

Article

The Role of Religious Coping in Understanding the Suicide Risk of Older Adults during COVID-19

Camila A. Pulgar ^{1,*} , Afroze N. Shaikh ², Laura Shannonhouse ² and Don Davis ²¹ Department of Family and Community Medicine, Wake Forest University School of Medicine, Winston-Salem, NC 27157, USA² Department of Counseling and Psychological Services, Georgia State University, Atlanta, GA 30303, USA

* Correspondence: capulgar@wakehealth.edu

Abstract: In the United States, racially diverse, homebound older adults have been among those most impacted by the COVID-19 pandemic. During times of disaster, persons impacted tend to turn to their faith to make sense of suffering. COVID-19 has been an unusual disaster, as physical distancing was required to keep those most susceptible safe. Due to the resulting social isolation and loneliness, suicidal behaviors and ideation (e.g., desire to die) have increased during the pandemic. Suicide desire is encapsulated by two states: thwarted belongingness (T.B., chronic loneliness and lack of reciprocal care) and perceived burdensomeness (P.B., belief that one is a burden to others and society) and has historically been inversely correlated with religiosity. Therefore, understanding how religious coping can contribute to the relationship between the impact of COVID-19 on T.B. and P.B. in homebound older adults is important in understanding their suicide risk. Our participants (ages 62–101) varied in suicidality. Increases in suicide desire over time were associated with higher levels of negative religious coping. Implications for treatment are provided, particularly the importance of fostering belongingness, buffering perceived burdensomeness with older adults, and promoting positive religious coping and support. Suggestions for future research are also provided.

Keywords: COVID-19; older adults; religious coping; suicide; thwarted belongingness; perceived burdensomeness



Citation: Pulgar, Camila A., Afroze N. Shaikh, Laura Shannonhouse, and Don Davis. 2022. The Role of Religious Coping in Understanding the Suicide Risk of Older Adults during COVID-19. *Religions* 13: 731. <https://doi.org/10.3390/rel13080731>

Academic Editors: David Wang and Eu Gene Chin

Received: 26 April 2022

Accepted: 6 August 2022

Published: 11 August 2022

Publisher's Note: MDPI stays neutral with regard to jurisdictional claims in published maps and institutional affiliations.



Copyright: © 2022 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

1. Introduction

In 2019, around 54.1 million Americans were over 65 years old (U.S. Census Bureau 2020), making up 17% of the population. According to the Centers for Disease Control and Prevention (CDC), suicide ranks as the 15th highest cause of death among adults aged 55 and older in the United States. Older adults make up 47.2% of all suicides in the United States (CDC 2022a). Suicide disparities affect older adults considerably. For example, in a twenty-year review, suicide rates increased for males ages 75 and older, and older adult males were 3–4 times more likely to die by suicide (Garnett et al. 2022). Of note, suicide death by firearms continued to increase for men (Garnett et al. 2022). Men aged 75 and older have the highest suicide rate at 40.5 per 100,000 (CDC 2022a). Therefore, suicide among older adults is an imperative public health concern requiring additional research that explores the complexity of potential risk factors among older adults (Eades et al. 2019). During the COVID-19 pandemic, suicide rates and risk continued to increase among older adults (Wand et al. 2020), further establishing the crucial need to understand potential protective mechanisms for suicide desire in this population.

For older adults with chronic health issues, the pandemic has increased their risk for infection and mortality (Richardson et al. 2020). Although necessary to stop the spread of the virus, the social distance mandates in the United States during the pandemic might have a detrimental side effect on older adults. Social isolation is especially difficult for older individuals (Liu et al. 2020), increasing their risk of suicide and mortality (Luo and Hendryx 2022; Sarangi et al. 2021). Older adults have been found at higher risk for death

during the pandemic (Reger et al. 2020), especially those with marginalized identities (Shannonhouse et al. 2020). The pandemic has been labeled the “perfect storm” (Reger et al. 2020) for suicide mortality. As the pandemic continues to have a strong impact in our world, affecting all aspects of life, bringing with it continued social isolation, social distancing, and quarantine, understanding the impact on mental health and suicidal ideation within vulnerable communities is crucial during this time (McElroy-Heltzel et al. 2022). It is thus imperative to better understand the mechanisms that can potentially aid in protecting older adults during stressful times, such as during a global pandemic, or conversely to understand those which can exacerbate the impact of stressors. Previous studies have shown a moderating effect between positive religious coping practices and well-being. For example, the daily use of religious coping to buffer the effects of stress on negative affect resulted in healthier metabolic functioning in an older adult sample (Whitehead and Bergeman 2020). Understanding how religious coping can moderate pandemic-related stress and suicidal behaviors (desire) is a valuable next step.

1.1. Interpersonal-Psychological Theory of Suicide and Older Adults

It is established that people have a fundamental need to belong. The interpersonal-psychological theory of suicidal behavior (IPTs), advanced by Joiner (2005), outlines that an individual will not die by suicide unless they have the desire and the ability to do so. The theory explains that when the need to belong and the ability to contribute to the overall prosperity of those around an individual are lacking (i.e., thwarted belongingness and perceived burdensomeness), suicide desire ensues. For older adults, Van Orden et al. (2008) found that suicide risk may be the result of thwarted belongingness (T.B., chronic loneliness and lack of reciprocal care) and perceived burdensomeness (P.B., a belief that one is a burden to friends and family, and society) combined with an acquired capability for suicide (Joiner 2005; Van Orden et al. 2010). Joiner (2005) explains that acquired capability is a heightened state of absence of fear and pain related to suicidal ideas and behaviors; this results in the idea of suicide becoming less frightening and the act of suicide becoming more likely.

Following the IPTs, both T.B. and P.B. must exist for someone to feel suicidal desire. When the need to belong is thwarted, negative well-being and mental health challenges arise, and individuals experience increased suicidal behaviors (Joiner 2005). T.B. is rooted in extreme social disconnection or isolation, and P.B. is identified by the perception of being a burden to others (Van Orden et al. 2010). T.B. and P.B. are dynamic, their impact can vary across time, context, and relationships (Van Orden et al. 2010). Older adults are vulnerable to loneliness and decreased belongingness as they experience the death of partners/friends, reduced mobility, functional impairment, or the need to move out of familiar environments (Segal et al. 2018). Moreover, social isolation has been identified as a significant risk factor for older adults’ suicidal behavior (Van Orden and Conwell 2011). Thwarted belongingness occurs when the need to belong is unmet and the individual feels isolated, increasing their desire for death (Van Orden et al. 2010). Van Orden and Conwell (2011) explain that when older adults experience social isolation, this is an indicator that the need to belong may be thwarted.

