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Religious Commitment and Intent to Die by Suicide during the Pandemic

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Abstract: Suicide is the second leading cause of death in 10–34-year-olds in the U.S. It is vital to identify protective factors that promote resilience in a suicide crisis. *Background*: This study explored the contributions of religious commitment (RC) and religious service attendance to decreased suicide intent in 18–34-year-olds. Possible moderators were investigated, including church-based social support, pandemic-related faith struggles (PRFS), and moral objections to suicide. *Methods*: Participants completed an online survey reporting on RC, suicide intent, church-based social support, religious service attendance, PRFS, and moral objections to suicide. *Results*: In the convenience sample of 451 18–34-year-olds (M = 24.97; 47.23% female), religious participants reported significantly less suicide intent than non-religious participants. RC and moral objections to suicide were more strongly negatively correlated with suicide intent than religious service attendance, but religious service attendance was associated with lower suicide intent in a regression model. Almost four times more religious young adult participants reported PRFS than not, and PRFS was found to moderate the benefits of social support received in their faith communities. *Conclusions*: It is suggested that professional caregivers use religious service attendance as a straightforward way to assess a possible protective factor for suicidal religious young adults. Professional caregivers may also assess for moral objections to suicide, which may provide simple decision rules in a suicide crisis. The large number of religious young adults reporting PRFS in this study suggests the need for professional caregivers to assess for spiritual struggles, which may confer suicide risk. Because of the interplay of spiritual risks and protections, mental health providers who are unsure of how to address these in therapy may need to collaborate with and make referrals to faith leaders to increase protections and reduce risks in suicidal religious young adults.

Keywords: religious commitment; religious service attendance; suicide; religious coping

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1. Introduction

Suicide has been the tenth leading cause of death in the U.S. and the *second* leading cause of death for 10–34-year-olds (Hedegaard et al. 2021). In 2017, the suicide rate for 15–24-year-olds was the highest ever recorded for this age group (McIntosh and Drapeau 2018). The 2020 Annual Report of the Center for Collegiate Mental Health (2021), based on 185,440 college students at 153 institutions, indicates that the steady rise in threats to self slowed during the pandemic but remains a concern in this age group.

One approach to addressing the suicide rate is identifying protective factors that enhance resilience during a suicidal crisis (National Action Alliance for Suicide Prevention: Research Prioritization Task Force 2014). This approach aligns with an integrated dual-factor model of mental health (Greenspoon and Saklofske 2001) and with the public health model (Winslow 1920), which is a comprehensive approach that examines the determinants of well-being and disease (Gatseva and Argirova 2011). This study took a broad approach

and focused on both risks and protections, the protective factors that protect against suicide intent, as well as the risk factors that are associated with suicide intent and the possible interactions between them.

1.1. Aims

This cross-sectional study will explore religious commitment (RC) as a potential protective factor in a sample of young adults while considering the relationship of RC to other risks and protective factors for suicide. Hypothesis 1: As RC increases, suicide intent will significantly decrease. Hypothesis 2: As religious service attendance increases, suicide intent will significantly decrease. Hypothesis 3: Pandemic-related faith struggles (PRFS) will moderate the effects of religious service attendance on suicide intent. Hypothesis 4: RC will remain significantly associated with suicide intent when statistically controlling for religious service attendance, church-based social support (CBSS), belonging needs, reasons for living (RFL), especially moral objections to suicide, and suicide death impact. Hypothesis 5: RC will remain related to suicide intent in different demographic groups. Findings will help clarify how mental health professionals and faith leaders can support suicidal religious young adults.

