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## The Moderating Effects of Religious/Spiritual Coping on the Depression-Suicidal Thoughts Relationship

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The Moderating Effects of Religious/Spiritual Coping on the Depression-Suicidal Thoughts  
Relationship

Rebecca Aryeh, M.S.

A DOCTORAL DISSERTATION SUBMITTED  
TO THE FACULTY OF  
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SPONSORING COMMITTEE:

	<u>10/25/2023</u>
ORLY CALDERON, PSY.D.	DATE
	<u>10/27/2023</u>
STEVEN PIRUTINSKY, PH.D.	DATE
	<u>10/26/2023</u>
KI EUN SHIN, PH.D.	DATE

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This dissertation represents not only an academic pursuit but also a reflection of my passion for understanding the many facets of the human experience. Exploring the intersection of religion and psychology has been a deeply personal and meaningful journey. It is with much gratitude that I acknowledge the invaluable contributions of all those mentioned and countless others who have touched my life along this journey. I hope that this work contributes, in some small way, to the betterment of both the Orthodox Jewish community and the field of clinical psychology.

With heartfelt appreciation,

Rebecca Aryeh

Long Island University Post

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### **Abstract**

Religious coping refers to the various ways individuals respond to distress, involving cognitive, emotional, and behavioral approaches centered around their religious or spiritual (R/S) beliefs. This coping mechanism can be classified into two main facets: positive religious coping, which involves constructive approaches, and negative religious coping, encompassing struggles in the spiritual realm. During periods of depression, some individuals rely on religious or spiritual coping mechanisms. Currently, there is a lack of research examining the moderating effect of positive and negative religious coping on the relationship between depression and suicidal thoughts, especially within the Jewish community. The primary objective of the present study was to address this gap by focusing on a clinical population of individuals who identified as Orthodox Jewish and reported experiencing depression. As part of a clinical intake, participants completed Likert-scale self-report questionnaires assessing their levels of depression, utilization of positive/negative R/S coping, and levels of suicidal thoughts. Results indicated that while positive and negative R/S coping do not moderate the relationship between depression and suicidal thoughts, these constructs serve as protective and risk factors for suicidality, independent of depression, respectively. The current findings carry significant clinical implications, emphasizing the importance of clinicians evaluating both religious coping styles and depressive symptoms amongst religious individuals to identify potential risks of suicidal thoughts.

**Key words:** Major Depressive Disorder, Depression; Suicidality, Suicidal Thoughts, Suicide, Suicidal Ideation; Religion, Religious Coping, Religious Struggles

## **The Moderating Effects of Religious/Spiritual Coping on the Depression-Suicidality Relationship**

### **Introduction**

Adults with major depressive disorder (MDD) are at increased risk of dying by suicide, with suicide being the second leading cause of death in young adults and the third leading cause of death in the older adult population in the United States, and one of the leading causes of death in the adult population worldwide (CDC, 1999-2019). An estimated 90% of suicide victims suffer from mental illness, with MDD accounting for 59-87% of all suicides (Borentain et al., 2020; Cai et al., 2021). Approximately two percent of adults with MDD attempt suicide in their lifetime (Dong et al., 2018). However, not all those with MDD are at risk for suicidality— which is defined to include suicidal ideation (SI), suicidal planning (SP), and behaviors that are deliberately self-injurious with the intent of suicide (Reynolds & Johnston, 1994).

According to the interpersonal theory of suicide (IPTS), SI and suicidal behavior are caused by the co-occurrence of three constructs: perceived burdensomeness, thwarted belongingness, and an acquired capability for suicide (Joiner, 2007). Thus, an individual with MDD who does not possess the presence of these risk factors is unlikely to act on their SI. Within existing literature, it is observed that religion/spirituality (R/S) can act as both factors that increase risk and those that provide protection against suicidal ideation (SI) and behaviors related to suicide. This observation is especially relevant when considering the interrelationships between religion and elements such as perceived burdensomeness, thwarted belongingness, and the acquired capability for suicide (Schussman, 2017). Religious coping, or R/S-focused cognitive, emotional, and behavioral responses to stress, correlates with decreased suffering and perceived burdensomeness, and increased belongingness for some, while for others, it is

associated with an increased struggle that causes damaging effects on mental health (Braam & Koenig, 2019; He et al., 2019; Schussman, 2017).

Research shows that specifically within the Orthodox Jewish community, positive religious coping can diminish perceived burdensomeness through a sense of belonging and purpose; deter the acquired capability for suicide with moral teachings; provide coping mechanisms like prayer and meditation; offer hope, personal meaning, and connection to oneself, others, and God countering hopelessness; and influence attitudes toward suicide within cultural contexts (Barzilay et al., 2015; Hamdan & Peterseil-Yaul, 2020; Schussman, 2017). Conversely, some studies show that within the Orthodox Jewish community, negative religious coping might heighten perceived burdensomeness by attributing struggles to divine punishment, amplify thwarted belongingness if personal beliefs conflict with community norms, and is correlated with increased hopelessness, unworthiness, and interpersonal struggle (Barzilay et al., 2015; Hamdan & Peterseil-Yaul, 2020; Schussman, 2017; Mijatović, 2021). This paper aims to better understand the ambiguous role of R/S coping in the depression-suicidality relationship within the Orthodox Jewish community.

### **Literature Review**

Depression differs from typical mood fluctuations and ephemeral emotional reactions to life stressors. Especially when persistent or moderate to severe in intensity, depression is a serious health condition. According to the American Psychiatric Association (2022), MDD, the most prevalent amongst this disorder group, is a mood disorder characterized by depressed mood, and/or a loss of interest or pleasure in most activities, experienced for at least a 2-week period. Diagnosis is made based on the presence of at least five of the following symptoms (at least one of which must be depressed mood or diminished pleasure): significant weight loss or

gain; insomnia or hypersomnia; psychomotor agitation or retardation; fatigue or loss of energy; feelings of worthlessness or guilt; difficulty concentrating; and suicidal ideation, suicide attempts, or recurrent thoughts of death (American Psychiatric Association, 2022, p.160).

Universally, depressive disorders are among the most severe and common psychiatric disorders across the world, associated with significant impairments in physical, social, interpersonal, cognitive, and role functioning (Christensen et al., 2020; Li et al., 2021). MDD is estimated to occur in 10% of the adult population yearly, or in one in six adults in the United States (Kalin, 2020; NIMH, 2020; World Health Organization (WHO), 2021), classifying it as the leading cause of disability worldwide (Rehm & Shield, 2019; Rubio et al., 2020; WHO, 2021). MDD affects women twice more than men (CDC, 2017; Otte et al., 2016), and half of those who experience one episode of MDD will have one or more recurrences within their lifetime (Moriarty et al., 2021).

There are many negative consequences associated with MDD, including diminished quality of life, functional impairment, increased risk of developing conflictual relationships, poor socio-economic outcomes, increased probabilities of unemployment, educational difficulties, and declining physical health (Leach & Butterworth, 2020; Rubio et al., 2020; WHO, 2021). Especially when left untreated, MDD increases the chances of engaging in risky behaviors such as substance use and abuse, self-harm, and suicide (Skegg, 2005; Slee et al., 2008; Weintraub et al., 2017).

### **MDD and Suicidality**

There is a clear link in the literature between MDD and suicidality (Dong et al., 2018; Reynolds et al., 2006; Rubio et al., 2020). The prevalence of SI among those with MDD is estimated to be as elevated as 86.7%. As SI is a precondition for suicide attempts (SA) in those

with MDD, 95% of those who attempt suicide have previous SI (Cai et al., 2021; Innamorati et al., 2015; Kumar & Srivastava, 2005).

The severity and length of MDD are associated with greater suicidality, such that those with a more severe case of MDD exhibit a higher risk for SI, intent, and attempts (Bolton et al., 2010; Reynolds et al., 2006). Often, those with depression have thoughts and experiences that lead to a sense of suffering and hopelessness about escaping the pain, thereby seeing suicide as the only solution (Dong et al., 2018). The elements considered in the suicidal symptom criteria of MDD typically appear gradually, beginning with thoughts of death, then moving to SI, SP, and ultimately to SA and suicide completion (Brådvik, 2018). SI is strongly predictive of SA, and both SI and SA are predictive of suicide deaths and can result in negative consequences such as injury and hospitalization (Klonsky et al., 2016; WHO, 2014).

