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ORIGINAL PAPER

Influence of Religion on Attitude Towards Suicide: An Indian Perspective

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Abstract This cross-sectional survey was aimed to compare attitudes towards suicide and suicidal behaviour among randomly selected sample ($N = 172$) belonged to Hindu and Muslim religions. Data were collected through face-to-face interview. Hindus differed from Muslims regarding suicidal attempts among family ($\chi^2 = 12.356$, $p < .002$) and community members ($\chi^2 = 20.425$, $p < .000$). Our study also showed that suicidal behaviours were comparatively low among Muslim participants than Hindus. Further, Muslims hold more negative attitudes towards suicide than Hindus. An enhanced understanding of attitudes towards suicide among general population may be crucial to plan educational, intervention and prevention programs.

Keywords Attitudes · Hindu · Muslim · Suicide · Urban community

Introduction

Suicide prevention is a major public health target in the world. Suicide has been defined as a deliberate action which has life-threatening consequences, and the result of the action can be entirely predictable (World Health Organization 2004). In addition, suicide is influenced by cultural, religious, legal, historical, philosophical, socioeconomic and traditional factors (IASP 2009). A recent national study revealed that suicide death rates in India are among

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the highest in the world and most commonly occur between the ages of 15 and 29 years, especially in women (Patel et al. 2012). For instance in the year 2010, 187,000 suicidal deaths occurred in India that amount to one-fifth of all suicides in the world (Patel et al. 2012; Phillips and Cheng 2012).

Religion in India has been characterized by a diversity of religious beliefs and practices and 93 % of Indians associate themselves with a religion (Metapedia 2012). In general, religiousness influences the individuals' attitudes and actions (Shojaiizand 2005). Further, religion permeates into all aspects of one's life and it is not possible to isolate it (Mbiti 2006). Almost a century ago, Durkheim pointed out a formidable conceptualization of the link between religion and suicide (Bernice and Sharon 2007). An extensive literature indicate that religious people are considerably hold more intolerant attitudes towards suicide than less religious people (Hjelmeland 2008; Joe et al. 2007; Maimon and Kuhl 2008; Robins and Fiske 2009). There are varying attitudes towards suicide in different religions. For example, while Islamic law deems suicide a crime as grave as murder, in Hinduism, life is seen as a cycle and reincarnation is seen as part of this cycle; therefore, attitude to suicide may be more liberal (Bhugra 2010). Research also suggests that countries with large numbers of Muslims tend to have lower suicide rates (Shah and Chandia 2010). On the other hand, the Muslim population of India is the third largest in the world and gives an opportunity to compare the influence of Hinduism and Islam on the suicidal attitudes among comparable population of the two religions side by side. Therefore, the purpose of the present study was to examine and compare attitudes towards suicide among Hindu and Muslim followers. The study also investigated religion differences in suicidal attempts, suicidal thoughts among self, family and community members.

Materials and Methods

This was a cross-sectional descriptive survey carried out among the general population residing in an urban community.

In this study, households were randomly selected from the government's household registry. The sample under study was randomly selected from 1897 of 436 households in a geographically defined area of Bangalore City. The total population of this selected community was 1897, of whom 47.7 % ($n = 905$) belonged to the age group of 18–65 years. Majority ($n = 241$, 57.38 %) were Muslims followed by 39.76 % ($n = 167$) of Hindus and 2.86 % ($n = 12$) of Christians and contradicted with the 2011 census that showed majority population (80.5 %) belonging to Hindus. However, this area was selected considering logistic feasibility. House-to-house survey was conducted among 50 % of the randomly selected houses. The inclusion criteria for the present study was (a) who are above 18 years of age or older (b) individuals who had lived in the target community for at least 3 months and (c) who were willing to participate in the study. Persons who were suffering from severe psychiatric illnesses, severe physical illness and cognitive disorders were excluded. A total of 216 individuals were invited to participate in the study. However, after exclusion of individuals who refused to participate which included eight people who had attempted suicide ($n = 21$) and those who could not be reached after several home visits ($n = 23$), the final sample consisted of 172 individuals.

