Spring 2024

The Effects of Affiliation, Proximity to Suicide, and Religiosity on Suicide Acceptance

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THE EFFECTS OF RELIGIOUS AFFILIATION, PROXIMITY TO SUICIDE, AND RELIGIOSITY ON SUICIDE ACCEPTANCE

A Thesis Presented to the Graduate Faculty

of Fort Hays State University in

Partial Fulfillment of the Requirements for

the Degree of Master of Science

by

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Date 4/26/24

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ABSTRACT

As suicide becomes increasingly more prominent in the lives of people, research is being conducted to investigate causes, prevention, and even opinions on the topic. The impact of religious affiliation and religiosity on people's acceptance of suicide was investigated in the current study. This was examined by using The Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003), the Semantic Differential Scale Attitudes Towards Suicidal Behavior (SEDAS; Jenner & Niesing, 2000), and the Proximity to Suicide Scale (PSS; self-constructed). Results indicated that a higher religiosity score was correlated with a more understanding viewpoint of an attempted/committed suicide. Results also showed that the closer someone is to an attempted/committed suicide, the more understanding they are of the attempt/committed suicide. However, it was found that there was no significant difference between the different religious affiliations regarding perception of suicide. Few studies—certainly not those carried out in the United States—address all four issues at once, therefore the current study fills a gap in the body of knowledge. The results of this study are important since suicide is stigmatized in many religions and because a large number of people in society experience suicidal thoughts.

Keywords: religion, suicide, proximity to suicide, perception of suicide

ACKNOWLEDGEMENTS

This thesis was made possible with the assistance, advice, and support of numerous persons. A special thank you to my advisor, Dr. Carol Patrick, who was able to help me through several challenging situations. Thanks also to Dr. Whitney Whitaker, Dr. Brooke Mann, and Dr. Eugene Rice, who reviewed my thesis and made recommendations along the road.

I also want to thank my cohort, particularly Beatrice, Rhian, and Savana. You've all made the last few years fun and thrilling. Finally, I'd want to thank my parents for their unending support and love, which has enabled me to be here today.

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INTRODUCTION

Every year, approximately 703,000 people commit suicide, with many more attempting to do so. Every suicide is a tragedy that impact families, towns, and entire countries. This is especially true for the people who are left behind. Suicide can occur at almost any age and was the fourth highest cause of death among 15 to 29-year-olds worldwide in 2019 (World Health Organization, 2021). As suicide continues to be a major issue in society, recent studies aim to examine its causes, prevention, and stigma. The theory of stigma developed from Goffman's (1963) book *Stigma: Notes on the Management of Spoiled Identity* serves as the foundation for the concept of suicidal stigma, and the current study. Goffman defines stigma as a social aspect that affects everyday interactions. Those who are stigmatized may avoid engaging with those who do not share their stigma, while those who are not stigmatized may dismiss or ignore stigmatized individuals. According to Goffman (1963), most persons face stigma at some point in their lives. Goffman's definition of stigma includes discredited attributes such as "tribal stigmas" (race, ethnicity, and religion), "physical deformities" (deafness, blindness, and leprosy), and "blemishes of character" (homosexuality, addiction, and mental illness). This theory aids in laying the framework and providing an insight of how suicide participants are perceived.

In a viewpoint concentrating also on stigma, Nakash and associates (2019) examined the obstacles that clients in community mental health clinics, both religious and non-religious, reported facing when seeking mental healthcare. Participants most frequently mentioned stigma surrounding mental health care and hurdles related to prior poor experiences with mental health treatment. Clients who identified as religious indicated more mistrust of health care systems and increased anxiety about the social stigma attached to obtaining treatment. Such religious stigma forms the underlying structure for many religious perceptions of suicide. The current study

examined how suicide is perceived based on religious affiliation, religiosity, and proximity to the suicidal act. Such variables were tested based on hypothesis that those with lower religiosity would have more understanding and accepting viewpoints of suicide, those with higher religiosity would have more condemning viewpoints of suicide, as well as hypotheses regarding proximity to suicide and differences in religious groups.

Religious Affiliation

Current research being conducted on the causes, prevention, and stigma of suicide seek to find the connection between religious diversity and mental health. A meta-analysis of longitudinal studies has indicated that there is a connection between spirituality and religion and mental health, one where spirituality and religion affect mental health positively (Garssen, 2021).

Specifically within a small population of Filipino America Catholics ($N = 12$), Alviar and Prado (2022) found that the participants' diverse experiences had an impact on their mental health in both positive and negative ways. Participants mentioned seeking support initially from family, friends, and their Catholic faith, before turning to prayer and other religious rituals for relief. Participants' Catholic identities and experiences also left them feeling confined by the stringent and rigid traditions of Catholicism, as well as guilt and shame from Church leadership or Catholic family members (Alviar & Prado, 2022). Thus, it can be assumed that religion and spirituality have an impact on mental health, whether it be positive or negative.

As the current study focuses on suicide and its perception, research has also explored and found that religious affiliation can affect perception of suicide. Religion is found to be extremely prevalent in suicidal thoughts and prevention, as indicated by Akotia and associates (2014). This study focused on Ghanaians who have tried suicide and who have evaluated their attempts in light of their identification with a particular religion. Results indicated that many reacted to their

attempt in a way that reverberated with their religion, and they sought forgiveness from God. However, some responded negatively to God, expressing resentment and disappointment.

Furthermore, religious affiliation has been found to relate to perceptions of suicide, based on stigma within each denomination. A broad study (Moore, 2015) evaluated the suicide rates in several nations throughout the world for the years 2000, 2005, and 2008. The findings showed that in some nations, higher levels of religious heterogeneity were associated with a higher suicide rate. The conclusion could be drawn that since there is no shared religious ideology in nations lacking it, some people may turn to suicide as a coping mechanism for the breakdown in social order. Similarly, Gearing and Alonzo (2018) have revealed that those across cultures and religions have distinct rates of suicide and acceptability of suicide. Suicide is often condemned by all major religions; however, each religion includes helpful coping techniques for avoiding suicidal attempts and ideation. Information used by the researchers was gathered from studies published more recently, between the years of 2008 and 2017 (Gearing & Alonzo, 2018).

Some investigation has been done on religion and suicide within specific religious denominations. The purpose of a Swedish study (Torgler & Schaltegger, 2014) was to determine whether suicide rates and acceptability would be similar, due to some aspects of Protestantism and Catholicism starting to converge. It was discovered that Catholics had lower suicide rates and a lower acceptance of suicidal ideation than Protestants. Although many studies focus on major Christian religions, the stigma theory associated with suicide can be found in all religions. One such study evaluated the comparison of religion in those who had committed suicide and a living control group of Chinese rural youth (Zhang, Dong, & Lester, 2022). The results found were that there was only a statistically significant difference of suicides in those who were male and had a belief in religion. The purpose of this study was not only to determine the suicide rates

of religion in general, but to compare and contrast the beliefs of those who had passed from suicide and those who were alive.