In addition to the severity of depression, longitudinal studies of MDD patients found that previous SA, psychiatric hospitalizations, co-occurring alcohol and substance abuse, social isolation, anxiety and personality disorders, impulsive-aggressive traits, poor clinical and personal support, and more years of education (i.e. pressure to be successful) are associated with an increased risk in suicidality (Baldessarini & Tondo, 2020; Bolton et al., 2010; Pompili et al., 2013). Male gender is associated with risk of completed suicide in a depressed population. While women exhibit more SI and SA, men engage in more violent suicidal behavior and therefore have more deaths due to suicide (Baldessarini & Tondo, 2020; Freeman et al., 2017).

### **MDD and Suicidality in the Orthodox Jewish Community**

According to the Pew Research Center (2015), Jews represent 1.9% of the US population. Of the Jewish population, 79% report belief in God and 71% report that religion is important to them. Only one in ten Jews identify as Orthodox (Pew Research Center, 2015), defined as a

commitment to the traditional system of religious laws and values (Hamdan & Peterseil-Yaul, 2020). As per the Pew Research Center (2015), approximately three-quarters of Orthodox Jews report finding meaning in their religious lifestyle. Approximately 26% of Orthodox Jews report that things in their lives are “going excellent” and 59% report that they are “going good” (Pew Research Center, 2015).

Yet, in studies conducted on Jewish individuals and depression and suicidality, it has been found that depression rates are higher in Jews than in other religions (Bonelli et al., 2012; Gearing & Alonzo, 2018). Additionally, Orthodox Jews are more hesitant than individuals in other religions to seek professional or informal support due to the stigmas attached to it (Hamdan & Peterseil-Yaul, 2020). Therefore, those who feel ashamed may not seek help, which in turn, increases depressive feelings (Hamdan & Peterseil-Yaul, 2020). Amongst Jews, it has been found that suicidal behavior occurs less often in religious than in non-religious individuals (Hamdan & Peterseil-Yaul, 2020), and suicide rates are lowest amongst Jewish individuals compared to other religions (Bonelli et al., 2012; Gearing & Alonzo, 2018). While depression and suicidality are typically correlated, it appears that within the Jewish community, the relationship is not as strong (Bonelli et al., 2012; Dong et al., 2018; Gearing & Alonzo, 2018; Reynolds et al., 2006; Rubio et al., 2020). Some explanations for this discrepancy include the protective role of Jewish faith or social support (Hamdan & Peterseil-Yaul, 2020), or suicidality being deemed as immoral in Orthodox Judaism (Gearing & Alonzo, 2018).

Moreover, level of religiosity is found to be inversely related to self-injurious thoughts and behaviors (Gearing & Alonzo, 2018). This may be due to Judaism’s views on suicidality and self-harm. According to Jewish law, the preservation of one’s life is prioritized above all else. As such, Jewish law condemns self-harm, stating in Leviticus 19:28 that “*You shall not make gashes*

*in your flesh for the dead, or incise any marks on yourselves.*” This is further explained in Deuteronomy 14:15, that harming one’s body violates the Biblical commandment to protect one’s life and health (Abramowitz, 2014; Hamdan & Peterseil-Yaul, 2020). Furthermore, in Jewish law, suicide is viewed as murder, an abandonment of the fundamental principles of Judaism (Abramowitz, 2014; Hamdan & Peterseil-Yaul, 2020). Dying by suicide is associated with perceived spiritual ramifications, wherein the soul is believed to enter a state of limbo, prevented from reuniting with the body or entering the realm of souls, as its time of departure is not deemed by God (Gearing & Alonzo, 2018). Moreover, there are some opinions that those who die by suicide cannot be given the proper burial and blessings according to Jewish law (Minkowitz, 2019). Thus, while some individuals view suicidality as an escape from pain and distress (Al-Dajani et al., 2019; Dong et al., 2018; Verrocchio et al., 2016) Orthodox Jews may view suicide as a worse alternative to staying alive (Gearing & Alonzo, 2018). Accordingly, studies have shown that those at higher risk for suicide were less committed to the Jewish religion and perceived religion as less important (Barzilay et al., 2015; Hamdan & Peterseil-Yaul, 2020).

### **Theories of Suicidality**

Various models have been proposed by suicide researchers that differ in their emphasis on psychological, psychiatric, social, cultural, cognitive, and neurobiological factors in predicting the risk of suicidality (O’Connor et al., 2020; van Heeringen, 2000). The interpersonal theory of suicide (IPTS) (Joiner, 2007) posits that suicidality is caused by the combined presence of three interpersonal constructs: perceived burdensomeness, thwarted belongingness, and an acquired capability for suicide. Perceived burdensomeness refers to the belief that one's existence is a burden on others (i.e. family members, friends, society) and one’s death would be more

beneficial to others than their life (Smith et al., 2020; Van Orden et al., 2010). Thwarted belongingness refers to an unmet need for interpersonal connection, where one feels alienated from others and not an integral part of a group. The theory also asserts that the capability to engage in suicidal behavior is distinct from the desire to engage in suicidal behavior. Suicidal behavior occurs only when SI is present within the context of the acquired capability for suicide (Forkmann et al., 2020). Acquired capability involves two components: elevated pain tolerance (i.e. via non-suicidal self-injury, previous suicide attempts, combat exposure, childhood abuse, or mental rehearsal of painful events), and fearlessness about death. Individuals who have all three of these factors— an acquired capability for suicide, perceived burdensomeness, and thwarted belongingness, may act on their SI and engage in serious suicidal behavior (Hjelmeland & Loa Knizek, 2019, Smith et al., 2020).

The integrated motivational-volitional model (IMV) of suicidal behavior (O'Connor, 2011) suggests that suicidal behavior results from a multifarious interplay of factors. The model integrates various theoretical approaches and concepts from several suicidality researchers. Specifically, the IMV draws from the concepts of perceived burdensomeness and thwarted belongingness from the IPTS (Van Orden, 2005), Baumeister's (1990) theory of suicide as an escape from the self, which suggests that people may turn to suicide when they feel that they have lost control over their lives, and research from Shneidman (1985), who argued that suicidal behavior results from a desire to end psychological pain. The model identifies two key components: the motivational component and the volitional component. The motivational component of the model includes factors such as mental illness, environmental stressors, and personality traits, which can influence an individual's desire to die by suicide. The volitional



component includes factors such as impulsivity, access to means, and past suicidal behavior, which can influence an individual's ability to act on suicidal thoughts (O'Connor, 2011).

The model suggests that suicidal behavior can occur only when both components are present. The presence of the motivational component alone is not sufficient to lead to suicidal behavior, as the individual must also have the ability to carry out the act. Similarly, the presence of the volitional component alone is not sufficient to lead to suicidal behavior, as the individual must also have the motivation to die by suicide (O'Connor, 2011).

### **Religion/Spirituality and Depression**

Throughout the literature, the role of R/S in the depression-suicidality relationship is unclear, as while some research characterizes R/S as intensifying depressive and suicidal symptoms, other research has found R/S to be a preventative factor of such symptomology (Cureton & Fink, 2019; Lawrence et al., 2016).

As a construct, R/S generally incorporates a worldview that provides meaning and purpose to life through belief in a transcendent reality (Braam & Koenig, 2019). R/S is a multidimensional concept, involving personal beliefs and public, private, and cognitive practices. Previous research has looked at the associations between R/S, MDD, and suicidality, as depression and suicidality are often associated with a loss of hope and meaning, while religion is associated with the opposite (Braam & Koenig, 2019).

Research has found that peoples' relationships to R/S are multifaceted and nuanced, often including dialectical tensions between seeking and stagnation, as well as concurrent strengths and struggles (Captari et al., 2022). Practicing religion can neutralize life stress, and can both prevent the onset of, as well as shorten the length of a depressive episode (Braam & Koenig, 2019). Moreover, religious support and private religious practices such as prayer and meditation

are associated with lower levels of depression and SI. Religious attendance is most highly correlated with a decline in depression over time, most likely because of the positive effects of communal support, directly combatting thwarted belongingness (Cole-Lewis et al., 2016). However, while for some R/S can increase meaning, purpose, peace, and existential well-being, for others R/S can serve as an additional struggle. Some grapple with existential questions, leading to a sense of doubt, despair, and confusion (Pargament, 1992; Pargament & Exline, 2022). Additionally, struggles with trusting the divine, confronting supernatural evil spirits, as well as R/S-based interpersonal conflict, including conflict related to differences in religious beliefs, practices, values, and opinions, are correlated with a decline in mental health over time (Braam & Koenig, 2019; He et al., 2019; Lawrence et al., 2016; Pargament & Exline, 2022).

