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Research Paper

Association between Religiosity and Suicide Risk in Young Adults: A Study Centered on Hindu Culture

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ABSTRACT

Aim/Objective: Increasing suicide rate has become a major problem worldwide. Religiosity has been an extensively studied factor that is believed to impact suicide by many researchers. Due to inconsistent findings and lack of research in this field, this study tries to find the association between religiosity and suicide risk while also studying the association of suicide risk with five major dimension of religiosity. It also tries to find gender differences in religiosity and suicide risk. **Methods:** The sample consisted of 116 Hindus between the ages of 18-25. The data was collected both in offline and online mode. Hindi adaptation of Centrality of Religiosity Scale (CRS) and Suicide Behaviors Questionnaire (Revised) were used to collect the data. **Results:** Findings suggest a negligible correlation between religiosity and suicide. No significant gender difference was found in religiosity and suicide risk. **Conclusion:** The data found no significant association between religiosity and suicide risk in Hindus. Possible reasons include a tolerant view of suicide, multicultural influences, and diverse religious denominations. Further research is needed to understand these findings and improve coping methods for at-risk populations.

Keywords: *Religiosity, Hinduism, Dimensions of Religiosity, Suicide, Suicide Risk*

Suicide is a global public health problem. Asia accounts for 60% of the world's suicides, so at least 60 million people are affected by suicide or attempt suicide in Asia each year (Vijaykumar, 2015). The analysis of the statistics report presents us with many peculiarities, like the difference in male to female ratio in suicide, methods used in suicide, and protective factors that effect suicide. A report compiled by National Crime Records Bureau in 2021 showed that a total of 1,64,033 suicides were reported in the country during 2021, showing an increase of 7.2% in comparison to 2020, and the rate of suicides increased by 6.2% during 2021 over 2020 (Suicide Rate means Number of Suicides per One Lakh population). The overall male: female ratio of suicide victims for the year 2021 was 72.5: 27.4, which is higher as compared to year 2020 (70.9: 29.1) this indicates that the rate of male suicide increased further in India. The figure reported is the highest ever recorded in the country since the NCRB began reporting suicides in 1967. This is a legitimate source of concern. At times like these it is important to look further into the factors that affect suicide so that they can be used to predict suicide behavior and develop

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interventions. McLean et. al, mentioned many such factors like self-harm, substance misuse, affective disorder etc. Yet there are many factors which demand more attention due to lack of in-depth research about their relationship with suicide in Indian culture. One such factor is Religiosity.

According to the American Psychological Association, religiosity is defined as the extent or quality of one's religious experience. Until the 1960s, religiosity was measured by church attendance or membership. In the last two decades this has been changed and a multidimensional view of religiosity has become more prominent. Two approaches have been used to develop this view: conceptual method in which dimensions are assumed intuitively and factor analytic method in which empirical data is analyzed to determine factors which affect religious involvement most prominently (Black, 1987). Findings from many researches (King, 1967; King, 1969; King & Hunt, 1972; King & Hunt, 1975; Glock & Stark, 1965; Fukuyama, 1961; Lenski, 1961) provide significant support to the multidimensional view of religiosity.

The bulk of literature indicates that religion act as a protective factor against suicide (Dervic et al., 2004b; Lizardi et al., 2007; McCullough et al., 2001; Neeleman et al., 1997; Stack, 1983b) but there are contradictory findings where it has been found that there are aspects of religion that potentially represent a risk factor for some followers (Gearing & Alonzo, 2018). Sisask et al. (2010) in their cross-cultural study investigated the effect of high religiosity as protective factor against attempted suicide, no effects were found in India and Vietnam. Gearing and Alonzo (2018b) believed that this inconsistency is due to different ways of measuring religiosity where some measure religious affiliation and others measure religious attendance and adherence to beliefs.