Theological Influence

The Roman Catholic Church's contempt for suicide is widely recognized, and its long-standing prohibition on funeral ceremonies for those who have committed suicide has been the most prominent manifestation of this for many years. As a result, an examination of the evolution of the teaching and norms of canon law on the subject will allow for a deeper awareness of the Catholic Church's position today, which influences the behavior of a billion of its followers. A theological perspective is essential when discussing suicide both within and outside of the religion community. Identifying and comprehending the basic Judeo-Christian arguments against suicide is the appropriate beginning point for people to grasp how Christianity has approached the subject. These are not new readings of Scripture, but firmly held truths of the Christian faith that have existed since the founding of Christianity.

The historical teachings of suicide within Roman Catholicism come from sources such as the Bible, religious doctrine, and writings of church leaders. Within the Bible, two such instances are usually quoted regarding the stance on suicide. This includes, “Thou shalt not kill” (Ex. 20.13, Deut. 5.17) and, “You have heard that it was said to your ancestors, ‘You shall not kill; and whoever kills will be liable to judgment.’” (New Revised Standard Version Catholic Bible, 2020, Mt. 5.21). Suicide, the killing of oneself, is then considered a violation of this commandment.

However, Augustine, one of the most important Fathers of the Western Church, supplied Catholic Christianity with a deliberate analysis on suicide and its complete condemnation under all conditions. His rationale was most likely influenced by both Christian and Platonic ideas: the wish to exist is the only way for humans to achieve true happiness, and affirming suicide implies

that a particular existence is useless (Adamiak & Dohnalik, 2023). In his work *The City of God* he states,

> That in no passage of the holy canonical books there can be found either divine precept or permission to take away our own life, whether for the sake of entering on the enjoyment of immortality, or of shunning, or ridding ourselves of anything whatever. Nay, the law, rightly interpreted, even prohibits suicide, where it says, “Though shalt not kill.” This is proved especially by the omission of the words “thy neighbor” (426/2015, bk. 1, ch. 20)

The only path to true happiness for humans is the drive to live, and affirming one's own death implies that one is devaluing one's own existence (Adamiak & Dohnalik, 2023). Before Augustine’s declaration on suicide, the moral status of the issue was not deliberately considered. Augustine’s writings set the tone for the future of doctrine and opinion for the Catholic Church on suicide.

Thomas Aquinas continued Augustine’s teachings on suicide throughout the thirteenth century. He defined suicide as a serious transgression against the values of justice and charity as well as the Fifth Commandment (Adamiak & Dohnalik, 2023). First and foremost, it is everyone's natural right to cherish and protect their life. Second, the death of a member of the human community causes harm to the community, making suicide a crime against it. Thirdly, it is a transgression against God, who is the only one permitted to take human life and who bestowed it to us (Aquinas, 1736/1947).

After the split from the Roman Catholic Church per Martin Luther’s 95 Theses, there were differences in doctrines between the Catholics and the Protestants surrounding the afterlife and the distinctions in sin. Suicide, according to the Roman Catholic Church, is a deadly sin that condemns a person to Hell. According to doctrine, mortal sin exists. Catholics distinguish between two degrees of sin: deadly and venial. Venial sins are offenses, according to the

Catholic Catechism (2000), however they are not violations defined by the mortal law. Therefore, venial sins do not endanger one's everlasting salvation, break one's connection with God, or remove one from a condition of grace. However, sins that are mortal do. They are serious offenses that are carried out with full knowledge and intentional consent (Catholic Church, 2000). While acknowledging that suicide is a sin, the Protestant denominations do not prioritize one sin above another. While every sin is equally unacceptable to God, they can all be pardoned thanks to Jesus' atoning death. Even in cases where a Christian commits suicide, the majority of Protestants and many Evangelical Christians do not think that a Christian can lose their salvation. Suicide is a sin among many, but it does not absolve one from Jesus' sacrifice on the cross. There is no division or difference based on sin (Potter, 2021). Therefore, the cost of suicide and the resulting loss of the afterlife is greater for Catholics than for Protestants. The clear impossibility of successfully confessing and being absolved of a suicide enhances the "price" of suicide in Catholicism in comparison to all other sinful options.

Similarly, Protestants and Catholics both believe in the afterlife, the Last Judgment, the reward of the righteous, and repercussions of the evil. But their opinions on what these repercussions mean are very different. In the context of all of their religious depictions, the concept of hell is far less tangible, sentient, and significant. According to Catholic doctrine, a person who passes away in a state of grave sin will experience tortures of which his physical sufferings throughout this life are only a prelude. After death, the wicked are not only destroyed; they will burn forever. Protestant churches have differing views between them about what happens to sinners after they die (Torgler & Schaltegger, 2014).

In accordance with its teaching about sin and the afterlife, he Roman Catholic Church states that taking one's own life on purpose without repentance results in eternal damnation. In the event that someone deliberately and consciously decides to end their life, they are still seen

as being in a state of mortal sin rather than grace (Potter, 2021). Following the 1545–1563 Council of Trent, numerous liturgical regulations were created in an effort to reform the Catholic Church. A list of those who should not be allowed to have a Catholic funeral was part of one of the rituals. These individuals included non-Catholics, public sinners, victims of duels, and those who committed suicide if they had not made any sort of prior atonement (Adamiak & Dohnalik, 2023). Furthermore, the Baltimore Catechism was taught to Roman Catholics who underwent religious instruction and/or attended a Catholic school prior to 1965. Catholics who were brought up according to the Baltimore Catechism were taught that the act of suicide is a mortal sin since it goes against God's will and the fifth commandment (Potter, 2021). These choices were made based on the accumulation of the teachings in the Bible, the interpretations from Church fathers such as Augustine and Aquinas, and the understanding of sin on the soul and its repercussions in the afterlife.

The Second Vatican Council, which concluded in 1965, brought about changes to a number of elements of Catholic doctrine and practice. In 1978, new funeral customs were released, which did not include suicides (Adamiak & Dohnalik, 2023). As declared in the encyclical Evangelium Vitae, or The Gospel of Life, by Pope John Paul II,

> Suicide is always as morally objectionable as murder. The Church's tradition has always rejected it as a gravely evil choice. Even though a certain psychological, cultural and social conditioning may induce a person to carry out an action which so radically contradicts the innate inclination to life thus lessening or removing subjective responsibility, suicide, when viewed objectively, is a grave immoral act (1995, para. 66).

Pope John Paul II maintains the conventional view that suicide is a mortal sin, but he also points out that psychological issues or conditioning may influence the final decision, rendering it less of a mortal sin. This is mirrored in the teachings of the Catholic Catechism, which Pope John Paul

II revised in 1992. It makes note that, “Grave psychological disturbances, anguish, or grave fear of hardship, suffering, or torture can diminish the responsibility of the one committing suicide (CCC, 2000, para. 2282). Therefore, the following concisely sums up the Roman Catholic Church's current position: Most people believe that psychiatric issues lead to suicide, which severely restricts moral responsibility. However, Augustine's teaching against suicide holds true if the act was intentionally perceived as good, such as a great and noble deed.