1.2. Religious Commitment and Other Risk and Protective Factors

It has been proposed that religious beliefs may protect an individual from attempting suicide (Lawrence et al. 2016) and that "a high level of commitment to a few life-preserving religious beliefs, values, and practices will lower suicide levels" (Stack 1983, p. 362). The construct of "a high level of commitment" can be operationalized as religious commitment (RC), which refers to how much a person "adheres to his or her religious values, beliefs, and practices and uses them in daily living" (Worthington et al. 2003, p. 85). As noted by Masters (2013), intrinsic religiosity may be the very framework for religious individuals' lives. Yarhouse et al. (2018) found that students in their study with greater levels of intrinsic religiosity reported fewer psychological symptoms than less religious peers. Steffen et al. (2017) explored the mechanism between religiosity and well-being and found that people trying to live their religion in their daily lives was an important contributor to well-being, where the extent to which people attempted to live out their faith in their daily lives had the greatest positive effect on their mental health. Subjective religiosity (i.e., the importance of religion in one's life) or RC have been found to be negatively associated with suicidal ideation (Abdullah et al. 2023; Fakhari et al. 2021; Taliaferro et al. 2009; Taylor et al. 2011; Wu et al. 2015) but not with suicide attempts (Kaslow et al. 2004) and not in all samples (Kleiman and Liu 2013; Zhang et al. 2010). Other religious factors that have been tested include self-identification as a religious/spiritual person, as measured by the item: "To what extent do you consider yourself a religious or spiritual person?" (VanderWeele et al. 2017). Using data from the Black Women's Health Study, VanderWeele et al. (2017) found that religious coping and self-identification as a very religious/spiritual person were associated with lower mortality, but religious service attendance was the strongest predictor of lower mortality in this cohort.

Regular religious service attendance has been found to be protective against suicide in large prospective cohort studies (Chida et al. 2009; Li et al. 2016a, 2016b; VanderWeele et al. 2016). When found to be protective, religious service attendance refers to attending religious services at least once a week (Chen et al. 2020). While RC may help clarify the benefits of religious service attendance, regular service attendance may not protect in all circumstances because regular service attenders die by suicide. For example, VanderWeele et al. (2016) identified seven suicide deaths among nurses who attended services once per week or more. Not only is it not known how religious service attendance decreases suicide risk, but it is not known in what circumstances regular service attendance might either confer risk or fail to protect. It is also not known how the pandemic may have conferred risk or failed to protect, given the restriction on the size of gatherings during the pandemic.

Religious coping may also protect against suicidal behaviors. Vitorino et al. (2021) found a positive association between religious/spiritual coping and lower suicidal ideation. Religious coping has been found to be important during serious and threatening circumstances (Pargament 1997), such as a pandemic (Captari et al. 2022). Pankowski and Wytrychiewicz-Pankowska (2023) noted the "massive effect" (p. 511) of the pandemic on all spheres of people's lives. Faith and spirituality were found to have been important during the pandemic (Kowalczyk et al. 2020). An increase in religious coping (e.g., prayer) was reported during the pandemic (Molteni et al. 2021). While positive religious coping during the pandemic was associated with better mental health (Saud et al. 2021; Thomas and Barbato 2020), spiritual struggle has been associated with negative outcomes (Currier et al. 2019; Trevino et al. 2010). Pargament et al. (2004) followed 268 medically ill, elderly, and hospitalized patients over two years. They found that negative methods of religious coping (e.g., spiritual discontent and feeling punished by God) were tied to less independence in daily living, poorer cognitive functioning, poorer quality of life, and more depressed mood at both baseline and follow-up. Pankowski and Wytrychiewicz-Pankowska (2023) performed a meta-analysis of studies during the pandemic and found a statistically significant negative relationship between negative religious coping and flourishing. However, not all types of spiritual struggle worsen mental health (Currier et al. 2019). This study will examine the association of pandemic-related faith struggles (PRFS) with suicide intent—a negative mental health outcome.

Another variable associated with lowered suicide risk is social support. Substantial evidence links social isolation and mortality (Holt-Lunstad et al. 2017). Perceptions of social support have been found to predict lower levels of suicidal ideation (Chioqueta and Stiles 2007) and suicide attempts (Kleiman and Liu 2013), and the incidence of suicide death has been found to decrease with increasing social integration (Tsai et al. 2015). Religious social support has been found to mediate between religiosity and mental health (including suicidal behaviors) in college students (Hovey et al. 2014) and between church attendance and psychological distress in a community sample (Ellison et al. 1997). However, changes in social support in the National Nurses Study related to religious service attendance only explained about a quarter of the association between attendance and health (VanderWeele et al. 2017).

Individuals with religious affiliations have reported more reasons for living and more moral objections to suicide than those without religious affiliations (Dervic et al. 2011). Dervic et al. (2004, 2011) and Lizardi et al. (2008) have suggested that moral objections to suicide may function as a protective factor against suicide attempts in religiously affiliated subjects. Others (Garlow et al. 2005; Neeleman et al. 1998) have suggested that a low incidence of suicide among African Americans may be partly attributable to orthodox beliefs, including the unacceptability of suicide. Not all would agree that "human beings are moral animals" (Seligman 2002, p. 133). However, certain ubiquitous virtues have been identified in many philosophical and religious traditions that contribute to a fulfilling life that "allow the human animal to struggle against and to triumph over what is darkest within us" (Dahlsgaard et al. 2005, p. 212). What is not clear is how human virtues may be related to moral objections to suicide or to decision-making in the context of suicide.