As described above, people from every religion, culture, and demographic group rely upon religion to conceptualize life events, either leading to an increase or a decrease in mental well-being. These ways of responding to distress, or R/S-focused cognitive, emotional, and behavioral responses to stress, are often conceptualized as religious coping (Pargament, 1992; Pargament & Exline, 2022). Religious coping is rooted in the human search for meaning, significance, and purpose. There are two facets of religious coping: positive and negative religious coping (i.e. spiritual struggles) (Pargament & Exline, 2022; Rosmarin, 2018).

### **Positive Religious Coping**

Positive religious coping pertains to beliefs that cultivate and reflect a secure and supportive connectedness with the transcendental, the universe, and others (Captari et al., 2022; Counted et al., 2020; Cowden et al., 2021). This aspect of religious coping assists people in the search for significance in stressful times (Rosmarin, 2018) creating an “expansion of consciousness by which theological truths are viscerally experienced amidst suffering” (Captari

et al., 2022, p. 2). Coping in this manner strengthens peoples' beliefs in a benevolent divine presence and purpose, leading to intensified meaning, peace, and gratitude, and refuting feelings of despondency, hopelessness, and confusion (Captari et al., 2022). Often, it provides a sense of meaning and purpose, emotional comfort, hopefulness, self-development, personal control, personal restraint, intimacy with others, physical health, spirituality, and closeness to God (Rosmarin, 2018; Wortmann, 2013). Positive religious coping involves benevolent religious reappraisals, collaborative religious coping, seeking spiritual support, spiritual connection, religious purification, seeking help from clergy or members of the community, religious helping, and religious forgiveness (Pargament et al., 1998; Pargament & Exline, 2022).

### **Negative Religious Coping**

On the contrary, negative religious coping reflects a less secure relationship with God (Park et al., 2018). It refers to experiences of tension, conflict, or strain surrounding what people view as sacred, occurring in the context of contending with a life stressor (Pargament & Exline, 2022). Negative religious coping is typically not a straightforward trajectory (Pargament & Exline, 2021). These struggles do not indicate an immature connection to R/S, rather, a natural feature of R/S life that people from every religion, culture, and demographic group are susceptible to (Pargament & Exline, 2021). This coping style is utilized when people draw on R/S in a psychologically maladaptive manner, typically involving struggles in at least one of the three following domains: intrapersonal, interpersonal, and divine (Rosmarin, 2018).

Intrapersonal spiritual struggles, one facet of negative religious coping, involve internal issues with R/S themes, often representing the tension between the physical body and the lofty soul. Healthy "body-soul dynamics" (Rosmarin, 2018) include genuine spiritual striving on behalf of the body and gentle tolerance and compassion on behalf of the soul. Those who have

intrapersonal spiritual struggles experience the opposite: self-criticism, intolerance, and punishment for not meeting the unattainable expectations of the soul, leading to a lack of sincere effort in R/S practices due to hopelessness, thereby perpetuating the cycle (Rosmarin, 2018). Common examples include excessive guilt or hopelessness over sinning or one's religious level; consistent self-judgment of one's potential or spiritual status; self-criticism for struggling or experiencing psychopathological symptoms; pressuring oneself to aim for over-stringent and unattainable R/S standards; and removing oneself from R/S practices due to feeling unworthy of engaging in R/S (Pargament, 2001; Rosmarin, 2018).

Interpersonal spiritual struggles, another facet of negative religious coping, refers to social difficulties relating to R/S themes or that arise from an R/S context. These struggles are two-fold, as not only do individuals experience R/S strain, but they experience social isolation as well, often leading to an increase in intrapersonal spiritual struggles (Pargament & Exline, 2021). Examples of interpersonal spiritual struggles include conflict with clergy or community members often about sacred matters, or witnessing wrongdoings on behalf of religious individuals, leading to increased disconnection from R/S (Rosmarin, 2018).

Lastly, divine spiritual struggles involve conflicts, tensions, and questions surrounding a person's faith, and their understanding and perception of God (Pargament & Exline, 2021). Often, divine spiritual struggles arise in the context of seemingly unfair outcomes that occur or learning about unjust events in history (Rosmarin, 2018). Individuals may develop maladaptive cognitive schemas relating to God, believing that God plays a role in their suffering (Pargament & Exline, 2021). Examples of divine spiritual struggles include people questioning God's omnipotence, God's love for them, feeling anger or disappointment toward God, fearing punishment or disapproval from God, feeling isolated from God, or viewing God as malevolent

or unjust (Koenig, 2012; Pargament et al., 1998). Some may doubt God's existence or lose faith altogether, which can lead to an increase in intrapersonal and interpersonal spiritual struggles in addition to divine spiritual struggles (Rosmarin, 2018).

Though research findings have suggested that negative religious coping is utilized significantly less frequently than positive religious coping, negative religious coping is a more consistent predictor of well-being than positive religious coping (Park et al., 2018). Negative religious coping is strongly related to decreased psychological and physical health, and increased mortality in medically ill elderly patients (Pargament, 2001; Park et al., 2018).

### **Religious Coping and Depression/Suicidality**

The relationships between religious coping style, depression, and suicidality are scarcely studied. Few studies have shown that positive religious coping is inversely related to the development of psychological disorders, especially depression, and anxiety in Jewish, Muslim, and Christian samples (Pirutinsky et al., 2020; Thomas & Barbato, 2020). In a population of Christians with MDD, this coping style is associated with stress relief, a sense of self-control, hope, and self-esteem (De Berardis et al., 2020). Moreover, religious affiliation, a feature of positive religious coping, is associated with a lower risk of suicidality (Lawrence et al., 2016). There are various mechanisms responsible for this. Firstly, religious affiliation and participation in religious activities contribute to an increase in social support (Rasic et al., 2011, Pulgar et al., 2022). Moreover, religious doctrines condemn suicide, often viewing it as a moral transgression with negative implications for the afterlife, thereby deterring people from engaging in suicidal behaviors (Lawrence et al., 2016). Lastly, individuals often utilize religious beliefs and practices to cope in stressful situations, oftentimes finding purpose in their suffering, thereby decreasing the chances of engaging in suicidal behaviors (Lawrence et al., 2016; Stark & Bainbridge, 1980).

Conversely, many studies suggest that negative religious coping is related to an increase in psychopathology, including anxiety, social problems, physical illness, impulse control, negative affect, and low self-esteem, and leads to a decline in mental health over time (Pargament & Exline, 2021; Park et al., 2018). The effect of negative religious coping on levels of depression has been debated in the literature, though this coping style is associated with maladaptive emotional regulation, leading to severely distressing emotional states, which is a precursor for mood disorders (Francis et al., 2019; Pargament & Exline, 2021; Park et al., 2018). Negative religious coping is associated with increases in SI, likely because this coping style leads to increases in hopelessness (De Berardis et al., 2020). Moreover, the connection between negative religious coping and increased levels of distress has been found in a general population representing diverse religions, socio-demographic groups, and nationalities (Pargament & Exline, 2021). While it is possible for growth to emerge from spiritual struggles, it is more likely for psychopathology to develop (Pargament & Exline, 2021).

### **The Present Study**

Religion's role in decreasing the risk of suicidality among those suffering from depression remains unclear. As such, the present study aims to examine the moderating effects of religious coping on the relationship between depression and suicidality in Orthodox Jewish adults, as there are limited studies on this topic. Understanding the results can have major implications clinically. In the United States alone, 93% of Americans report a belief in God, and 50% report that R/S is a very important factor in their lives (Gallup Poll, May 8- 11, 2008). Because of the predominance of religion and spirituality in people's lives, it is crucial to identify the role religion plays as a potential risk or protective factor in the connection between MDD and suicidality. This holds particular significance, as individuals with MDD might depend on

religious or spiritual coping mechanisms to help them navigate their emotional challenges (Rosmarin, 2018). However, if someone resorts to negative religious or spiritual coping strategies, which are associated with a higher likelihood of suicidality (De Berardis et al., 2020), they could find themselves in a precarious situation. Accordingly, to reduce suicidality in patients with MDD, it is specifically important to identify factors that contribute to or prevent SI and SP, which can then be incorporated into the treatment of MDD and suicide prevention.