Social disconnection and social stresses may increase both T.B. and P.B. for some older adults, putting them at greater risk of suicide (Eades et al. 2019). Given the potential trend toward increasing T.B. and P.B. over time as we age, understanding the changes to how one perceives their belonging and burdensomeness during late adulthood is vital for mental health professionals to respond to suicide risk comprehensively.

1.2. Religious Coping

Religious Coping can be defined as “the use of cognitive and behavioral techniques in the face of stressful life events, which arise out of one’s religion or spirituality” (Tix and Frazier 1998, p. 411). Religious coping is neither “problem nor emotion-focused coping” (Krägeloh et al. 2012, p. 1118); rather, it involves the use of religious concepts and behaviors

as a coping response to life stressors (Krägeloh et al. 2012). For example, this type of coping opens an individual to utilize religious resources such as pastoral counseling, church events, and programs (Hill and Pargament 2008).

The Brief Religious Coping Instrument (B-RCOPE; Pargament et al. 1998, 2011) is a multidimensional instrument that gathers information about an extremely expansive scope of adapting reactions that include the utilization of religious concepts and activities. Pargament's (1997) religious coping theory explains that religious coping is grounded in the idea that individuals will use their understanding and experience of the sacred to make sense of and face life stressors (Pargament et al. 2011). Per Pargament, the term *sacred* refers to not only traditional notions of God and divinity of higher powers, but also to other aspects of life that are associated with the divine (Pargament and Mahoney 2005). The B-RCOPE has two dimensions: *positive religious coping* (i.e., Looking for a stronger connection with God) and *negative religious coping* (i.e., Questioning God's love for me).

Studies on religious coping have found that both dimensions differentially affect how individuals cope with stressors (Ano and Vasconcelles 2005; Pargament 1997; Shannonhouse et al. 2020). Positive religious coping is considered adaptive and includes personal, internal cognitive coping efforts stemming from individuals' constructive and collaborative relationship with God or their faith (Kim et al. 2015). In contrast, negative religious coping refers to a person's tendency to struggle internally with faith, such as perceiving one's relationship with God as unstable, plagued by guilt, and distant (Kim et al. 2015; Pargament et al. 1998).

An extended body of research has demonstrated links between healthy religiosity, better mental health, and an improved sense of well-being (Chen et al. 2020; Koenig et al. 2012; Paloutzian and Park 2013; Pargament et al. 2013). Specifically, religious practices have been associated with greater levels of meaning in life (Park et al. 2013), satisfaction with life (Abu-Raiya and Agbaria 2016), attachment security (Granqvist and Kirkpatrick 2013), self-control (e.g., McCullough and Willoughby 2009), comfort (Exline et al. 2000), and lower levels of depression and anxiety (Hood et al. 2009). Furthermore, as Pargament et al. (2000) stated, "it is not enough to know that the individual prays, attends church, or watches religious television. Measures of religious coping should specify how the individual is making use of religion to understand and deal with stressors" (p. 521). Understanding how older adults make sense of stressors via religious coping is an important next step in understanding the mechanism of suicide in this population.

This research attempts to better understand the role of religious coping in older adults and their experience with this style of coping during stressful times, such as a global pandemic. McElroy-Heltzel et al.'s (2018) study suggests that positive religious coping may be one mechanism for reducing suicide risk in an older adult population during COVID-19. Their results align with previous studies on suicide risk and religion during COVID-19 (Fitzpatrick et al. 2020), where religion was shown to be an important resource against suicidality in a diverse sample.

It has been demonstrated that religiosity can be a protective factor against suicidality in the general population (Jacob et al. 2018). Moreover, religion and spirituality (R/S) have been shown to be associated with greater physical and mental health (Abu-Raiya et al. 2015; Aten et al. 2019; Cummings and Pargament 2012; Gall and Guirguis-Younger 2013), fewer suicide attempts (Burshtein et al. 2016), and fewer suicide deaths (Barranco 2016; VanderWeele 2017).

However, many people also experience spiritual struggles—experiences of tension, strain, or conflict around religion or spirituality (Pargament 2011; Pargament and Exline 2021). In recent years, the term spiritual struggles has been used synonymously with negative religious coping. In a study of older adults being treated for depression, about 50% reported religious/spiritual struggles (Murphy et al. 2016). The relationship between spiritual struggles and suicide has also been noted in the literature (Raines et al. 2020). Even though religious/spiritual struggles are widespread and experienced by many people, some may be reluctant to talk about such struggles because they might see spiritual struggles as

a morally charged challenge or fear judgmental or shaming responses from others (Exline and Grubbs 2011). In efforts to expand the literature on the protective qualities of religious coping against suicide desire, this study looked at the use of religious coping and suicide desire in older adults in the context of the pandemic.

1.3. COVID-19 and Older Adults

COVID-19 has challenged every aspect of life for almost three years. In the United States (U.S.), the COVID-19 pandemic has caused over 900,000 reported deaths as of April 2022, and adults 65–74 years old account for 22.6% of those deaths (CDC 2022b; Larkin 2022). Older adults are disproportionately high risk and at increased risk for severe COVID-19-associated illness and death (Christie et al. 2021). The colossal impact of COVID-19 in healthcare systems worldwide leads to significant losses of health and life, particularly for older adults who require intensive care (D’Adamo et al. 2020).

Older adults also experience loneliness and social isolation, increasing the risk to their mental and physical health (Sepúlveda-Loyola et al. 2020; Rodney et al. 2021). Evidence suggests that social disconnectedness is associated with great suicide risk later in life. Furthermore, during the pandemic precautions of social lockdown, older people may be especially vulnerable to suicide through a heightened sense of disconnectedness from society, physical distancing, and loss of usual social opportunities, increasing their risk of heightened anxiety and depression (Santini et al. 2020).