In order for caregivers to support suicidal religious people, it is important to understand the protective contributions of religious service attendance, RC, religious social support, and moral objections to suicide. It is also important to understand how risk factors, such as negative religious coping and PRFS, might confer an increased risk of suicide. In addition to PRFS, the risk of suicide has been found to be associated with having fewer RFL (Linehan et al. 1983) and thwarted needs for belonging and meaningful contribution (Joiner 2005). An additional risk is suicide loss. Suicide-bereaved individuals with higher feelings of closeness to the deceased are at elevated risk for serious mental health outcomes, such as depression and anxiety, as well as increased risk of suicidal ideation (Cerel et al. 2017a, 2017b) and suicide attempts (Pitman et al. 2016). This study will explore known risks and protections to better understand the contribution of RC as protection against suicide intent.

2. Materials and Methods

2.1. Measures

The Religious Commitment Inventory (RCI-10; Worthington et al. 2003) assesses adherence to religious values, beliefs, and practices. Two subscales include Intrapersonal RC ("I spend time trying to grow in understanding of my faith") and Interpersonal RC ("I enjoy spending times with others of my religious affiliation").

The Suicide Behaviors Questionnaire-Revised (SBQ-R; Osman et al. 2001) taps four dimensions of suicidal behaviors. Item 4 was used to measure suicide intent: "How likely is it that you will attempt suicide someday?"

The Church-based Social Support scale (CBSS scale; Krause and Hayward 2013) measures perceptions of social support specific to FCs. We included four subscales: (1) belonging in a congregation, (2) emotional support received from fellow church members (ESR), (3) emotional support given to fellow church members (ESG), and (4) spiritual support. Religious service attendance was measured by CBSS scale item 15: "How often do you attend religious services?"

PRFS items included three Likert-type items followed by open-ended items: "I have been struggling with my faith during the pandemic", "I have been struggling with my relationship with God during the pandemic", and "I have been struggling with connecting with my FC during the pandemic".

The Interpersonal Needs Questionnaire (INQ-15; Van Orden et al. 2012) includes two subscales: Perceived burdensomeness (feeling one is a burden) and Thwarted belongingness (feeling low belonging). The RFL Scale (Linehan et al. 1983) assesses the importance of various RFLs, including Survival Coping Beliefs, Responsibility to Family, Child-Related Concerns, Fear of Suicide, Fear of Social Disapproval, and Moral Objections to Suicide.

The Suicide Exposure Experience Screener (SEES; Maple et al. 2022) includes two items: (1) participants' reported closeness to the person who died by suicide; (2) participants' reported impact of this death. Because the validity of online surveys may suffer from random responses (Osborne and Blanchard 2011), three security questions tested for random responding or loss of attention. Demographic questions included age, birth sex, self-identified gender, race/ethnicity, marital status, education, income, and religion.

The Gordon-Conwell Theological Seminary Institutional Review Board approved the study on 26 September 2020.

2.2. Participants

Any 18–34-year-old in three educational settings in the U.S. was invited to complete a survey measuring RC, suicide intent, religious service attendance, PRFS, CBSS, belonging needs, RFL, suicide death impact, and three security questions. To increase the range of RC, 18–25-year-old MTurk participants were invited to complete the survey.

3. Results

3.1. Sample

A convenience sample of 451 18–34-year-olds with a mean (*M*) age of 24.97 (standard deviation [*SD*] = 4.26) completed the online survey. The sample included 45 18–25-year-old U.S. MTurk respondents. See Table 1 for demographics. Some participants (n = 168) met or exceeded the cutoff score on SBQ-R, suggesting some risk for suicide (Osman et al. 2001). While many (n = 192) experienced the loss of one person to suicide, only a few reported the person who died by suicide was close (n = 12) or very close (n = 8). Some (n = 12) no longer felt the suicide death had a significant effect, and others (n = 8) reported a devastating impact. We analyzed the data with and without the participants who did not answer all three security questions correctly, and the results did not differ significantly, so all respondents were included in the final sample. See Table 2 for good to excellent reliabilities and correlations between measures.

Table 1. Demographics of the sample.