The current research is a secondary analysis of a larger study on Jewish persons and tested the hypotheses within a religious sample exclusively within the Jewish community. There is value in studying the Jewish religious experience, as most studies of religion in the United States utilize predominately Christian or Muslim samples, which may not be generalizable to other faith traditions. Moreover, clinicians often feel ill-equipped to address R/S matters in treatment (Rosmarin, 2018), and this study can impress the importance of working together with theological, spiritual, or religious figures to understand religious coping according to the Jewish tradition, which can lead to more culturally specific and effective treatment. Further, though depression and suicidality are typically positively correlated, amongst the Jewish population, depression rates are higher than in other religions, though suicide rates are lower (Bonelli et al., 2012; Gearing, & Alonzo, 2018). Explanations for this have been cited in previous literature (Bonelli et al., 2012; Gearing & Alonzo, 2018; Hamdan & Peterseil-Yaul, 2020), though the role of religious coping has never been assessed. As such, this study may expose another possible mechanism for this discrepancy.

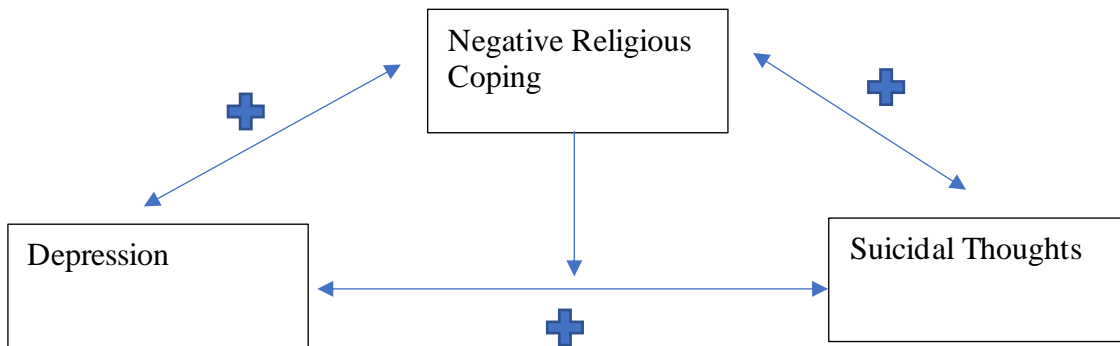
The following hypotheses were tested for the participants in the study:

1. Scores on the depression and suicidal thoughts measures would be positively correlated.
2. Negative religious coping and positive religious coping would be negatively correlated.

3. Negative religious coping would contribute to a stronger positive relationship between depression and suicidal thoughts.

**Figure 1**

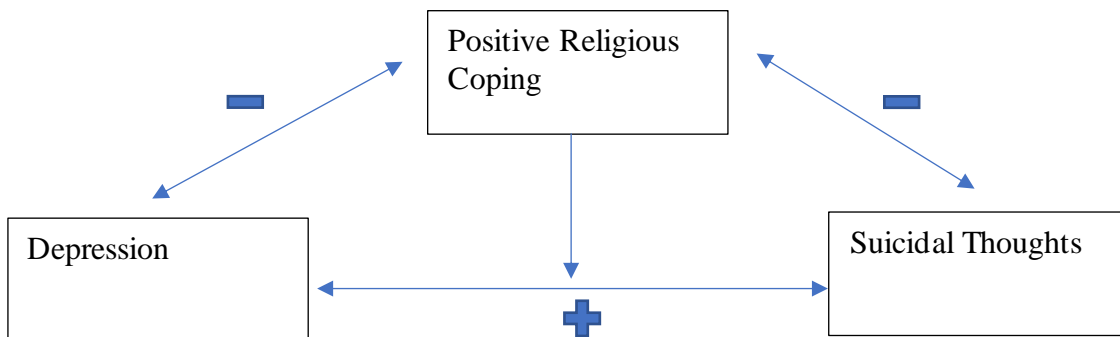
*Negative Religious Coping Moderating Depression and Suicidal Thoughts*



4. Positive religious coping would weaken the positive relationship between depression and suicidal thoughts.

**Figure 2**

*Positive Religious Coping Moderating Depression and Suicidal Thoughts*



## Method

### Participants

Participants consisted of adult patients presenting to a large multisite clinic in the NYC area. The participants included in this study are part of larger sample and were chosen based on



meeting the following inclusion criteria: 18+ years of age; self-identification as an Orthodox Jew (*Chassidic*, or members relating to the Jewish Hasidim and their beliefs and practices, *Yeshiva Orthodox*, or a sect of the religious Jewish community which includes Jews who study in yeshiva, *Modern Orthodox*, or a sect within Orthodox Judaism which synthesizes Jewish values and law with the modern world, *Sephardic Orthodox*, or Orthodox Jews originating from Spain, Portugal or North Africa); current residency in the United States; fluency in the English language; score in the mild to severely depressed range on the depression measure; completion of the demographic, suicidal thoughts, and religious coping measures. Exclusion criteria included: below 18 years of age; self-identification of non-Orthodox Jewish, Buddhist, Catholic, Hindu, Muslim, Protestant Christian, Spiritual without religious affiliation, or no religion; score in the minimal depressed range on the depression measure.

### **Demographic Variables**

There were 221 participants for the present study, 36.6% identifying as male ( $n = 81$ ), 62.0% identifying as female ( $n = 137$ ), and 1.4% identifying as other ( $n = 3$ ). Nearly all the participants identified as white ( $n = 205$ ), and all identified as Jewish Orthodox ( $n = 221$ ). The age of participants ranged from 18 to 43 ( $M = 28.26$ ,  $SD = 5.76$ ). Table 1 provides a summary of demographic variables.

**Table 1***Demographic Characteristics of the Sample*

Variable	<i>n</i> (%)	
Income	< \$25,000	80 (36.2%)
	\$25,000- \$50,000	29 (13.1%)
	\$50,001- \$75,000	28 (12.7%)
	\$75,001- \$100,000	29 (13.1%)
	\$100,001- \$130,000	18 ( 8.1%)
	> \$130,001	37 (16.8%)
Sex	Female	137 (62.0%)
	Male	81 (36.6%)
	Other	3 ( 1.4%)
Marital Status	Single	136 (61.5%)
	Married	77 (34.9%)
	Divorced	8 ( 3.6%)
Education	Some High School	19 ( 8.6%)
	High School Diploma	51 (23.1%)
	Some College	54 (24.4%)
	College Diploma	60 (27.2%)
	Graduate Degree	37 (16.7%)
Working Status	Self-employed	17 ( 7.7%)
	Homemaker	12 ( 5.4%)
	Student	59 (26.7%)
	Unemployed	18 ( 8.2%)
	Other	11 ( 5.0%)
	Ethnicity	White
Latino or Hispanic		1 ( 0.5%)
Other		15 ( 6.8%)
Jewish Sect	Chassidish	35 (15.8%)
	Yeshiva Orthodox	69 (31.2%)
	Modern Orthodox	84 (38.0%)
	Sephardic Orthodox	9 ( 4.1%)
	Other (Orthodox)	24 (10.9%)

## **Design and Procedure**

The study follows a correlational model utilizing archival data. The Long Island University Post Institutional Review Board determined that because this study uses retrospective data, it need not undergo further review. The original study was approved by the McLean Hospital/Harvard Medical School Institutional Review Board. Informed consent was received from each of the participants. Data were collected between January 2017 and May 2022 from adult patients presenting to the offices of the Center for Anxiety for clinical treatment. As part of the intake process, patients filled out various questionnaires to assess baseline information. At intake, patients were asked to complete self-report measures of depression, suicidal thoughts, and religiosity using Psych-Surveys™ software, which allows for seamless electronic administration of measures in clinical settings. This study focuses on analyzing the data from these intake measures.