Data Collection Instruments

The questionnaire has two sections.

a. *Personal data* included information about the gender, age, marital status, family monthly income, education and religion of participants.
b. The attitude towards suicide questionnaire (ATTS) was used to measure participants' attitude towards suicide and suicidal behaviour (Renberg and Jacobsson 2003). The original version of the tool consisted of 61 items. The present study adopted first three items to measure exposure to suicidal problems (ideation and attempts) and suicide by self and significant others in the family and outside the family. For example: (1) Have you attempted suicide? (2) Is there anyone in your closest surroundings who have attempted suicide and who have reported suicidal thoughts, suicidal plans or has threatened to take their life? (A) In the family (father/mother, child, husband/wife, girlfriend/boyfriend). (B) Others (other relatives, friends, work- and schoolmates, others). (3) Has anyone you personally know committed suicide? (A) In the family (father/mother, child, husband/wife, girlfriend/boyfriend). (B) Others (other relatives, friends, work- and schoolmates, others).

The ATTS includes 37 statements (to measure attitude) about suicidal behaviour with a five-point Likert answering scale. The attitude items present a view on suicide; for example, "people have a right to commit suicide" and the respondents were asked to give a response on a five-point scale ranging from 1 = strongly disagree to 5 = strongly agree. The higher scores therefore represent greater agreement with the items. The reliability coefficients vary from .38 to .86 for the scale (Renberg and Jacobsson 2003). Psychometric properties of the original ATTS questionnaire have been well documented (Renberg and Jacobsson 2003; Salander Renberg et al. 2008). The ATTS is also appropriate for a wide range of population; it is not limited for use among certain age groups, people with specific cultural backgrounds or those working in certain professional disciplines (Kodaka et al. 2010).

Data Collection Procedure

Data were collected by visiting the randomly selected houses. Initially after explaining about the study and obtaining written informed consent, the head of the family was invited to participate (women in case of the absence of men) in the study. An English version of the questionnaire was used for data collection. Data were collected through face-to-face interviews at the participant's home. Despite the random sampling procedure, individuals without education and primary education and women were substantially overrepresented in our sample and could be due to the fact that data were collected during working hours.

Ethical Considerations

The ethics committee of the concerned hospital approved the study protocol. The aim and purpose of the study were thoroughly explained to all participants, and written informed consent was obtained. Participation was voluntary, confidentiality was assured, and those in need were referred for psychiatric consultation.

Statistical Analysis

The data were analysed using appropriate statistical procedures, and the results were presented in narratives and tables. Descriptive (frequency and percentage) and inferential statistics (Chi-square test) were used to interpret the data. Wherever numbers were less in a category, those categories were clubbed while doing Chi-square analysis. Prevalence of self-reported suicidal expression was classified as an affirmative response to any of the questions; i.e. all response alternatives except "never" were aggregated (Renberg 2001). The results were considered significant at $p < 0.05$.

Results

One hundred and seventy individuals responded, giving an overall response rate of 79.6 %. The majority ($n = 116$, 67.4 %) were women, and 33 % ($n = 56$) were men. Majority of the sample comprised of Muslims ($n = 104$, 60.5 %) than Hindus ($n = 68$, 39.5 %). With regard to age, 61.7 % were aged below 35 years and 82.6 % were married ($n = 142$). The mean income (Indian rupees) of the participants was Rs/- 1106 ± 7.770 (M ± SD) (Table 1).

