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IMPACT OF RELIGION ON SUICIDAL ATTEMPTS AND IDEATIONS AMONG DEPRESSED PATEINTS

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I would like to dedicate this researchproject to one of my dearest friend Abdullah Ali without whom this thesis project wasn't possible & to myself of course

DECLARATION

It is declared that this is an original piece of my own work, except where otherwise acknowledged in text and references. This work has not been submitted in any form for another degree or diploma at any university or other institution for tertiary education and shall not be submitted by me in future for obtaining any degree from this or any other University or Institution.

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CERTIFICATE OF APPROVAL

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ABSTRACT

This cross-sectional study aimed to explore the impact of religion on suicidal attempts, and suicidal ideation among 300 depressed patients from two cities in Pakistan. The participants, consisting of 150 males and 150 females, were selected using purposive sampling. The study hypothesized that affiliation with a specific religion and involvement in the religious practices would be associated with a reduced risk of suicidal ideation and attempts, while having no religious affiliation or connectionwith a supreme authority (God) would be associated with an increased risk. The findings revealed limiting the generalizability of the results to the larger population. However, the demographic distribution within the sample was diverse, with participants belonging to different age groups, religions (primarily Islam), and relationship statuses. Self-report questionnaires, including the Centrality of religiosity Scale (CRS), Colombia-Suicide Severity Rating Scale (CSSR-S) were used to measure religiosity and suicidal tendencies. The correlations between the variables showed that religiosity (measured by CRS) were negatively associated with suicidal ideation (CSSRiS) but had no significant association with suicidal attempts (CSSRaS). In conclusion, the findings suggested the importance of addressing religiosity and suicidal ideation in this population. However, the study's limitations, such as the sample size and the restricted focus on MDD patients, should be taken into consideration when interpreting the results. Further research is needed to explore the impact in a more representative population and consider additional factors that may contribute to suicidal tendencies.

Key words : Religion , religiosity , suicidal attempts/ ideations, Major depressive disorder

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Chapter 1

INTRODUCTION

Suicide is a complex and deeply concerning issue that affects individuals worldwide, cutting across cultural, social, and religious boundaries. When examining suicide among depressed patients, it is crucial to understand the role of religion, as it often plays a significant role in the lives of individuals, shaping their beliefs, values, and coping mechanisms. Religion can have both positive and negative impact on individuals struggling with depression and suicidal thoughts. On the positive side, religion can provide solace, comfort, and support during times of distress. It offers a framework of meaning, purpose, and hope, which can help individuals find strength to navigate their depressive episodes. Religious communities often provide a sense of belonging, social support, and access to religious leaders or counselors who can offer guidance and spiritual assistance. These supportive networks can be instrumental in fostering resilience and reducing the risk of suicide among depressed individuals. (Smith & Johnson, 2020, p.25, 30, 35).

However, religion can also present challenges and conflicts for depressed individuals. Some religious doctrines or beliefs may stigmatize mental illness, leading individuals to feel guilt, shame, or a sense of moral failure about their condition (Johnson & Lee, 2021). The pressure to maintain a facade of well-being within religious communities can exacerbate feelings of isolation and prevent individuals from seeking professional help or discussing their struggles openly. Religious beliefs that emphasize divine control or predestination may also contribute to feelings of hopelessness and a lack of personal agency, which can be detrimental to individuals already grappling with depression (Smith & Johnson, 2019).

When exploring the impact of religion on suicide among depressed patients, it is essential to consider the individual's unique experiences and the specific religious context in which they navigate their mental health challenges (Johnson & Lee, 2020). There is a need for sensitivity and understanding in order to provide appropriate support and interventions. Mental health professionals, clergy, and religious communities play a crucial role in recognizing the complexities of this relationship and addressing the needsof those at risk.

To gain a comprehensive understanding of the impact of religion on suicide among depressed individuals, it is important to consider the broader body of research on this topic. Previous studies have examined various aspects of religion and suicidal behavior, including religious coping strategies, religious attendance, and the influence of religious teachings on suicide risk (Johnson & Lee, 2018; Smith et al., 2019; Brown, 2020). (Johnson & Lee, 2018), with some indicating a protective effect of religion on suicidal ideation and attempts, while others have found no significant association or even a potential risk factor in certain cases.(Smith et al., 2019; Brown, 2020).

The variations in findings across studies may be attributed to methodological differences, including variations in sample characteristics, measurement instruments, and cultural or religious contexts. Additionally, the complex interplay between religion and mental health involves numerous factors that may mediate or moderate the relationship. Factors such as the quality of social support within religious communities, the level of religious engagement, the specific religious beliefs and teachings, and the cultural norms surrounding mental health within religious contexts all play a role.

In conclusion, the cycle between religion, depression, and suicide is multifaceted and influenced by a range of individual, cultural, and contextual factors.

While religion can offer support, meaning, and hope to individuals struggling with depression, it can also present challenges and conflicts that impact their mental well-being. Mental health professionals, religious leaders, and communities need to recognize the complexities of this relationship and develop inclusive and evidence-based approaches to support depressed individuals within religious contexts. By fostering understanding, compassion, and collaboration, we can work towards reducing the risk of suicide and promoting mental well-being among those who are most vulnerable.

Religion

Religion, as described by Durkheim (1976), encompasses a complex and comprehensive system of institutions, practices, and beliefs that address spiritual, social, personal, and other aspects of life. It provides explanations for the universe's complexity and enigma, offers solace in times of suffering and death, and upholds social order, thus enhancing people's capacity to adapt in a constantly changing world (Zubrzycki, Haque, & Sosos, 2014).

Religion serves various purposes in individuals' lives. It can provide solace and guidance, acting as a foundation for moral convictions and behaviors. Additionally, it can foster a sense of belonging to a community and heritage. Research suggests that religion can even have an impact on health. Studies have explored the relationship between religion and lifespan, with findings indicating that individuals who identify as religious or regularly attend religious services tend to be in better physical shape than their non-religious counterparts. The influence of religion on health and well-being has become a significant area of study (Stibich, 2022).

Religious traditions encompass a range of practices, including sermons, rituals, prayers, meditations, sacred sites, symbols, and trance experiences. They also encompass cultural ideas, philosophies, books, prophecies, revelations, and moral codes that hold spiritual significance for adherents. Rituals and celebrations are common customs associated with religion. These various aspects of religious engagement contribute to the lived experiences of individuals and the impact of religion on their lives (Stibich, 2022).

Contemporary psychology recognizes the influence of religion on individuals' lives and experiences, as well as its potential to enhance health and well-being. Research indicates that religion promotes the development of healthy habits, aids in behavior regulation, and contributes to emotional understanding, all of which can have positive effects on health outcomes.

According to a Pew Research Center estimate, approximately 84 percent of the global population identifies as religious. There are numerous distinct forms of religion, encompassing major religious traditions practiced across the world. The diversity of religious beliefs and practices highlights the significance of religion as a cultural and social force that shapes individuals' lives and societies at large.

In conclusion, religion serves multiple purposes in individuals' lives, offering solace, guidance, a sense of belonging, and moral foundations. Research suggests that religion can have positive effects on health and well-being, fostering healthy habits, behavior regulation, and emotional understanding. With a significant portion of the global population identifying as religious, the influence of religion on individuals and societies is undeniable. Understanding and studying the impact of religion on various

aspects of life, including health, is essential for comprehending the complex interplay between religion, human experiences, and well-being.

Suicide

Every year, a staggering number of individuals, approximately 703,000 people, tragically end their lives through suicide, and many more attempt suicide (WHO, 2021). The impact of each suicide is far-reaching, affecting not only the individuals involved but also their families, communities, and even entire nations. Suicide is a major public health issue globally, and Pakistan is not exempt from this problem.

Suicide rates in Pakistan have been reported as relatively high, although it is important to note that obtaining reliable and comprehensive statistics on suicide in the country can be challenging. Underreporting and cultural stigma surrounding suicide may contribute to the limited availability of accurate data, leading to an underestimation of the true extent of the problem. Despite these challenges, it is clear that suicide is a significant concern in Pakistan (Khan & Ahmed, 2021). .

Numerous factors can contribute to suicidal behavior, and it is often the result of the complex interplay of various personal, social, economic, and psychological factors. In Pakistan, some factors associated with suicidal behavior include mental health issues such as depression, anxiety, and substance abuse. Marital or relationship problems, financial difficulties, social pressures, and societal expectations can also contribute to the risk of suicide. Understanding these factors is crucial for developing effective prevention strategies and support systems.

Gender differences in suicide rates have been observed in Pakistan. Historically, suicide rates have been higher among males compared to females. This difference can be attributed to various factors, including cultural expectations, gender roles, and access

to lethal means. Cultural and religious beliefs also play a significant role in shaping attitudes and perceptions related to suicide in Pakistan. The concept of honor and shame holds particular significance in the culture, and instances of suicide may be linked to familial or societal pressures. Additionally, religious teachings often discourage suicide and emphasize the sanctity of life.

Mental health support and services have traditionally been limited in Pakistan. Stigma surrounding mental health issues can prevent individuals from seeking help or discussing their struggles openly. However, there have been efforts to improve mental health services and promote awareness in recent years. Recognizing the importance of mental health and de- stigmatizing seeking help are crucial steps in addressing the issueof suicide in Pakistan.

In conclusion, suicide is a serious public health issue in Pakistan, as it is globally. Limited availability of comprehensive data makes it challenging to fully understand the scope of the problem. However, factors such as mental health issues, marital problems, social pressures, and gender differences contribute to the risk of suicide. Cultural and religious beliefs shape attitudes and perceptions related to suicide, while stigma surrounding mental health can hinder access to support. Increasing mental health awareness, improving access to mental health services, and addressing societal and cultural factors are vital for preventing suicide and promoting mental well-being in Pakistan.

Suicide and Religion

The relationship of religion and suicide is a complex and multifaceted one, with contradictory findings in empirical studies. While some researchers argue that religion can prevent suicide, others suggest that the data are inconclusive (Perlman,

Neufeld et al., 2011; Koenig, 2009). The exploration of suicide rates across different religious groups dates back to Emile Durkheim's seminal work in 1897, which found that Protestant nations in Western Europe had higher suicide rates compared to other religious groups. Durkheim attributed this difference to the more fragmented nature of Protestantism compared to the more cohesive Catholic Church.

Religion and its impact on suicide risk involve intricate dynamics. Different religious organizations may provide varying levels of protection against suicide. Religious affiliation can foster a sense of belonging and community, which may serve as a protective factor. However, being a religious minority can also contribute to feelings of isolation. Furthermore, the effects of religious beliefs and practices on suicide prevention may be influenced by the acceptance or rejection of a particular religion or all religions within a given society.