## **Measures**

### ***PHQ-8***

Depression was measured using the Patient Health Questionnaire-8, a scale created by Kroenke et al. (2009) (see Appendix B). This 8-item scale was adapted from the PHQ-9 (Kroenke et al., 2001); the scales are identical, though the PHQ-8 omits the question relating to suicidality. All items relate to depression symptoms, reflecting the criteria for MDD in the DSM-5. These items are rated on a four-point Likert scale ranging from 0 = *not at all* to 3 = *nearly every day*. Scores range from 0-24. A total score of 0-4 represents no significant depressive symptoms; 5 to 9, mild symptoms; 10 to 14, moderate symptoms; 15 to 19, moderately severe symptoms; and 20 to 24, severe symptoms (Kroenke et al., 2009). Previous assessments of this scale suggest that it has high internal consistency, strong test–retest reliability, and criterion and

construct validity (Pressler et al., 2010). This measure demonstrated a high level of internal reliability in the present sample ( $\alpha = .82$ ).

### ***Suicidal Thoughts Survey***

Suicidal thoughts, specifically SI, and thoughts of suicidal intent and self-harm were measured utilizing two questions from the University of the Washington Risk Assessment Protocol (UWRAP) a self-report scale created by Linehan et al. (2000), and a question from the PHQ-9 (Kroenke & Spitzer, 2002) (see Appendix C). The overall suicidal thoughts score represents a mean of participants' responses to these 3 items. The UWRAP questions ask: "*On a scale of 1 to 7, what is your urge to harm yourself now?*" and "*On a scale of 1 to 7, what is your intent to kill yourself right now?*" The PHQ-9 item asks "*Over the last 2 weeks, how often have you been bothered by any of the following problems? Thoughts that you would be better off dead, or hurting yourself in some way?*" A score of 1 represents *not at all*, 2 represents *several days*, 3 represents *more than half the days*, and 4 represents *nearly every day*. Scores range from 3 to 18, with 3 indicating no level of suicidality, and 18 representing a high level of suicidality. A mean of 1 indicates no suicidality and a mean of 6 indicates high suicidality. The PHQ-9 item has been validated for measuring SI in previous studies (Elbogen et al., 2020; Hellmuth et al., 2012; Iversen et al., 2009). Both the UWRAP and PHQ-9 scales are reliable and valid according to previous research (Kroenke et al., 2001; Landes & Linehan, 2015; Linehan et al., 2012). This measure demonstrated a high level of internal reliability in the present sample ( $\alpha = .86$ ) and an exploratory factor analysis suggested that all items loaded on a single factor (eigenvalue = 2.423), accounting for 80.76% of the variance.

### ***Religious Coping Survey***

Positive and negative religious coping items were based on the Brief Religious Coping Questionnaire (RCOPE) created by Pargament et al. (1998) adapted by the researchers at Center for Anxiety to be a briefer scale for intake purposes (see Appendix D). Additionally, the RCOPE particularly targets Christian samples and is not a culturally appropriate measure for Jewish samples. As such, a factor analysis was conducted to make this scale briefer and culturally appropriate for clinical intake purposes. The original scale has high internal validity, construct validity, predictive validity, and incremental validity (Pargament et al., 2011). An exploratory factor analysis (Principal Components extraction, Direct Oblimin rotation) suggested that there were 2 factors with eigenvalues above 1 that explained 71% of the variance, representing positive and negative aspects of S/R, measured on an ordinal scale. Items loadings within were high for both positive ( $M = .84$ ,  $SD = .04$ , Range: .79 - .90), and negative factors ( $M = .83$ ,  $SD = .05$ , Range: .76 - .87), and there was no cross-loading ( $M = .11$ ,  $SD = .07$ , Range: .19 - .008). The positive religious coping scale consists of 3 items relating to belief in God, active involvement in a faith community, and utilizing R/S to cope with stressors ( $M = 8.17$ ;  $SD = 3.09$ ). The higher the score, the higher the level of positive religious coping. This measure demonstrated an acceptable level of internal reliability in the present sample ( $\alpha = .68$ ). The negative religious coping scale consists of 3 items relating to feeling punished by God, questioning God's love for his creatures, and R/S making it more difficult to cope with stressors ( $M = 3.61$ ;  $SD = 3.32$ ). The higher the score, the higher the level of negative religious coping. For each scale, items are rated on a five-point Likert scale ranging from 0 = *not at all* to 4 = *very much*. Each scale's scores range from 0-12. Factor analyses show that this measure demonstrated a high level of internal reliability in the present sample ( $\alpha = .76$ ). These factors negatively correlated to a moderate degree ( $r = .13$ ).

### **Data Analysis**

This research sought to explore the moderating effects of positive and negative religious coping on the depression-suicidality relationship. This study tested a correlational moderation model utilizing a linear regression. The data were tested for normal distribution. Hierarchical regression analyses were used to investigate how the two moderating variables, positive and negative religious coping, moderate the relationship between depression and suicidal thoughts in the Orthodox Jewish community. Pearson correlation was conducted to analyze the strength and direction of the relationship between positive and negative religious coping. Gender was measured as categories, income on an ordinal scale, and marital status and education level were measured as frequencies on a nominal scale. Suicidal thoughts and positive and negative coping were measured on an interval scale. Data were tested for normality and outliers.

## **Results**

### **Preliminary Analysis/ Descriptive Statistics**

Measures of central tendency and variability were calculated to identify the level of depression, negative and positive religious coping, and suicidal thoughts for participants. We also tested for normal distribution to ensure that the variables for this sample met the assumptions necessary for calculations of correlations. We tested for correlation amongst variables prior to testing for a moderation effect.

### ***Depression***

In order to assess for symptoms of depression, participants completed the PHQ-8. Scores on the PHQ-8 ranged from 5 to 24, with an average of 11.79 ( $SD = 5.38$ ). These results suggest that on average, participants fell in the moderate range of depressive symptomatology. The skewness and kurtosis of PHQ-8 scores suggest that the scores were normally distributed

(skewness = .57; kurtosis = -.78). Three participants failed to complete the PHQ-8 measure, which lowered the sample of this measure to 218.

### ***Positive Religious Coping***

Scores on the positive religious coping scale ranged from 0 to 12, with an average of 8.21 ( $M = 8.21, SD = 3.03$ ). These results are similar to past research using this measure, suggesting that this sample has average positive religious coping styles (Pargament et al., 2011). The skewness and kurtosis of scores suggest that the scores were normally distributed (skewness = -.53; kurtosis = -.57). Similarly, the same three participants failed to complete the positive religious coping measure, which lowered the sample of this measure to 218.

### ***Negative Religious Coping***

Scores on the negative religious coping scale ranged from 0 to 12, with an average of 3.61 ( $M = 3.61, SD = 3.29$ ). These results are similar to past research using this measure, suggesting that this sample has average negative religious coping styles (Pargament et al., 2011). The skewness and kurtosis of scores suggest that the scores were normally distributed (skewness = .87; kurtosis = -.18). Similarly, the same three participants failed to complete the negative religious coping measure, which lowered the sample of this measure to 218.