Demographic	Number
Birth sex	
Male	149
Female	213
Race	
African American	27
American Indian	3
Asian	47
White	287
Ethnicity	
Not Spanish	307
Chicano	2
Cuban	4
Mexican	4
Mexican-American	5
Puerto Rican	6
South American	13
Marital status	
Never married	255
Married	96
Divorced	4
Separated	2
Religion	
Catholic	39
Jewish	3
Protestant	198
Other	55
None	61
Born again	200

Table 2. Reliabilities and correlations between measures.

Measures and Subscales	Reliabilities [1]	RCI-10	SBQ-R	SBQ-R Item 4	CBSS	PRFS	INQ-15	RFL	SEES
RCI-10	0.97								
Intrapersonal	0.96	1.00 [2]		−0.35 **					
Interpersonal	0.93								
SBQ-R	0.80	−0.002	1.00	0.87 **					
CBSS	0.93								
Belonging	0.87								
ESR	0.89	0.84 **	−0.08	−0.28 **	1.00				
ESG	0.91								
Spiritual	0.86								
PRFS	0.85	−0.31 **	0.03	0.05	−0.27 **	1.00			
INQ-15	0.94								
Burdensome	0.94	0.02	0.64 **	0.51 **	−0.05	−0.03	1.00	·	
Not belonging	0.91								
RFL	0.94								
Survival	0.96								
Responsibility	0.83								
Child-related	0.89	0.43 **	0.15 *	−0.19 **	0.38 **	−0.14 *	0.44 **	1.00	
Suicide fear	0.82								
Disapproval	0.81								
MOS	0.83								
SEES	0.78	0.09	0.20	0.19	0.19	−0.04	0.16	−0.11	1.00

[1] Cronbach's alpha [2] Pearson correlation coefficients. * $p < 0.01$ ** $p < 0.0000$.

3.2. Hypotheses

Hypothesis 1: *RC and suicide intent.*

The RCI-10 was significantly negatively correlated to suicide intent ($r = -0.35$, $p < 0.0000$). It was correlated to the CBSS scale and its subscales, to RFL and the moral objections to suicide subscale of the RFL ($r = 0.71$ $p < 0.0000$), and to religious service attendance ($r = 0.67$ $p < 0.0000$). Suicide intent was significantly and negatively correlated to religious service attendance ($r = -0.26$, $p < 0.0000$), to the CBSS scale and its subscales, to RC, and to the moral objections to suicide subscale ($r = -0.36$, $p < 0.0000$).

Hypothesis 2: *Religious service attendance and suicide intent.*

Religious service attendance was negatively significantly correlated to overall SBQ-R ($r = -0.26$ $p < 0.0000$) and to suicide intent ($r = -0.26$ $p < 0.0000$).

Hypothesis 3: *PRFS, religious service attendance, and suicide intent.*

In regression analyses, religious service attendance was moderated by combined PRFS items, $F(2, 240) = 15.01$, $p < 0.0000$. For individual PRFS items, religious service attendance was moderated by only item 1 ("I have been struggling with my faith during the pandemic"): $F(2, 240) = 14.48$, $p < 0.0000$.

Participants with PRFS had higher SBQ-R item 4 scores, as did those not struggling and not receiving CBSS (Figure 1). Lower suicide intent scores were reported by low PRFS participants who received CBSS.