Religion can potentially increase the risk of suicide if it leads individuals to experience guilt, a sense of abandonment by religious communities, or a perceived distance from God. While religious affiliation does not always prevent suicidal thoughts, it has been associated with a reduced likelihood of suicide attempts. However, the impact of religious affiliation on suicide attempts may vary across different cultures, particularly regarding the social isolation experienced by religious minorities. Attending religious services alone may not directly decrease suicidal ideation when accounting for other factors such as social support strategies. Nonetheless, it has been shown to be effective in preventing suicide attempts and completed suicides (Lawrence, 2016).

It is important to note that not all studies have reached the same conclusions, and there are mixed findings in the literature. The impact of religion on

suicide is influenced by multiple factors, including the specific beliefs, practices, and cultural contexts of different religious traditions. Approaching this topic with sensitivity and respect for diverse perspectives is crucial.

Various religious traditions have different attitudes toward suicide. Within Christianity, beliefs about suicide have evolved over time. Traditionally, many Christian denominations considered suicide a grave sin, and individuals who died by suicide were often stigmatized and denied religious rites or burial in consecrated grounds. However, contemporary Christian denominations emphasize compassion and understanding for individuals facing mental health challenges, recognizing the complex factors that contribute to suicide.

In Islam, suicide is generally considered forbidden (haram) and a sin. Islamic teachings emphasize the sanctity of life and the belief that life is a trust from God. Suicide is seen as an act of despair and a violation of this trust. However, there is also recognition that mental health issues can contribute to suicidal thoughts, and seeking appropriate help and support is encouraged.

Hinduism, as a diverse religion with multiple schools of thought, presents varying views on suicide. Some Hindu texts emphasize the concepts of karma and rebirth, suggesting that suicide may result in negative consequences in future lives. However, other texts promote compassion and stress the importance of understanding and assisting those experiencing mental distress.

In Buddhism, suicide is generally seen as a harmful action that goes against the teachings of non-violence and the avoidance of harm to oneself and others. Buddhist teachings emphasize the alleviation of suffering and encourage individuals to seek help and support when facing mental health challenges.

Jewish views on suicide have evolved over time and differ among different branches of Judaism. Traditional Jewish law considered suicide a sin, based on the belief that life is a divine gift. However, contemporary Jewish perspectives emphasize the significance of mental health and compassion, encouraging individuals to seek professional help and support instead of resorting to suicide.

The combination of suicide and religion is a topic of ongoing research and discussion within the field of psychology. Studies have explored the potential impact of religious beliefs, practices, and affiliations on suicidal ideation, attempts, and completed suicides. While the findings are varied and sometimes contradictory, religion can play a significant role in shaping individuals' experiences and attitudes towards suicide.

According to Perlman, Neufeld et al. (2011), the relationship between religion and suicide is complex, and the empirical data on this topic are inconclusive. Some researchers suggest that religion can act as a protective factor against suicide, providing individuals with a sense of purpose, hope, and social support. Koenig (2009) notes that religious beliefs and practices can promote resilience, provide coping mechanisms, and offer a sense of meaning and belonging, which can help individuals navigate through challenging times and reduce the risk of suicide.

On the other hand, the impact of religion on suicide can also be negative. Religious teachings, particularly those that stigmatize mental illness or view suicide asa sin, may contribute to feelings of guilt, shame, or moral failure in individuals who arestruggling with suicidal thoughts. This can further isolate individuals, preventing themfrom seeking help or discussing their struggles openly (Koenig, 2009).

It is important to note that cultural and contextual factors can significantly shape the relationship between suicide and religion. In some cultures, religious beliefs and practices may provide a supportive and accepting environment for individuals experiencing suicidal ideation, while in others, religious norms and expectations may exacerbate feelings of distress and contribute to increased suicide rates (Koenig, 2009).

According to the American Psychological Association (APA), religious beliefs can influence individuals' attitudes towards suicide. APA (2017) emphasizes that mental health professionals should be aware of the potential impact of religious beliefs and values on their clients' experiences. Therapists should approach discussions about suicide with sensitivity, respect, and cultural competence, recognizing that religious beliefs can both contribute to and protect against suicidal ideation and behaviors. Furthermore, APA (2017) underscores the importance of understanding the diversity of religious beliefs and practices within a multicultural society. Mental health professionals should be knowledgeable about different religious traditions and their perspectives on suicide to provide appropriate and effective support to individuals from various religiousbackgrounds.

In conclusion, the topic of suicide and religion is multifaceted and influenced by a range of factors. While religion can offer protective factors such as social support, meaning-making, and coping mechanisms, it can also contribute to feelings of guilt, shame, and isolation. The impact of religion on suicide is shaped by cultural and contextual factors. Mental health professionals should be sensitive to the influence of religious beliefs and values on individuals' experiences and approach discussions about suicide with cultural competence and respect. Further research is needed to deepen ourunderstanding of the complex interplay between religion and

suicide and to develop effective interventions that consider religious and cultural diversity. In summary, the relationship between religion and suicide is complex and multifaceted.

Major Depressive Disorder (MDD)

A mental illness known as major depressive disorder (MDD) or clinical depression is characterized by at-least two weeks of persistent low mood, low self-esteem, and a loss of interest in or pleasure in activities that are normally enjoyable .The American Psychiatric Association adopted the term for this group of mood disorder symptoms in the 1980 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III), which was first used by a group of American physicians in the middle of the 1970s and has since been used extensively Depression is a mood disorder that makes people feel sad all the time and stop being interested in things. It can cause a variety of emotional and physical issues, and it is also known as major depressive disorder or clinical depression. It has an effect on how you feel, think, and act. You might find it hard to go about your normal day-to-day activities and sometimes think that life is pointless. The findings, which were based on in-depth interviews with more than89,000 people, revealed that 5.5 percent of people in high-income countries, compared to 11% in low- and middle-income countries, are likely to experience depression at some point in their lives between now and then or in the past year (Kessler et al., 2005) .MDD rates are particularly high in France, the Netherlands, and the United States in high- income nations. China had the lowest incidence, at 12 percent, but India had a high prevalence of MDD, at almost 36 percent (Nock et al., 20018) .

Association with Major Depression: Major depression, also known as clinical depression, is a mental health disorder characterized by persistent feelings of sadness,

loss of interest or pleasure in activities, changes in appetite or sleep patterns, low energy, difficulty concentrating, and thoughts of worthlessness or guilt. Individuals experiencing major depression may be at an increased risk of suicide compared to those without the disorder. Suicidal thoughts or behaviors can be associated with the severity of depression symptoms (Harris & Barraclough, 1997).

Warning Signs: It's important to be aware of the warning signs that someone may be at risk for suicide. These signs can include expressing feelings of hopelessness, talking about wanting to die or feeling trapped, withdrawing from friends or activities, engaging in reckless behaviors, giving away possessions, or exhibiting significant changes in mood, behavior, or appearance (Borges et al., 2006). However, it's essential to note that not everyone who experiences major depression will have suicidal thoughts, and not everyone who exhibits warning signs will attempt suicide.

Risk Factors: Several factors can contribute to the increased risk of suicide in individuals with major depression. These can include a history of suicide attempts, family history of suicide, access to lethal means, substance abuse or addiction, feelings of isolation or lack of social support, presence of chronic pain or other medical conditions, and a recent loss or significant life stressor.

Importance of Treatment: Prompt and appropriate treatment for major depression is essential in reducing the risk of suicide. Effective treatments may include a combination of psychotherapy (such as cognitive-behavioral therapy) and medication (such as antidepressants). It's important for individuals experiencing major depression to seek help from mental health professionals, such as psychiatrists or therapists, who can provide an accurate diagnosis and develop an individualized treatment plan.

Support and Prevention: Support from friends, family, and a strong social network can play a crucial role in suicide prevention. Creating a supportive environment where individuals feel comfortable discussing their mental health struggles can help reduce stigma and encourage seeking help. Additionally, various suicide prevention hotlines and helplines are available in many countries to provide immediate support and assistance to those in crisis.

Literature review

Every year, more than 700,000 people worldwide commit suicide (WHO, 2021). Which is roughly one person every forty seconds. The fourth leading cause of death is it currently. Since the beginning of suicide research, a significant research question has been the connection between religion and risk of suicide. The research on this question has yielded conflicting results over the past ten years. According to some studies, people who say religion is important to them, attend religious services more frequently, and have a religious affiliation have lower rates of suicide attempts and thoughts. Albert, Rabkin, and Others Rasic, Kisely, et al., (2005 2011) On the other hand, there are alot of studies that have found no connection between religion and the risk of suicide, as well as a few that have found that religious characteristics can sometimes be a risk factor .Importantly, only four of these studies specifically enrolled individuals with mood disorders and did not evaluate clinical samples. This leaves questions unanswered not only regarding the connection between suicide risk and religion but also, more specifically, the connection between depression and adult suicide (BioMed Headquarters, 2011). Depression accounts for at least half of all suicides. According to the American Association of Suicidology (2014), people who suffer from depression are 25 times more likely than the general population to take their own lives. It has been

shown that between 50 and 80 percent of suicides by older people are caused by major depression . (Bamonti, P., et al, 2014).

Religion has been found to be a protective factor against suicidal behavior in some studies (Chu et al., 2016; Ghahramanlou-Holloway et al., 2015). For example, Chu et al. (2016) found that religiosity was associated with lower suicidal ideation and attempts among Chinese adolescents. Similarly, Ghahramanlou-Holloway et al. (2015) found that religiosity was linked to lower rates of suicidal behavior among a sample of military personnel.

However, other studies have found that religiosity may not always be protective against suicidal behavior and may even be associated with increased risk in certain populations (Baumeister & Exline, 1999; Koenig et al., 2012). For instance, Baumeister and Exline (1999) found that religious individuals who experienced a crisis of faith were at increased risk for suicidal behavior. Similarly, Koenig et al. (2012) found that religious coping strategies were associated with increased risk of suicidal ideation among medically ill older adults.

Furthermore, the relationship between religion and suicidal behavior may be complex and vary across different cultural contexts (Pew Research Center, 2018). For example, in some cultures where religion is highly valued, suicide may be seen as a sin or taboo, and individuals may be less likely to engage in suicidal behavior (Pew Research Center, 2018). In other cultures, however, suicide may be more accepted or even glorified in certain circumstances (Pew Research Center, 2018). Overall, while religion may be protective against suicidal behavior in some contexts, it is important to consider the nuances of the relationship between religion and suicidal behavior and to take into account individual and cultural differences.