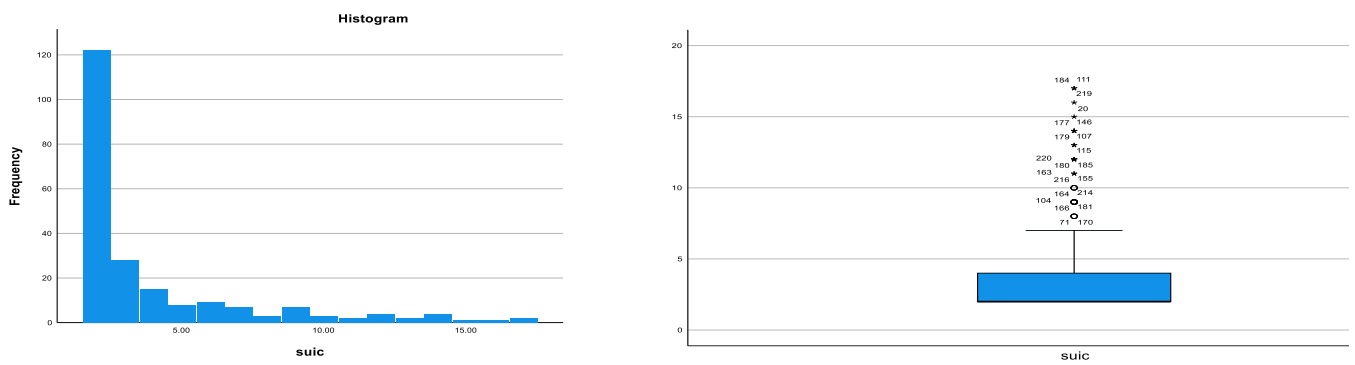
### ***Suicidal Thoughts***

Scores on the 3-item measure of suicidal thoughts ranged from 3 to 18, with an average score of 3.94 ( $M = 3.94, SD = 3.36$ ). The kurtosis of this measure is slightly elevated (kurtosis = 2.65), presenting a slight deviation from a normal distribution. The distribution appears skewed, characterized by a concentration of values at the lower end (individuals reporting no suicidal thoughts), followed by a prolonged tail representing a group of individuals reporting suicidal thoughts. The skewness was in the average range (skewness = 2.06). Table 2 presents a summary

of all these results. It has been found that this degree of skew and kurtosis has only a slight impact on the power or Type I error and that regression models are robust to this degree of departure from normality, especially in samples of 200 or more (Stevens, 1996; Tabachnick & Fidell, 2001). The normality of the residuals will be evaluated in hypothesis testing to ensure that the kurtosis of the suicidal thoughts scale does not interfere with the assumptions of the analyses.

**Figure 3**

*Histogram and Boxplot of Suicidal Thoughts*



**Table 2**

*Descriptive Statistics of PHQ-8, Positive and Negative R/S Coping and Suicidal Thoughts Scores*

Variable	<i>n</i>	<i>M</i>	<i>SD</i>	Skewness	Kurtosis
PHQ-8	218	11.79	5.38	.57	-.78
Pos. Relig. Coping	218	8.21	3.02	-.53	-.57
Neg. Relig. Coping	218	3.61	3.29	.87	-.18
Suicidal Thoughts	218	3.94	3.36	2.06	2.65

*Note.* PHQ-8 = Patient Health Questionnaire-8 (Kroenke et al., 2009)

**Hypothesis 1**

To test the first hypothesis that scores on the depression and suicidal thoughts measures will be positively correlated, a Pearson correlation was conducted. Suicidal thoughts scores were significantly positively correlated with PHQ-8 scores, such that higher levels of suicidal thoughts



were associated with higher levels of depression ( $r = .39$ , 95% CI [.27, .5],  $p < .001$ ); this indicates that suicidal thoughts score account for 15.21% of variance in depression scores ( $R^2 = .15$ ).

## **Hypothesis 2**

To test the second hypothesis that negative religious coping and positive religious coping will be negatively correlated: To determine the relation between variables, Pearson correlations were computed. Positive religious coping was significantly negatively correlated with negative religious coping scores, such that higher levels of positive religious coping were associated with lower levels of negative religious coping ( $r = -.17$ ,  $p = .01$ , 95% CI [-.3, -.04]); this indicates that positive religious coping scores account for 2.89% of variance in negative religious coping scores ( $R^2 = .028$ ).

## **Hypothesis 3**

### ***Correlation Among Variables***

To test the third hypothesis that negative religious coping will contribute to a stronger positive relationship between depression and suicidal thoughts: First, correlations among the three variables were computed, and then a regression analysis was conducted. Negative religious coping scores were significantly positively correlated with PHQ-8 scores, such that higher levels of negative religious coping were associated with higher levels of depression ( $r = .39$ , 95% CI [.27, .5],  $p < .001$ ); this indicates that negative religious coping scores account for 15.21% of variance in depression scores ( $R^2 = .15$ ).

Negative religious coping scores were significantly positively correlated with suicidal thoughts scores, such that higher levels of negative religious coping were associated with higher levels of suicidal thoughts ( $r = .37$ , 95% CI [.25, .48],  $p < .001$ ); this indicates that negative

religious coping scores account for 13.69% of variance in suicidal thoughts scores ( $R^2 = .1369$ ).

Table 3 summarizes these results.

**Table 3**

*Correlations Among Variables*

Variable	1.	2.	3.	4.
1. Pos. Relig. Coping	1	-.17*	-.14*	-.18*
2. Neg. Relig. Coping		1	.39*	.37*
3. PHQ-8			1	.39*
4. Suicidal Thoughts				1

*Note.* PHQ-8 = Patient Health Questionnaire-8 (Kroenke et al., 2009)

\* $p < .05$

***Regression Predicting Suicidal Thoughts***

A hierarchical regression model, (Step 1) with depressive symptoms and negative religious coping, was conducted to predict suicidal thoughts. Results suggest that the model including depression and negative religious coping significantly predicts suicidal thoughts scores ( $R^2 = .215$ ,  $F(2, 216) = 29.54$ ,  $p < .001$ ). The model accounted for 21.5% of the variance in the suicidal thoughts scores.

The following is the best fitting unstandardized regression equation:

$$\text{Suicidal Thoughts} = 3.96 + .19(\text{Depression}) + .26 (\text{neg. relig. coping})$$

This model suggests that for every one-unit increase in depression, suicidal thoughts would increase .19 points, and for every one-unit increase in negative religious coping, suicidal thoughts would increase .26 points.

In Step 2 of the model, the interaction between depressive symptoms and negative religious coping was added. While the full model accounted for 22.5% of the variability in suicidal thoughts scores ( $R^2 = .226$ ,  $F(2, 216) = 29.54$ ,  $p < .001$ ), the addition of the interaction only accounted for 1.2% and was not a significant increase over the previous step ( $R^2_{\text{change}} = .012$ ,  $p = .07$ ). Therefore, the model without the interaction is a better fitting model.

Results of this regression showed a significant main effect of depression on suicidal thoughts ( $b = .18$ ,  $SE = .04$ ,  $p < .01$ ), indicating that those with higher depression scores also had higher suicidal thoughts scores. There was also a main effect of negative religious coping on suicidal thoughts ( $b = .23$ ,  $SE = .07$ ,  $p < .05$ ), such that higher scores on negative religious coping were associated with higher suicidal thoughts. The interaction effect was non-significant and did not add significantly to the model ( $b = .02$ ,  $SE = .01$ ,  $p > .05$ ), showing that negative religious coping does not moderate the relationship between depression and suicidal thoughts, which does not support the hypothesis.

Since the suicidal thoughts score was kurtotic, residuals were checked and found to be sufficiently normally distributed (skewness = 1.44, kurtosis = 2.93), sufficiently meeting the assumptions of linear regression. It should be noted that residuals were kurtotic largely due to a high proportion of accurate predictions since there were a higher number of values close to zero.

The following is the best fitting unstandardized regression equation:

$$\text{Suicidal thoughts} = 3.82 + .19(\text{Depression}) + .26(\text{neg. relig. coping})$$

#### Table 4

*Regression Models Predicting Suicidal Thoughts from Negative R/S Coping and Depression*

Model 1	Model 2
---------	---------

Variable	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Constant	3.96*	.20		3.82*	.22	
Depression (A)	.19*	.04	.29	.18*	.04	.39
Neg. Rel. Coping (B)	.26*	.07	.26	.23*	.07	.37
A X B				.02	.01	.26

\* $p < .05$

## Hypothesis 4

### *Correlations Among Variables*

To test the fourth hypothesis that positive religious coping will weaken the positive relationship between depression and suicidal thoughts: First, correlations were computed among the three variables, and then a regression analysis was conducted. Positive religious coping scores were significantly negatively correlated with PHQ-8 scores, such that higher levels of positive religious coping were associated with lower levels of depression ( $r = -.14$ , 95% CI [-.27, -.01],  $p = .04$ ); this indicates that positive religious coping scores account for 1.96% of variance in depression scores ( $R^2 = .0196$ ).

Positive religious coping scores were significantly negatively correlated with suicidal thoughts scores, such that higher levels of positive religious coping were associated with lower levels of suicidal thoughts ( $r = -.18$ , 95% CI [-.31, -.05],  $p = .01$ ); this indicates that positive religious coping scores account for 3.24% of variance in suicidal thoughts scores ( $R^2 = .0324$ ).