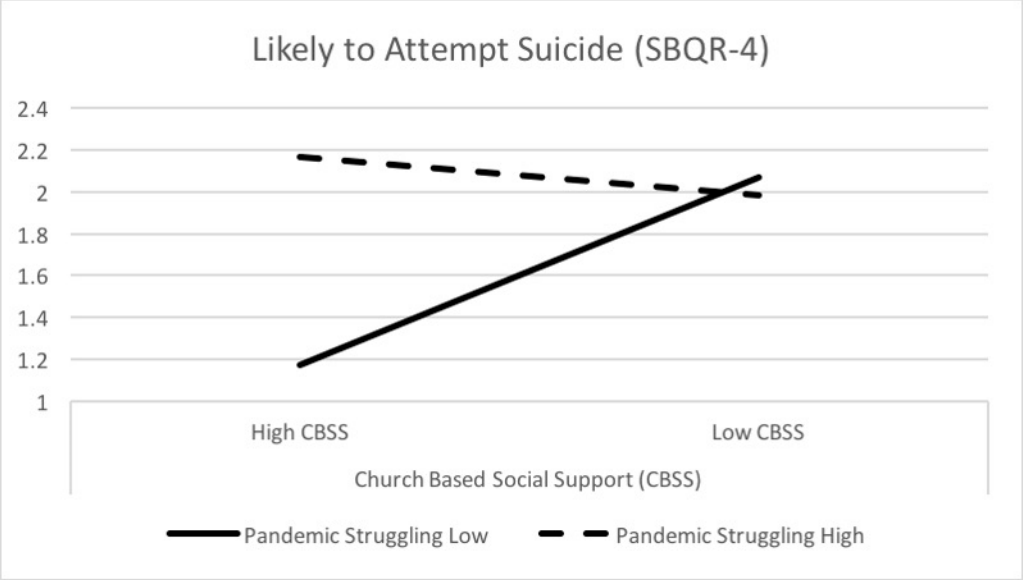

Figure 1. Interaction between PRFS and CBSS.

PRFS. A subset of respondents ($n = 160$) provided qualitative responses to the three PRFS items. We used numerically aided phenomenology (Kuiken and Miall 2001) to analyze these. Four frequently occurring themes, comprising close to 100 percent of all responses, were identified: (1) not religious/atheist (e.g., "I don't believe in any faith"), (2) loneliness, separated from others (e.g., "I feel very alone"), (3) stronger, closer to God (e.g., "It has been a difficult time for everyone but I feel as though during the pandemic I actually got closer with God"), and (4) struggling, doubting, less religious, (e.g., "The complications in my life has increased and has made me question my faith more times than ever").

All responses were then coded for the themes either occurring or not occurring. A hierarchical cluster analysis using the average linkage method assigned participants to

three clusters. Group One (n = 109) included participants more likely to say they were lonely, separated from others, and struggling with their faith, and unlikely to say they were not religious. Group Two (n = 23) included participants who responded that they were atheist or not religious. Group Three (n = 28) were more likely to say they were stronger or closer to God in the pandemic. The groups were compared on several variables.

RC. Group Two reported significantly less RC, $F(2, 157) = 48.15$, $p < 0.001$. A multivariate analysis of variance (MANOVA) with the RCI subscales was significant (Wilk's $\Lambda = 0.6$, $p < 0.001$), with Group Two reporting the lowest Intrapersonal and Interpersonal RC.

Suicidal behaviors. A MANOVA of the SBQ-R items was significant (Wilk's $\Lambda = 0.86$, $p < 0.01$), and follow-up ANOVAs were significant for all items: the first ($F(2, 157) = 11.1$, $p < 0.001$, $\eta^2 = 0.12$), second ($F(2, 157) = 7.1$, $p < 0.001$, $\eta^2 = 0.08$), third ($F(2, 157) = 5.3$, $p < 0.01$, $\eta^2 = 0.06$), and fourth ($F(2, 157) = 4.7$, $p < 0.01$, $\eta^2 = 0.06$). Bonferonni-corrected post hoc tests found Group Two to be higher than Groups One and Three across all four items ($p < 0.01$). Group Two reported a greater lifetime prevalence of frequency of suicidal ideation and attempts, greater frequency of suicidal ideation over the last year, greater likelihood the respondent has told someone about their suicide intent, and greater likelihood the respondent will attempt suicide someday than Groups One and Three.

CBSS. Group Two did not report CBSS because they reported being atheist and not religious. Groups One and Two did not differ significantly on CBSS or its subscales except that a t-test was significant for religious service attendance, with Group One reporting significantly more average religious service attendance ($M = 7.19$, $SD = 1.58$) than Group Three ($M = 6.30$, $SD = 2.30$), $t(106) = 2.08$, $p = 0.02$.

RFL. A MANOVA for the six RFL scales was significant (Wilk's $\Lambda = 0.52$, $p < 0.001$). Follow-up ANOVAs were significant for Moral objections to suicide ($F(2, 157) = 50.0$, $p < 0.001$, $\eta^2 = 0.38$), Fear of suicide ($F(2, 157) = 4.1$, $p < 0.05$, $\eta^2 = 0.05$), Responsibility to family ($F(2, 157) = 3.4$, $p < 0.05$, $\eta^2 = 0.042$), and Child-related concerns ($F(2, 157) = 6.0$, $p < 0.01$, $\eta^2 = 0.071$). Bonferroni–adjusted post hoc tests found that Groups One and Three endorsed more moral objections to suicide items (e.g., "I believe only God has the right to end a life.") compared to Group Two ($p < 0.001$). Group One reported more Moral objections to suicide than Group Three ($p < 0.05$). Group Two endorsed more Fear of suicide items (e.g., "I am afraid of the actual "act" of killing myself (the pain, blood, violence).") than Group Three ($p < 0.05$). Group One endorsed more Responsibility to family items (e.g., "I have a responsibility and commitment to my family", $p < 0.05$). Twenty-five percent of Group One reported being married, compared to 12 percent of Group Three and none of Group Two. Group Two endorsed fewer Child-related concerns items (e.g., "The effect on my children could be harmful.") than Groups One ($p < 0.05$) and Three ($p < 0.01$).