E. Durkheim (2005), in his religious integration theory stated that higher integration into religious life lowers the risk of suicide. The level of religious integration is determined by the individual's adherence to shared religious belief and practices. He argued that religions prohibit suicide with approximately equal intensity so it depends on the number of beliefs the individual follow which determine the level of integration. If one religion has higher integration than the other, the former will have lower suicide rate. He stressed on the relationship between religious affiliation and suicide. Stack and Kposowa (2011) found that affiliation with Islam is associated with low suicide acceptability. They concluded that religious integration perspective has significant empirical support when it comes to suicide acceptability. Other researchers have also reported similar findings (eg. Stack, 2013) but this was only true for suicide acceptability, researchers have found no such significant association when it comes to other aspect of suicide like suicide ideation (eg. Stack & Lester, 1991b; Lawrence et al., 2015).

On the other hand, Stack (1983) proposed the theory of religious commitment. He argued that not every religious belief protects against suicide instead there are few core belief and practices like belief in afterlife, which majorly act as protective factors against suicide. In his study he found that overall suicide rate is negatively correlated with religious commitment, according to a multiple regression analysis of suicide rates from 25 different countries. Nevertheless, this association is exclusive to women, who are typically the most devout in society.

From a different perspective Network theory of suicide, proposed by Pescosolido and Georgianna (1989), argues that social support which an individual receives by associating themselves with a religious group protects them against suicide behavior. Support for this theory comes from many researches, For example., Greater church attendance was found to be related to lower suicide ideation (Stack & Lester, 1991b), religious service attendance acted as protective factor against suicidal ideation, but does protect against suicide attempts (Lawrence et al., 2015), it was also found that social support mediated the relation between public religious practice and suicide ideation and attempt (Robins & Fiske, 2009).

The major limitation of these studies is that they are heavily focused of western culture. In a meta-analysis published in 2015, Wu et al. found that the impact of religion on suicide differs depending on environment and culture. Gearing and Lizardi (2008) in their review of literature reported that there exists a limited number of researches on suicide and Hindus. Some researchers believe that albeit discouraged, Hinduism has more tolerance towards suicide in comparison to other religions due to belief in afterlife and reincarnation (Agoramoorthy and Hsu 2017; Gearing and Lizardi 2009; Hassan 1983; Ineichen 1998; Kamal and Loewenthal 2002).

METHODS

Objective

- To find the difference in religiosity score among male and female
- To find the difference in suicide risk among male and female
- To find correlation between religiosity and suicide risk
- To find correlation between different dimensions of religiosity and suicide risk

Hypothesis

- H1: Females will have higher religiosity score than Males
- H2: Males will have higher suicide risk than females
- H3: There is significant correlation between religiosity and suicide risk
- H4: There is significant correlation between dimensions of religiosity and suicide risk

Participants and sampling

The sample was collected using a convenience sampling method. This study includes a total sample of 116 young adults (18-25) from Lucknow district belonging to Hindu religion. Total sample consists of 62 males and 54 females. Data was collected using both offline (physical questionnaire) and online (google forms) methods.

Instruments

1. **Hindi adaptation of Centrality of Religiosity Scale (CRS):** CRS is a measure of the centrality, importance or salience of religious meanings in personality. It is a multidimensional measure of religiosity developed by huber. It is based on five core dimensions of religiosity which are public practice, private practice, religious experience, ideology and the intellectual dimensions, intensity of these dimensions together define the religious life of an individual. The scale contains a total of 20 items including 5 items having two versions. In the case of two version items, the higher score is chosen and the total is calculated by summing all the scores obtained. The Hindi version adapted 14 items while keeping Indian practices in mind. The

Hindi adapted version of the CRS was validated in healthy participants. The scale showed a good test–retest reliability and Cronbach's alpha was 0.95 (Grover and Dua 2019).