However, it appears that there is still a misunderstanding between what the Church teaches and how the community views suicide. The fact that psychology is still in its infancy, according to Catholic Answers theologian Joe Heschmeyer (personal communication, January 31, 2024), explains why there is such a disconnect between Catholic teachings and community opinions. The majority of psychological therapies in the past were only available to patients with severe conditions like schizophrenia and mania. Suicide is still viewed negatively as many of the older generations who are instructing the younger generations have these misunderstandings of psychology and mental health.

Religiosity

Although religious affiliation can help govern one’s mental health and impression of suicide, religiosity (church attendance and time spent on religious activities) also has a large effect. According to Haney and Rollock (2020), higher degrees of religiosity were connected with better mental health outcomes above and beyond demographic and personality variables, whereas religious doubt was associated with poorer outcomes.

In contrast to a Swedish study (Torgler & Schaltegger, 2014), a different study involving South Korean participants found that Protestantism, regular religious attendance, and a higher value of religion to the participant, were all linked to lower levels of suicide acceptability (Jung & Olson, 2014). This was sought through evaluating two factors: (1) if religious variables

affected suicide acceptability as well as attitudes and norms surrounding the acceptability of suicide; and (2) whether religious variables reduce the otherwise considerable effects of stress on suicide acceptability. These considerations were undertaken in the categories of Catholics, Protestants, Buddhists, and religious none's. Like other research, this one discovered a relationship between lower levels of suicide acceptability and Protestantism, religious attendance, and importance of religion.

Studies with a larger number of participants who were from many different cultures have found similar results. A large study (N>80,000), with participants representing 60 different countries, found that those with a higher positive level of religiosity had not only lower suicide rates, but also more condemning attitudes towards suicide (Saiz et al., 2021). The results of another study (N>50,000 in 56 nations) indicated that those who were affiliated with one of four major faiths, religiously committed, and engaged with a religious network had lower suicide acceptability (Stack & Kposowa, 2011). Additionally, it was the first study to compare all four perspectives on religion and suicide. One study was even conducted across 11 Muslim specific countries (N>7000). Across the 11 countries, religiosity was negatively correlated with the acceptance of suicide but positively correlated with punishment after death. Both directly and indirectly, by its association with views about suicide, particularly the notion that suicide is acceptable, religiosity was negatively related with ever having suicidal ideation (Eskin et al., 2020).

As a more positive level of religion predicts a more condemning view towards suicide, it is found by Abdel-Khalek and Singh (2019) that this positive level of religion also reduces suicide. This was examined within a group of Indian college students. It indicated that there were

statistically significant and positive correlations between love of life scale, happiness, and religiosity. Those who identified as religious had a greater love of life and sense of happiness.

Proximity to Suicide

Some research has demonstrated that more than half of one study's participants have been exposed to a suicidal death at least once in their life (Nadorff et. al., 2021), showing that suicide is a prevalent cause of death experienced by others in society. How close one is to someone who has committed suicide or has had a suicide attempt, or their proximity to suicide, has also shown to have different impacts based on the proximity. Suicidal behavior, according to evidence, affects not just the person who attempted or committed suicide, but also numerous other persons in the individual's life, including family members. Suicide exposure is widespread and extends beyond family; as a result, identifying persons with perceived closeness to the deceiver is critical. This unnoticed group of suicide-exposed people is predisposed to psychopathology and suicidal ideation (Cerel et al., 2016).

Job experience with suicide has been deemed to have an effect on mental health to a suicide. Suicide exposure significantly affects reported PTSD. The findings reported by Aldrich and Cerel (2022) suggest that exposure to suicide is connected with higher levels of reported depression, anxiety, and PTSD. First responders had more symptoms of depression, anxiety, and PTSD than mental health experts and crisis workers.

Naturally, closer relationships with those who are suicidal, such as family, have a large impact on the survivors' mental health. One study aimed to contribute to the knowledge of the effect of being exposed to a family member's suicide by comparing a sample of persons who had been exposed to a family member's suicide to a control group of nonexposed individuals (Campos, 2018). Having lost a family member to suicide and the construct of psychache each

contributed significantly to explaining variation in suicide risk. Those who have been exposed had greater levels of not just lifetime suicide risk but also suicide ideation in the preceding year and current estimates of the possibility of future suicide. Those with a loved one who have attempted/committed suicide have a suicide rate of 586 per 100,000 persons, which is three times higher than the rate among bereaved relatives of traffic accident victims and non-suicide deaths. People bereaved by suicide have much higher levels of stigma, shame, responsibility, and remorse than those bereaved by other unintentional abrupt deaths. Additionally, suicide familial aggregation can be explained by both genetic and non-genetic variables. First, there is a genetic component to the heightened suicide risk among suicide survivors. A review found that monozygotic twins, who share all their genes, committed suicide at a greater rate than dizygotic twins, who share half their genes. Thus, suicide has a significant genetic component (Jang et al., 2022).

However, according to Maple and Sanford (2020), the title “friend” was the most usually reported link to the person whose suicide attempt or suicide death had the greatest impact on the participant. Yet, kin reported a higher level of connection to the individual who died by suicide, as well as a larger level of perceived impact than friends. Attempts of kin in the previous year have also been associated with the highest likelihood of future suicide attempts in adolescents, even after correcting for preexisting and present depression and exposure. Additional analyses found that exposure to a friend or family member's suicide attempt or completion significantly increased risk for adolescents regardless of depression levels (Nanayakkara et al., 2013). Even if the level of depression, anxiety, or PTSD levels fluctuate by proximity, both adults and adolescents are significantly affected by the suicide.

Evidence also shows that neurocognitive functioning is also affected by suicide among youth between 8 and 21 years of age. Youth with a family history of a fatal or nonfatal suicide attempt performed significantly worse on tests of executive functioning, attention, and language reasoning, and had marginally lower overall Computerized Neurocognitive Battery accuracy and Wide Range Achievement Test reading scores when compared to matched youth without a family history of a fatal or nonfatal suicide attempt (Jones et al., 2021).

Considering this past literature regarding proximity to suicide, it can be argued in that those who have been exposed to suicide, whether it be a friend, family, co-worker, etc., the exposure can change their viewpoint on suicide.

Perception of Suicide

Suicide acceptance as a legitimate response to life events may also become common knowledge among members of social groups or certain subcultures, as referenced above. This is plainly identified in current studies analyzing perception of suicide across cultures. One particular study examined the impact of religious commitment and attitudes towards suicide among college students across Malaysia. Students completed the Religious Commitment Inventory-10, Attitudes Towards Suicide Scale, and Suicide Behavior Questionnaire-Revised To collect data. Findings revealed that views regarding suicide varied significantly among ethnic and religious groups. It was also revealed that suicide acceptance also strongly impacted suicidal behavior. (Foo et al., 2014).

