ago; there is also a higher risk of suicide amongst men with no religious affiliation compared with men with a religious affiliation. These data suggest, whether one believes or not in a particular religious teaching, that religious people do think differently about the meaning of life and tend to be more reluctant to consider suicide (assisted or not) as an option. Secondly, consistent with previous research, these effects are more powerful among the elderly, in whom there is a higher risk of suicide; and among women compared with men. Thirdly, the study included those taking their lives through assisted suicide. This is especially important, as it shows that trends found for unassisted suicide are also found in assisted suicide. The constraints affecting decisions to take one’s life in both situations may actually reflect individual and group predispositions for suicide including beliefs about the meaning and purpose of life; individual and group resiliency factors including religiosity; and styles of thinking that conclude suicide is a logical and rational option or not an option. This is where religious beliefs and practices, cultural beliefs and practices, individual and group processes emerge as relevant and influential factors.

This study therefore suggests that the constraints and risk factors in assisted suicide are not that different from the unassisted suicide population. We need to understand the cultural underpinnings of suicidal behaviour and thinking, attitudes to the meaning of life and what value we place on life and at what cost. The role of age, gender, religious affiliations and practice show consistent and strong associations with suicide. Investigations of environmental, personality and biological vulnerabilities should take place alongside investigations of resiliency factors. Research can then inform social policy, clinical practice and legal decisions. Research on this can also guide preventative actions, if we can disentangle the critical factors that either reduce risk or protect against suicide.

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References

Commentary: Religion, religious attitudes and suicide

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Introduction

Religion may play a significant role in the identity of an individual. A key component of an individual’s culture, religion can act both as a protector against emotional distress and also as a precipitant. The relationship between religion and spirituality on the one
hand, and between religion and mental health on the other, is multi-faceted and complex. If they practise, individuals' explanatory models of their psychological and emotional distress will be strongly influenced by their religious values. Religious beliefs and rituals can act as buffers against stress and provide an element of comfort to distressed individuals. It is inevitable that religious beliefs and values held by any individual for whom these are important will affect how help is sought and where help is sought from.

In their paper, Spoerri et al. provide some evidence that the protective effect of Roman Catholicism is slightly weaker in women. Their finding that suicide by poisoning increases with age is not surprising but its increase and relationship to those with no religious affiliation and Protestant women is interesting. The roles of gender and religious practice and degree of commitment to religious beliefs, rituals and taboos may give an insight that could help develop culturally appropriate intervention strategies. The protection provided by Roman Catholicism in older individuals is evident. However, whether these attitudes and trends continue to change over the next decade or two remains to be seen.

Attitudes to religion and suicide have changed as societies and cultures have evolved. A shift from socio-centric or collectivist societies to ego-centric or individualistic societies has been accompanied by an increase in common mental disorders. This has meant that presentation of pathology in patients has also changed.

Attitudes to certain clinical procedures may be affected by the religious beliefs. The relationship between religion and mental health can be both beneficial and negative, as are the effects of culture. Religions are not entirely homogenous, so some individuals may pick and choose only certain aspects of religious practice, and others may use all the rituals and beliefs. Formal religions may provide external support, structure and internal perceptions that can shape an affected individual’s ‘world view’ of their illness. In addition, teachings from religion do get absorbed into the individual’s inner world in the shape of moral beliefs. External beliefs and expectations of family, kinship and society will shape an individual’s response to distress and help-seeking.

Religion and suicide
Rates of suicide and suicidal behaviours vary across countries and have also changed over centuries. These variations are related to a number of factors in reporting; for example, in countries where the act of suicide is punishable by law, the reported rates are likely to be lower. Social factors, such as anomic and unemployment, are likely to be related to rates of suicide. Personal and individual factors, such as gender, age, social status, religion and other socio-demographic factors, may also play a role. The relationship between age and gender in understanding the process of suicide and suicidal behaviour is well-recognized across cultures. As religion and religious values play a key role in attitudes to depression and suicide, but not all cases of suicide suffered from depression, an interesting interaction between suicide, depression and religion, along with capacity and consent, starts to emerge. As noted above, religion can play a key role in protecting individuals. Dervic et al. found that suicidal attempts among depressed patients were less likely in patients who had religious affiliations compared with those who did not. Religious affiliations perhaps may mean many things, and thus need to be differentiated from beliefs, rituals and attitudes as well as from religiosity. Religiosity has been seen as a normal constituent of human behavioural repertoire.

In religions such as Hinduism (which is more than just a religion, but also a philosophy and a way of life), where life is seen as a cycle and reincarnation is seen as part of this cycle, attitudes to suicide may be more liberal. However, in India, the suicidal act remains punishable by law. In Islam, on the other hand, self-harm and suicide are prohibited, indicating that rates would be expected to be low. However, under these circumstances, a disclosure of suicidal thought and ideation may be artificially lower. In Christianity, attitudes to suicide vary. In the Middle Ages, the clergy believed that suicide occurred as a result of the temptations by the Devil. Suicides were buried at a distance from the community and their bodies pierced with a stake to offer protection against their malevolent souls. Over the centuries, attitudes towards suicide changed and the proportion attributed to mental illness increased. Retterstøl and Ekberg, in a comprehensive review, note that some changes have occurred in the understanding of mental suffering and attitudes of the Catholic and Orthodox churches (for example, although suicide is proscribed, the previous practice of refusal to bury and punishment have been abandoned). They highlight that a restrictive attitude to suicide in a population may increase the threshold for such acts, but, if the taboos are too strict, people who need help may not ask for it. Depending upon the severity of disorder and distress, and the level of suffering, the individual may consider suicide, as is shown in cases of physician-assisted suicide. Their religious values may well play a role in this decision and clinicians must be aware of this. The meaning of suffering due to mental or physical disorders (which may be interpreted from a religious standpoint) might also play a role in deciding whether an individual chooses suicide as the best option.

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References
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