2. **Suicide Behaviours Questionnaire Revised:** The four items in the Suicidal Behaviours Questionnaire (SBQ) are rated on a 5-point Likert scale for item number two and a 6-point Likert scale for item number four. The answers on item number two varied from "never" to "very often." Responses to item number four ranged from "never" to "very likely." There were 6 and 5 responses to items no. 1 and 3, respectively. Total score is obtained by summing all individual items. Item 1 inquiries about past attempts and/or ideation of suicide, item 2 checks for frequency of suicide ideation in past 12 months, item 3 evaluates the threat of suicide and item 4 looks into the self-evaluated likelihood of future suicide attempts. The authors suggested a cut-off score of 7 and above to identify high suicide risk for undergraduate students. The questionnaire has been used with clinical and nonclinical populations, and ethnically diverse groups. High internal consistency (Cronbach's alpha ranged from .76 to .88) and concurrent validity (correlation ranged from .61 to .93) were reported (Osman et al. 2001) it was validated in undergraduate students, high school students, adults in psychiatric inpatient settings, and adolescents in psychiatric inpatient settings.

Procedure

The focus of the study was to investigate the association between religiosity and suicide risk in young adults. 116 sets of data were collected for the purpose of this research. Participants were fully informed about the research prior to data collection. All participants (N = 116) gave their informed consent after being assured that the information they provided would be kept confidential. Hindi adaptation of Centrality of Religiosity scale was used to asses Religiosity and its dimensions, Suicide Behaviors Questionnaire (Revised) was used to obtain data on suicide risk. Participants were thanked for their participation once the data was collected. Result was found using SPSS.

Statistical analysis

After successful collection of data, scoring was done using Excel 2016. Using SPSS version 29, the raw scores were subjected to independent sample t test analysis to analyze gender differences in variables, Pearson Product-Moment Correlation analysis was used to find association between variables and fisher's transformation was used to find differences in correlation between genders.

RESULTS

A total of 116 participants are included in this study, all belonging to Hindu religion. Their age ranged from 18-25 (*M*= 20.86, *SD*= 1.90). The total sample consisted of 54 females and 62 males. The demographic profiles of participants are presented in Table 1.

Table 1 Demographic Profile of Participants

Characteristics	***N***	**%**
Age *Mean (SD)*	20.86 (1.90)	
Gender Male	62	46.6

Characteristics	***N***	**%**
Female	54	43.4
Socioeconomic status		
High	8	6.9
Middle	100	6.9
Low	8	86.2
N	116	100

Table 2 shows that the gender differences in religiosity and suicide risk was not significant. An independent sample t test revealed that Males (*M*= 3.86, *SD*= .68) have almost similar religiosity score as females (*M*=3.73, *SD*=.69); *t*(114)= 1.04, *p*= .14, 95% CI [-.12, .39], but males (*M*= 11.10 , *SD*= 2.76) scored significantly higher in experience dimension as compared to females (*M*= 10.06 , *SD*= 2.82); *t*(114)= 2.00, *p*= .024, 95% CI [.01, 2.07] . It was also found that males (*M*= 6.53, *SD*= 4.10) have lower suicide risk than females (*M*= 7.35, *SD*= 4.00) but it was not significant; *t*(114)= -1.09, *p*= .14, 95% CI [-2.31, .68]. In case of different aspects of suicide, males (*M*= 1.94, *SD*= 1.11) have significantly lower score than females (*M*= 2.31, *SD*=1.16) only on past attempt; *t*(114)= -1.79 , *p*= .03, 95% CI [-.80, .04]. On other aspects the difference is not significant.

Table 2 Gender based comparison of Religiosity and suicide risk

	Male		**Female**				
Variables	***M***	***SD***	***M***	***SD***	**T(114)**	***p***	**Cohen's d**
Religiosity	3.86	.68	3.73	.69	1.04	.15	.195
Intellect	10.76	2.74	10.33	2.31	.89	.19	.167
Ideology	12.00	2.82	11.52	2.86	.91	.18	.170
Public Practice	11.05	3.09	11.04	3.01	.02	.49	.004
Private Practice	12.98	1.44	13.04	1.54	-.19	.42	-.036
Experience	11.10	2.76	10.06	2.82	2.00	.02*	.373
Suicide risk	6.53	4.10	7.35	4.00	-1.09	.14	-.202
Past Attempt	1.94	1.11	2.31	1.16	-1.79	.03*	-.334
Frequency	1.98	1.35	2.41	1.45	-1.63	.053	-.303
Threat	1.44	.69	1.56	.79	-.87	.19	-.162
Likelihood	1.18	1.79	1.07	1.51	.33	.37	.062