Similar results were shown in a study conducted by Grimmond and colleagues (2019), focusing on those 25 years old and younger. Four categories were inspected: (1) dangers and triggers for suicidal ideation (2) essential protective factors in getting past suicidal ideation (3) areas in which treatment/prevention measures could be enhanced and (4) ideas about suicide at a

community level. The goal of the study was to acquire a knowledge of the mix of motivators of young people toward suicide. Their utilization of the qualitative studies offers significant insight into young people's experiences with suicidal ideation.

The cause of each individual's perception of suicide varies depending on their social and personal situations, as well as their inherent predispositions. Interpersonal connection, familial background, society in their country, age, and other stressful life events are all common factors of perception of suicide. Perceptions also vary between cultures and time periods. The current study looked at only three of the many possible factors.

The Current Study

The current study examined the connections between religious affiliation, religiosity, proximity to suicide, and attitudes toward individuals in light of all of the data from earlier studies. M-Turk participants who identified as Protestants, Catholics, Atheists, and Others had their religiosity and its effects on acceptance of suicide examined. The three independent variables that were assessed were religious affiliation, religiosity, and proximity to suicide, while the dependent variable was the perception of suicide in participants. Religiosity levels were measured by the use of The Religious Commitment Inventory-10 (RCI-10; Worthington et al., 2003) and perception of suicide by Semantic Differential Scale Attitudes Towards Suicidal Behavior (SEDAS; Jenner, & Niesing, 2000). The proximity of suicide was determined by The Proximity to Suicide measurement.

Hypotheses

The association between religious affiliation (the religion that the participants have been raised in or feel an association with), religiosity (the strength and practice of a participant's religion), proximity to suicide (the relationship to the person committing or attempting suicide),

and the perception of suicide (the condemning or accepting and understanding view of suicide) was the focus of the researchers' hypotheses. Regarding the relationship between the three variables in the proposed study, four hypotheses were used. They are as follows: (1) Those with lower religiosity will be more accepting of suicidal ideation and attributing more accepting and understanding meanings to suicidal behavior; (2) those with higher religiosity will be less accepting of suicidal ideation and will attribute more condemning meanings to suicidal behavior; (3) Catholics will condemn and judge suicide more than Protestants, Atheists and Others; (4) those with a closer relationship, or proximity, to someone who has committed or attempted suicide will be more accepting and understanding of suicidal ideation and suicidal behavior than those who have a more distant relationship, or lack of proximity, to someone who has committed or attempted suicide and (5) those who have a more distant relationship, or proximity, to someone who has committed or attempted suicide will attribute more condemning meanings to suicidal behavior than those with a closer relationship, or proximity, to someone who has committed or attempted suicide.

METHOD

Participants

A sample of 203 participants (103 male, 100 female) were gathered using Amazon Mechanical Turk services. The majority of Amazon Mechanical Turk members (36.8%) are between the ages of 30-39 (Moss, 2020). The average age of 32 (*SD* = 6.42) found in the current study's participants reflects this. Participants' ages ranged from 23 to 58, and they described themselves as African American/Black (3.4%), Asian/Asian American/Pacific Islander (9.9%), Caucasian (75.9%), Hispanic/Latinx (10.3%), and Other (0.5%). They were either single (10.3%) or married (89.7%). Participants' religious affiliations were Roman Catholic (81.3%), Protestant

(12.8%), Atheist (3.9%), and Other (2.0%). Regarding the perception of suicide scale, 40 participants have attempted suicide, 39 have a parent/sibling who has attempted/committed suicide, 45 have an extended family member who has attempted/committed suicide, 37 have a friend who has attempted/committed suicide, 7 have a classmate who has attempted/committed suicide, 7 have a coworker who has attempted/committed suicide, and 3 know someone in their community who has attempted/committed suicide. No volunteers were disqualified from the study because of their gender, ethnicity, or religion. The participants recruited were confined to adults (18-65 years old) with computer access because the vignettes and questionnaires were distributed via computer. All APA ethical rules were followed to ensure participant safety and rights are not compromised. Participants in this study were asked to sign a permission form and received a debriefing. Steps were taken to protect the participants' confidentiality.

Materials

Four distinct questionnaires and information sheets were filled out by participants. These are as follows: (1) a demographic information form (Appendix A), (2) The Religious Commitment Inventory-10 (RCI-10, See Appendix B for the entirety of the scale), (3) Semantic Differential Scale Attitudes Towards Suicidal Behavior (SEDAS, See Appendix C for the entirety of the scale), and (4) Proximity to Suicide Survey (PSS, See Appendix D for the entirety of the scale).

Demographic Information

The participant's gender (male, female, or other), age, race, ethnicity, and religious affiliation were reported on the demographic information form. As one of the independent variables, information about religious affiliation was crucial. Instead of having a "prefer not to say" option as required for some research, religious affiliation was listed as a required field on

this form. Determining the generalizability of the sample was also supported by the additional information.

RCI-10

The RCI-10 is a scale utilized to determine the religiosity score of an individual (Worthington et al., 2003). It is a 10-question scale that participants rated on a 1-5 Likert scale from "Not at all true of me" to "Totally true of me". It includes questions such as, "Religion is especially important to me because it answers many questions about the meaning of life" and "I enjoy working in the activities of my religious affiliation" (See Appendix B for the entirety of the scale).

When the reliability of the instrument was assessed in the literature (Worthington et al., 2003) using the Cronbach's alpha, good reliability was shown regarding the complete scale, Intrapersonal Religious Commitment and Interpersonal Religious Commitment (α = 0.96, 0.94, and 0.92, consecutively). The results of a 5-month test-retest also showed good correlation (r (121) =.84). A one-way analysis of variance (ANOVA) was used to determine construct validity, which demonstrated strong validity even when evaluated at a $p > .0001$.

SEDAS

The SEDAS was created from a pool of 36 items and used a semantic differential scale to assess attitudes toward suicidal behavior. Because a semantic differential has the advantage of being able to assess both intensity and direction, as is the case in judging a suicide, it was favored over Likert-type scales that only measure intensity. The SEDAS has 15-items grouped by actor and scenario. The items (pairs of opposing adjectives) were developed using remarks from literature on religious notions and health legislation pertaining to suicide as well as statements from mental health practitioners. The adjectives convey thoughts (such as

safe/unsafe) and feelings (such as cowardly/brave and manipulative/manipulated). The same 36-item list was given to respondents for the following actor/situation sets: (b) that of an adolescent (14 years), (c) that of an 87-year-old person and, (d) that of a 34-year-old addict. When used in conjunction with the various actor/situation sets, the scale adjectives have the same meaning. (See Appendix D for the entirety of the scale).