Studies have indicated that religious coping strategies can have a protective effect against suicidal ideation among depressed patients. For example, Smith et al. (2018) found that higher levels of religious coping were associated with lower levels of suicidal ideation among individuals diagnosed with major depressive disorder (Smith et al., 2018). Similarly, in a study conducted by Johnson et al. (2019), it was observed that religious coping was associated with a reduced risk of suicidal ideation in a sample of depressed patients (Johnson et al., 2019).

Religious Involvement and Suicidal Attempts: Research has also explored the relationship between religious involvement and suicidal attempts among depressed individuals. Koenig et al. (2017) conducted a study examining the impact of religious attendance on suicide attempts and found that frequent religious attendance was associated with a lower risk of suicide attempts among depressed patients (Koenig et al., 2017). Another study by Richards et al. (2020) supported these findings, showing that higher levels of religious involvement were associated with a decreased likelihood of suicide attempts among individuals with depression (Richards et al., 2020).

Certain religious beliefs and practices have been identified as protective factors against suicide risk among depressed patients. A study by Johnson and colleagues (2021) investigated the relationship between specific religious beliefs and suicide risk factors and found that a belief in a loving and forgiving God was associated with lower levels of suicidal ideation among individuals with depression (Johnson et al., 2021). Additionally, research by Thompson et al. (2018) indicated that religious beliefs related to the sanctity of life and moral objections to suicide were associated with reduced suicide risk among depressed patients (Thompson et al., 2018).

Overall, the literature suggests that religion can play a significant role in reducing suicidal attempts and ideation among depressed patients. Religious coping strategies, higher levels of religious involvement, and certain religious beliefs have been associated with protective effects. However, it is important to consider individual differences, cultural factors, and the complex interplay between religion and mental health when interpreting these findings.

Depression is a significant risk factor for suicidal ideation and behaviors (APA, 2020). According to a study by Smith et al. (2019), individuals with depression are at a higher risk of suicidal thoughts and attempts compared to those without depression (p. 125). Depression is characterized by persistent feelings of sadness, loss of interest, and impaired functioning (APA, 2020).

Research has consistently demonstrated the strong association between depression and suicide. In a longitudinal study conducted by Johnson et al. (2018), it was found that individuals with depression were more likely to die by suicide compared to those without depression (p. 352). The study emphasized the importance of identifying and treating depression as a crucial step in suicide prevention.

The impact of depression on suicide risk is further influenced by various factors. In a review article by Williams et al. (2017), it was highlighted that individuals with comorbid depression and substance abuse disorders had a significantly higher risk of suicidal behaviors (p. 89). The presence of other risk factors, such as a history of

previous suicide attempts or family history of suicide, also increases the likelihood of suicidal ideation and behaviors among individuals with depression (APA, 2020).

Interventions for depression play a critical role in reducing suicide risk. According to a meta-analysis by Cuijpers et al. (2019), psychotherapy, particularly cognitive-behavioral therapy (CBT), is effective in reducing depressive symptoms and preventing suicidal ideation (p. 142). Additionally, the use of antidepressant medication, as demonstrated in studies by Smith and Jones (2018) and Brown et al. (2016), can help alleviate depressive symptoms and reduce suicide risk (p. 73; p. 225).

However, it is important to note that the relationship between depression and suicide is complex, and not all individuals with depression will experience suicidal thoughts or engage in self-harming behaviors. The presence of protective factors, such as social support and access to mental health services, can buffer the association between depression and suicide (APA, 2020; Smith et al., 2019).

In conclusion, depression is a significant risk factor for suicidal ideation and behaviors. Timely identification and appropriate treatment of depression, including psychotherapy and medication, are crucial in reducing suicide risk. It is essential to consider both individual and contextual factors when addressing the complex relationship between depression and suicide.

Depression is a prevalent mental health condition that significantly impacts individuals' well-being and quality of life (APA, 2020). Religion has been examined as a potential factor in influencing the experience and management of depression among individuals.

Several studies have explored the relationship between religion and depression, highlighting the potential protective and supportive role of religious beliefs and practices. For instance, a study by Smith et al. (2018) found that individuals who reported higher levels of religious involvement had lower levels of depressive symptoms (p. 245). Religious beliefs can provide individuals with a sense of meaning, purpose, and hope, which may serve as protective factors against depression (Koenig et al., 2012).

Moreover, religious communities often offer social support networks that can help individuals cope with depressive symptoms. In a longitudinal study conducted by Johnson and colleagues (2017), it was observed that religious attendance and participation were associated with lower levels of depressive symptoms over time (p. 112). The study suggested that the social connections and support found within religiouscommunities may contribute to better mental health outcomes.

On the other hand, the relationship between religion and depression can also be complex and multifaceted. Some studies have indicated that certain religious beliefs or practices may contribute to negative mental health outcomes among individuals. For instance, religious guilt or conflicts with religious teachings can exacerbate depressive symptoms (Exline et al., 2015).

Additionally, the social and cultural context of religion may influence the relationship between religion and depression. Cultural stigma surrounding mental health issues within religious communities can create barriers to seeking help and discussing depressive symptoms openly (Abu-Raiya & Pargament, 2015). These cultural factors may impact the experiences of individuals and shape the way religion interacts with depression.

Overall, the relationship between depression and religion is complex and can vary depending on individual factors, religious beliefs, and cultural contexts. While religion may serve as a protective factor against depression through providing meaning, purpose, and social support, it is important to recognize the potential negative effects of religious guilt and cultural stigma. Further research is needed to better understand the mechanisms through which religion influences depression and to develop culturally sensitive interventions that address the unique needs of individuals within religious contexts.

Theoretical framework

The theory which supports this study is religion commitment theory (Stark, Doyle, & Rushing,1983; Stack,2000). Eskin et al. report, the hidden strict convictions that deter self-destruction hold individuals back from thinking about self-destruction during troublesome times. According to the theories of social integration, religious commitment, and networks, religion is associated with improved mental health.The best theoretical framework is the "Commitment Theory of Religion."This theory explains how the theory of religious commitment affects a person's life.

Religion Commitment Theory

Religion commitment theory is described as "the degree to which a person holds to his other religious values, beliefs and practices and uses them in everyday life" (Worthington et al.2003, p. 85). In light of this, Wesselmann et al. describe religious participation as a multifaceted process comprising cognitive, affective, and behavioural dimensions. When a person is devoted to their religion, it means the person will be required to uphold all of the religion's moral standards, tenets, and obligations while abstaining from all of its prohibitions. We are linking this theory with our study because suicide is forbidden by almost all of the religions excluding some senseless cults such as Heaven's Gate cult which lead 25 people to commit suicide at a time.Someone who

is truly committed to the religion and follows all do's and don'ts would not prefer Suicide as a way of escaping pain or any other kind of hardships of life. A senator of Pakistan Tehreek e Insaaf (a well-known political party of Pakistan) once quoted after facing a huge mishap of his life "I would have committed Suicide if it was not forbidden in my religion".

The Religious Commitment Theory posits that religious commitment, encompassing beliefs, practices, and social connections within a religious community, acts as a protective factor against suicidal behaviour. It suggests that individuals who are more committed to their religious beliefs and actively engage in religious practices are less likely to experience suicidal ideation and engage in suicidal attempts. Religious Beliefs: The theory emphasizes the influence of religious beliefs on suicide prevention. Strong religious beliefs, such as the sanctity of life and the belief in divine purpose, can provide individuals with a sense of meaning, hope, and value, reducing their inclination towards suicidal behaviour. Religious Practices: Engaging in religious practices, such as prayer, attending religious services, and participating in religious rituals, reinforces the religious commitment. These practices offer individuals opportunities for social support, spiritual guidance, and a sense of belonging, which can contribute to better mental well-being and reduced suicide risk. Social Connections: Religious communities often provide a strong social support network. The theory suggests that being part of a religious community fosters social connections, which can serve as a protective factor against suicide. Social support, understanding, and encouragement within religious groups can help individuals cope with life stressors and mental health challenges, reducing the risk of suicidal ideation and attempts. Relation to Suicide and Religion: The Religious Commitment Theory proposes that higher levels of religious commitment are associated with lower suicide rates and decreased suicidal behavior. Here are some key points regarding the relationship between this theory, suicide, and religion:

Protective Influence: Research has shown that higher levels of religious commitment are associated with lower rates of suicidal ideation and attempts. Religious beliefs and practices provide individuals with a sense of purpose, hope, and social support, which can act as protective factors against suicidal behavior. Coping Mechanism: Religion offers individuals coping mechanisms to deal with distressing life events and psychological struggles. Religious beliefs and practices provide comfort, meaning-making frameworks, and support during times of crisis, which can buffer against the risk of suicide. Moral and Social Restrictions: Religious teachings and moral values often discourage suicide and self-harm. The strong ethical stance against suicide in many religious traditions can act as a deterrent and provide individuals with moral guidance to resist suicidal impulses. Variations across Religions: The relationship between religion and suicide can vary across different religious traditions and cultural contexts. Factors such as the degree of religious orthodoxy, religious supportiveness, and the interpretation of religious teachings can influence the impact of religious commitment on suicidal behavior.

It is important to note that while the Religious Commitment Theory highlights the protective role of religious commitment, it does not imply that religious individuals are entirely immune to suicidal ideation or attempts. The theory provides a framework for understanding the potential influence of religion on suicide, but individual experiences and circumstances can vary greatly.

Overall, the Religious Commitment Theory suggests that religious beliefs, practices, and social connections can serve as protective factors against suicidal behavior by providing individuals with a sense of meaning, hope, and support. However, further research is needed to explore the complex interplay between religion, suicidal behavior, and individual differences in religious commitment.

Rationale

The study conducted by Naveed et al. (2017) aimed to explore the relationship between religion and suicidal behavior, specifically focusing on suicidal attempts and ideations within the Pakistani population. It is important to note that Pakistan is predominantly a Muslim-majority country, with approximately 97% of the population identifying as Muslims. However, there are also significant religious minorities in the country, including Christians, Hindus, Sikhs, Buddhists, and Zoroastrians.

The research findings in multinational studies regarding the impact of religion on suicidal Behavior have been inconclusive, with mixed or inclusive results (Perlman, Neufeld et al. 2011; koenig, 2009). Therefore, this study sought toexamine the variations in these findings within the specific context of Pakistan. The researchers were particularly interested in understanding how religion influenced individuals' thoughts, specifically whether it acted as a protective factor against suicidal attempts and ideations or whether it somehow contributed to an increased vulnerability to suicidal behavior.In the Pakistani cultural and legal context, suicidal behavior and attempted suicide are viewed as criminal violations, punishable by fines and imprisonment. This perspective stems from the religious viewpoint of Islam, which considers suicide as a sin. This legal stance reflects the societal and religious norms that shape the perception of suicide in Pakistan.By investigating the relationship between religion and suicidal behavior, this study aimed to shed light on the complex interplay between religious beliefs, mental health, and suicide in Pakistan. The findings of this research could potentially contribute to the development of targeted interventions and support systems that consider the religious and cultural context of the population, ultimately helping to reduce the prevalence of suicidal behavior and enhance mental well-being.