In this study, suicide desire is encapsulated by two states: thwarted belongingness (T.B., chronic loneliness and lack of reciprocal care) and perceived burdensomeness (P.B., belief that one is a burden to others and society) and has historically been inversely correlated with religiosity (Mason et al. 2018). Therefore, understanding the relationship between positive and negative religious coping and T.B. and P.B. in older adults that are isolated and homebound is essential to determine intentional mental health treatment plans that consider cultural factors within this population

2. Materials and Methods

2.1. Participants

Participants were older adults who received home-based services, ranging from age 62 to 101 years old. The first time point of longitudinal data was collected from 437 older adults taking part in a larger project. A subset ($n = 209$) completed the measure set for this study at a second timepoint. Those that did not participate at time two did so for various reasons, including death, medical concerns, and lack of response. These older adults had similar scores on study measures at time one, compared with those who remained in the study. Of the older adults who took part in both administrations and comprise our sample, the majority identified as female ($n = 155$, 74.2%), Black ($n = 138$, 66.0%; $n = 46$, 22.0% White; and $n = 18$, 8.6% more than one race), and heterosexual ($n = 206$, 98.6%). Most identified as Christian Protestant ($n = 157$, 78.5%), though other religious identities included Atheist ($n = 3$, 1.5%), Agnostic ($n = 4$, 2.0%), Jewish ($n = 3$, 1.5%), Muslim ($n = 1$, 0.5%), Catholic ($n = 8$, 4.0%), Orthodox ($n = 1$, 0.5%), and Mormon ($n = 1$, 0.5%). More than half of the sample were either widowed ($n = 74$, 35.4%), divorced/separated ($n = 73$, 34.9%), or single ($n = 41$, 19.6%), and reported living alone ($n = 126$, 63.0%). Roughly half of the participants identified that they attended a form of religious service or gathering either in-person ($n = 4$, 2.1%) or online ($n = 97$, 50.3%) during the pandemic. Data were analyzed using SPSS.

2.2. Procedure

This research followed a quantitative, prospective longitudinal cohort design. Community-dwelling older adults were recruited across six counties in a large metropolitan area in the southeastern region of the United States. Eligibility criteria included (a) being aged 60 and older, (b) receiving home-delivered meal services (HDM), and (c) having no diagnosis of dementia or cognitive impairment. Recruitment occurred through coordination with the local Area Agency on Aging (AAA), facilitating contact with the participants,

and dementia or cognitive impairment screening. Following confirmation of eligibility, participants consented via phone.

Following the longitudinal design, data were first collected in Spring 2019, before the pandemic, through in-person interviews at the participants' homes, after which they received USD 10 compensation for their participation. Then, following COVID-19 physical distancing policies, the same participants were targeted via phone interviews and Qualtrics software in Fall 2020, and participants were provided USD 20 compensation after the interview. Additionally, data collectors received training, weekly supervision, instruction on aging-specific language, and a safety protocol to enact in the presence of suicide desire. Study procedures were approved by an academic Institutional Review Board, the county aging services agencies that organize HDM, and county governments (i.e., Boards of Commissioners).

2.3. Measures

Suicide Desire. The Interpersonal Needs Questionnaire (INQ; [Van Orden et al. 2010](#)) was administered at both time points and used to measure suicide desire through two subscales: Perceived Burdensomeness (6 items) and Thwarted Belongingness (9 items). Each item is scored on a 7-point Likert-type scale, in which 1 represents "not true at all for me" and 7 represents "very true for me." The scales have yielded internal consistencies of 0.84 and 0.94 with older adult samples ([Lutz and Fiske 2017](#)) and 0.81 ([Hill et al. 2015](#)) for Perceived Burdensomeness and Thwarted Belongingness, respectively. Sample items include: "*These days, the people in my life would be better off if I were gone*" (Perceived Burdensomeness) and "*These days, I often feel like an outsider in social gatherings*" (Thwarted Belongingness). In the present study, the INQ had good internal consistency (P.B. $\alpha = 0.90$, T.B. $\alpha = 0.88$).

Religious Coping. The Brief Religious Coping Instrument (B-RCOPE; [Pargament et al. 2011](#)) was surveyed at time two (T2) and used to measure how participants coped with the COVID-19 pandemic through two constructs: positive religious coping (7 items) and negative religious coping (7 items). Each item is scored on a 4-point Likert-type scale assessing action frequency, in which 1 represents "not at all" and 4 represents "a great deal." Sample items include "*How much or how frequently did you question God's love for you?*" (negative religious coping) and "*How much or how frequently did you seek God's love and care?*" (positive religious coping). Over 30 studies encompassing 5835 participants, the Brief RCOPE manifested consistently strong reliabilities of both positive (median $\alpha = 0.92$) and negative (median $\alpha = 0.81$) coping, along with evidence of predictive and concurrent validity ([Pargament et al. 2011](#)). In the present study, the B-RCOPE had an internal consistency of $\alpha = 0.92$ for positive religious coping and $\alpha = 0.66$ for negative religious coping. After further analysis, removing a single item (i.e., *How much or how frequently did you decide the devil made this happen*) brought the negative religious coping internal consistency to $\alpha = 0.77$. No mention was found in the literature regarding the applicability of this item regarding the personification of evil and older populations; however, further exploration may be warranted.

3. Results

Our participants (ages 62–101) varied in suicidality. As older adult participants' suicide desire increased, so did their negative religious coping. A hierarchical regression analysis was conducted to assess suicide desire (i.e., perceived burdensomeness and thwarted belongingness) when examining the incremental addition of our variables in this order: (1) sex, (2) pre-COVID suicide desire, (3) positive and negative religious coping. Descriptive statistics and correlations are provided in Table 1. Negative religious coping was significantly correlated to P.B. ($r = 0.19$, $p = 0.006$) and T.B. ($r = 0.22$, $p = 0.001$). The hierarchical regression results with P.B. and T.B. as the outcomes are provided in Tables 2 and 3, respectively.

Table 1. Descriptive Statistics and Correlations ($N = 209$).