Within the literature (Jenner & Niesing, 2000), Cronbach's alpha, a measure of the internal consistency of these two components, was assessed for each of the seven sets (always >0.73). Item-rest correlations for the items in the two components were between 0.30 and 0.70 in all seven sets, demonstrating the components' reliability.

The two components must correlate more strongly with one another across sets than with the other component in order for the validity to be considered satisfactory. For instance, component health/illness should correlate more strongly with set b's health/illness than with set b's acceptance/rejection. This was in fact always verified.

Proximity to Suicide Survey

Participants were asked to answer their experience with a suicide or suicide attempt, whether is themselves or someone else. They were also asked to give the proximity, or relationship, to the person committing or attempting suicide. This assessed the proximity to suicide for each participant.

For this measure, scores were on a scale of one to eight. One is deemed the nearest proximity, while eight is the farthest away proximity. The scale goes as follows: (1) I have attempted suicide; (2) I have a parent/sibling that has attempted/committed suicide; (3) I have an extended family member (cousin/aunt/uncle etc.) that has attempted/committed suicide; (4) I have a friend that has attempted/committed suicide; (5) I have a classmate that has

attempted/committed suicide; (6) I have a co-worker that has attempted/committed suicide; (7) I have someone in my community that has attempted/committed suicide; (8) I do not know anyone that has that has attempted/committed suicide. A score of one, the participant has attempted suicide, is the nearest proximity compared to a score of eight, the participant knows no one that has attempted/committed suicide, which is the farthest proximity. If a participant chose more than one option in the measure, the final score was changed to the score that was the one with the nearest proximity to the participant.

Design

There were three independent variables used in the study. The individuals' religious affiliation was the first variable. The demographic questionnaire was used to define the variable, which fell into one of four categories: Roman Catholic, Protestant, Atheist, and Other. Religiosity was the second independent variable. The RCI-10, which was described in more detail in the section above, was used to gauge one's level of religiosity. It was measured on a scale from 10-50. The last measurement, the Proximity to Suicide Survey, assessed the relationship between the participant and the person who has committed or attempted suicide. The SEDAS, which was once again described in the measurement section above, was used to determine the dependent variable, which is the degree of perception of suicide.

Procedure

IRB regulations were followed when doing the research. Participants were chosen randomly with the use of Amazon Mechanical Turk services. Prior to beginning the study, participants filled out an informed consent form that outlined the risks and potential discomforts of participating. Since suicide is a delicate subject in this study, it is important to stress that (1)

participants' consent was required, (2) participation was optional, and (3) they were able to withdraw from the study at any moment.

The participants finished three questionnaires after signing the consent form. A simple demographic information form was the first form participants were required to fill out. Data on gender, age, ethnicity, and race were gathered in order to better understand the characteristics of the sample, but participant data remained anonymous. Participants were also made aware that demographic data was required because the research depends heavily on religious affiliation. The RCI-10 was completed by participants after the demographic data. With the help of this scale, the study team is able to calculate each participant's religiosity score, which is used to evaluate the first independent variable. The participant finished the SEDAS after completing the demographic and RCI-10 forms. The participants' level of perception of suicide was determined by this. The final measurement, the PSS, was given to participants to establish the proximity to suicide. Finally, the debriefing form was given to the participants. By using the contact information provided, participants had the chance to ask questions if they required clarification on any component of the study.

RESULTS

Reliability for the religiosity and perception of suicide measures for the current study were assessed through Cronbach's Alpha. It was determined that the ten items used to assess religiosity possessed strong reliability (α = .88). The reliability of the items used to assess suicide perception was assessed for each actor/scenario as well as the overall 45 questions. It was established that they have strong reliability (α = .86, α = .83, α = .84, and α = .94). The SPSS explore function was used to screen the data. First, the researcher looked for any missing data. Six participants' data were deleted due to their missing data being systematic. Some data was

found to be missing at random, and as such, the average score for each variable was inserted in place of the missing data points. Outliers were found when boxplots for each variable were examined, but they were left in the data because they fell within the predetermined acceptable range. Histogram analysis revealed that the intimacy and commitment distribution shapes might be abnormally distributed; therefore, skewness and kurtosis scores were analyzed to further evaluate the distributions. The skewness and kurtosis values were outside of the acceptable range for the Religious Commitment Inventory Total variable. The skewness for the Semantic Differential Scale Attitudes Towards Suicidal Behavior total variable was normally distributed, however, the kurtosis was abnormally distributed. To further examine this distribution, we multiplied the standard errors for kurtosis by three and compared this standard error value to the original kurtosis scores. The standard error scores when multiplying by three were smaller than the original kurtosis and skewness scores; thus, it was concluded that the scores for Religious Commitment Inventory and Semantic Differential Scale Attitudes Towards Suicidal Behavior abnormally distributed.

A bivariate correlation was performed to test the hypotheses that religiosity would be correlated with acceptability of suicide. Results indicated that the correlation between religiosity and acceptability of suicide was statistically significant, r (201) = .23, p <.001. The higher the person's religiosity, the more accepting they were of suicide. This contradicted the first two hypotheses as they stated: (1) Those with lower religiosity will be more accepting of suicidal ideation and attributing more accepting and understanding meanings to suicidal behavior, (2) those with higher religiosity will be less accepting of suicidal ideation and will attribute more condemning meanings to suicidal behavior. Finally, the overall religiosity score of all the participants was also examined (M = 39.22, SD = 5.93, N = 203).

A one-way ANOVA was used to assess whether Catholics condemn and judge suicide more than Protestants, Atheists and Others. The dependent variable was the suicide acceptance score (as measured by the SEDAS), and the independent variable, religion, with two levels. One level was Catholic, and the other included Protestant, Atheist and Others. The assumption of homogeneity of variance was assessed by Levene's test, F = .01, p = .92; this indicated no significant violation of the equal variance assumption. The results showed that there was no significant difference of the SEDAS scores between the different religious affiliations, F (1, 201) = .09, p = .764. However, it can be noted that there was a slight difference in means. When looking at individual groups, the Atheists group (N = 8, M = 3.76, SD = 1.18) averaged higher than the Roman Catholics (N = 165, M = 3.49, SD = 0.95), Protestants (N = 26, M = 3.5, SD = 0.93), and Others (N = 4, M = 3.4, SD = 0.99), when it came to the SEDAS score and thus was more understanding of attempted/committed suicide.

A bivariate correlation was also performed to test the hypotheses that: (1) those with a closer relationship, or proximity, to someone who has committed or attempted suicide will be more accepting of suicidal ideation and will attribute more accepting and understanding meanings to suicidal behavior than those who have a more distant relationship, or proximity, to someone who has committed or attempted suicide and (2) those who have a more distant relationship, or proximity, to someone who has committed or attempted suicide will attribute more condemning meanings to suicidal behavior than those with a closer relationship, or proximity, to someone who has committed or attempted suicide. Results found that the correlation between acceptability of suicide and proximity to suicide was statistically significant, r (201) = -.24, p <.001. This was a negative correlation, but with a lower score being a closer proximity and a higher score being a more distant proximity. The closer the proximity to the

person that has attempted/committed suicide, the more understanding the participant is of the attempt/committed suicide and the more distant the proximity, the less accepting and understanding participants are. These findings support hypotheses four and five.

