicing to become Buddhas must agree to abide by this principle of abstaining from harm, termed '*ahi.msa*' (Sangharakshita 1996). According to Sangharakshita (1996), killing oneself is killing a living being and is, therefore, considered a negative action that results in another form of suffering. Additionally, it is suggested that '*moha*,' or delusion, is the motivation of suicide, as suicide reflects a failure to realize that death is the ultimate suffering (Keown 1998).

It is recommended that when assessing the suicide risk of a person who practices a form of Buddhism, it is necessary to assess for that person's level of commitment to the attitude of both Theravada and Mahayana Buddhism toward suicide (Disayavanish and Disayavanish 2007). In addition, it is necessary to assess for the individual's beliefs regarding the life after death, and their commitment to the practice of meditation (Disayavanish and Disayavanish 2007).

Native American Religions and Suicide

There are 4.1 million American Indians and Alaska Natives in the United States (U. S. Census Bureau 2002). Suicide is the sixth leading cause of death among Native Americans (Andrew and Krouse 1995). The rate of suicide among the Native American population is approximately 1.7 times higher than the overall U.S. suicide rate (Indian Health Service 1998–1999).

Native American adolescent males (15–24 years of age) are the highest risk group for suicide among Native Americans, with a suicide rate approximately 2.5 times higher than

male counterparts of the same age in the general U.S. population (Wissow 2000). Over 24% of Native American youth have attempted suicide one or more times in their lives (Chino and Fullerton-Gleason 2006), with more than 16% attempting suicide in the past year (Shaughnessy et al. 2004).

Suicide is highly comorbid with substance abuse among Native Americans. Research has demonstrated that alcohol was present in 69% of all completed suicides by Native Americans (May et al. 2002). Other risk factors for suicide among Native Americans include depression, drug and alcohol use, victimization by violence (Alcantara and Gone 2007; Andrew and Krouse 1995; Chino and Fullerton-Gleason 2006), previous suicide attempts (Borowsky et al. 1999; Shaughnessy et al. 2004), friends or family members attempting or completing suicide, physical or sexual abuse, somatic symptoms, health concerns (Borowsky et al. 1999), family disruption, poor social support network, loss of ethnic/native identity, and lack of religious or spiritual identification (Alcantara and Gone 2007). For younger adult females, interpersonal conflict and partner violence are also risk factors (Olson et al. 1999).

Native Americans, consisting of over 500 federally recognized tribes representing a diverse range of indigenous languages and cultural customs (U. S. Census Bureau 2002), also represent a unique set of cultural/spiritual beliefs. While each individual tribe is governed by specific customs and traditions, this review focuses on general principles that research has identified as common across tribal communities.

Native Americans conceptualize time as a cycle rather than as linear, as do European Americans. This notion applies to human beings as well as to time. Every person cycles from birth to death. Death, therefore, is conceived of not as an end but as a beginning of new life. A new life results from either reincarnation as a human, transmigration into an animal, or a transcendent life in another world. However, it is important to note that Native Americans believe that no one can know with certainty what will happen after death (Hultkrantz and Hultkrantz 1987). Contrary to European Americans, Native Americans usually avoid the issue of death and focus more on this life than an after life (Hultkrantz and Hultkrantz 1987).

Spirituality has been posited as an important protective factor against suicidality for Native Americans (Alcantara and Gone 2007; Garoutte et al. 2003). Commitment to cultural spirituality has been shown to decrease the risk of attempted suicide (Garoutte et al. 2003). Even after controlling for age, gender, level of education, alcohol/substance abuse, and psychological impairment, Native Americans with a higher cultural/spiritual orientation had a decreased prevalence of suicide when compared to those with lower cultural spiritual orientation. Furthermore, having positive relationships with tribal leaders has consistently been shown to be a protective effect against suicidality among Native Americans (Alcantara and Gone 2007; Borowsky et al. 1999). Additionally, attention and caring from one's family, adults or tribal leaders, parental expectations and positive feelings toward school have been found to be protective factors against suicidality for female Native American youth (Pharris et al. 1997). Among male Native American youth, involvement in traditional activities, school enjoyment, academic performance, and caring exhibited by family members, adults, and/or tribal leaders were identified as protective factors against suicide (Pharris et al. 1997).

It is recommended that when assessing for suicide risk in Native American individuals, special attention should be paid during the assessment to the evaluation of the presence of comorbid alcohol and/or substance abuse. Additionally, it is important to assess the person's support network, particularly the quality of relationships with family members and tribal leaders, as well as their connection to their cultural group and/or tribe.

African Religions and Suicide

There is very little research in the area of traditional African or indigenous religiosity and suicidality. Although many world perspectives and religious denominations have been investigated relating to death and suicide, "the darkness of suicide is most pervasive in Africa" (Leenaars 2004, p. 397). An estimated 6% of the world's population or 100 million persons adhere to traditional African and African Diasporic Religions, including Candomble, Fon, Lukumi, Santeria, Shango, Vodoun (Adherents 2008). Memberships to these African religions are not necessarily based on race, ethnicity, or geographical location.

Limited research indicates that suicide rates are lower in African religions in comparison to other religious groups (e.g., Christianity or Islam) (Lester and Wilson 1988, 1990). In a study comparing the attitudes of Nigerian and American students, Yoruba ethnic students from Nigeria were found to have a more negative attitude toward and less accurate information about suicide (Canetto and Lester 1995). However, the members of the Yoruba ethnic group are predominantly Muslims, so it is not possible to distinguish findings between those Yoruba students affiliated with Islam or traditional African religious beliefs.