### *Regression Predicting Suicidal Thoughts*

A hierarchical regression model with depressive symptoms and positive religious coping was conducted to predict suicidal thoughts. Results from the first step suggest that the model including depression and positive religious coping significantly predict suicidal thoughts scores

( $R^2 = .174$ ,  $F(2, 216) = 22.70$ ,  $p < .001$ ). The model accounted for 17.4% of the variance in the suicidal thoughts scores.

The following is the best fitting unstandardized regression equation:

$$\text{Suicidal Thoughts} = 3.96 + .24 (\text{Depression}) -.14 (\text{Pos. Relig. Coping})$$

This model suggests that for every one-unit increase in depression, suicidal thoughts would increase .24 points in the scale and for every one-unit increase in positive religious coping, suicidal thoughts would decrease .14 points.

In Step 2 of the model, the interaction between depressive symptoms and positive religious coping was added, but only explained 0.6% of the variability, which is not significant ( $R^2_{\text{change}} = .006$ ,  $p = .23$ ). Therefore, the model without the interaction is a better fitting model.

In examining the coefficients, there was a main effect of depression on suicidal thoughts ( $b = .24$ ,  $SE = .04$ ,  $p < .05$ ), indicating that those with higher depression scores also had higher suicidal thoughts scores. There was also a main effect of positive religious coping on suicidal thoughts ( $b = -.13$ ,  $SE = .07$ ,  $p < .05$ ), such that higher scores on positive religious coping were associated with lower suicidal thoughts. The interaction was non-significant and did not add significantly to the model ( $b = .02$ ,  $SE = .01$ ,  $p > .05$ )

Since the suicidal thoughts score was kurtotic, residuals were checked and found to be sufficiently normally distributed (skewness = 1.67, kurtosis = 3.13), sufficiently meeting the assumptions of linear regression. It should be noted that residuals were kurtotic largely due to a high proportion of accurate predictions since there were a higher number of values close to zero.

The following is the best fitting unstandardized regression equation:

$$\text{Suicidal Thoughts} = 3.93 + .24 (\text{Depression}) - .14 (\text{Pos. Relig. Coping})$$

While depression and positive religious coping significantly contributed to the prediction of suicidal thoughts, the interaction of the two did not significantly contribute to the model, showing that positive religious coping does not moderate the relationship between depression and suicidal thoughts, which does not support the hypothesis.

**Table 5**

*Regression Coefficients for Hierarchical Linear Regression Predicting Suicidal Thoughts from Positive Religious Coping and Depression*

Variable	Model 1			Model 2		
	<i>B</i>	<i>SE B</i>	$\beta$	<i>B</i>	<i>SE B</i>	$\beta$
Constant	3.96*	.21		3.93*	.21	
Depression (A)	.24*	.04	.38	.24*	.04	.39
Pos. Rel. Coping (B)	-.14*	.07	-.13	-.13*	.07	.37
A X B				-.02	.01	.26

\* $p < .05$

### Discussion

Individuals with MDD are at risk for suicidality, with various protective and risk factors cited in the literature that either reduce or increase the likelihood of an individual with MDD engaging in suicidality, respectively (Baldessarini & Tondo, 2020; Bolton et al., 2010; Dong et al., 2018; Pompili et al., 2013; Reynolds et al., 2006; Rubio et al., 2020). R/S has been cited as both risk and protective factors for both depression and suicidality (Cureton & Fink, 2019; Lawrence et al., 2016). Specifically, individuals with MDD often turn to their R/S beliefs and practices for guidance during challenging times (Rosmarin, 2018), and the type of R/S coping

that an individual utilizes can significantly influence their mental health, either by providing helpful support or presenting potential challenges. As such, this study focused on the moderating effect of religious coping styles on the depression-suicidality relationship, specifically among Orthodox Jews—an underrepresented minority community.

Along those lines, we hypothesized that: 1) depression and suicidal thoughts will be positively correlated; 2) negative religious coping and positive religious coping will be negatively correlated; 3) negative religious coping will bolster the positive relationship between depression and suicidal thoughts; 4) positive religious coping will weaken the positive relationship between depression and suicidal thoughts.

Supporting our first hypothesis, results indicated that depression and suicidal thoughts were significantly positively correlated within our population. This is consistent with previous research suggesting that individuals with MDD are at greater risk for SI, SP, and SA, and the greater the severity and length of MDD, the higher the level of SI, intent, and attempts (Bolton et al., 2010; Dong et al., 2018; Reynolds et al., 2006; Rubio et al., 2020).

In support of our second hypothesis, results indicated that negative and positive religious coping are negatively correlated, though to a small degree. Consistent with previous research, individuals tend to employ one form of R/S coping more frequently, at the expense of the other (Pargament & Exline, 2021; Park et al., 2018; Thomas & Barbato, 2020). This can be attributed to factors including cognitive dissonance, or individual differences with varying inclinations toward either negative or positive R/S coping.

However, according to our study, while there is a negative correlation between negative and positive religious coping, it does not imply an absolute absence of both coping types in individuals, as indicated by only a *slight* negative correlation. As with many psychological

phenomena, the relationship between positive and negative religious coping is complex and subject to individual variations. Individuals may simultaneously experience benefits such as personal growth, emotional solace, and community belonging, while also facing challenges like rigid dogma, guilt, or conflicts arising from the misuse of religious beliefs (Pargament, 1992). This dual nature of religion reflects its ability to simultaneously help and hinder individuals, showcasing its intricate role in shaping human lives. As such, religion cannot be reduced to a single perspective or interpretation. Individuals' psychological landscapes frequently unveil a bipolar disposition rather than a unipolar one (Landes & Linehan, 2015; Linehan et al., 2012). Understanding this is crucial for appreciating the depth and diversity of religious experiences.

Contrary to our initial hypothesis, our third hypothesis did not find evidence supporting an interaction effect between negative religious coping and depression in predicting suicidal thoughts. Despite this lack of interaction, both negative religious coping and depression were individually identified as significant predictors of suicidal thoughts. These results indicate that negative religious coping and depression have distinct and influential roles in the emergence or exacerbation of suicidal tendencies. Additionally, when combined, these factors exhibit an additive effect on the likelihood of experiencing suicidal thoughts or behaviors. However, it is important to note that the combination of negative religious coping and depression does not result in an exponential increase in suicidal thoughts risk.

Similarly, regarding our fourth hypothesis, the study findings suggest that the interplay between depressive symptoms and positive religious coping did not significantly influence the level of suicidal thoughts. This means that the effect of depression on suicidal thoughts remained relatively consistent across different levels of positive religious coping. However, results show that positive religious coping serves as a protective factor against suicidal thoughts in a broader



sense, as higher levels of positive religious coping were associated with lower levels of suicidal thoughts. These results have clinical implications, as individuals who utilize positive religious coping as a resource, even in the absence of depression, find it beneficial in guarding against the risk of suicidal thoughts.

Theoretical frameworks on suicidality, notably the IPTS (Joiner, 2007) and the IMV (O'Connor, 2011), elucidate how negative religious coping can influence suicidality without the presence of depression, and how positive religious coping can act as a protective factor against suicidality, independent of depression. As per the findings presented in the IPTS (Joiner, 2007) and the IMV (O'Connor, 2011), there are specific elements that, when amalgamated, elevate the likelihood of individuals engaging in suicidal actions. This risk persists even in the presence of protective factors and is not dependent on the existence of mental illness. These contributing factors encompass perceived burdensomeness, thwarted sense of belonging, acquired capability for suicide (Joiner, 2007), environmental stressors, a desire to alleviate psychological distress, impulsiveness, availability of means, and absence of social support (O'Connor, 2011).

Negative religious coping can exacerbate these factors, increasing the likelihood that individuals will encounter the factors delineated by Joiner (2007) and O'Connor (2011). Firstly, negative religious coping can intensify feelings of perceived burdensomeness by internalizing detrimental beliefs, distorting self-perception, and escalating emotional distress (Pulgar et al., 2022). For example, if religious teachings stress punishment for specific actions, individuals employing negative religious coping might construe their struggles as proof of their intrinsic unworthiness, thereby magnifying their sense of burdensomeness and desire to alleviate psychological distress (Pulgar et al., 2022). Moreover, negative religious coping can increase thwarted belongingness. Interpersonal spiritual struggles, an aspect of negative religious coping,

can contribute to an absence of social support via isolation and negative emotions toward one's community, further increasing the risk of suicidality (Pargament & Exline, 2021; Pulgar et al., 2022; Barzilay et al., 2015; Hamdan & Peterseil-Yaul, 2020; Schussman, 2017; O'Connor, 2011). Furthermore, negative religious coping might influence an individual's attitude toward pain, suffering, and death, potentially reducing the fear associated with these experiences and aligning with the acquired capability for suicide (Mijatović, 2021).