Table 2 shows significant differences between the participants regarding their own suicidal experiences and suicidal behaviour among family and community members. Hindus significantly more often indicated suicidal attempts among family members compared to 13.5 % of Muslim participants ($\chi^2 = 12.356$, $p < 0.002$). Similarly, statistically significant differences were found between Muslim and Hindu participants with

Table 1 Demographic characteristics of the participants

Variables	Groups	Religion						χ^2-value	df	p Value
		Hindu		Muslim		Total				
		n	%	*n*	%	*n*	%			
Age	<25	12	17.6	33	31.7	45	26.2	6.526	4	0.163
	26–35	31	45.6	30	28.8	61	35.5			
	36–45	15	22.1	25	24	40	23.3			
	46–55	7	10.3	12	11.5	19	11			
	>55	3	4.4	4	3.8	7	4.1			
Marital status	Married	57	83.8	85	81.7	142	82.6	.468	2	0.791
	Unmarried	9	13.2	17	16.3	26	15.1			
	Widowed	2	2.9	2	1.9	4	2.3			
Gender	Male	24	35.3	32	30.8	56	32.6	.383	1	0.536
	Female	44	64.7	72	69.2	116	67.4			
Education	Illiterate	16	23.5	31	29.8	47	27.3	2.592	3	0.459
	Primary	33	48.5	38	36.5	71	41.3			
	Secondary	15	22.1	26	25	41	23.8			
	Graduation	4	5.9	9	8.7	13	7.6			

Table 2 Suicidal attempts and expressions among self and others

Variables	Response	Religion						χ^2-value	df	*p* Value
		Hindu		Muslim		Total				
		n	%	*n*	%	*n*	%			
Made suicide attempt	Yes	12	17.6	17	16.3	29	16.9	.050	1	0.824
	No	56	82.4	87	83.7	143	83.1			
Suicide attempt among family members	Yes	20	29.4	14	13.5	34	19.8	12.356	2	0.002*
	No	48	70.6	90	86.	138	80.2			
Suicidal thoughts among family members	Yes	23	33.8	27	25.9	50	29.1	8.801	2	0.012*
	No	45	66.2	77	74	122	70.9			
Know someone expressed suicidal thoughts	Yes	15	22	19	18.3	34	19.8	6.573	2	0.034*
	No	53	77.9	85	81.7	138	80.2			
Know someone completed suicide	Yes	21	30.8	6	5.8	27	15.8	20.425	3	0.001*
	No	47	69.1	98	94.2	145	84.3			

regard to suicidal thoughts among their family ($\chi^2 = 8.801$, $p < 0.012$) and community members ($\chi^2 = 6.573$, $p < 0.034$). More number of Hindu participants agreed sharing suicidal thoughts among family ($N = 23$, 33.8 %) and community members ($N = 15$, 22 %) compared to Muslim participants. Likewise, 31.8 % ($N = 21$) of Hindus than Muslims ($N = 6$, 5.8 %) agreed that they knew people who died of suicide in their community ($\chi^2 = 20.425$, $p < 0.001$).

Comparing attitudes related to suicide, significant difference were found between Hindu and Muslim participants. Muslim participants disagreed that "Suicide is an acceptable means to terminate an incurable disease" (65.4 %) than Hindus (42.7 %, $p < 0.058$). While majority of Hindu participants were "undecided" to a statement regarding whether "Suicide is a subject that one should rather not talk about", nearly half (47.1 %) of Muslim participants disagreed compared to Hindus ($\chi^2 = 9.327$, $p < 0.053$). Statistically significant difference was found between the Hindu and Muslim participants regarding whether "Suicide happens without warning" ($\chi^2 = 9.767$, $p < 0.045$). More number of Hindu participants (64.7 %) agreed to the above statement than Muslims ($N = 65$, 62.5 %). Muslim participants (68.2 %) agreed that "Anybody can commit suicide" (47 %, $p < 0.025$). Nearly half of the Muslim participants disagreed that "People who talk about suicide do not commit suicide" ($\chi^2 = 29.268$, $p < 0.001$) (Table 3).