** Significant at .05 level*

Pearson Product-Moment Correlation analysis is presented in table 3. Results indicate that there is negligible correlation between Religiosity and Suicide risk, *r*(116)= -.09, *p*= .31, 95% CI [-0.27, 0.094].

Table 3 Pearson Correlation between religiosity and suicide risk

Variable	***n***	***M***	***SD***	**1**	**2**
1. Religiosity	116	3.80	.68	--	
2. Suicide Risk	116	6.91	4.06	-.09	--

Table 4 indicates that there is significant but negligible correlation between Religiosity and suicide risk in males, *r*(62)= -.26, *p* = .04, 95% CI [-0.48, -0.011]. In the case of females, table 5 indicates a negligible correlation *r*(54)= .12, *p* = .37, 95% CI [-0.15, 0.38].

Significant difference is found in correlation between male and female using fisher's transformation, z= -2.04, p< 0.05.

Table 4 Pearson Correlation between Religiosity and suicide risk in males

Variable	*n*	*M*	*SD*	1	2
1. Religiosity	62	3.86	.68	--	
2. Suicide Risk	62	6.53	4.10	-.26*	--

*. Correlation is significant at the 0.05 level (2-tailed).

Table 5 Pearson Correlation between Religiosity and Suicide risk in females

Variable	*n*	*M*	*SD*	1	2
1. Religiosity	54	3.73	.69	--	
2. Suicide Risk	54	7.35	4.00	.12	--

Table 6 shows Pearson correlation between dimensions of religiosity and suicide risk. It has been found that there is negligible correlation between intellect and suicide risk $r(116)$= -.03, p = .72, 95% CI [-0.21, 0.15], ideology and suicide risk $r(116)$= -.08, p = .40, 95% CI [-0.26, 0.1], public practice and suicide risk $r(116)$= -.08 , p = .37, 95% CI [-0.26, 0.1], private practice and suicide risk $r(116)$= .04, p = .67, 95% CI [-0.22, 0.14], experience and suicide risk $r(116)$= -.15 , p = .10, 95% CI [-0.32, 0.033].

Table 6 Pearson Correlation between dimensions of religiosity and suicide risk

Variables	*n*	*M*	*SD*	1	2	3	4	5	6
1. Intellect	116	10.56	2.55	--					
2. Ideology	116	11.78	2.83	.55**	--				
3. Public Practice	116	11.04	3.04	.58**	.65**	--			
4. Private Practice	116	13.01	1.48	.41**	.41**	.41**	--		
5. Experience	116	10.61	2.82	.50**	.67**	.67**	.41**	--	
6. Suicide Risk	116	6.91	4.06	-.03	-.08	-.08	.04	-.15	--

***. Correlation is significant at the 0.01 level (2-tailed).*

DISCUSSION

Overall research findings are very different from the bulk of the research present on the similar topic. Mean religiosity score indicates an average religiosity level for the whole sample. Results show that there are no significant gender differences in religiosity thus rejecting the first hypothesis. Loewenthal et al. (2002) suggested, in their research, that the truth about the notion of females being more religious than males depends highly on the culture and method of measurement. In Hinduism both male and female are required to take part in most of the religious activities, this can be accounted as one of the reasons behind the finding of this research. On the other hand, differential gender Socialization has been one of the reasons used to explain the gender differences in religiosity (Walter & Davie, 1998), Miller and Stark in 2002 indicated the lack of empirical evidence on this view and proposed a risk priority model to explain the gender differences in religiosity. Their study found that males considered being non-religious as risk taking behavior. They suggested that physiological preference for risky behavior is the reason behind males being less religious than females. The findings of this study can be explained in context with changing dynamics of society where females are becoming more independent, engaging in outdoor activities,

having very similar gender roles and rights as males thus also having almost equal level of religiosity.