The influence of religion and spirituality on suicidality in Africa is not only limited by the scarcity of research, but by the profound impact of HIV. On average, individuals infected with HIV versus the general population are up to 40 times more likely to complete suicide (Jones and Dilley 1993; Meel and Leenaars 2005). Although this influence of HIV as a suicidal risk factor is declining in North American, it reportedly remains high in Africa (Marzuk et al. 1997; Meel and Leenaars 2005). Stigma relating to HIV, although on the decline, also remains a significant issue and risk factor for suicide in Africa (Mancoske et al. 1995; Meel and Leenaars 2005). Despite historical low rates of suicide in Africa, recent findings have found a steep increase in suicide in some areas, such as in South Africa (Meel 2003). Another potential confounding factor is euthanasia. Although euthanasia and assisted suicide are forbidden in many African countries, such as South Africa, there is a reported growing debate on these questions (Leenaars et al. 2001).

Due to the limited research, it is not possible to present clear guidelines for mental health practitioners working with suicidal issues among adherents to traditional African religions. However, clinicians may want to carefully assess the unique influence that such religious beliefs exert on a person's experiencing suicidality. In addition, clinicians may want to assess for related stigma issues, including HIV concerns. Finally, it is recommended that further research needs to be directed to this area. Far too few studies have investigated the beliefs regarding suicide in African religions (Canetto and Lester 1995).

Atheism, Agnosticism, and Suicidality

Research has steadily demonstrated that a person's religiosity can impact their suicidal behavior, both in terms of protective and risk factors (Gearing and Lizardi 2008). The influence of religiosity on suicidality uniquely varies for each individual, as well as differs across and within religious denominations. Consequently, in conducting suicide assessments it is recommended that a religion's influence, degree of affiliation, and the risk and protective factors for each person be evaluated. Such recommended clinical protocols should also extend to persons who do not subscribe to any religious denomination or set of beliefs, specifically those who identify as agnostics or atheists.

Determining the prevalence of atheists or agnostics is difficult, as these self-identified persons are not a congruent group or religious denomination. It is estimated that persons who identify Atheism as their religious preference represent between less than 0.5 and

2.5% of the population in many countries where much larger numbers claim no religious preference (Adherents 2008; Barrett et al. 2001). According to the American Religious Identification Survey (ARIS) (2001), approximately 13.2% of Americans defined themselves as non-religious; however, only 0.4% as atheists and 0.5% as agnostics (Adherents 2008). Thus, it is not surprising that only a few studies have investigated the influence of Atheism or Agnosticism on suicidality.

Atheists generally ascribe to a belief that there is no God, supreme power, or subsequently, no afterlife. Research in this area has tended to center on end-of-life and palliative care. In a Smith-Stoner (2007) survey of self-identified atheists found a clear and strong preference for physician-assisted suicide (PAS) and evidence-based medical interventions related to end-of-life care. Over 95% of participants supported PAS, as an important consideration in palliative care medicine (Smith-Stoner 2007). Clinicians were therefore recommended to proactively and directly address PAS and suicide issues with atheists related to suffering and end-of-life issues, as well as maintaining respect for client philosophical beliefs or non-beliefs (Smith-Stoner 2007). Research has also found that atheistic or agnostic health care professionals are more likely to favor PAS or euthanasia than religiously affiliated health care professionals (Anderson and Caddell 1993; Baume et al. 1995). Although there is exceptionally limited data on Atheism and suicide, limited research including case studies recognize that these beliefs may impact and influence life and death attitudes and decisions (Jaschke and Doi 1989).

It is recommended that mental health practitioners explore the potential impact of agnostic or atheistic beliefs may exert on a person in relation to suicidality, including attraction to death or repulsion to life. Specifically, clinicians should assess for the influence of these beliefs if the person is experiencing significant physical, psychological, or emotional pain.

Further Recommendations for Assessing the Influence of Religion on Suicidality

Although specific clinical recommendations for assessing the relationship between religious affiliation and suicidality have been offered for each religious group presented, clinical assessments require more attention as they often fail to examine the relationship between a person's religiosity and suicidality. Practice guidelines for incorporating a detailed evaluation of religiosity and its impact on clients' suicidality are offered by Gearing and Lizardi (2008). Fundamental to any thorough clinical assessment, they recommend the following general practice guidelines to be used to guide clinicians in evaluating the influence and impact of clients' religiosity on their suicide risk: (1) assess the importance of religion to the client and their identity; (2) assess the role of religiosity during previous times of stress and difficulties; (3) assess how suicide is conceptualized and perceived in the client's religion; and (4) assess the value of strengthening the client's religiosity and participation in their religion.

Conclusion

Suicidality is influenced by a number of established risk and protective factors. Frequently, the influence of religion on suicide risk is overlooked, minimized, or ignored in clinical assessments. This is problematic as research across religious traditions has consistently demonstrated an association between religiosity and suicide. Although this remains an under-investigated area that requires further research, it is essential for mental health

practitioners to examine the degree of religious affiliation and commitment of their clients irrespective of religious denomination. This review demonstrates that each religion, large or small, has a unique conceptualization of death and suicide. The specific risk and protective factors for suicide may also vary according to each distinct religion, thus, requiring mental health practitioners to incorporate individualized assessments of their clients' relationships with their identified religious groups.

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