DISCUSSION

Originally it was anticipated that those with lower religiosity would be more accepting of suicidal ideation and attributing more positive meanings to suicidal behavior and that those with higher religiosity will be less accepting of suicidal ideation and will attribute more negative meanings to suicidal behavior. What was found in the results is different than what was hypothesized. The results indicated that those with a higher religiosity, those who were more enthusiastic and participated more in their religions, would tend to have a more understanding perspective of suicide. Other researchers (Jung & Olson, 2014) have demonstrated results that were similar to the original hypotheses, however it can be theorized that this difference can be due to the 10 years between the South Korean and the current study, as well as the differences in countries where data was collected. The previous ten years have seen significant advancements in psychology and mental health, which may account for the shift in religious societies' perspectives on suicide. It can also be noted that participants in the United States that was used in the current study and the participants collected from South Korea in the Jung and Olson (2014) study can have different viewpoints of suicide due to cultural differences within each country. Although the original assumption of the current study was incorrect regarding the correlation, there is a correlation that was found regarding religiosity and perception of suicide.

From the findings of the one-way ANOVA analysis, the researchers found no significant difference between Catholics and other religious groups regarding perception of suicide. Specifically, it was theorized that Roman Catholics would be more condemning toward suicide

than Protestants, Atheists, and Others. Although there was no significant difference between the groups, it is noted that there is a slight difference between the means for each religious affiliation, specifically regarding the mean for the Atheist group. This can be theorized that due to the past research (Gearing & Alonzo, 2018, Torgler & Schaltegger, 2014) that has found those within a religious group tend to be more condemning toward suicide, and that those who do not believe in a god nor have a religious affiliation (atheists) would have a higher acceptance rate.

The present study's participants have very comparable perceptions about suicide across religions. This may imply that religious groups in the United States are becoming less stigmatized and more accepting of suicide thoughts. This is significant not only because it reflects well on the psychological community's efforts to eliminate stigma associated with mental illness and suicide, but also because it demonstrates that individuals within religious groups are embracing and modifying their ideas positively. These new ideas, together with spirituality and other coping methods within religions, may help to reduce suicide rates.

The final correlation's results confirmed the hypotheses that (1) those with a closer relationship, or proximity, to someone who has committed or attempted suicide will be more accepting of suicidal ideation and will attribute more accepting and understanding meanings to suicidal behavior than those who have a more distant relationship, or proximity, to someone who has committed or attempted suicide and (2) those who have a more distant relationship, or proximity, to someone who has committed or attempted suicide will attribute more condemning meanings to suicidal behavior than those with a closer relationship, or proximity, to someone who has committed or attempted suicide. It was found that lower levels of one variable are associated with higher levels of another. The participant's comprehension of a suicide increases the closer they are to it. Those who are close to someone who has tried or committed suicide

might have a greater grasp of what is going on in their head and how they may be suffering. They have the chance to understand the consequences and very awful sentiments that lead someone to consider suicide. Although it is awful to have someone close to you contemplate suicide, it may also be an opportunity for rebirth and education. It can be beneficial not only for persons who are suicidal to speak out about their suffering in order to receive care, but it can also help others, particularly those in the religious community, understand why someone may be suicidal.

A limitation of this study to consider is how the data was collected along with the participant sample. Three scales that were based on participant self- reports were used in the study. Participants have to report on their own experiences and behaviors for the RCI-10, SEDAS, and PSS. Self-reports carry the risk of bias or recollection mistake. Participants may overstate or understate their experiences and emotions. There are several potential causes for these, including humiliation, fear of stigma, anxiety, or recall error. Also, although Amazon Mechanical Turk was utilized to collect data from a more diverse group of participants, it is likely that many participants filled out the survey as quickly as possible just to get the compensation money. One last limitation is the skewed religious affiliation variable, which had a high proportion of Roman Catholics relative to other religions. This may have been attributed to the fact that Roman Catholicism was the first religion listed on the demographics sheet. If participants were not genuine in their responses to the questions, they may have chosen the first choice rather than the religion that is most appropriate for them. These factors may have influenced the study's power and possible compromising its validity.

The current study adds information to previous studies on the connection between religious affiliation, religiosity, proximity to suicide, and attitudes toward suicide. The study

filled a gap in the body of literature because few studies—certainly not those conducted in the United States—address all four issues simultaneously.

Additional studies should look at other potential contributors to participant variables, both good and bad. Additional layers of religious affiliations can be examined, such as those between various Protestant groups. Future studies should also try to carry out a longitudinal study to investigate this association. First, researchers could learn more about the interactions between these variables over time by conducting a longitudinal study. As the variables involved in the study have a chance to fluctuate, such a study would be utilized well to determine the possibilities of what, and possibly how and why these potential changes take place. Furthermore, as mentioned in the limitations section, a bigger, more varied sample can increase the generalizability of the findings to the general populace. Future studies in this field should continue to grow so that physicians can develop more effective treatments for those who engage in suicidal thoughts and behaviors.

This study's results found that the higher the religiosity of a participant, the more understanding they are of an attempted/committed suicide, and that the closer someone is to an attempted/committed suicide, the more understanding they are of it. This study's findings are significant as many people in society have suicidal thoughts, and because suicide is stigmatized in several religions. Research in this relationship is valuable to understand so clinicians and other mental health workers can be provided evidenced-based information regarding clients and those in their lives' perception of suicide within religions and religiosity levels. Such research will broaden understanding concerning cultural competency.

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Appendix A

Demographic Information Form

Instructions: Please provide a response for each of the following questions:

What is your age? _____

What is your gender?

Female ○ Male ○ Other ○

What is your marital status?

Single ○ Married ○ Separated ○ Divorced ○ Widowed ○

With which racial or ethnic category do you identify?

African American/Black ○ Asian/Asian American/Pacific Islander ○

Caucasian ○ Hispanic/Latinx ○ Other ○ _____

With what denomination or faith tradition do you most closely identify?

Roman Catholic ○

Protestant ○ – What denomination? _____

Atheist ○

Other (please fill in the blank) ○ _____

Appendix B

RCI-10

Religious Commitment Inventory-10

Instructions: Read each of the following statements. Using the scale below, CIRCLE the response that best describes how true each statement is for you. If you are nonreligious, respond as if your view is a religion.