Variables	Mean	SD	Range	1	2	3	4	5
1. T1 Perceived Burdensomeness	9.60	6.82	6–42	—				
2. T2 Perceived Burdensomeness	8.89	6.31	6–42	0.43 **	—			
3. T1 Thwarted Belongingness	20.40	11.84	9–61	0.48 **	0.28 **	—		
4. T2 Thwarted Belongingness	18.46	11.68	9–63	0.23 **	0.62 **	0.42 **	—	
5. Positive R/S coping	20.91	7.17	7–28	0.16	0.14	0.02	0.04	—
6. Negative R/S coping	7.07	2.44	6–23	0.12	0.19 *	−0.02	0.22 *	0.21 *

* $p < 0.01$, ** $p < 0.001$.**Table 2.** Summary of hierarchical regression analysis for T2 Perceived Burdensomeness.

Variables	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Intercept	9.89	0.86		6.29	0.94		2.93	1.60	
Sex (1 = Female)	−1.35	0.99	−0.09	−1.64	0.90	−0.11	−1.91	0.91	−0.13
T1 Perceived Burdensomeness				0.40	0.06	0.43 **	0.37	0.06	0.40 **
Positive R/S coping							0.07	0.06	0.08
Negative R/S coping							0.32	0.16	0.12
Change in R^2	0.01			0.19 **			0.03		

Note: The Intercept scoring is for a male older adult. ** $p < 0.001$.**Table 3.** Summary of hierarchical regression analysis for T2 Thwarted Belongingness.

Variables	Step 1			Step 2			Step 3		
	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β	<i>B</i>	<i>SE B</i>	β
Intercept	20.98	1.58		11.91	2.00		4.01	3.17	
Sex (1 = Female)	−3.39	1.84	−0.13	−2.41	1.68	−0.09	−2.50	1.68	−0.09
T1 Thwarted Belongingness				0.41	0.06	0.41 **	0.41	0.06	0.42 **
Positive R/S coping							0.01	0.10	0.00
Negative R/S coping							1.09	0.30	0.23 **
Change in R^2	0.02			0.17 **			0.05 *		

Note: The Intercept scoring is for a male older adult. * $p < 0.01$, ** $p < 0.001$.

3.1. Predicting Perceived Burdensomeness in Older Adults

Hierarchical regression was conducted to examine the predictive relationship between sex, T1 P.B., positive R/S coping, negative R/S coping, and T2 P.B. In the first step of the hierarchical regression model, sex was the sole predictor. T1 P.B. was added to the model in the second step. In the third step, positive R/S and negative R/S coping were inputted into the hierarchical regression model. Sex was not a significant predictor of T2 P.B. ($B = -1.35$, $\beta = -0.09$) and only accounted for approximately 1% of its variance. While controlling for sex, T1 P.B. ($B = 0.40$, $\beta = 0.43$) was a significant predictor of T2 P.B. With every one-unit increase in T1 P.B., T2 P.B. increased by approximately 0.40 units. T1 P.B. added approximately 19% of variance to the model, and the change in R^2 was statistically significant between Step 1 and Step 2.

While controlling for sex and T1 P.B., positive R/S coping ($B = 0.07$, $\beta = 0.08$) and negative R/S coping ($B = 0.32$, $\beta = 0.12$) were not significant predictors in the hierarchical regression. Positive R/S coping and negative R/S coping added approximately 3% of variance to the model, and the change in R^2 was not statistically significant between Step 2 and Step 3.

3.2. Predicting Thwarted Belongingness in Older Adults

A second hierarchical regression was conducted to examine the predictive relationship between sex, T1 T.B., positive R/S coping, negative R/S coping, and T2 T.B. In the first step

of the hierarchical regression model, sex was the sole predictor. In the second step, T1 T.B. was added to the model. In the third step, positive R/S and negative R/S coping were inputted into the hierarchical regression model. Sex was not a significant predictor of T2 T.B. ($B = -3.39$, $\beta = -0.13$) and only accounted for approximately 2% of its variance.

While controlling for sex, T1 T.B. ($B = 0.41$, $\beta = 0.41$) was a significant predictor of T2 T.B. With every one-unit increase in T1 T.B., T2 T.B. increased by approximately 0.41 units. T1 T.B. added approximately 17% of variance to the model, and the change in R^2 was statistically significant between step one and step two.

While controlling for sex and T1 T.B., positive R/S coping ($B = 0.01$, $\beta = 0.00$) was not a significant predictor of T2 T.B. However, negative R/S coping ($B = 1.09$, $\beta = 0.23$) was a significant predictor in the hierarchical regression, while controlling for sex and T1 T.B. With every one-unit increase in negative R/S coping, T2 T.B. increased by approximately 1.09 units. Positive R/S coping and negative R/S coping added approximately 5% of variance to the model, and the change in R^2 was statistically significant between Step 2 and Step 3.

4. Discussion

This study provides insightful information about how and when older adults struggle during the pandemic; there is emerging evidence that suggests that suicide desire has increased for older adults during the pandemic (Asthana et al. 2021; Wand et al. 2020), making it imperative for researchers to explore the impact of the pandemic on mental health for older adults.

At first glance, suicidal desire (P.B. and T.B. separately) during the pandemic does not appear vastly different in aggregate from the pre-COVID-19 levels of these constructs. However, the above analysis allows us to provide a more nuanced understanding of how religiosity in practice was related to individual changes in suicide desire throughout the pandemic. Specifically, for older adults we showed a degree of consistency across these constructs over time, and that increases in T.B. were associated with reports of more negative religious coping (assessed at Time 2).

First, the test-retest stability of both P.B. and T.B. were significant, albeit low. Time 1 P.B. and Time 1 T.B. were statistically significantly related to Time 2 P.B. and Time 2 T.B. This suggests that while there is some inertia in how these aspects of suicide desire are manifested in any individual, there is far more variability with other factors accounting for roughly 80% of the values at Time 2. Consistent with Jahn et al. (2015), this result is more supportive of treating these constructs as a state rather than trait variables. Clinically, such a finding is encouraging because there is reason to believe that altered socioenvironmental factors and mental health intervention can ameliorate these pathways of suicide desire. Suicidality is individually experienced and can change.