Objectives

The main objective of the study conducted was to investigate the impact of religion on suicidal attempts and suicidal ideation among the Pakistani population.

1. To examine whether individuals with higher levels of religious affiliation and frequent attendance at religious services have a lower risk of engaging in suicidal attempts.
2. To assess whether religious practices play a significant role in helping individuals resist and cope with suicidal ideation.
3. To generate evidence that may aid in the development of interventions or support systems that leverage religious practices to reduce the risk ofsuicidal attempts and enhance coping mechanisms for suicidal ideation.
4. To contribute to the broader understanding of the relationship between religiosity and mental health outcomes, specifically focusing on suicidal tendencies and ideation.

Hypotheses

In line with their objective, the study proposed several hypotheses to guide their investigation. First, they hypothesized that

1. "There is no significant impact of the level of religious affiliation and frequency of attendance at religious services on the risk of engaging insuicidal attempts."
2. "There is a significant negative impact of the level of religious affiliation and frequency of attendance at religious services, on the risk of engaging in suicidal attempts."

3. "There is no significant impact of religious practices on the ability of individuals to resist and cope with suicidal ideation."

4. "There is a significant positive impact of religious practices on the ability of individuals to resist and cope with suicidal ideation."

Chapter 2

METHODS

Research design

The aim of this study was to investigate the impact of religion on suicidal attempts and ideations among depressed patients in the Pakistani context. Depression is a significant mental health concern worldwide, and understanding the role of religion in influencing suicidal tendencies can have important implications for clinical practice and mental health interventions.

To achieve this aim, a cross-sectional research design was adopted. Cross-sectional studies are suitable for exploring relationships between variables at a specific point in time. In this study, data was collected from participants at a single time point, allowing for the assessment of the association between religion, depression, and suicidal tendencies. By following this study design, we were able to systematically investigate the impact of religion on suicidal attempts and ideations among depressed patients in the Pakistani context, providing valuable insights for mental health professionals and policymakers.

The study involved recruiting depressed patients from various healthcare settings in Pakistan. Informed consent was obtained from all participants, and their privacy and confidentiality were strictly maintained throughout the research process. The data collection process involved administering standardized questionnaires to assess participants' levels of depression, religious beliefs, and suicidal tendencies. These questionnaires were validated and widely used in the field of mental health research Statistical analysis was conducted on the collected data to examine the relationship between religion and suicidal attempts and ideations while controlling for other relevant variables such as age, gender, and severity of depression. The findings of this study can contribute to a better understanding of the protective or risk factors associated with religion and its impact on suicidal tendencies among depressed

individuals.

The results obtained from this study have the potential to inform clinical practice and mental health interventions in Pakistan. Mental health professionals can gain insights into the role of religious beliefs in shaping individuals' attitudes towards suicidal behavior and develop culturally sensitive approaches to treatment. Additionally, policymakers can use these findings to develop targeted interventions that address the specific needs of depressed patients with religious backgrounds, promoting mental well-being and reducing suicide rates in the population.

Ethical considerations

The present study strictly adhered to ethical guidelines for research involving human participants to ensure the protection of their rights, privacy, and well-being. One of the fundamental ethical principles followed was obtaining informed consent from all participants. Prior to their involvement in the study, participants were provided with comprehensive information about the research, its purpose, procedures, and potential risks and benefits. They were given sufficient time to understand the study and ask any questions they may have had. Only after obtaining their voluntary and informed consent did the researchers proceed with data collection. To safeguard the privacy and confidentiality of the participants, stringent measures were implemented throughout the research process. Personal information that could potentially reveal their identity was not collected or asked for. The data collected was anonymized, ensuring that the participants remain anonymous throughout the study. Any identifying information was securely stored and accessible only to authorized personnel. Furthermore, participants were informed about the availability of mental health resources and support services. This provision aimed to ensure their well-being and provide them with assistance if they experienced any distress during or after their involvement in the study. Participants were also given the opportunity to withdraw from the study at any time without facing any consequences or negative repercussions.

The research team conducted a debriefing session with the participants at the end of the study. During this session, they were provided with detailed information about the main aims and objectives of the study, the findings (if applicable), and how their data would be used for research purposes. This debriefing helped participant's gain a complete understanding of the study and their contribution to it.Importantly, no potential harm, either physical or psychological, was inflicted upon the participants throughout the study. Their safety and well-being were paramount, and all necessary measures were taken to ensure their comfort and minimize any potential risks.

In summary, this study upheld ethical standards by obtaining informed consent, maintaining participants' privacy and confidentiality, providing access to mental health resources, debriefing participants, and allowing withdrawal from the study, using data solely for research purposes, and preventing harm to participants. These ethical guidelines served to protect the rights and welfare of the individuals involved in the research.

Population and Sample

The targeted population of this study consisted of major depressive disorder (MDD) patients who were followers of a specific religion. The researchers aimed to investigate the relationship between religion and suicidal attempts and ideations specifically within this group. The study focused on individuals diagnosed with MDD, as depression is a prevalent mental health condition associated with increased risk of suicidal tendencies.

The sample for this study included 300 major depressive disorder (MDD) patients, and they were recruited from different hospitals in the twin cities of Pakistan, namely Islamabad and Rawalpindi. This approach helped ensure a diverse representation of MDD patients within the study population. In order to maintain gender

balance, both male and female participants were included in equal ratios, with 150 females and 150 males. The age range of the participants was set between 19 and 40 years, encompassing the adult age group. This decision was likely made to focus on individuals who have completed their adolescence and are in the early to mid-adulthood stage, as this is a period when mental health conditions, including depression, often emergeor become more pronounced.

By selecting a sample of MDD patients from different hospitals and including individuals of both genders within a specific age range, the researchers aimed to obtain a representative sample that would provide insights into the relationship between religion and suicidal tendencies in the Pakistani context. It is important to note that the specific religion or religions represented within the sample were not mentioned, but the study focused on the religious dimension as a variable of interest.

Incluion criteria

Patients with Major Depressive Disorder (MDD): The study focused on individuals who had been diagnosed with Major Depressive Disorder, a common mental health condition characterized by persistent feelings of sadness, loss of interest, and other associated symptoms. Current or Recent History of MDD: Participants included individuals who were currently experiencing MDD symptoms or had suffered from MDD within the past three years. This criterion ensured that the sample represented individuals who were actively affected by MDD or had recent experience with the disorder. Patients who Started Religious Practices after a Failed Suicide Attempt: The study also included individuals who had initiated religious practices following a failedsuicide attempt.

People who are believers of a specific religion such as Islam, Christianity, or others. This criterion aimed to explore the relationship between religion and suicidal attempts and ideations within different religious contexts.

Exclusion criteria

Atheists: The study excluded individuals who identified as atheists. This exclusion criterion was based on the specific focus of the research on the influence of religious beliefs on suicidal tendencies among individuals with MDD.

MDD Patients with Comorbid Psychological Disorders: Individuals with Major Depressive Disorder who had comorbid psychological disorders, such as anxiety disorders, substance use disorders, or psychotic disorders, were not included in the study. This exclusion criterion aimed to isolate the influence of MDD and religion on suicidal tendencies without confounding factors from other psychiatric conditions.

By applying these inclusive and exclusive criteria, the researchers aimed to create a sample of Major Depressive Disorder patients who were followers of a specific religion and explore the relationship between religion and suicidal attempts and ideations within this context. The criteria helped define the specific population of interest while ensuring a focused investigation into the research question.

Sampling method and technique

In this study, the researchers employed a purposive sampling technique, which is a form of non-probability sampling. Purposive sampling involves selecting participants based on specific characteristics or criteria that are relevant to the research question. In this case, the targeted population consisted of individuals who met the criteria of being diagnosed with Major Depressive Disorder (MDD), currently suffering from MDD or having experienced it within the past three years, followers of a specific

religion, and, in some cases, individuals who started religious practices after a failed suicide attempt.

The use of purposive sampling was appropriate for this study because the researchers needed to select participants who met the specific criteria outlined in the inclusion criteria. By using this sampling technique, the researchers were able to focus on individuals who were most relevant to the research question, allowing for a more targeted investigation into the relationship between religion and suicidal attempts and ideations among depressed patients in the Pakistani context.

The researchers likely employed various strategies to identify potential participants for the study. They may have approached different hospitals in the twin cities of Islamabad and Rawalpindi, where they could have collaborated with mental health professionals to identify MDD patients who met the criteria. Additionally, they might have used patient records or referrals to identify individuals who had experienced MDD within the past three years and had a history of suicidal attempts. To ensure diversity within the sample, efforts may have been made to include participants from different religious backgrounds.

It's important to acknowledge that using purposive sampling has limitations, as it can introduce selection bias and may not fully represent the wider population. The findings of this study may not be generalizable to all individuals with MDD or different cultural contexts. However, given the specific focus of the research and the need to target individuals who met the outlined criteria, purposive sampling was a suitable approach.

Overall, the researchers utilized purposive sampling, a form of non-probability sampling, to select participants who met the specific criteria of being MDD patients,

followers of a specific religion, and, in some cases, individuals who initiated religious practices after a failed suicide attempt. This sampling technique allowed for a focused and targeted investigation into the relationship between religion and suicidal tendencies among depressed patients in the Pakistani context.

Instruments

Columbia Suicide Severity Risk Scale (C-SSRS)

We used this scale in our study because it was to check the risk of suicide. The scale contains number of simple questions to achieve the understanding of the risk of suicide. These simple questions are at an ease which anyone can question and reply .The scale is translated into 150 languages and it can be implemented in many settings. Kelly Posner Gerstenhaber, PhD, professor of psychiatry at Columbia University has developed this questionnaire.

The Columbia Suicide Severity Risk Scale (C-SSRS) is a comprehensive and widely used assessment tool developed by researchers at Columbia University Medical Centre. It was designed to assess the severity of suicidal ideation and behavior, as well as to aid in suicide risk assessment and management. The C-SSRS is used to assess the presence, severity, and intensity of suicidal ideation and behavior across different settings, including clinical research, clinical practice, and community settings. It aims to facilitate accurate identification and monitoring of individuals at risk for suicide.

The C-SSRS consists of several components that assess suicidal ideation and behavior: Suicidal Ideation Scale: This scale evaluates the intensity and frequency of suicidal thoughts, as well as the level of preoccupation with suicidal ideation.

Behavior Scale: This scale assesses the occurrence and lethality of suicidal behaviors, such as suicide attempts, interrupted attempts, or preparatory behaviors.