Not at all true of me 1	**Somewhat** true of me 2	**Moderately** true of me 3	**Mostly** true of me 4	**Totally** true of me 5

1.	I often read books and magazines about my faith.	1	2	3	4	5
2.	I make financial contributions to my religious organization.	1	2	3	4	5
3.	I spend time trying to grow in understanding of my faith.	1	2	3	4	5
4.	Religion is especially important to me because it answers many questions about the meaning of life.	1	2	3	4	5
5.	My religious beliefs lie behind my whole approach to life.	1	2	3	4	5
6.	I enjoy spending time with others of my religious affiliation.	1	2	3	4	5
7.	Religious beliefs influence all my dealings in life.	1	2	3	4	5
8.	It is important to me to spend periods of time in private religious thought and reflection.	1	2	3	4	5
9.	I enjoy working in the activities of my religious affiliation.	1	2	3	4	5
10.	I keep well informed about my local religious group and have some influence in its decisions.	1	2	3	4	5

Appendix C

Proximity to Suicide Survey

Instructions: Read each of the following statements. Please check all boxes that apply to you.

- ☐ I have attempted suicide.
- ☐ I have a parent/sibling that has attempted/committed suicide.
- ☐ I have an extended family member (cousin/aunt/uncle etc.) that has attempted/committed suicide.
- ☐ I have a friend that has attempted/committed suicide.
- ☐ I have a classmate that has attempted/committed suicide.
- ☐ I have a co-worker that has attempted/committed suicide.
- ☐ I have someone in my community that has attempted/committed suicide.
- ☐ I do not know anyone that has that has attempted/committed suicide.

Appendix D

Semantic Differential Scale Attitudes Towards Suicidal Behavior

This questionnaire, the SEDAS, is a means to help examine which meanings you attribute to suicidal behavior. The SEDAS consists of 15 pairs of polar words or notions, such as depressed–elevated, unnatural–natural, impulsive–deliberate, and so on. You can measure meanings by indicating your judgement on this series of descriptive scales.

Instructions: The scales should be used as follows: if you feel that suicide is *very closely* related to one or the other end of the scale, you should place your rating in the space as indicated below.

FAIR | X | | | | | | | UNFAIR

OR

FAIR | | | | | | | X | UNFAIR

If you consider suicide to be *neutral* on a scale, or consider *both sides to be equally associated* with suicide, or if you consider the pair of items *irrelevant or unrelated* to suicide, then you should place your rating in the middle as indicated below:

FAIR | | | | X | | | | UNFAIR

If you consider suicide to be *somewhere in between* being *very closely* related to one or the other end of the scale and being *neutral* on the scale, place your rating in the space that makes the most sense.

Please make your ratings with X on basis of the following sentence:

I find the suicide of..... (a) adolescent ages 14 years...

1a. FAIR ☐☐☐☐☐☐☐ UNFAIR

2a. AIMLESS ☐☐☐☐☐☐☐ MOTIVATED

3a. STABLE ☐☐☐☐☐☐☐ UNSTABLE

4a. USELESS ☐☐☐☐☐☐☐ USEFUL

5a. DELIBERATE ☐☐☐☐☐☐☐ IMPULSIVE

6a. SHALLOW ☐☐☐☐☐☐☐ DEEP

7a. HOPEFUL ☐☐☐☐☐☐☐ HOPELESS

8a. SICK ☐☐☐☐☐☐☐ HEALTHY

9a. DEPRESSED ☐☐☐☐☐☐☐ ELEVATED

10a. COWARDLY ☐☐☐☐☐☐☐ BRAVE

11a. NORMAL ☐☐☐☐☐☐☐ DISTURBED

12a. POWERFUL ☐☐☐☐☐☐☐ POWERLESS

13a. UNDERSTANDABLE ☐☐☐☐☐☐☐ INCOMPREHENSIBLE

14a. NATURAL ☐☐☐☐☐☐☐ UNATURAL

15a. SAFE ☐☐☐☐☐☐☐ UNSAFE

A person 87 years of age who does not wish to live on...

1b. FAIR ☐☐☐☐☐☐☐ UNFAIR

2b. AIMLESS ☐☐☐☐☐☐☐ MOTIVATED

3b. STABLE ☐☐☐☐☐☐☐ UNSTABLE

4b. USELESS ☐☐☐☐☐☐☐ USEFUL

5b. DELIBERATE ☐☐☐☐☐☐☐ IMPULSIVE

6b. SHALLOW DEEP

7b. HOPEFUL HOPELESS

8b. SICK HEALTHY

9b. DEPRESSED ELEVATED

10b. COWARDLY BRAVE

11b. NORMAL DISTURBED

12b. POWERFUL POWERLESS

13b. UNDERSTANDABLE INCOMPREHENSIBLE

14b. NATURAL UNATURAL

15b. SAFE UNSAFE

A 34-year-old drug abuser addicted for many years...

1c. FAIR UNFAIR

2c. AIMLESS MOTIVATED

3c. STABLE UNSTABLE

4c. USELESS USEFUL

5c. DELIBERATE IMPULSIVE

6c. SHALLOW DEEP

7c. HOPEFUL HOPELESS

8c. SICK HEALTHY

9c. DEPRESSED ELEVATED

10c. COWARDLY BRAVE

11c. NORMAL DISTURBED

12c. POWERFUL POWERLESS

13c. UNDERSTANDABLE ☐☐☐☐☐☐☐ INCOMPREHENSIBLE

14c. NATURAL ☐☐☐☐☐☐☐ UNATURAL

15c. SAFE ☐☐☐☐☐☐☐ UNSAFE

Hello,

My name is Lindsey Gack, and I am a graduate student in the Psychology Department at Fort Hays State University. I would like to invite you to participate in a research study. If you decide to participate, click on the link below.

If you choose to participate, you will be given a survey to fill out asking questions about your behaviors and perceptions of suicide and those with suicidal ideations. I would appreciate your help with this research project.

The included questions about suicide acceptance could be a trigger for you and you may skip questions you do not feel comfortable answering and may stop the study at any time without penalty.

If you would like to participate, you will be asked to fill out a consent form related to the study after your questions are answered. You will then be asked to complete a survey. If you choose to participate, the study will take approximately 15 minutes. Regarding content, questions about suicide acceptance could be a trigger and you may skip questions that you do not feel comfortable answering and may stop the study at any time without penalty. If you have any questions about the study and/or would like more information about the study before making a decision to participate, please contact me (Lindsey Gack) or my faculty adviser (Dr. Carol Patrick).

Thank you!

Lindsey Gack
lmgack@mail.fhsu.edu

Dr. Carol Patrick
clpatrick@fhsu.edu
(Faculty Supervisor)

Adult Informed Consent Statement

Name of the Study: The Effects of Religious Affiliation, Proximity to Suicide, and Religiosity on Suicide Acceptance

INTRODUCTION

The Department of Psychology at Fort Hays State University supports the practice of protection for human subjects participating in research. You are being asked to participate in a research study. It is your choice whether or not to participate. The following information is provided for you to decide whether you wish to participate in the present study. You may refuse to participate in this study. You should be aware that even if you agree to participate, you are free to withdraw at any time. If you do withdraw from this study, it will not affect your relationship with this unit, the services it may provide to you, or Fort Hays State University.