Second, while positive religious coping was not a significant predictor in either of our models, negative religious coping was a significant predictor for T.B. Religiousness, in general, has been noted as a protective factor against suicide (Mason et al. 2018), and positive religious coping has been shown in older adults to mitigate the risk of the likelihood of attempting suicide (Suresh et al. 2020). Here we demonstrate that the practice of negative religious coping behaviors may predict increased suicide risk. Religion acts as a means of belonging, connecting individuals to a community and a place in the cosmos (Pargament 2011). Our data suggest that a greater sense of thwarted belongingness increases when that connection is shaken. Research shows that religion can serve as a buffer against suicide. Furthermore, we suggest that when one's connection to that belonging through faith is challenged, it exacerbates the general unbelonging, which has been shown predictive of suicide desire.

In a study of religious coping in Botswana, Shannonhouse et al. (2019) showed that negative religious coping served as a mediative pathway from the resource loss experienced due to drought to the presentation of current trauma symptoms. Interestingly, drought and COVID-19 could be classified as chronic disasters, which often feature cascading mental

health consequences since their ongoing nature makes the resolution timeframe uncertain. Chronic disasters may result in more difficult recovery for survivors (Stain et al. 2011). Unfortunately, the current study implies that when the nature of such a chronic stressor does result in negative religious coping practices, recovery may include recapturing a sense of belongingness with one's creator, which has ramifications for suicidality.

Also, we found no significant relationships between gender and either P.B. or T.B. Results show that female participants tend to score lower than males on P.B. (which is argued to be the stronger predictor of suicide); however, this is not a significant difference. Other studies show no significant gender differences for P.B. For example, Donker et al. (2014) found that higher levels of perceived burdensomeness (P.B.) were associated with increased suicidal ideation in both genders. In Cukrowicz et al.'s (2011) study on P.B. and its impact on suicide desire, the results did not support the hypothesis that perceived burdensomeness exerts a greater impact on suicide ideation in males than females.

4.1. Implications

For therapists and mental health providers supporting older adults during the pandemic, strategies from Joiner et al. (2009) for targeting perceptions of burdensomeness may be helpful. For example, they suggested collaborating with the individual to generate evidence (e.g., identifying social supports or future aspirations) that indicates the patient's life is worth more than their death. Additionally, engaging in conversations about feelings of burdensomeness and what kind of support clients need should identify in what ways they are helpful to their loved ones and society.

Future research should also test these interventions with older adults. Some researchers have successfully treated geriatric depression with cognitive behavioral therapy (Areán et al. 2010; Piquart et al. 2006; Teismann et al. 2018). Therefore, perceptions of the burden on others may also be treated successfully in collaborative therapy work.

Higher engagement in negative religious coping was a significant predictor of suicide desire during the pandemic when controlling for pre-pandemic suicide data. Negative religious coping has been negatively related to the quality of life and increased stress (Gardner et al. 2014). This study supports prior work that negative religious coping exacerbates negative psychological outcomes (Gardner et al. 2014; Pargament et al. 2011, 2013). It may be beneficial to study the absence of this coping practice further. One of the stressors during the pandemic for older adults was not being able to attend church service; this might have impacted religious practices in addition to impacting how connected and supported older adults felt during the pandemic.

For mental health practitioners serving the mental health needs of older adults struggling during the pandemic, assessing clients' religious identity and their current religious coping practices is recommended where applicable. The lack of access to religious community and support might have impacted how individuals feel towards the "sacred" (Pargament et al. 2011). Pargament et al. (2013) argue that spiritual beliefs and practices, possibly including a secure bond with God and spiritual connectedness, can be a protective factor against physical and mental health problems. When applicable, engaging in religious and spiritual conversations and assessments with clients can provide a therapist with insightful information about coping and its effect on mental health.

The sensitive nature of religious struggles should also be considered here. While the pastor or spiritual care provider may be the most equipped to help someone struggling with their faith, there may be a social disincentive for someone to disclose such struggles with their faith leader. Conversely, attending to religious and spiritual concerns is often outside of the training and scope of competence for mental health professionals. However, as demonstrated by the above data, internal struggles with one's religious worldview can spill over into constructs traditionally the domain of the counselor/psychologist—feelings of isolation and suicidal desire. Neglecting this aspect of a client's worldview and coping is done at the clinician's peril, as the downstream consequences suggested by the IPTS may be severe.

The authors recommend clinicians approach religious and spiritual struggles and practices with curiosity and openness. The clinician should use basic counseling skills to not impose the clinician's beliefs or practices onto the client and to ask open-ended questions for a better understanding of the client's experiences with the divine. In addition, attend to the clinician's religious and spiritual struggles, experiences, and biases. Finally, more detailed recommendations can be found in [Jones \(2019\)](#), [Pargament and Exline \(2021\)](#), and [Vieten et al. \(2013\)](#) for recommendations on how to best support clients navigating spiritual and religious struggles.

4.2. Limitations

Although this study supports the importance of P.B., T.B., and religious coping in the desire for suicide in older adults, the study's limitations must be considered. For instance, results might have limited generalizability since this was a community-based sample not representative of the population. Using a self-report survey instrument presents limitations as participants may have been biased or input untruthful responses. Future research is needed to investigate the complex relationship between P.B., T.B., religious coping, and suicide desire in depth. There was considerable attrition from Time 1 to Time 2 (52.2%), potentially compounding the self-report nature of this study. It may be that T1 participants who experienced stronger negative mental health symptoms during the pandemic were more reluctant to participate in the follow-up survey. If this shirker behavior did occur, then the relatively consistent aggregate values of T.B. and P.B. observed would underrepresent the prevalence of these constructs at T2 in the population.

The sample was relatively small and contained a disproportionate number of females and Christian Protestants; future work should include a more diverse sample regarding gender and religious denomination. Similarly, other religious coping measures could be more inclusive for participants who might not identify with God as coping. Furthermore, the item "How much or how frequently did you decide the devil made this happen" reduced the internal consistency of the negative religious coping construct with this population. Further research may consider the applicability of this item with older adults when conducting religious and spiritual research and determine which populations this item may not apply to or be appropriate for given individual culture's personification of "evil."

5. Conclusions

In summary, the presence of faith appears less important in the context of mental health struggles and suicidality than how one connects with the practice of that faith. Furthermore, it appears that the internal existential isolation associated with "losing one's faith" or maladaptively using one's faith can have ripple effects beyond religiosity. Losing one's sense of belonging or existentially struggling with it is quite isolating, which can contribute to suicidal desire.