Discussion

The purpose of the current study was to examine the influence of religion on general population attitudes towards suicide. The results of the present study were inconsistent with previous studies from various countries that found the rate of suicidal attempt to be higher among Hindus than Muslims (Gearing and Lizardi 2009; Rezaeian et al. 2008; Zuraida and Ahmad 2007). The present study had shown no significant difference between the participants regarding suicidal attempts. However, results of the present study showed

Table 3 Participants' responses to attitudes towards suicide questionnaire

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
It is always possible to help a person having suicidal thought	Strongly disagree/ disagree	10	14.7	13	12.5	5.581	4	0.233
	Undecided	7	10.3	7	6.7			
	Agree/ strongly agree	51	75	84	80.8			
Suicide can never be justified	Strongly disagree/ disagree	3	4.4	8	7.7	2.878	4	0.719
	Undecided	12	17.6	13	12.5			
	Agree/ strongly agree	53	77.9	82	78.9			
Committing suicide is among the worst thing to do to ones relatives	Strongly disagree/ disagree	1	1.5	3	2.9	5.081	3	0.166
	Undecided	4	5.9	16	15.4			
	Agree/ strongly agree	63	92.7	85	81.8			
Most suicide attempts are impulsive actions	Strongly disagree/ disagree	6	8.8	9	8.7	1.385	4	0.847
	Undecided	10	14.7	14	13.5			
	Agree/ strongly agree	52	76.5	81	77.9			
Suicide is an acceptable means to terminate an incurable disease	Strongly disagree/ disagree	29	42.7	68	65.4	9.112	4	0.058*
	Undecided	23	33.8	21	20.2			
	Agree/ strongly agree	16	23.6	15	14.4			
Once a person has made up his/her mind about committing suicide no one can stop him/her	Strongly disagree/ disagree	34	50	48	46.2	3.583	4	0.465
	Undecided	17	25	32	30.8			
	Agree/ strongly agree	17	25	24	23.1			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
Many suicide attempts are made because of revenge or to punish someone else	Strongly disagree/ disagree	22	32.4	29	27.9	3.873	4	0.423
	Undecided	17	25	18	17.3			
	Agree/ strongly agree	29	42.6	57	54.8			
People who commit suicide are usually mentally ill	Strongly disagree/ disagree	22	32.3	48	46.1	3.612	4	0.461
	Undecided	20	29.4	26	25			
	Agree/ strongly agree	26	38.2	30	28.9			
It is a human duty to try to stop someone from committing suicide	Strongly disagree/ disagree	7	10.3	12	11.5	7.609	4	0.107
	Undecided	11	16.2	7	6.7			
	Agree/ strongly agree	50	73.5	85	81.7			
When a person commits suicide, it is something that he/she has considered for a long time	Strongly disagree/ disagree	16	23.5	29	27.9	6.971	4	0.137
	Undecided	18	26.5	38	36.5			
	Agree/ strongly agree	34	50	37	35.6			
There is a risk of evoking suicidal thoughts in a person's mind if you ask about it	Strongly disagree/ disagree	21	30.8	26	25	2.444	4	0.655
	Undecided	12	17.6	23	22.1			
	Agree/ strongly agree	35	51.5	55	52.9			
People who make suicidal threats seldom complete suicide	Strongly disagree/ disagree	21	30.9	53	51	7.893	4	0.096
	Undecided	20	29.4	22	21.2			
	Agree/ strongly agree	27	39.7	29	27.9			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
Suicide is a subject that one should rather not talk about	Strongly disagree/ disagree	27	39.7	49	47.1	9.327	4	0.053*
	Undecided	21	30.9	15	14.4			
	Agree/ strongly agree	20	29.4	40	38.5			
Loneliness could for me be a reason to take my life	Strongly disagree/ disagree	17	25	31	29.8	1.263	4	0.868
	Undecided	12	17.6	18	17.3			
	Agree/ strongly agree	39	57.3	55	52.9			
Almost everyone has at one time or another thought about suicide	Strongly disagree/ disagree	12	17.7	29	27.9	8.868	4	0.064
	Undecided	20	29.4	18	17.3			
	Agree/ strongly agree	36	52.9	57	54.8			
There may be situations where the only reasonable resolution is suicide	Strongly disagree/ disagree	27	39.7	49	47.1	8.422	4	0.077
	Undecided	11	16.2	24	23.1			
	Agree/ strongly agree	30	44.1	31	29.8			
I could say that I would take my life without actually meaning to do so	Strongly disagree/ disagree	20	29.4	36	34.6	2.808	4	0.591