Contrarily, positive religious coping can offer individuals a sense of purpose, self-worth, and connection within their religious community. This can help individuals seek comfort and guidance from spiritual beliefs, foster a sense of forgiveness and redemption, and cultivate supportive relationships within a religious context, which can mitigate feelings of being a burden on others, increase social support, and combat thwarted belongingness (Hamdan & Peterseil-Yaul, 2020; O'Connor, 2011; Pulgar et al., 2022). Moreover, positive religious coping can act as a deterrent to the acquired capability and desire to alleviate psychological distress through suicide by enhancing a sense of belongingness and purpose, providing individuals with a framework for understanding and managing their emotional pain and suffering in healthier ways, and providing religious and moral teachings against suicidality (Barzilay et al., 2015; Hamdan & Peterseil-Yaul, 2020; Schussman, 2017).

These results have many clinical implications. Firstly, they underscore the importance of comprehensively examining various factors contributing to suicidal behaviors, including religious coping strategies and depression. It is crucial to assess individuals for negative religious coping, regardless of whether they display symptoms of depression, and vice versa, as both factors play a relevant role in assessing the risk of suicidal tendencies. Additionally, clinicians should capitalize on their clients' use of positive religious coping, as it is identified as a

protective factor against depression and suicide risk. More specifically, clinicians should address positive and negative religious coping styles in their intake paperwork as part of their cultural assessment, and use that information to help create treatment goals, if relevant. Clinicians can then target negative religious coping behaviors and thoughts as they would other maladaptive thoughts and behaviors, and capitalize on the strengths associated with positive religious coping, particularly using a cognitive behavioral therapy framework. These results also underlie the importance of clinicians working with religious leaders to better support clients, leading to more culturally competent care. By addressing these factors, mental health professionals can gain a more holistic understanding of an individual's risk and tailor effective strategies to promote their well-being and safety.

The present study has several limitations that should be considered when interpreting the findings. Firstly, the specific nature of the sample limits generalizability beyond a clinical population within the Orthodox community. Moreover, the study did not analyze specific sects within the Orthodox community, which could have offered valuable insights into the differences between positive and negative religious coping styles and their roles in depression and suicide risk. Future studies should expand the sample to include a more diverse range of participants from different sects of Judaism or religious backgrounds and non-clinical participants, to be able to generalize results more widely. Secondly, the correlational design of the study limits the ability to establish causation, leaving open the possibility that the relationship between religious coping, depression, and suicidal thoughts could be bidirectional or influenced by other factors. Additionally, this study places an exclusive focus on depression as it relates to suicidality, potentially overlooking other contributing factors to suicidality (i.e. other mental health disorders such as anxiety). Future research should expand its scope to investigate a wider array of

independent variables while also exploring the moderating effect of religious coping styles in these associations. Moreover, using more sensitive measures to assess the religious coping constructs would enhance the study's validity. Specifically, each religious coping measure included only three items, and a more established and multi-dimensional measure could have provided a more comprehensive understanding of the facets of religious coping. Lastly, a limitation of this study pertains to the non-normality of the suicidality data. While it is acknowledged that the data exhibited skew and kurtosis, the decision to employ linear regression and correlation analyses was made based on previous research indicating that this degree of non-normality has only a marginal impact on the susceptibility to Type I errors (Stevens, 1996; Tabachnick & Fidell, 2001). Moreover, it has been found that regression models, particularly in samples of 200 or more, remain robust in the face of such departures from normality. Although alternative regression models, like negative binomial regression, are available and designed to handle datasets with numerous zeros, they were not employed in this study because the existing literature (Stevens, 1996) suggests that a linear regression continues to yield comparable results.

Despite certain limitations, the study possesses notable strengths that contribute to its validity and reliability. One of the strengths of our study is that our measurement tool specifically targets suicidal thoughts, avoiding the conflation of various aspects of suicidality, such as suicidal behavior or intent, which allows for more accurate interpretation of correlation analyses. Additionally, the study employed rigorous analyses, ensuring the robustness of the statistical methods used to draw conclusions from the data. Another strength is the relatively good sample size despite its specificity to an Orthodox community, providing sufficient data to make meaningful inferences to this traditionally understudied population. These strengths bolster

the credibility of the findings and add valuable insights into the relationship between religious coping, depression, and suicidal thoughts within the examined population.

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Appendix A

Demographic Questionnaire

Directions: Please fill out the survey below.

Age: \_\_\_\_\_

Gender:

Female

Male

Other: \_\_\_\_\_

Marital Status:

Single (never married)

Married

Domestic partnership

Divorced

Separated

Widowed

What is your ethnicity?

Black/African-American

Asian-American

White

Latino or Hispanic

Multi-racial

Other

What is your current religious affiliation (if any)?

Buddhist

Catholic

Hindu

Jewish

Muslim

Protestant Christian

Spiritual without religious affiliation

None

Other

If Jewish, please select the subgroup you currently identify with the most:

Chassidish

Yeshiva Orthodox

Modern Orthodox

Conservative

Reform

Reconstructionist

Jewish Renewal

Humanistic

Sephardic-Religious

Sephardic-Traditional

Sephardic-Secular

None

Other

## Appendix B

## PHQ-8 Questionnaire (Kroenke et al., 2001)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

- 1) Little interest or pleasure in doing things
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 2) Feeling down, depressed, irritable or hopeless
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 3) Trouble falling or staying asleep, or sleeping too much
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 4) Feeling tired or having little energy
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day

- 5) Poor appetite or overeating
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 6) Feeling bad about yourself—or that you are a failure or have let yourself or your family down
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 7) Trouble concentrating on things, such as school work, reading or watching television
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day
- 8) Moving or speaking so slowly that other people could have noticed? Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual
  - a) Not at all
  - b) Several days
  - c) More than half the days
  - d) Nearly every day

## Appendix C

## Suicidal Thoughts Questionnaire (Kroenke et al., 2001; Linehan et al., 2000)

1) On a scale of 1 to 7, what is your urge to harm yourself now?

Low                    1        2        3        4        5        6        7                    High

2) On a scale of 1 to 7, what is your intent to kill yourself right now?

Low                    1        2        3        4        5        6        7                    High

3) Over the last 2 weeks, how often have you been bothered by any of the following

problems: Thoughts that you would be better off dead or of hurting yourself in some way

- a. 1= Not at all
- b. 2= Several days
- c. 3= More than half the days
- d. 4= Nearly every day

## Appendix D

## Religious Coping Questionnaire (Pargament K. I. et al.,1998)

1) Do you believe in God/Higher Power?

- a. 0 = Not at all
- b. 1 = Slightly
- c. 2 = Fairly
- d. 3 = Moderately
- e. 4 = Very much

2) Are you active in a faith community or congregation?

- a. 0 = Not at all
- b. 1 = Slightly
- c. 2 = Fairly
- d. 3 = Moderately
- e. 4 = Very much

3) Does your spirituality/religion help you to cope?

- a. 0 = Not at all
- b. 1 = Slightly
- c. 2 = Fairly
- d. 3 = Moderately
- e. 4 = Very much

4) Do you feel punished by God/Higher Power?

- a. 0 = Not at all



- b. 1 = Slightly
  - c. 2 = Fairly
  - d. 3 = Moderately
  - e. 4 = Very much
- 5) Do you question God's/Higher Power's love for you?
- a. 0 = Not at all
  - b. 1 = Slightly
  - c. 2 = Fairly
  - d. 3 = Moderately
  - e. 4 = Very much
- 6) Does your spirituality/religion make it harder to cope?
- a. 0 = Not at all
  - b. 1 = Slightly
  - c. 2 = Fairly
  - d. 3 = Moderately
  - e. 4 = Very much