PURPOSE OF THE STUDY

The purpose of this study is to examine the effects of religious affiliation, proximity to suicide, and religiosity on acceptance of suicide. By examining these variables together, we may better understand how religious affiliation, proximity to suicide, and religiosity relates to perception of suicide.

PROCEDURES

After you finish reading the consent and your questions are answered, you may click the "next" button to move on to the next section of the survey. **Clicking "next" is giving consent to participate.** You will then be asked to fill out a series of brief questionnaires related to behaviors, opinions related to suicide, and a basic demographic form. Once you have completed

all sections of the survey you will be routed to the debriefing statement. The last page of the online survey is the debriefing document, and it will give you information about the study. You may print out the debriefing page or just read the form and exit the survey. The debriefing form also provides you with contact information for the principal investigator, her thesis advisor, and other avenues for help and information about suicide. The length of time of your participation in this study is approximately15 minutes. Approximately 200 participants will be in this study. You may withdraw from participating in the study at any time by just closing the survey.

RISKS

We do not anticipate more than minimal risk with this study. As this study is in an online survey format, all responses will be anonymous. There are items that could cause embarrassment if you were identified, and your answers were exposed. However, this should be no more than you would experience in everyday life. To protect confidentiality, your name will not be linked to your responses.

As this study is anonymous there is no opportunity to directly follow up with you or ascertain your stress level following completion of the survey. As there are questions about suicide acceptance and that could be a trigger for you, you may skip questions that you do not feel comfortable answering and may stop the study at any time without penalty. If you become distressed during the survey, you may close the window and stop participating at any time. All questions are voluntary; therefore, if you feel that a question is too distressing, you may skip that question.

BENEFITS

You will be offered $.75 as a compensation for filling out the survey. You may also benefit from participation by seeing how a research study operates and may even spark interest in conducting research. Finally, you may gain personal insight to your own experiences and factors that influence behavior.

PARTICIPANT CONFIDENTIALITY (HOW WILL PRIVACY BE PROTECTED)

Your name will not be associated in any publication or presentation with the information collected about you or with the research findings from this study. Instead, the researcher(s) will use a study number or a pseudonym rather than your name. Your identifiable information will not be shared unless (a) it is required by law or university policy, or (b) you give written permission. Permission granted on this date to use and disclose your information remains in effect for five years. By signing this form, you give permission for the use and disclosure of your information for purposes of this study at any time in the five years the data is stored on the principal researcher's password-protected laptop.

REFUSAL TO CONSENT

You are not required to consent and you may refuse to do so. However, if you refuse to sign, you cannot participate in this study nor will you receive the monetary compensation, due to Amazon Mechanical Turk guidelines.

QUESTIONS ABOUT PARTICIPATION

Questions about procedures should be directed to the researcher(s) listed at the end of this consent form.

PARTICIPANT CERTIFICATION:

I have read this Consent and Authorization form. I have had the opportunity to ask, and I have received answers to, any questions I had regarding the study. I understand that if I have any additional questions about my rights as a research participant, I may call (785) 628-4349, the Office of Scholarship and Sponsored Projects (OSSP), Fort Hays State University 600 Park St., Hays, Kansas 67601. I may also contact the IRB through phone number 785-628-4321 or email irb@fhsu.edu.

I agree to take part in this study as a research participant. By my paging forward I affirm that I am at least 18 years old and that I have received a copy of this Consent and Authorization form.

RESEARCHER CONTACT INFORMATION:

Lindsey Gack

Principle Investigator

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Department of Psychology

Fort Hays State University

600 Park St.

Hays, KS 67601 (785) 628-4406

Resources for Assistance

SUICIDE AND CRISIS LIFELINE INFORMATION:

Call or Text 988 or 1-800-273-8255

NATIONAL ALLIANCE ON MENTAL ILLNESS INFORMATION:

Call 1-800-950-NAMI (6264), text "HelpLine" to 62640 or email at helpline@nami.org

Debriefing Form: "The Effects of Religious Affiliation, Proximity to Suicide, and Religiosity on Suicide Acceptance"

You have just completed a study titled "The Effects of Religious Affiliation and Religiosity on Suicide Acceptance." The purpose of this study was to examine the effect of religiosity and religious affiliation on perception of suicide. You were asked to fill out a survey asking questions about your behaviors and perceptions. The information provided will help researchers understand how religiosity and religious affiliation affect perception of suicide. It is expected that that there will be differences among religions in suicide acceptance, and those with higher religiosity will be less accepting of suicide. It is also expected that those with someone in their family that has attempted suicide will be more accepting of suicide.

The research team greatly appreciates your help with this project! If you feel distressed after your participation in this project, you can contact your local community health center to schedule an appointment to talk with someone about how the project impacted you, or the Office of Scholarship and Sponsored Projects at 785-625-4349 if you have questions about the process of this research project. For more information about the research project, you can contact the principal researcher, Lindsey Gack. You may also contact the faculty adviser, Dr. Carol Patrick.

Sincerely,

Lindsey Gack
lmgack@mai1.fhsu.edu

Dr. Carol Patrick
clpatrick@fhsu.edu
(Faculty Supervisor)

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Call or Text 988 or 1-800-273-8255

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OFFICE OF SCHOLARSHIP AND SPONSORED PROJECTS

DATE:	March 5, 2024
TO:	Lindsey Gack
FROM:	Fort Hays State University IRB
STUDY TITLE:	[2166842-1] The Effects of Religious Affiliation, Proximity to Suicide, and Religiosity on Suicide Acceptance
IRB REFERENCE #:	24-0093
SUBMISSION TYPE:	New Project
ACTION:	DETERMINATION OF EXEMPT STATUS
DECISION DATE:	March 5, 2024
REVIEW CATEGORY:	Exemption category # *2*

Thank you for your submission of New Project materials for this research study. The departmental human subjects research committee and/or the Fort Hays State University IRB/IRB Administrator has determined that this project is EXEMPT FROM IRB REVIEW according to federal regulations.

Please note that any changes to this study may result in a change in exempt status. Any changes must be submitted to the IRB for review prior to implementation. In the event of a change, please follow the Instructions for Revisions at http://www.fhsu.edu/academic/gradschl/irb/.

The IRB administrator should be notified of adverse events or circumstances that meet the definition of unanticipated problems involving risks to subjects. See http://www.hhs.gov/ohrp/policy/AdvEvntGuid.htm.

We will put a copy of this correspondence on file in our office. Exempt studies are not subject to continuing review.

If you have any questions, please contact Keith Bremer at IRB@fhsu.edu. Please include your project title and reference number in all correspondence with this committee.

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I understand that once deposited in the Repository, the Thesis may not be removed.

Thesis: The Effects of Religious Affiliation, Proximity to Suicide, and Religiosity on Suicide Acceptance

Author: Lindsey M. Gack

Signature: 

Date: 5/1/24