Author Contributions: Data curation, A.N.S.; Funding acquisition, A.N.S. and L.S.; Project administration, L.S.; Writing—original draft, C.A.P.; Writing—review & editing, C.A.P., L.S. and D.D. All authors have read and agreed to the published version of the manuscript.

Funding: This work was supported by the United States Department of Health and Human Services (HHS), via the Administration for Community Living (ACL) Grant #90INNU0010-01-00.

Institutional Review Board Statement: The Georgia State University Institutional Review Board approved this research (IRB #H19166).

Informed Consent Statement: Informed consent was obtained from all subjects involved in the study.

Data Availability Statement: Not applicable.

Conflicts of Interest: The authors declare no conflict of interest. The funders had no role in the study's design; the collection, analysis, or interpretation of the data; the writing of the manuscript, or

the decision to publish the results. The opinions expressed in this article are those of the authors and do not necessarily reflect the views of HHS.

References

- Abu-Raiya, Hisham, and Qutaiba Agbaria. 2016. Religiousness and subjective well-being among Israeli-Palestinian college students: Direct or mediated links? *Social Indicators Research* 126: 829–44. [CrossRef]
- Abu-Raiya, Hisham, Kenneth I. Pargament, Neal Krause, and Gail Ironson. 2015. Robust links between religious/spiritual struggles, psychological distress, and well-being in a national sample of American adults. *American Journal of Orthopsychiatry* 85: 565–75. [CrossRef] [PubMed]
- Ano, Gene G., and Erin B. Vasconcelles. 2005. Religious coping and psychological adjustment to stress: A meta-analysis. *Journal of Clinical Psychology* 61: 461–80. [CrossRef] [PubMed]
- Areán, Patricia A., Patrick Raue, R. Scott Mackin, Dora Kanellopoulos, Charles McCulloch, and George S. Alexopoulos. 2010. Problem-solving therapy and supportive therapy in older adults with major depression and executive dysfunction. *American Journal of Psychiatry* 167: 1391–98. [CrossRef]
- Asthana, Niraj K., Eamonn Mehaffey, and Daniel D. Sewell. 2021. COVID-19 associated suicidal ideation in older adults: Two case reports with a review of the literature. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry* 29: 1101–16. [CrossRef]
- Aten, Jamie D., Wendy R. Smith, Edward B. Davis, Daryl R. Van Tongeren, Joshua N. Hook, Don E. Davis, Laura Shannonhouse, Cirleen DeBlaere, Jenn Ranter, Kari O'Grady, and et al. 2019. The psychological study of religion and spirituality in a disaster context: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy* 11: 597–613. [CrossRef]
- Barranco, Raymond. 2016. Suicide, religion, and Latinos: A macrolevel study of US Latino suicide rates. *The Sociological Quarterly* 57: 256–81. [CrossRef]
- Burshtein, Shimon, Bruce P. Dohrenwend, Itzhak Levav, Nomi Werbeloff, Michael Davidson, and Mark Weiser. 2016. Religiosity as a protective factor against suicidal behaviour. *Acta Psychiatrica Scandinavica* 133: 481–88. [CrossRef]
- Centers for Disease Control and Prevention (CDC). 2022a. WISQARS (Web-Based Injury Statistics Query and Reporting System). Available online: <https://www.cdc.gov/injury/wisqars/index.html> (accessed on 30 June 2022).
- Centers for Disease Control and Prevention (CDC). 2022b. COVID Data Tracker. Available online: <https://covid.cdc.gov/covid-data-tracker> (accessed on 30 June 2022).
- Chen, Ying, Eric S. Kim, and Tyler J. VanderWeele. 2020. Religious-service attendance and subsequent health and well-being throughout adulthood: Evidence from three prospective cohorts. *International Journal of Epidemiology* 49: 2030–40. [CrossRef]
- Christie, Athalia, S. Jane Henley, Linda Mattocks, Robyn Fernando, Amy Lansky, Farida B. Ahmad, Jennifer Adjemian, Robert N. Anderson, Alison M. Binder, Kelley Carey, and et al. 2021. Decreases in COVID-19 cases, emergency department visits, hospital admissions, and deaths among older adults following the introduction of COVID-19 vaccine—United States, September 6, 2020–May 1, 2021. *MMWR. Morbidity and Mortality Weekly Report* 70: 858–64.
- Cukrowicz, Kelly C., Kimberly A. Van Orden, Jennifer Cheavens, Micheal Ragain, and Ronald Cook. 2011. Perceived burdensomeness and suicide ideation in older adults. *Psychology and Aging* 26: 331–38. [CrossRef]
- Cummings, Jeremy P., and Kenneth I. Pargament. 2012. Religious coping with workplace stress. In *Psychology of Religion and Workplace Spirituality*. Edited by Peter C. Hill and Bryan J. Dik. Charlotte: Information Age Publishing, pp. 157–77.
- D'Adamo, Heather, Thomas Yoshikawa, and Joseph G. Ouslander. 2020. Coronavirus disease 2019 in geriatrics and long-term care: The ABCDs of COVID-19. *Journal of the American Geriatrics Society* 68: 912–17. [CrossRef] [PubMed]
- Donker, Tara, Philip J. Batterham, Kimberly A. Van Orden, and Helen Christensen. 2014. Gender-differences in risk factors for suicidal behaviour identified by perceived burdensomeness, thwarted belongingness and acquired capability: Cross-sectional analysis from a longitudinal cohort study. *BMC Psychology* 2: 20. [CrossRef]
- Eades, Allison, Daniel L. Segal, and Frederick L. Coolidge. 2019. Suicide risk factors among older adults: Exploring thwarted belongingness and perceived burdensomeness in relation to personality and self-esteem. *International Journal of Aging & Human Development* 88: 150–67. [CrossRef]
- Exline, Julie J., Ann Marie Yali, and William C. Sanderson. 2000. Guilt, discord, and alienation: The role of religious strain in depression and suicidality. *Journal of Clinical Psychology* 56: 1481–96. [CrossRef]
- Exline, Julie J., and Joshua B. Grubbs. 2011. "If I tell others about my anger toward God, how will they respond?" Predictors, Associated Behaviors, and Outcomes in an Adult Sample. *Journal of Psychology and Theology* 39: 304–15. [CrossRef]
- Fitzpatrick, Kevin M., Casey Harris, and Grant Drawve. 2020. How bad is it? Suicidality in the middle of the COVID-19 pandemic. *Suicide & Life-Threatening Behavior* 50: 1241–49. [CrossRef]
- Gall, Terry Lynn, and Manal Guirguis-Younger. 2013. Religious and spiritual coping: Current theory and research. In *APA Handbook of Psychology, Religion, and Spirituality*. Edited by Kenneth I. Pargament, Julie J. Exline and J. W. Jones. Washington, DC: American Psychological Association, vol. 1, pp. 349–64.
- Gardner, Timothy M., Christian U. Krägeloh, and Marcus A. Henning. 2014. Religious coping, stress, and quality of life of Muslim university students in New Zealand. *Mental Health, Religion & Culture* 17: 327–38. [CrossRef]
- Garnett, Matthew F., Sally C. Curtin, and Deborah M. Stone. 2022. Suicide mortality in the United States, 2000–2020. *NCHS Data Brief* 433: 1–8.