Similarly, no statistically significant gender difference was observed for suicide risk thus rejecting the second hypothesis but results indicate that females scored significantly higher in past attempt aspect as compared to males. This supports the finding of Lewinsohn et al. (2001) who reported that females have high incidence rate for suicide in adolescence but this gender difference diminishes in young adulthood. Although results from this study suggest similar levels of suicide risk between both genders, we cannot ignore the constant growing number of male suicides across globe and in India as well. More in depth research is needed in this area to better understand the factors affecting it, especially in the case of young adults as most of the research, concerning this area, are on adolescents.

The major purpose of this study was to find the association between religiosity and suicide risk while also studying its association with five major dimensions of religiosity in Hindu population. While there is a significant difference in correlation between both genders, the overall finding indicate that negligible correlation exists between religiosity and suicide risk hence the third hypothesis is rejected. Similar findings are obtained when checking for association between the dimensions of religiosity and suicide risk as a consequence the fourth hypothesis is rejected.

This is contradictory to many researches conducted on religions of western countries. One of the reasons behind this finding could be the lack of strict criticism against suicide in Hinduism, as mentioned by Ineichen (1998) in his study where he compared Islam and Hinduism's influence on suicide. Theory of religious integration, proposed by E. Durkheim (2005), is based on the principle that religion strictly abolish suicide and thus reduce its risk but in Hinduism the belief in afterlife, rebirth and immortality of soul might result in more tolerant view towards suicide as compared to other western religions. Also, acceptance of practices like Prayopavesa/Praya (fasting till death), mentioned in Manusmriti in part 6 verse 31 and 32, adds support to this view. From a different perspective, network theory of suicide proposes that the social support gained from associating oneself to religion and participating in different public practices act as a protective factor against suicide. Results from this study indicate a higher score on private practices as compared to public practice which is a common occurrence in Hinduism as it is not necessary to regularly attend temples and it is also very common to build a temple at home unlike other religions. For example, in Islam frequently attending prayers in mosques is recommended in the Quran (al-Baqarah 2:43). Similarly, it is considered very important to attend church in Christianism.

Findings from this research is consistent with some other researches that also found no association between religiosity and suicide (Hills & Francis, 2005; Wingate et al., 2005; Ames et al., 2018). Ellison et al. (1997) suggested that religious homogeneity or the extent to which community residents follow to a single religion or a small number of faiths is inversely associated to suicide rate. Keeping in mind the multiculturalism in India and the number of religious denominations in Hinduism, the association between religiosity and suicide risk may become ambiguous.

There are also some limitations in this study. The sample of this study comes from an urban area of India. It only consists of young adults belonging to mostly middle-class families. Caution should be taken while generalizing the results to other areas of India and other age

groups. Furthermore, this study was conducted only on Hindu subjects, keeping in mind the diversity of India similar study should also be conducted on other religions as well.

The present finding indicates the need to further study the association between religion and suicide in India, especially in subjects with serious suicide attempts. Future studies can look into the impact of religion on suicide in minority groups as well as other religions present in India. Studies should also be conducted on different age groups to account for any age-based differences. Findings from these studies will aid authorities in creating a better preventive approach towards suicide while also providing relevant information needed to improve religion based coping approaches.

CONCLUSION

The data revealed that there is no significant correlation between religiosity and suicide risk in Hindus. There can be multiple reasons behind this finding like more tolerant view towards suicide, effect of multiculturalism, presence of high number of religious denominations and many more. This indicates the need for further research on this topic to better understand the mechanism and factors that contributed to this finding. Such findings can be used to improve religion based coping methods and help in identifying the population at risk.

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Conflict of Interest

The author(s) declared no conflict of interest.

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