Interpersonal Needs. A MANOVA of the INQ-15 subscales was significant (Wilk's $\Lambda = 0.89$, $p < 0.001$), as was the follow-up ANOVA for Perceived Burdensomeness ($F(2, 157) = 8.84$, $p < 0.001$, $\eta^2 = 0.10$). Bonferonni-corrected post hoc tests found Group Two endorsed more Perceived Burdensomeness items than Groups One and Three ($p < 0.01$).

Hypothesis 4: *Associations between RC, religious service attendance, CBSS, INQ-15, RFL, SEES, and suicide intent.*

RC, religious service attendance, CBSS, INQ-15, RFL, and SEES were regressed on suicide intent. INQ-15 and CBSS were positively associated with suicide intent, and religious service attendance was negatively associated with suicide intent, $F(3, 88) = 20.78$ $p < 0.0000$. Because RC was found to be strongly correlated with religious service attendance, CBSS, and moral objections to suicide, we omitted religious service attendance, CBSS, and RFL from the regression analysis; the only contributor to suicide intent was interpersonal needs, $F(1, 132) = 101.68$, $p < 0.0000$.

We regressed subscales on suicide intent to understand which aspects of these variables are associated with suicide intent. Perceived burdensomeness was positively associated with suicide intent, and religious service attendance was negatively associated with suicide intent, $F(2, 74) = 47.21$, $p < 0.0000$. With religious service attendance, CBSS subscales, and

moral objections to suicide excluded, suicide intent was positively related to Perceived burdensomeness, $F(1, 113) = 130.79$, $p < 0.0000$.

Hypothesis 5: *RC, demographics, and suicide intent.*

Marital status, religious service attendance, and age predicted suicide intent, with RC omitted from the model, $F(3, 72) = 5.34$, $p = 0.002$. Because religious service attendance and RC are strongly correlated, religious service attendance was omitted from the model, and RC was found to predict suicide intent with marital status, $F(2, 114) = 4.21$, $p = 0.02$.

Those who reported being divorced reported more suicide intent than married respondents ($p = 0.05$), $F(4, 357) = 2.98$, $p = 0.02$. Married respondents reported more RC than divorced ($p = 0.001$) or never married respondents ($p < 0.0000$), $F(4, 356) = 14.34$, $p = 0.0000$ and more CBSS than never married respondents ($p < 0.0000$), $F(4, 356) = 9.74$, $p < 0.0000$. RC (but not suicide intent) differed by age, $F(16, 342) = 4.04$, $p < 0.0000$. For example, respondents age 33 reported more RC than respondents age 22 ($p = 0.01$).

Respondents who identified as Protestant reported less suicide intent than Catholic ($p < 0.0000$), Jewish ($p = 0.05$), or None ($p < 0.0000$) respondents, $F(4, 350) = 16.93$, $p < 0.0000$. Protestant respondents also reported more RC than any other religion (with Catholic respondents reporting more RC than None, $p < 0.0000$), $F(4, 351) = 107.57$, $p < 0.0000$, more CBSS than any other religion (with Catholic respondents reporting more CBSS than None, $p < 0.0000$), $F(4, 351) = 61.12$, $p < 0.0000$, and more belongingness than Catholic ($p < 0.0000$) and None ($p < 0.0000$) respondents, $F(4, 351) = 15.5$, $p < 0.0000$. Catholic respondents reported more RFL than Jewish ($p < 0.01$), Protestant ($p = 0.01$) or None ($p = 0.004$) respondents (with Protestant respondents reporting more RFL than None, $p < 0.0000$), $F(4, 351) = 9.39$, $p < 0.0000$). Compared to those respondents who did not identify as born again ($n = 157$), those who identified as born again ($n = 200$) reported less suicide intent, $F(1, 354) = 42.68$, $p < 0.0000$, more RC, $F(1, 355) = 616.23$, $p < 0.0000$, more CBSS, $F(1, 355) = 314.19$, $p < 0.0000$, more belongingness, $F(1, 355) = 37.65$, $p < 0.0000$, and more RFL, $F(1, 355) = 17.54$, $p < 0.0000$.