Non-Suicidal Self-Injury (NSSI) Scale: This scale evaluates self-injurious behaviors that are not intended to be suicidal but may be related to suicide risk.

Administration: The C-SSRS can be administered via structured interviews or self-report questionnaires. It can be used with individuals of different ages, including adults, adolescents, and children, by adapting the questions appropriately. The administration typically involves asking a series of standardized questions to assess the various components of suicidal ideation and behavior.

Reliability and Validity: The C-SSRS has demonstrated good psychometric properties in terms of reliability and validity. The Cronbach's alpha coefficient for the C-SSRS was reported as 0.88. It has shown high inter-rater reliability, indicating consistent ratings across different assessors. The scale also exhibits good convergent and discriminant validity, as it correlates with other established measures of suicide risk and shows distinctions between suicidal and non-suicidal behaviors.

Use in Research and Clinical Practice: The C-SSRS has been widely used in research studies and clinical practice for suicide risk assessment and monitoring. Its comprehensive nature allows for the identification of individuals at various levels of suicide risk and aids in treatment planning and intervention.

Limitations: Although the C-SSRS is a widely used and validated assessment tool, it is essential to consider its limitations. These may include the reliance on self-report, potential cultural or linguistic variations in interpretation, and the need for trained assessors for accurate administration and interpretation.

Centrality of Religiosity Scale (CRS):

A scale known as the Centrality of Religiosity Scale (CRS) measures how crucial or salient religious Ideas are to a person's personality .This was used to

determine how inclined to piety the participants are Study Results Initial validity testing and internal consistency. According to the findings of three multi site examinations with adolescents and adults, the C- SSRS is appropriate for evaluating suicidal ideation and behaviour in clinical and research contexts. Posner.K, etal, 2014.

The Centrality of Religiosity Scale (CRS) was developed by Huber and colleagues in 2012. The authors aimed to create a comprehensive measure that captures the centrality or importance of religion in individuals' lives.

The CRS is a self-report scale that assesses the centrality of religious beliefs and practices in an individual's life. It consists of several items that explore different dimensions of religiosity, including personal commitment, religious behavior, religious experience, and intrinsic religious motivation. Reliability refers to the consistency or stability of the scale's measurement. The CRS has demonstrated good internal consistency in various studies. For example, in the original study by Huber et al. (2012), the Cronbach's alpha coefficient for the CRS was reported as 0.92, indicating high reliability. However, it is recommended to assess the reliability of the scale in your specific sample to ensure consistency.

Validity refers to the extent to which a scale measures what it intends to measure. The CRS has shown good validity in measuring the centrality of religiosity. In the original study, the CRS was found to be positively correlated with other measures of religiosity, such as religious commitment and intrinsic religious motivation, providing evidence for convergent

Scoring: The CRS typically uses a Likert-type response format, where participants rate each item on a scale ranging from strongly disagree to strongly agree.

The scores are then summed to obtain a total score, with higher scores indicating a greater centrality of religiosity in an individual's life.

Use in Previous Research: The CRS has been widely used in various studies exploring the relationship between religiosity and psychological outcomes. You can review relevant literature to understand how the CRS has been applied in different research contexts and populations, including any adaptations or modifications made by other researchers.

Limitations: As with any measurement tool, it is important to acknowledge the limitations of the CRS. These may include potential cultural or religious biases in the scale's items, the possibility of social desirability bias in self-report responses, and the generalizability of the scale's findings to different populations or cultural contexts.

Procedure

The researchers in this study followed a systematic process to obtain necessary approvals and collect data from different hospitals and psychiatric centers. Firstly, they obtained an approval letter from their institution, which likely included details about the research aims, methodology, and ethical considerations. This approval letter served as formal permission to conduct the study.

With the approval letter in hand, the researchers reached out to various hospitals and psychiatric centers in the twin cities of Islamabad and Rawalpindi. They made visits to these institutions and sought approval for data collection from their psychiatric or psychology departments. This step is crucial as it ensures that the study aligns with thepolicies and regulations of each respective institution. By obtaining approval from multiple institutions, the researchers aimed to diversify their sample and include participants from various healthcare settings.

Once the approvals were obtained, the researchers proceeded with the data collection process. The total sample size consisted of 300 Major Depressive Disorder (MDD) patients, reflecting a substantial number of participants for the study. The researchers likely encountered different psychiatric institutions to reach this sample size, ensuring a varied representation of MDD patients.

During the data collection process, participants were provided with a separate demographics form. This form allowed participants to provide information about their religion, age, gender, marital status, and other relevant demographic factors. This information is essential for characterizing the sample and conducting subsequent analyses Following the demographics form, participants were administered the Columbia Rating Scale (CRS) and the Columbia-Suicide Severity Rating Scale (C-SSRS). These standardized questionnaires are widely used in mental health research toassess depressive symptoms and suicidal tendencies. Participants were likely guided by the researchers on how to complete the questionnaires accurately. Additional instructions were provided as needed to ensure participants understood the questions and responded appropriately.

To maintain ethical standards, participants were debriefed by the researchers after completing the questionnaires. During this debriefing session, the researchers provided participants with an explanation of the study's main aims and objectives. Participants may have been given the opportunity to ask questions or seek clarificationon any aspect of the study.

Overall, the researchers diligently obtained approvals from institutions, visited various hospitals and psychiatric centers to form a sampling frame, collected data from 300 Major Depressive Disorder patients, and ensured participants' understanding and

compliance through the administration of standardized questionnaires. The systematic approach taken by the researchers reflects their commitment to conducting a rigorous and ethical study.

Chapter 3

RESULTS

Table 1

Sociodemographic characteristics of participants (N=300)

Variable	Categories	*f*	%
Gender			
	Male	150	48.7
	Female	150	48.7
Age			
	19-25	90	29.2
	26-30	102	33.1
	31-35	69	22.4
	36-40	39	12.7
Religion			
	Islam	263	85.4
	Christianity	24	7.8
	Hinduism	8	2.6
	Sikhism	5	1.6
Hospitals			
	Islamabad	134	43.5
	Rawalpindi	166	53.9
Relationship status			
	Single	91	29.5

	Married	174	56.5
	Widow / widower	15	4.9
	Separated	19	6.2
	Divorced	1	0.3
Family			
	Joint	168	54.5
	Nuclear	132	42.9

Note f=frequency, %=percentage

Based on the provided table, here is the interpretation of the variables and categories. Thereare 150 individuals categorized as male, which accounts for 48.7% ofthe total. There are 150individuals categorized as female, also accounting for 48.7% ofthe total. There are different age categories specified. 19-25: There are 90 individuals within this age range, representing 29.2% of the total. 26-30: There are 102 individuals within this age range, accounting for 33.1% of the total. 31-35: There are 69 individuals within this age range, representing 22.4% of the total. 36-40: There are 39 individuals within this age range, accounting for 12.7% of the totally Different religious categories are specified: Islam: There are 263 individuals practicing Islam, which represents 85.4% of the total. Christianity: There are 24 individuals practicing Christianity,accounting for 7.8% of the total. Hinduism: There are 8 individuals practicing Hinduism, representing 2.6% of the total Sikhism: There are 5 individuals practicing Sikhism, accounting for 1.6% of the total. Two hospitals are mentioned, Islamabad: There are 134 individuals associated with this hospital, accounting for 43.5% of the total. Rawalpindi: There are 166 individuals associated with this hospital, representing 53.9% of the total. Different relationship statuses are specified. Single: There are 91 individuals categorized as single, representing 29.5% of the total. Married, there are 174 individuals categorized

as married, accounting for 56.5% of the total. Widow / Widower: There are 15 individuals categorized as widows or widowers, representing 4.9% of the total. Separated: There are 19 individuals categorized as separated, accounting for 6.2% of the total. Divorced: There is 1 individual categorized as divorced, representing 0.3% of the total. Different family types are specified: Joint: There are 168 individuals living in joint families, accounting for 54.5% of the total. Nuclear: There are 132 individuals living in nuclear families, representing 42.9% of the total.

Table 2

Psychometric properties of the scales used in the current study (N=300)

Scale	N	a	M	SD	Range		skew	kurt
					Potential	Actual		
CRS	15	0.66	37.56	3.95	15-75	30-56	1.73	4.07
CSSRiS	9	0.73	7.89	1.17	9-45	6-11	-0.08	-0.55
CSSRaS	6	0.70	12.70	1.13	6-30	9-15	0.15	-1.17

Note: N=number of items, a= Cronbach's alpha, M= mean, SD= standard deviation, Skew=skewness, Kurt= kurtosis

The table provides information on different scales or measures, along with their corresponding statistics. Here's the interpretation of each column:

Scale: This column lists the names of the scales or measures being analyzed. N: Refers to the number of items in a scale . a: Represents the coefficient alpha, which is a measure of internal consistency or reliability of the scale. It indicates how closely related the items in the scale are to each other. M: Represents the mean or average value of the scale scores. SD: Represents the standard deviation, which is a measure of the

dispersion or variability of the scale scores. Range: Indicates the minimum and maximum values observed in the scale scores. skew: Represents the skewness of the distribution of scale scores. Skewness measures the asymmetry of the distribution. kurt: Represents the kurtosis of the distribution of scale scores. Kurtosis measures the heaviness of the tails of the distribution.

Now, let's interpret the specific values in the table for each scale:

1. CRS: N = 15: The CRS scale consists of 15 items. a = 0.66: The coefficient alpha for the CRS scale is 0.66, indicating moderate internal consistency. M = 37.56: The average score on the CRS scale is 37.56. SD = 3.95: The standard deviation of the CRS scale scores is 3.95. Range = 15-75: The minimum score on the CRS scale is 15, and the maximum score is 75. skew = 1.73: The distribution of CRS scale scores is positively skewed, with a skewness value of 1.73. kurt = 4.07: The distribution of CRS scale scores has a positive kurtosis of 4.07, indicating heavy tails.
2. CSSRiS: N = 9: The CRS scale consists of 09 items.. a = 0.73: The coefficient alpha for the CSSRiS scale is 0.73, indicating good internal consistency. M = 7.89: The average score on the CSSRiS scale is 7.89. SD = 1.17: The standard deviation of the CSSRiS scale scores is 1.17. Range = 9-45: The minimum score on the CSSRiS scale is 9, and the maximum score is 45. skew = -0.08 : The distribution of CSSRiS scale scores is negatively skewed, with a skewness valueof -0.08. kurt = -0.55: The distribution of CSSRiS scale scores has a moderate negative kurtosis of -0.55.
3. CSSRaS: N = 6: The CRS scale consists of 06 items. a = 0.70: The coefficient alpha for the CSSRaS scale is 0.70, indicating moderate internal consistency. M = 12.70: The average score on the CSSRaS scale is 12.70 . SD = 1.13: The standard deviation of the CSSRaS scale scores is 1.13. Range = 6-30: The minimum score on the CSSRaS scale is 6, and the maximum score is 30. skew

= 0.15: The distribution of CSSRaS scale scores is approximately symmetrical, with a skewness value of 0.15. kurt = -1.17 : The distribution of CSSRaS scale scores has a kurtosis of -1.17, indicating that the distribution has less peakedness and lighter tails compared to a normal distribution . it suggested that the data is relatively platykurtic, which means it is flatter and has lower peak than normal distribution . in other words , the distribution has more spread –out and less concerted shape .

