Diversity and Equality in Health and Care 2014;11:277–9

Did you see?

Kleiman EM and Liu RT (2014) Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *British Journal of Psychiatry* 204(4):262–266. doi:10.1192/bjp.bp.113.128900

Cook CC (2014) Suicide and religion. *British Journal of Psychiatry* 204(4):254–255.

Dr Chris King MRCPsych
Locum staff grade officer, CAMHS, Leicester Partnership NHS Trust, Leicester, UK

Two papers recently published in the *British Journal of Psychiatry* 204(4) explore the issue of faith and self-harm. In a prospective study, Kleiman and Liu (2014), describe the relationship between frequent religious service attendance and suicide in adult US citizens. An accompanying editorial (Cook, 2014) highlights some of the findings of the study, and discusses some of the issues raised.

Kleiman and Liu aimed to determine whether individuals who frequently attended religious services were less likely to die by suicide than those who attended less frequently. The data analysed were from a sample collected in the US between 1988 and 1994, with follow-up mortality data up until 2006. In a sample of 20 014, 25 people were known to have died from suicide over the study period. The study found that those who attended religious services 24 times a year or more were 67% less likely to die by suicide compared to those who attended less frequently. The study concluded that frequent attendance at religious services is a long-term protective factor against suicide. Kleiman and Liu discuss how religious service attendance is one component of religiousness, that religiousness acts as a buffer to suicide, and that the theories on why this is so include the protective social network religion provides, and the deterrent of religious prohibitions on suicide.

In the editorial, Cook (2014) highlights the significance of this research, as the first prospective study of religious service attendance and completed suicide. While he highlights the modest power of the study, given the lower-than-expected suicide rate in the sample, Cook focuses on the positive effects of religion, stating that 'the overall balance of findings is thought by many to reveal a benefit for religious beliefs and practises in relation to mental health and physical wellbeing'. Cook also states that 'whatever kinds of religious service the individuals attended, we know that the teachings and traditions to which they were exposed would have particular implications for anyone contemplating suicide'. Cook argues that there is a body of evidence which confirms lower levels of suicidal ideation and behaviour among those who are religious.

Kleiman and Liu (2014) recognise some of the limitations of their study. One major limitation is the modest sample power due to the small number of suicides seen; 25 in a sample of 20 014 between 1988 and 2006. This should not have been unexpected, given the source of the data, which was the Third National Health and Nutrition Examination Survey (NHANES III) carried out by the National Center for Health Statistics (NCHS) (1994). The original study focused on the assessment of health and nutritional status of adults and children in the US, and its goals included the need for descriptive information about the health status of selected population groups of the United States, so some population groups were oversampled in proportion to the national distributions. A total of 30% of the study sample were Mexican-American and another 30% were black American (these groups comprising 5% and 12% respectively of the general population) (NCHS, 1994). This is significant when considering suicide risk, given the much lower risk of suicide in these groups, less than half that of white American and Native American peoples, as reported by the Centers for Disease Control and Prevention (2014). A larger number of elderly people were also selected for NHANES III (20% of the study sample, compared to 16% of the general population). In addition, the sample was selected from the 'civilian, non-institutionalized' population (NCHS, 1994), presumably excluding those who were in psychiatric hospitals, prisons, or serving in the armed forces.

The subjects of the NHANES III study were required to understand and sign a consent form for physical health assessment, and undergo assessment by examination and investigations. The examination period lasted up to three and a half hours, with extra

efforts being made to ensure participation by subjects; 'techniques included appealing to the subject person's sense of responsibility and community spirit' (NCHS, 1994). It seems likely that these selection techniques would exclude those subjects with a higher risk of mental health disorders, and select those who were more community-minded, and possibly more likely to be religious. While this may have been thought to be acceptable for a study examining health and nutritional status, if these methods were used primarily for recruiting subjects for study of mental health issues, it potentially raises ethical issues about how coercive recruitment techniques may have been used.

Apart from the frequency of attendance of religious services, nothing else was known about the religion of any of the participants in the study, including religious affiliation, beliefs or any other markers of religiosity. It is also difficult to interpret the results when considering the diversity of the group described as 'less frequent attenders at religious services' as defined by those attending religious services less than 24 times a year. This would include those who attended services between 0 and 23 times a year, those who worship in their own way at home, those who believe in a god but are not religiously active, as well as atheists and agnostics.