4. Discussion

Religious young adult participants reported significantly less suicide intent than non-religious young adult participants. Both RC and religious service attendance were negatively correlated with suicide intent, suggesting a protective effect for religion, consistent with the literature linking RC and religious service attendance with positive health outcomes (Matthews et al. 1998; VanderWeele et al. 2016). The correlation in this study between RC and suicide intent was stronger ($r = -0.35$, $p < 0.0000$) than that reported by Hovey et al. (2014) between intrinsic religiosity and suicidal behaviors ($r = -0.13$, $p <= 0.05$) and similar to that reported by Abdullah et al. (2023) between RC and suicidal ideation ($r = -0.32$, $p < 0.01$).

The strong positive correlations between RC, religious service attendance, CBSS, and moral objections to suicide suggest that these are related constructs yet distinct. Their negative correlations to suicide intent suggest that these constructs figure meaningfully in the calculations of suicidal religious young adults as they estimate the likelihood that they will attempt suicide. While these variables were associated with less suicide intent, moral objections to suicide and RC were more strongly negatively correlated with suicide intent than CBSS and religious service attendance.

In regression analyses, religious service attendance was consistently negatively associated with suicide intent, and RC was removed from the regression models despite RC being more strongly correlated to suicide intent. Other literature suggests that RC may have mediating indirect effects on outcomes. Religious service attendance has been found to be the strongest religious predictor of lower mortality, stronger than self-identification as a very religious/spiritual person, weakening the associations between religious coping and self-identification as a very religious/spiritual person on lower mortality (VanderWeele et al. 2017). Morton et al. (2017) found that religious engagement (self-identification as

religious, intrinsic religiosity, and positive religious coping) had indirect effects on health through church activity (church attendance and other church activities), positive religious support, and emotionality. Abdullah et al. (2023) found that RC mediated between impulsivity and suicidal ideation. In this sample of young adults, RC did not have direct effects on suicide intent, though religious service attendance did.

Almost four times more religious young adult respondents reported PRFS than did not, suggesting that the pandemic was associated with spiritual struggles for many of them. While Groups One and Three reported similar RC, Group One reported more PRFS, more moral objections to suicide, and more religious service attendance. Group One's qualitative responses to PRFS item one, which was found to moderate between suicide intent and religious service attendance, centered primarily (n = 63) on the theme of feeling alone (e.g., "I have not had the sense of community with others who believe similar things. We do not have the casual interactions that develop relationships") and secondarily on the theme of suffering (n = 24) "How could a loving god let this [pandemic] destroy so many lives?") While Group One reported more frequent religious service attendance, Group One also reported more PRFS. PRFS moderated the benefits of CBSS. CBSS was associated with lower suicide intent in those with lower PRFS but not in those with higher PRFS, suggesting that spiritual struggles may moderate the benefits of religious service attendance and CBSS, consistent with research that has found that "religion is associated with greater physical and mental health except . . . when religious people feel angry or punished by God or deserted by God" (Koenig et al. 2012, p. 97). Professional caregivers who provide support to religious suicidal young adults should note that CBSS may not be protective among those religious suicidal young adults with spiritual struggles. While Pargament and Exline (2022) provide guidance on how mental health providers can work with spiritual struggles in psychotherapy, mental health providers might collaborate with and make referrals to faith leaders when necessary (Vieten et al. 2013).

It is interesting to note that while Group One reported more PRFS, they attended religious services more frequently than Group Three, who reported fewer PRFS. It may be that religious service attendance sustained suicidal religious individuals by giving them the hope of finding meaning in suffering or a resolution of PRFS. Meaning in life has been found to have weak-to-moderate associations with health (Czekierda et al. 2017). As noted by Morton et al. (2017), stressful events feel less threatening when one believes that they are meaningful instead of pointless and random. Spirituality may reduce the risk of suicide by providing meaning in the midst of suffering (Bryan et al. 2015). In one study, meaning in life differentiated between suicidal and non-suicidal religious youth (Wilchek-Aviad and Malka 2016). As Holocaust survivor and psychiatrist Viktor Frankl (2006) wrote, "Life is potentially meaningful under any conditions, even those which are most miserable" (p. 137). Group One may have attended more religious services as a means to finding meaning in the midst of their PRFS.