- Granqvist, Pehr, and Lee A. Kirkpatrick. 2013. Religion, spirituality, and attachment. In *APA Handbook of Psychology, Religion, and Spirituality*. Edited by Kenneth I. Pargament, Julie J. Exline and J. W. Jones. Washington, DC: American Psychological Association, vol. 1, pp. 139–55. [\[CrossRef\]](#)
- Hill, Peter C., and Kenneth I. Pargament. 2008. Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *Psychology of Religion and Spirituality* 5: 3–17. [\[CrossRef\]](#)
- Hill, Ryan M., Yasmin Rey, Carla E. Marin, Carla Sharp, Kelly L. Green, and Jeremy W. Pettit. 2015. Evaluating the Interpersonal Needs Questionnaire: Comparison of the reliability, factor structure, and predictive validity across five versions. *Suicide & Life-Threatening Behavior* 45: 302–14. [\[CrossRef\]](#)
- Hood, Ralph W., Jr., Peter C. Hill, and Bernard Spilka. 2009. *The Psychology of Religion: An Empirical Approach*, 4th ed. New York: Guilford Press.
- Jacob, Louis, Josep Maria Haro, and Ai Koyanagi. 2018. The association of religiosity with suicidal ideation and suicide attempts in the United Kingdom. *Acta Psychiatrica Scandinavica* 139: 164–73. [\[CrossRef\]](#)
- Jahn, Danielle R., Erin K. Poindexter, and Kelly C. Cukrowicz. 2015. Personality disorder traits, risk factors, and suicide ideation among older adults. *International Psychogeriatrics* 27: 1785–94. [\[CrossRef\]](#) [\[PubMed\]](#)
- Joiner, Thomas E. 2005. *Why People Die by Suicide*. Cambridge: Harvard University Press.
- Joiner, Thomas E., Jr., Kimberly A. Van Orden, Tracy K. Witte, and M. David Rudd. 2009. *The Interpersonal Theory of Suicide: Guidance for Working with Suicidal Clients*. Washington, DC: American Psychological Association. [\[CrossRef\]](#)
- Jones, Russell Siler. 2019. *Spirit in Session: Working with Your Client's Spirituality (and Your Own) in Psychotherapy*. West Conshohocken: Templeton Press.
- Kim, Paul Youngbin, Dana L. Kendall, and Marcia Webb. 2015. Religious coping moderates the relation between racism and psychological well-being among Christian Asian American college students. *Journal of Counseling Psychology* 62: 87–94. [\[CrossRef\]](#) [\[PubMed\]](#)
- Koenig, Harold G., Dana E. King, and Verna Benner Carson. 2012. *Handbook of Religion and Health*, 2nd ed. New York: Oxford University Press.
- Krägeloh, Christian U., Penny Pei Minn Chai, Daniel Shepherd, and Rex Billington. 2012. How religious coping is used relative to other coping strategies depends on the individual's level of religiosity and spirituality. *Journal of Religion and Health* 51: 1137–51. [\[CrossRef\]](#) [\[PubMed\]](#)
- Larkin, Howard D. 2022. Global COVID-19 death toll may be triple the reported deaths. *JAMA* 327: 1438. [\[CrossRef\]](#) [\[PubMed\]](#)
- Liu, Kai, Ying Chen, Ruzheng Lin, and Kunyuan Han. 2020. Clinical features of COVID-19 in elderly patients: A comparison with young and middle-aged patients. *The Journal of Infection* 80: e14–e18. [\[CrossRef\]](#) [\[PubMed\]](#)
- Luo, Juhua, and Michael Hendryx. 2022. Mediation analysis of social isolation and mortality by health behaviors. *Preventive Medicine* 154: 106881. [\[CrossRef\]](#)
- Lutz, Julie, and Amy Fiske. 2017. Perceived burdensomeness in older and younger adults: Evaluation of the psychometric properties of the Interpersonal Needs Questionnaire. *Journal of Clinical Psychology* 73: 1179–95. [\[CrossRef\]](#) [\[PubMed\]](#)
- Mason, Karen, W. Blake Martin, and Esther Kim. 2018. Suicidal ideation and sense of community in faith communities. *Religions* 9: 40. [\[CrossRef\]](#)
- McCullough, Michael E., and Brian L. B. Willoughby. 2009. Religion, self-regulation, and self-control: Associations, explanations, and implications. *Psychological Bulletin* 135: 69–93. [\[CrossRef\]](#) [\[PubMed\]](#)
- McElroy-Heltzel, Stacey E., Ana Ordaz, Daryl R. Van Tongeren, Don E. Davis, Sarah Gazaway, and Joshua Hook. 2018. The role of spiritual fortitude and positive religious coping in meaning in life and spiritual well-being following Hurricane Matthew. *The Journal of Psychology and Christianity* 37: 17–27.
- McElroy-Heltzel, Stacey E., Laura R. Shannonhouse, Edward B. Davis, Austin W. Lemke, Mary Chase Mize, Jamie Aten, Matthew C. Fullen, Joshua N. Hook, Daryl R. Van Tongeren, Don E. Davis, and et al. 2022. Resource loss and mental health during COVID-19: Psychosocial protective factors among U.S. older adults and those with chronic disease. *International Journal of Psychology* 57: 127–35. [\[CrossRef\]](#) [\[PubMed\]](#)
- Murphy, Patricia E., George Fitchett, and Erin E. Emery-Tiburcio. 2016. Religious and spiritual struggle: Prevalence and correlates among older adults with depression in the BRIGHTEN Program. *Mental Health, Religion & Culture* 19: 713–21. [\[CrossRef\]](#)
- Paloutzian, Raymond F., and Crystal L. Park. 2013. *Handbook of the Psychology of Religion and Spirituality*, 2nd ed. New York: Guilford Press.
- Pargament, Kenneth I. 1997. *The Psychology of Religion and Coping: Theory, Research, Practice*. New York: Guilford Press.
- Pargament, Kenneth I. 2011. *Spiritually Integrated Psychotherapy*. New York: Guilford Press.
- Pargament, Kenneth I., and Annette Mahoney. 2005. Sacred matters: Sanctification as a vital topic for the psychology of religion. *The International Journal for the Psychology of Religion* 15: 179–98. [\[CrossRef\]](#)
- Pargament, Kenneth I., and Julie J. Exline. 2021. *Working with Spiritual Struggles in Psychotherapy: From Research to Practice*. New York: Guilford Publications.
- Pargament, Kenneth I., Annette Mahoney, Julie J. Exline, James W. Jones, and Edward P. Shafranske. 2013. Envisioning an integrative paradigm for the psychology of religion and spirituality. In *APA Handbook of Psychology, Religion, and Spirituality*. Edited by Kenneth I. Pargament, Julie J. Exline and James W. Jones. Washington, DC: American Psychological Association, vol. 1, pp. 3–19. [\[CrossRef\]](#)