	Undecided	30	44.1	48	46.2			
	Agree/ strongly agree	18	26.5	20	19.2			
Suicide can sometimes be a relief for those involved	Strongly disagree/ disagree	28	41.1	55	52.9	4.729	4	0.316
	Undecided	15	22.1	22	21.2			
	Agree/ strongly agree	25	36.7	27	26			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
Suicides among young people are particularly puzzling since they have everything to live for	Strongly disagree/ disagree	15	22	28	26.9	2.862	4	0.581
	Undecided	26	38.2	31	29.8			
	Agree/ strongly agree	27	39.7	45	43.3			
I would consider the possibility of taking my life if I were to suffer from a severe, incurable, disease	Strongly disagree/ disagree	28	41.2	45	43.2	1.681	4	0.794
	Undecided	18	26.5	23	22.1			
	Agree/ strongly agree	22	32.3	36	34.6			
A person once they have suicidal thoughts will never let them go	Strongly disagree/ disagree	21	30.9	25	24	4.999	4	0.287
	Undecided	14	20.6	20	19.2			
	Agree/ strongly agree	33	48.5	59	58.8			
Suicide happens without warning	Strongly disagree/ disagree	12	17.6	18	17.3	9.767	4	0.045*
	Undecided	12	17.6	21	20.2			
	Agree/ strongly agree	44	64.7	65	62.5			
Most people avoid talking about suicide	Strongly disagree/ disagree	9	13.2	16	15.4	4.478	4	0.345
	Undecided	12	17.6	14	13.5			
	Agree/ strongly agree	47	69.1	74	71.1			
If someone wants to commit suicide, it is his or her business and we should not interfere	Strongly disagree/ disagree	32	47.1	49	47.1	1.391	4	0.846
	Undecided	12	17.6	13	12.5			
	Agree/ strongly agree	24	35.3	42	40.4			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
It is mainly loneliness that drives people to suicide	Strongly disagree/ disagree	14	20.6	15	14.5	8.441	4	0.077
	Undecided	18	26.5	17	16.3			
	Agree/ strongly agree	36	52.9	72	69.2			
A suicide attempt is essentially a cry for help	Strongly disagree/ disagree	7	10.3	15	14.4	3.872	4	0.424
	Undecided	18	26.5	19	18.3			
	Agree/ strongly agree	43	63.2	70	67.3			
On the whole, I do not understand how people can take their lives	Strongly disagree/ disagree	6	8.8	12	11.5	8.110	4	0.088
	Undecided	15	22.1	31	29.8			
	Agree/ strongly agree	47	69.1	61	58.6			
Usually relatives have no idea about what is going on when a person is thinking of suicide	Strongly disagree/ disagree	8	11.7	13	12.5	8.164	4	0.086
	Undecided	9	13.2	25	24			
	Agree/ strongly agree	51	75	66	63.5			
A person suffering from a severe, incurable, disease expressing wishes to die should get help to do so	Strongly disagree/ disagree	21	30.9	39	37.5	6.006	4	0.199
	Undecided	15	22.1	10	9.6			
	Agree/ strongly agree	32	47	55	52.9			
I am prepared to help a person in a suicidal crisis by making contact	Strongly disagree/ disagree	13	19.2	25	24	1.899	4	0.754
	Undecided	17	25	23	22.1			
	Agree/ strongly agree	38	55.9	56	53.9			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
Anybody can commit suicide	Strongly disagree/ disagree	25	36.7	17	16.4	11.154	4	0.025*
	Undecided	11	16.2	16	15.4			
	Agree/ strongly agree	32	47	71	68.2			
I can understand that people suffering from a severe, incurable, disease commit suicide	Strongly disagree/ disagree	24	35.3	43	41.3	7.452	4	0.114
	Undecided	15	22.1	17	16.3			
	Agree/ strongly agree	29	42.7	44	42.3			
People who talk about suicide do not commit suicide	Strongly disagree/ disagree	13	19.1	46	44.3	29.268	4	0.001*
	Undecided	36	52.9	23	22.1			
	Agree/ strongly agree	19	27.9	35	33.7			
People do have the right to take their own lives	Strongly disagree/ disagree	30	44.1	52	50	2.999	4	0.558
	Undecided	8	11.8	16	15.4			
	Agree/ strongly agree	30	44.1	36	34.6			
Most suicide attempts are caused by conflicts with a close person	Strongly disagree/ disagree	7	10.3	21	20.2	3.371	4	0.498
	Undecided	8	11.8	10	9.6			
	Agree/ strongly agree	53	78	73	70.2			
I would like to get help to commit suicide if I were to suffer from a severe, incurable disease	Strongly disagree/ disagree	24	35.3	49	47.1	2.620	4	0.623
	Undecided	12	17.6	17	16.3			
	Agree/ strongly agree	32	47.1	38	36.5			