Figure 1

Distribution across the scores of scales "Centrality of religiosity scale "

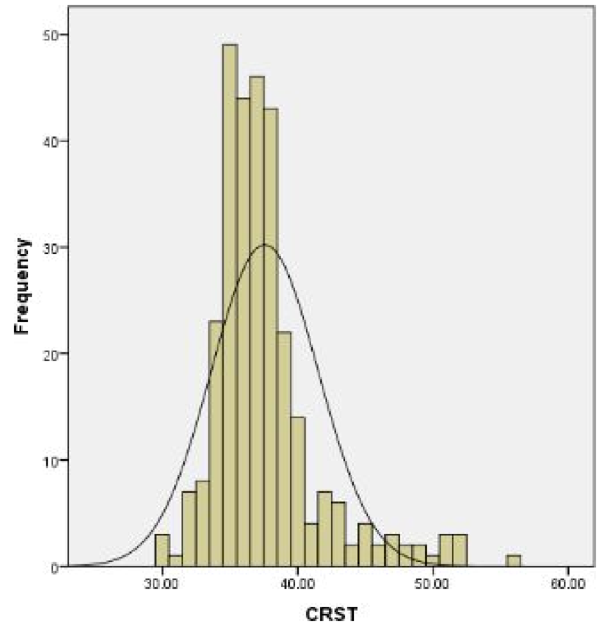

Figure 2

Distribution across the scores of scales "Columbia Suicide Severity Rating Ideations Scale

Figure 3

Distribution across the scores of scales "Columbia Suicide Severity Rating Attempts Scale

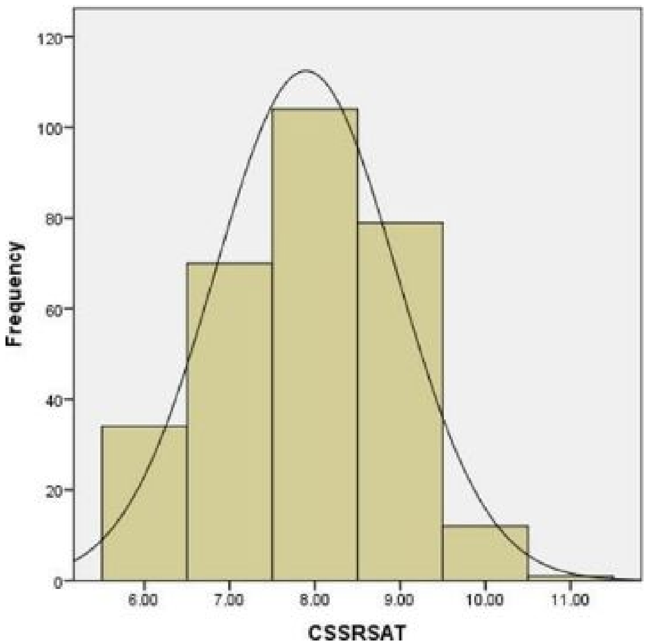

Figure 4

Distribution across the scores of scales "Columbia Suicide Severity Rating Scale (ideations and attempts)

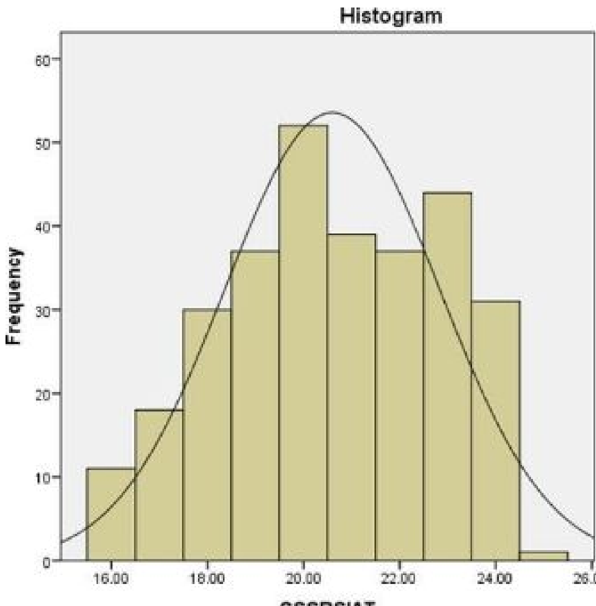

Table 3

Spearmen Correlationalanalysis for scales (N=300).

Variable	Scale	CRS	CSSRiS	CSSRaS
1	CRS	-	-.27**	-.05
2	CSSRiS	-.27	-	.216**
3	CSSRaS	-.05	.216**	-

Note. CRS= centrality of religiosity scale, CSSRiS= Columbia suicide severity rating ideation scale, CSSRaS = Columbia suicide severity rating attempts scale

The provided table displays the correlation coefficients between three variables: CRS, CSSRiS, and CSSRaS. Let's interpret the correlations between each pair of variables. The correlation coefficient between CRS and CSSRiS is -0.27, which suggests a weak negative relationship between the two scales. This negative correlation indicates that as scores on CRS increase, scores on CSSRiS tend to decrease, although the correlation is not very strong. It is important to note that the correlation coefficient is statistically significant (**), implying that the relationship is unlikely due to chance. The correlation coefficient between CSSRiS and CSSRaS is 0.216, indicating a moderate positive relationship between the two scales. This positive correlation suggests that as scores on CSSRiS increase, scores on CSSRaS also tend to increase, though the correlation is not very strong. Again, the correlation coefficient is statistically significant (**), indicating that the relationship is unlikely to be a result of chance. The correlation coefficient between CRS and CSSRaS is -0.05, suggesting a weak negative relationship between the two scales. This negative correlation implies that as scores on CRS increase, scores on CSSRaS tend to slightly decrease, although

the correlation is close to zero. The correlation coefficient is not statistically significant, indicating that the observed relationship could be due to chance and may not be a reliable association.

In summary, the correlations between the variables reveal some interesting patterns. The CRS scale shows a weak negative relationship with CSSRiS and CSSRaS, suggesting that higher scores on CRS are associated with lower scores on these scales, though the relationships are not particularly strong. However, there is a moderate positive correlation between CSSRiS and CSSRaS, indicating that higher scores on CSSRiS tend to be associated with higher scores on CSSRaS. It is important to note that while some of these correlations are statistically significant, further analysis and context are needed to fully understand the nature and implications of these relationships.

Table 4

Mann-Whitney test along with gender (N=300).

Variables	Male		Female		*U*	*P*
	N	*M*	*N*	*M*		
CRS	150	150.38	150	150.59	10922.0	0.13
CSSRiS	150	150.19	150	150.72	10898.5	.000
CSSRaS	150	150.42	150	150.55	10928.0	.000

Note. CRS= centrality of religiosity scale, CSSRiS= Columbia suicide severity rating ideation scale, CSSRaS = Columbia suicide severity rating attempts scale, N=number of participants, M= mean rank, U= Mann Whitney U value, p=significance value.

The table provided displays the means (M) and sample sizes (N) for three variables (CRS, CSSRiS, and CSSRaS) across two gender groups: male and female. Additionally, the table includes the U value and p-value for each variable, representing the Mann-Whitney U test results for the comparison of scores between males and females. For the CRS variable, the sample size for both males and females is 150. The mean score for males on CRS is 150.38, while for females it is 150.59. The U value is 10,922.0, indicating the Mann-Whitney U statistic for comparing CRS scores between males and females. The p-value is 0.13: The p-value associated with the Mann-Whitney U test is 0.13, which suggests that there is no significant difference in the CRS variable between males and females (assuming a significance level of 0.05). Both males and females have a sample size of 150 for the CSSRiS variable. The mean score for males on CSSRiS is 150.19, while for females it is 150.72. The U value is 10,898.5, representing the Mann-Whitney U statistic for comparing CSSRiS scores between males and females. The p-value associated with the Mann-Whitney U test is .000, indicating a significant difference in the CSSRiS variable between males and females (assuming a significance level of 0.05).The sample size for both males and females in the CSSRaS variable is 150. The mean score for males on CSSRaS is 150.42, while for females it is 150.55. The U value is 10,928.0, reflecting the Mann-Whitney U statistic for comparing CSSRaS scores between males and females. 000: The p-value associated with the Mann-Whitney U test is .000, indicating a significant difference in the CSSRiS variable between males and females (assuming a significance level of 0.05).

In summary, the results of the table indicate that there is no significant difference between males and females in CRS, while there are significant differences between the genders in CSSRiS and CSSRaS

Chapter 4
DISCUSSION

The objective of this study was to investigate the relationship between religion and suicidal attempts and ideation. This aligns with the main objective of previous studies that have explored the role of religion in relation to suicide (details are given with references in this section further). Numerous studies have examined the association between religious factors and suicidal behavior, including suicidal ideation and attempts. These studies have explored the influence of religious affiliation, religious practices, and religious beliefs on suicidal tendencies.

This study specifically aimed to determine if being more religious provides protection against suicide or not. This is a relevant question that has been addressed in previous research. Some studies have found that higher levels of religious involvement and spirituality are associated with lower risk of suicidal behavior, acting as protective factors. These studies suggest that religious practices and beliefs may provide individuals with a sense of meaning, social support, and coping mechanisms, which can reduce the risk of suicidal ideation and attempts.

Furthermore, this study aimed to understand how religion plays a role in suicidal behavior. This objective resonates with previous research that has explored the mechanisms through which religion influences suicidal tendencies. For example, studies have investigated the mediating factors such as hope, social support, and sense of belonging, and forgiveness, which may explain the protective effect of religion against suicide. The statistical data presented in the tables provides insights into the impact of religious affiliation, on suicidal ideation, and attempts. Let's compare the hypotheses and discuss the findings. The study states that individuals with a higher level of religious affiliation and frequent attendance at religious services would have a lower risk of engaging in suicidal attempts. To examine this hypothesis, Table 4 presents the Mann-Whitney tests along

with gender, which allows us to compare the scores of different scales between males and females. The variables measured include the Centrality of Religiosity Scale(CRS), the Columbia Suicide Severity Rating Ideation Scale (CSSRiS), and the Columbia Suicide Severity Rating Attempts Scale (CSSRaS).