Given the low power of the study, the fact that nothing is known of the religiosity or faith tradition of the participants or their mental health status (except for the presence of affective disorders at baseline), it is difficult to draw conclusions about the general population from the results and assert that there are implications for practice.

The reasons that any individual might be more or less likely to kill themselves are multiple and complex, and would include the circumstances, beliefs, sexuality and lifestyle of the individual, how much their beliefs fit in with the community around them, as well as religious attendance and other factors related to religion. In a European context, migration and citizenship status are also issues (see Borrill *et al*, 2010; Montesinos *et al*, 2013), as they may be in the US although not mentioned in these papers. Those who attend religious services frequently tend to do so for several reasons; some cultural, to adhere to requirements of their faith, and also because they find attending a source of comfort. While religious attendance may be protective for those individuals who do attend, it is difficult to argue convincingly that the protection extends to others, and it would be difficult to perform a study with the hypothesis that the presence of religion in a community can increase the risk of suicide in those who do not attend religious services, through a sense of alienation, rejection or condemnation.

Without linking suicide to mental health disorders, one could also question the value of performing a study linking suicide and religious service attendance. The articles make no mention of those who committed suicide due to chronic and severe pain or increasing disability. In the absence of religious beliefs or mental illness, suicide would neither be a sin, nor the result of pathological thinking. Perhaps, in a person who is competent and with capacity to make decisions, suicide could be considered as a valid and reasonable choice in certain circumstances. Without considering this, a study examining the link between religion and suicide is perhaps focusing on something that is ultimately nonsensical; what is being studied is how much people who do not believe in a religion comply with its values and beliefs.

Professor Cook's declaration of interest in his editorial, that he is an Anglican Priest and Director of the Project for Spirituality, Theology and Health at Durham University, perhaps entitles him to comment on the study from a pro-religious viewpoint. Kleiman and Liu (2014) make no such declarations so it is difficult to know how much their own beliefs lead to such a strong conclusion being drawn from the data when a more cautious interpretation may be more appropriate.

The articles highlight interesting points, including the importance of considering cultural and spiritual background when assessing suicide risk in patients, but it is difficult to uncritically accept the study to be strong evidence in support of religious service attendance as a protective factor against suicide. It might also be argued that authors should declare their own cultural or faith position when discussing matters of a moral or ethical nature.

DECLARATION OF INTEREST

The author is an atheist.

REFERENCES

Borrill J, Fox P, Roger D (2010) Religion, ethnicity, coping style & self reported self harm in a diverse non clinical UK population. *Mental Health Religion & Culture* 14(3):259–69.

Centers for Disease Control and Prevention (2014) *National Suicide Statistics at a Glance Suicide Rates Among Persons Ages 25–64 Years, by Race/Ethnicity and Sex, United States, 2005–2009.* Available at: www.cdc.gov/violence_prevention/suicide/statistics/rates04.html (accessed 03/06/2014).

Cook CC (2014) Suicide and religion. *British Journal of Psychiatry* 204(4);254–5.

Kleiman EM, Liu RT (2014) Prospective prediction of suicide in a nationally representative sample: religious service attendance as a protective factor. *British Journal of Psychiatry* 204(4):262–6.

Montesinos AH, Heinz A, Schouler-Ocak M, Aichberger MC (2013) Precipitating and risk factors for suicidal

behaviour among immigrant and ethnic minority women in Europe: A systematic review. *Suicidology Online* 4:60–80. www.suicidology-online.com/pdf/SOL-2013–4–60–80.pdf (accessed 10/06/2014).

National Centre for Health Statistics (1994) Plan and Operation of the Third National Health and Nutrition Examination Survey, 1988–94. *Vital and Health Statistics Series 1: Programs and collection procedures* 32:1–407.

ADDRESS FOR CORRESPONDENCE

Dr Chris King, Westcotes House, Westcotes Drive, Leicester, LE3 0QU, UK. Email: chrisking@doctors.org.uk