Table 3 continued

Variable	Response	Religion				χ^2-value	df	*p* Value
		Hindu		Muslim				
		n	%	*n*	%			
Suicide can be prevented	Strongly disagree/ disagree	3	4.4	6	5.7	1.051	4	0.902
	Undecided	9	13.2	13	12.5			
	Agree/ strongly agree	56	82.4	85	81.8			

higher rates of suicidal attempts and suicidal thoughts among family members of Hindus. Similarly, more number of Hindu participants agreed that they know people with suicidal thoughts and suicidal attempts in their community. However, the Hindu scriptures are relatively neutral on the subject of suicide (Colucci and Martin 2008). Yet, there are certain circumstances under which suicide is acceptable in the Hindu religion and community. Prayopavesa is acceptable when a religious follower is suffering from a terminal illness or is unable to perform self-grooming practices or restricted to old age yogis who have no desire or ambition left, and no responsibilities remaining in this life. Although "sati" (the act of a woman's self-mutilating death by burning in her husband's funeral pyre) has been declared illegal in India, there are reports of women's death by burning occurring in the present time (Kumar 2003). On the contrary, Islam views suicide as sinful and highly detrimental to one's spiritual journey. In the present study, 65.4 % ($N = 68$) Muslim participants disagreed that "Suicide is an acceptable means to terminate an incurable disease" (42.7 %, $p < .058$). Although, followers of Islam were less likely to be accepting of suicide (Shah and Chandia 2010; Stack and Kposowa 2011), more number of Muslims than Hindus in the present study opined that suicide is a subject to be discussed. However, nearly half of Muslim followers felt that "people who speak about suicide would not commit suicide". These negative attitudes could be due to their unawareness of the complex nature of suicide.

While findings of the present study support that Islam is more effective in the prevention of suicide than other religions (Stack and Kposowa 2011), it is important to remember that religion cannot be envisaged as a singular category that can prevent individuals from committing suicide (Gearing and Lizardi 2009). Finally, findings of the present study were in line with a number of studies having found that religious factors are associated with negative attitudes towards suicidal behaviour (Colucci and Martin 2008).

The present study has certain limitations such as small sample size, cross-sectional design and sample being restrict to urban community and overrepresentation of women and Muslim followers. Further, interviewer's bias may be possible, since the data were collected through interview method. However, main strengths of this study were random sampling and community based. Further, we assessed multiple dimensions of attitudes about suicide and the influence of religion among the general population. We strongly believe that these findings may be helpful in planning suicide prevention programs for specific cultural groups. Future studies need to be conducted among larger sample size and different populations. Furthermore, qualitative studies with focus group discussions are crucial to understand the phenomena in depth.

Conclusion

In conclusion, our findings highlight important religious differences regarding suicidal attempts, suicidal ideation and attitude towards suicide among general population. Like the previous research, our study also showed that suicidal thoughts and suicidal behaviours were comparatively low among Muslim participants than Hindus. Further, the present study revealed more negative attitudes were prevalent among Muslims towards suicide and suicidal behaviour. An enhanced understanding of attitudes towards suicide among general population may be crucial to plan educational, intervention and prevention programs.

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Compliance with Ethical Standards

Conflict of interest None.

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