The negative association between moral objections to suicide and suicide intent is consistent with other studies (e.g., Dervic et al. 2004). It has been suggested that a lower incidence of suicide among African Americans may be partly attributable to orthodox beliefs, including the unacceptability of suicide (Garlow et al. 2005; Neeleman et al. 1998). It may be that moral objections to suicide provide simple decision strategies to religious suicidal young adults in a suicide crisis. Mark Williams (1997) has highlighted the difficulties of suicidal individuals to problem solve effectively. For example, individuals in a suicide crisis may not remember and consider all relevant choice information and may not generate effective solutions. Davis-Stober et al. (2019) highlight the risky decision strategies of intoxicated individuals and show that some can benefit from simple mental rules or heuristic decision strategies. It may be that moral objections to suicide, combined with RC, may simplify the decision-making of religious suicidal young adults in a suicide crisis and provide a heuristic decision strategy, e.g., "A person committed to my beliefs does not take their life". As noted by Duckworth (2016), when making decisions, "We ask ourselves: Who am I? What is this situation? What does someone like me do in a situation like this?

The logic of anticipated costs and benefits doesn't explain their choices very well. The logic of identity does" (p. 248).

A robust finding in the literature is the relationship between suicide intent and INQ-15 and the Perceived burdensomeness subscale (Van Orden et al. 2012). Perceived burdensomeness may be more important than thwarted belonging because "relationships cannot meet the need to belong when the interactions are characterized by perceptions of burdensomeness" (Van Orden et al. 2012, p. 212). The finding that Groups One and Three reported less perceived burdensomeness than Group Two (who self-identified as not religious/atheist) is consistent with Mason et al. (2018), who found that congregants who attended one or more faith community activities per week reported significantly less perceived burdensomeness.

While suicide-bereaved individuals can be at elevated risk for suicidal ideation (Cerel et al. 2017a, 2017b) and suicide attempts (Pitman et al. 2016), suicide loss was not associated with suicide intent in this study. The reason for this finding may be that these respondents reported average closeness to the deceased and an average impact of suicide. Cerel et al. (2014) and others (Cerel et al. 2017b; Pitman et al. 2016) have found that suicide loss may not lead to suicide intent depending on the emotional closeness to the decedent. Also, it is not known how the impact of pandemic-related deaths may have affected the impact of suicide deaths in this sample of young adults.

Including those who did not answer all security questions accurately did not affect results significantly. This finding is consistent with Kung et al. (2018), who found that security questions do not affect survey validity.

A limitation of the study is that causation cannot be inferred from the self-report of a small convenience sample. The age range was limited to young adults, and the relevance of the findings to children or older adults and other educational settings is unknown.

Future possible research directions might focus on the protection of RC, moral objections to suicide, CBSS, and religious service attendance, how these are related yet distinct constructs, whether each variable's association with lower suicide intent is direct or indirect through other variables and how each may interact with spiritual struggles or negative religious coping. It would be important to understand how professional caregivers can assess religious service attendance, RC, moral objections to suicide, CBSS, and PRFS in suicidal religious young adults. Assessing the frequency of religious service attendance, weekly or more or less, may be more straightforward than assessing RC, moral objections to suicide, CBSS, and PRFS. Mental health providers and faith leaders may need to collaborate to address these risks and protections in suicidal religious young adults (Vieten et al. 2013).

5. Conclusions

RC and moral objections to suicide were associated with lower suicide intent, though religious service attendance had direct effects on suicide intent. Professional caregivers may use religious service attendance as a straightforward way to assess a possible protective factor for suicidal religious young adults. They may also assess for moral objections to suicide, which may provide simple decision rules in a suicide crisis. However, while religious young adult respondents with PRFS attended religious services more frequently than those without PRFS, they may not have been protected by the support they received in their faith community, suggesting that spiritual struggles may be a risk factor for suicide intent. The large number of religious young adults reporting PRFS in this study suggests the need for professional caregivers to assess for spiritual struggles. Because of the interplay of spiritual risks and protections, mental health providers who are unsure of how to address these in therapy may need to collaborate with and make referrals to faith leaders to increase protections and reduce risks in suicidal religious young adults.

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