Suicide is a relatively rare but devastating event, which challenges clinicians, public health physicians and society. As it is a relatively rare event, comprehensive studies that identify effective preventive actions are uncommon. Suicide is known to be more common amongst men, those with chronic physical illnesses including uncontrolled pain, and those with mental illnesses. Life events, social isolation, a lack of social support and meaningful employment can all add to the risk of suicide. Old age is an important risk factor for suicide, with rates gradually decreasing in the elderly but increasing in young people. The determination of suicide is a legal one and practice varies between countries; and uncertain causes of death may be overlooked. There is also little demographic information on death certificates, which makes studies of the epidemiology of suicide more difficult.

Durkheim’s study of suicide was first published in 1897 and demonstrated that suicide did not always occur because of mental illness and the primary causes of suicide were the collapse of social relationships or overpowering social relationships. Although it was not possible to infer causal relationships, he showed that the suicide rate was lower amongst Catholics and Jews compared with Protestants. A review of the literature on suicide and religion concluded that there were positive associations between religious practices (not just affiliations) and measures of mental health and well-being. The authors of this review invoke several potential mediating mechanisms: healthy behaviours and lifestyle associated with religious beliefs; increased social support; more favourable cognitive frameworks that are nurturing and help to manage distress; religious rituals help to manage distress; spiritual direction leads to a sense of certainty giving meaning to life; altered states of consciousness help to alleviate distress and anxiety; and all of these interacting at an individual and group level. Apart from the absence of prospective data and a lack of studies that investigate behaviours and attitudes, as opposed to religious affiliation alone, there were few studies that investigated suicide and religiosity.

As Shakespeare’s King Lear depicts, there are clearly constraints on suicidal behaviour that operate more generally among populations, constructed by societal beliefs and rituals around loss and tragedy. Just as cultural factors can, for example, lead to increased risks of suicide in some ethnic and racial groups, so too can some factors protect against suicide. Some religions proscribe suicidal acts, and it has long been regarded that those with these religious beliefs were less likely to actually take their lives, for example, Catholics and Muslims. In contrast, the Sati ritual found in Hinduism has been argued to perhaps portray suicide among Hindu women as a rational solution to life’s problems. Such explanations have been invoked to explain the higher suicide rates found in South Asian women reported in the early 1980s and 1990s in the UK and Indian populations all over the world. There are surprising few data on these issues.

If protective factors are found in specific religious groups, these might be shunned as being irrelevant to public health, perhaps even attracting controversy due to the powerful feelings that emerge when religious practices and contrasts in benefit are discussed. There may also be fears that such research or assertion is out of the realms of science but more in the realms of faith and politics. The ways of living, thinking and relating that are associated with religious beliefs and practices may actually benefit populations more widely without necessarily invoking religious orthodoxy or expectations of religious conversions. Cognitive behavioral therapies have flourished as secularized forms of therapy despite some origins in Buddhist philosophy.

The paper by Spoerri et al. in this month’s IJE is remarkable for three reasons. First, it shows clear associations showing a lower risk of suicide with membership of specific religious groups. Although not measuring religious practices at the individual level, the data are important given the lack of research studies. Greater protections against suicidal acts are found amongst Catholics compared with Protestants, confirming Durkheim’s findings from over a century ago.
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