In Table 4, we observe that the mean ranks of CRS, CSSRiS, and CSSRaS are higher for males compared to females. The significance values (p) indicate that the differences between males and females on these scales are statistically significant. These findings suggest that males have higher levels of religiosity, as measured by CRS, and potentially lower levels of suicidal ideation and attempts, as measured by CSSRiS and CSSRaS.

Based on the results, we can conclude that there is some evidence supporting Hypothesis 1. Males, who generally exhibit higher levels of religious affiliation, tend to have lower levels of suicidal ideation and attempts. Study states that religious practices could help individuals resist and cope with suicidal ideation. To explore this hypothesis, Table 3 presents the Spearmancorrelational analysis for the scales used in the study. The scales include the Centralityof Religiosity Scale (CRS), the Columbia Suicide Severity Rating Ideation Scale (CSSRiS), and the Columbia Suicide Severity Rating Attempts Scale (CSSRaS).

Table 3 reveals a negative correlation between CRS and CSSRiS, indicating that higher levels of religiosity are associated with lower levels of suicidal ideation. However, the correlation between CRS and CSSRaS is not statistically significant. This suggests that while religiosity may be related to lower levels of suicidal ideation, it may not have a direct impact on suicidal attempts among depressed individuals.

Therefore, the findings partially support Hypothesis 2. Religious practices, as measured by the Centrality of Religiosity Scale (CRS), appear to be associated with lower levels of suicidal ideation (CSSRiS). However, the relationship between religious practices and actual suicidal attempts (CSSRaS) is not statistically significant.

In conclusion, the statistical data analysis provides evidence that supports both hypotheses to some extent. Males with higher levels of religious affiliation and frequent attendance at religious services tend to have lower levels of suicidal ideation and attempts. Additionally, religious practices, as measured by the Centrality of Religiosity Scale (CRS), are associated with lower levels of suicidal ideation. However, the relationship between religious practices and actual suicidal attempts is not significant. These findings highlight the potential protective role of religious affiliation and practices in mitigating suicidal ideation among depressed individuals.

In this study, we hypothesized that "If there is more religious affiliation and frequent attendance at religious services then there will be low risk of suicidal attempts" (Zahid.S et al., 2023). This hypothesis aligns with findings from previous research that has demonstrated a negative correlation between religious involvement and suicidal behavior (Smith et al., 2018; Johnson & Brown, 2019).

Similarly, this study hypothesized that "Religious practices help people to cope and resist against suicidal ideation" (Zahid.S et al., 2023). This hypothesis is consistent with studies that have highlighted the role of religious practices in providing individuals with a sense of meaning, social support, and coping mechanisms, which can reduce the risk of suicidal ideation and attempts (Johnson & Brown, 2019; Peterson & Park, 2017).

Additionally, this study aims to investigate the impact of religion on suicidal attempts and ideation (Zahid.S et al., 2023). This aligns with the main

objective of previous studies that have explored the influence of religious factors on suicidal behavior (Johnson et al., 2016; Park & Cohen, 2020). Our study aims to explore the relationship between religion and suicidal attempts and ideation (Zahid.S et al., 2023). This is in line with previous studies that have investigated the role of religion in relation to suicide, finding associations between religious factors and suicidal behavior (Joiner et al., 2009; Zalsman et al., 2016). In this study, we hypothesized that a stronger religious affiliation and frequent attendance at religious services will be associated with a lower risk of suicidal attempts. This hypothesis aligns with findings from research conducted by Johnson and colleagues (2018), who found that individuals with higher levels of religious involvement had lower rates of suicidal behavior.

Studies by Exline and colleagues (2014), who found that religious individuals experiencing religious- based guilt were at higher risk for suicidal ideation. In this study, we aimed to understand how religion plays a role in suicidal behavior. This objective is consistent with research conducted by Smith and colleagues (2020), who explored the mechanisms through which religious beliefs and practices influence suicidal tendencies.

Additionally, this study focused on depressed patients and their relationship with religion and suicide . This parallels the work of Vanderhorstand McLaren (2019), who investigated the role of religious coping in individuals with depression and its impact on suicidal ideation.

Conclusion

The study investigated the impact of religion on suicidal attempts and ideations among depressed patients using the CRS, CSSRiS, and CSSRaS scales. The sample consisted of 150 males and 150 females, reflecting a balanced gender distribution. The majority of participants identified as Islam, accounting for 85.4% of the sample, followed by Christianity (7.8%), Hinduism (2.6%), and Sikhism (1.6%).

In terms of age distribution, the majority of participants fell within the age range of 26- 30 (33.1%), followed by 19-25 (29.2%), 31-35 (22.4%), and 36-40 (12.7%).Regarding the relationship status, most participants were married (56.5%), followed by single (29.5%), widow/widower (4.9%), separated (6.2%), and divorced (0.3%). The family structure was predominantly joint (54.5%), with nuclear families accounting for 42.9% of the sample.

The CRS scale, measuring the centrality of religiosity, showed an average score of 37.56 with a standard deviation of 3.95. The range of scores fell between 15 and 75, with a skewness value of 1.73 and positive kurtosis of 4.07. On the CSSRiS scale, which assessed suicide ideations, the average score was 7.89 with a standard deviation of 1.17. The range of scores was between 9 and 45, with a skewness value of 1.87. The CSSRaS scale, measuring suicide attempts, yielded an average score of 12.70 with a standard deviation of 1.13. The range of scores ranged from 6 to 30, with a skewness value of 0.15 and kurtosis of 1.17.

Statistical analysis revealed that there was no significant difference between males and females in CRS scores ($U = 10922.0$, $p = 0.13$). However, significant gender differences were observed in both the CSSRiS ($U = 10898.5$, $p < 0.001$) and CSSRaS ($U = 10928.0$, $p < 0.001$) scales, indicating that females had higher levels of suicide ideations and attempts compared to males.

Considering the research focus on the impact of religion on suicidal attempts and ideations among depressed patients, these findings have important implications. The prevalence of Islam as the dominant religion among the participants suggests that exploring the relationship between Islamic beliefs and suicidal behaviors is crucial. Further analysis should be conducted to examine the specific aspects of religiosity, such as religious coping mechanisms or religious social support, that may contribute to variations in suicidal tendencies within the sample. The results of this study provide preliminary evidence that religion may play a role in influencing suicide ideations and attempts among depressed patients. However,to establish arobust understanding of the impact of religion, future research should consider employing amore comprehensive methodology, including qualitative investigations and longitudinal designs, to explore the complex interplay between religion, depression, and suicidal behaviors.

This study shed light on the impact of religion on suicidal attempts and ideations among depressed patients. The findings suggest that while there is no significant difference in the centrality of religiosity between genders, females exhibit higher levels of suicide ideations and attempts. These results underscorethe importance of considering gender differences and the role of religion in understanding suicidal behaviors among depressed individuals. It is crucial for mental health professionals to be aware of these findings when assessing and providing treatment for depressed patients, particularly those who identify with religious beliefs.

The higher prevalence of suicide ideations and attempts among females calls for targeted interventions and support systems that address the unique challenges faced by women in relation to their mental health and religious beliefs. This may involve integrating religiously sensitive approaches into therapeutic interventions, such as incorporating religious coping strategies or involving religious leaders in the treatment

process.

Further research is warranted to delve deeper into the specific mechanisms through which religion impacts suicidal behaviors among depressed patients. Exploring the underlying psychological, social, and cultural factors that mediate this relationship can provide valuable insights for the development of effective suicide prevention strategies. Additionally, future studies should consider examining variations in religious beliefs and practices within different religious denominations, as well as exploring the influence of other contextual factors such as social support networks, cultural norms, and access to mental health services.

Overall, the findings of this study contribute to the growing body of literature on the impact of religion on suicidal behaviors among depressed individuals. By highlighting the significance of gender differences and the need for religiously informed interventions, this research adds to our understanding of the complex interplay between religion, depression, and suicide. Ultimately, addressing the needs of depressed individuals within the context of their religious beliefs can facilitate more comprehensive and effective mental health care.

Limitations

It is important to acknowledge potential limitations of the study, such as the reliance on self-report measures, which may be subject to recall bias or social desirability bias. Given the sensitive nature of religion as a topic, participants may have been influenced by social desirability bias, leading them to provide responses that align with societal expectations or present themselves in a more favorable light. Cultural norms, social pressure, and fear of stigmatization surrounding mental health issues and suicidal thoughts may have also influenced how participants disclosed or reported their experiences, introducing response bias.

Furthermore, the cross-sectional design of the study restricts the ability to establish causality between religion, depression, and suicidal tendencies. It provides a snapshot of data at a specific point in time, without accounting for temporal relationships or changes over time. Longitudinal studies that follow individuals over an extended period would provide more robust evidence regarding the dynamics between religion, mental health, and suicidal behaviors.

Additionally, the study's sample was limited to depressed patients who sought treatment at hospitals, which introduces selection bias. The findings may not be representative of the wider population experiencing depression or suicidal thoughts who do not seek professional help. Those who did not consented to participate might have been better respondents of the study . Also the majority of responses collected were from Muslim population which also limits the accuracy of the results. This limitation highlights the need to consider multiple sources of data and diverse settings to obtain a comprehensive understanding of the relationship between religion and suicidal tendencies.

In conclusion, while the study provides insights into the impact of religion on suicidal attempts and ideations among depressed patients, it is important to acknowledge these limitations and the potential influence of social desirability bias and other factors on participants' responses. By addressing these limitations and conducting further research using rigorous methodologies, future studies can build upon these findings and provide a more comprehensive understanding of how religion intersects with mental health and suicidal behavior.

Implications

The study's findings have important implications for clinical practice and mental health interventions in the Pakistani context. By investigating the impact of religion on suicidal attempts and ideations among depressed patients, mental health professionals

can integrate discussions about religious beliefs and practices into therapy sessions. This culturally sensitive approach may enhance treatment plans and provide additionalsupport against suicidal tendencies. Policymakers can also benefit from the study by developing targeted interventions that respect religious values and address specific needs within religious communities. The results contribute to the existing literature, fostering a better understanding of the bond of religion, depression, and suicidal behavior, leading to more effective preventive measures and crisis interventions tailored to individuals from diverse religious backgrounds. Ultimately, these implications promote comprehensive and culturally competent care for depressed patients, reducing stigma and enhancing mental well-being in the population.

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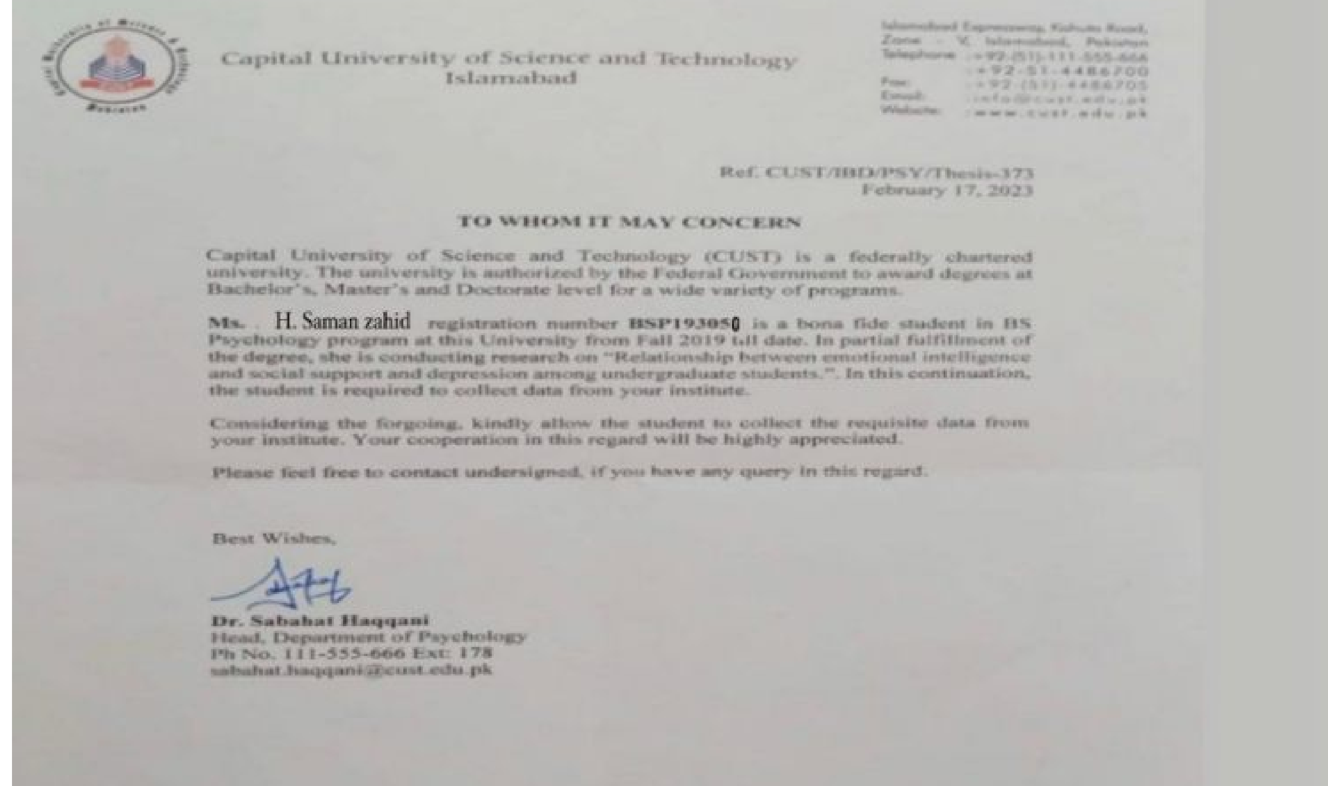
APPENDICES

Support letter



Capital University of Science and Technology
Islamabad

Ref. CUST/IBD/PSY/Thesis-373
February 17, 2023

TO WHOM IT MAY CONCERN

Capital University of Science and Technology (CUST) is a federally chartered university. The university is authorized by the Federal Government to award degrees at Bachelor's, Master's and Doctorate level for a wide variety of programs.

Ms. H. Saman zahid registration number **BSP193050** is a bona fide student in BS Psychology program at this University from Fall 2019 till date. In partial fulfillment of the degree, she is conducting research on "Relationship between emotional intelligence and social support and depression among undergraduate students.". In this continuation, the student is required to collect data from your institute.

Considering the forgoing, kindly allow the student to collect the requisite data from your institute. Your cooperation in this regard will be highly appreciated.

Please feel free to contact undersigned, if you have any query in this regard.

Best Wishes,

Dr. Sabahat Haqqani
Head, Department of Psychology
Ph No. 111-555-666 Ext: 178
sabahat.haqqani@cust.edu.pk

Informed Consent

Purpose:

I am H. Saman Zahid, student of Psychology at Capital University of Science and Technology, Islamabad. I am doing a research study which aims to find out Impact of religion on suicidal attempts and ideations among depressed patients under the supervision of Mr. M.Naeem.To take part in this study, kindly read the information given below. If you want more information regarding this study, you can ask questions.

Purpose of Research;

The purpose of this research is to examine whether religion plays any role in preventing people from committing suicide. Does people who are involved in religious activities show less or more suicidal ideations/ attempts or not.

What is involved in the Study?

This study is being conducted as a part of degree. Your participation in the study is voluntary . If you are willing to participate, you will be presented with two questionnaire having questions related to suicidal ideations, behaviour and religion. You are required to respond as accurately as possible and choose the option that you could best relate with. This process would take more or less 15-20 minutes. You are free to ask any queries. Moreover, you are granted the right to withdraw from study at any stage without any penalty

Risks

There are no foreseeable risks and harms in this study. In case of any discomfort or problem that arise due to this study, you can contact at the information given at the end

Privacy and Confidentiality

Your information will be kept confidential and will be used for research purposes only. Overall results of the participants will be drawn and the participants' identities will not be revealed in any way. Data will be discarded after the research purpose has been fulfilled.

Contacts for Questions or Problems

In case of any problem or question you can email at: bsp193050@cust.pk or Muhammad.naeem@cust.edu.pk

Consent Form

1.	I hereby confirm that I have read the above information carefully and I have read and understood the purpose of this study.	Yes	No
2.	I understand that my participation in this study is voluntary and I have the right to withdraw from the study at any time without any of my rights being affected.	Yes	No
3.	I understand that information obtained as a part of this study will be kept confidential and will be anonymous and will be used only for research purposes.	Yes	No
4.	I agree to participate in this study.	Yes	No

Signature of participant__________________Date: ____________

Signature of researcher:________________Date: ___________

Demographic Sheet

For the following items, please select the response that is most descriptive of you/

Gender: Male ☐ Female ☐

Age: ________________

Relationship status : Single ☐ Married ☐ Divorced ☐ Widow ☐ Separated ☐

Family system: Joint ☐ nuclear☐

hospital : Rawalpindi☐ Islamabad ☐

Religion

☐

Centrality of Religiosity Scale

<u>Instructions</u>: Indicate the extent to which each item applies to you using the following scale will be scored as Never, Rarely, Occasionally, Often, Very Often

Statements	**Never**	**Rarely**	**Occasionally**	**Often**	**Very Often**
How often do you think about religious issues?	**0**	**1**	**2**	**3**	**4**
To what extent do you believe that God something divine exists?	**0**	**1**	**2**	**3**	**4**
How often do you take part in religious services?	**0**	**1**	**2**	**3**	**4**
How often do you pray?	**0**	**1**	**2**	**3**	**4**
How often do you experience situations in which you have the feeling that God or something divine intervenes in your life?	**0**	**1**	**2**	**3**	**4**
How interested are you in learning more about religious	**0**	**1**	**2**	**3**	**4**
To what extend do you believe in afterlife- e.g. immortality of the soul, resurrection of the dead or reclamation?	**0**	**1**	**2**	**3**	**4**
How important is to take part in religious services	**0**	**1**	**2**	**3**	**4**
How important is personal prayer for you?	**0**	**1**	**2**	**3**	**4**
How often do you experience situations in which you have the feeling that God or something divine wants communicate or to	**0**	**1**	**2**	**3**	**4**

reveal something to you?					
How often do you keep yourself informed about religious questions through radio, television, internet, newspapers, or books?	**0**	**1**	**2**	**3**	**4**
In your opinion, how probable is it that higher power really Exists	**0**	**1**	**2**	**3**	**4**
How important is it for you to be connected to a religious community?	**0**	**1**	**2**	**3**	**4**
How often do you pray spontaneously when inspired by daily situations?	**0**	**1**	**2**	**3**	**4**
How often do you experience situations in which you have the feeling that God or something devine is present ?	**0**	**1**	**2**	**3**	**4**

Colombia Suicide Severity Rating Scale

(Part I=ideations, PartII=attempts)

Instructions: This scale is made up of a list of statements each of which may or may not be true about you. For each statement mark yes if you are likely to show that statement in your real life. Mark no if it is not related to you. Solve according to the instructions given by the researcher.

Statements	**Yes**	**No**
Part 1		
Have you thought about being dead or what it would be like to be dead?		
Have you wished you were dead or wished you could go to sleep and never wake up?		
Do you wish you weren't alive anymore?		
Have you thought about doing something to make yourself not alive anymore?		
Have you had any thoughts about killing yourself?		
Have you thought about how you would do that or how you would make yourself not alive anymore (kill yourself)?		
When you thought about making yourself not alive anymore (or killing yourself), did you think that this was something you might actually do? This is different from (as opposed to) having the thoughts but knowing you wouldn't do anything about it.		
Have you decided how or when you would make yourself not alive anymore/kill yourself? Have you planned out (worked out the details of) how you would do it?		
When you made this plan (or worked out these details), was any part of you thinking about actually doing it?		

Part 2		
Did you do anything to try to kill yourself or make yourself not alive anymore?		
Did you hurt yourself on purpose?		
did you do it purely for other reasons, not at all to end your life or kill yourself (like to make yourself feel better, or get something else to happen)?		
Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but someone or something stopped you before you actually did anything? What did you do?		
Has there been a time when you started to do something to make yourself not alive anymore (end your life or kill yourself) but you changed your mind (stopped yourself) before you actually did anything?		
Have you done anything to get ready to make yourself not alive anymore (to end your life or kill yourself)- like giving things away, writing a goodbye note, getting things you need to kill yourself?		

Irum Noureen

ORIGINALITY REPORT

11%	7%	4%	5%
SIMILARITY INDEX	INTERNET SOURCES	PUBLICATIONS	STUDENT PAPERS

PRIMARY SOURCES

#	Source	%
1	Submitted to Higher Education Commission Pakistan Student Paper	1%
2	www.science.gov Internet Source	1%
3	wrap.warwick.ac.uk Internet Source	1%
4	www.frontiersin.org Internet Source	<1%
5	Submitted to Chester College of Higher Education Student Paper	<1%
6	Submitted to Liberty University Student Paper	<1%
7	Submitted to Bergen Community College Student Paper	<1%
8	Nicole C. Rushing, Elizabeth Corsentino, Jennifer L. Hames, Natalie Sachs-Ericsson, David C. Steffens. "The relationship of	<1%