- Pargament, Kenneth I., Bruce W. Smith, Harold G. Koenig, and Lisa Perez. 1998. Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion* 37: 710–24. [CrossRef]
- Pargament, Kenneth I., Harold G. Koenig, and Lisa M. Perez. 2000. The many methods of religious coping: Development and initial validation of the RCOPE. *Journal of Clinical Psychology* 56: 519–43. [CrossRef]
- Pargament, Kenneth, Margaret Feuille, and Donna Burdzy. 2011. The Brief RCOPE: Current psychometric status of a short measure of religious coping. *Religions* 2: 51–76. [CrossRef]
- Park, Crystal L., Donald Edmondson, and Amy Hale-Smith. 2013. Why religion? Meaning as motivation. In *APA Handbook of Psychology, Religion, and Spirituality*. Edited by Kenneth I. Pargament, Julie J. Exline and James W. Jones. Washington, DC: American Psychological Association, vol. 1, pp. 157–71. [CrossRef]
- Pinquart, Martin, Paul R. Duberstein, and Jeffrey M. Lyness. 2006. Treatments for later-life depressive conditions: A meta-analytic comparison of pharmacotherapy and psychotherapy. *The American Journal of Psychiatry* 163: 1493–501. [CrossRef] [PubMed]
- Raines, Amanda Medley, Kathryn S. Macia, Joseph Currier, Sidonia E. Compton, Chelsea R. Ennis, Joseph I. Constans, and C. Laurel Franklin. 2020. Spiritual struggles and suicidal ideation in veterans seeking outpatient treatment: The mediating role of perceived burdensomeness. *Psychology of Religion and Spirituality* 14: 229–36. [CrossRef]
- Reger, Mark A., Ian H. Stanley, and Thomas E. Joiner. 2020. Suicide mortality and coronavirus disease 2019-A perfect storm? *JAMA Psychiatry* 77: 1093–94. [CrossRef]
- Richardson, Safiya, Jamie S. Hirsch, Mangala Narasimhan, James M. Crawford, Thomas McGinn, Karina W. Davidson, and the Northwell COVID-19 Research Consortium. 2020. Presenting characteristics, comorbidities, and outcomes among 5700 patients hospitalized with COVID-19 in the New York City area. *JAMA* 323: 2052–59. [CrossRef] [PubMed]
- Rodney, Tamar, Nia Josiah, and Diana-Lyn Baptiste. 2021. Loneliness in the time of COVID-19: Impact on older adults. *Journal of Advanced Nursing* 77: e24–e26. [CrossRef]
- Santini, Ziggi Ivan, Paul E. Jose, Erin York Cornwell, Ali Koyanagi, Line Nielsen, Carsten Hinrichsen, Charlotte Meilstrup, Katrine R. Madsen, and Vibeke Koushede. 2020. Social disconnectedness, perceived isolation, and symptoms of depression and anxiety among older Americans (NSHAP): A longitudinal mediation analysis. *The Lancet: Public Health* 5: e62–e70. [CrossRef]
- Sarang, Ashish, Sozan Fares, and Noha Eskander. 2021. Suicide trends in the elderly during the ongoing COVID-19 Pandemic-a public health urgency. *The Southwest Respiratory and Critical Care Chronicles* 9: 31–36. [CrossRef]
- Segal, Daniel L., Sara Honn Qualls, and Michael A. Smyer. 2018. *Aging and Mental Health*. Hoboken: John Wiley & Sons.
- Sepúlveda-Loyola, Walter Aquiles, Isabel Rodríguez-Sánchez, Patricia Pérez-Rodríguez, Felipe Ganz, Rocio Torralba, Daniel Vicentini de Oliveira, and Leocadio Rodríguez-Mañas. 2020. Impact of social isolation due to COVID-19 on health in older people: Mental and physical effects and recommendations. *The Journal of Nutrition, Health & Aging* 24: 938–47. [CrossRef]
- Shannonhouse, Laura R., Jacquelyn A. Bialo, Aaron R. Majuta, Melissa R. Zeligman, Don E. Davis, Stacey E. McElroy-Heltzel, Jamie D. Aten, Edward B. Davis, Daryl R. Van Tongeren, and Joshua N. Hook. 2019. Conserving resources during chronic disaster: Impacts of religious and meaning-focused coping on Botswana drought survivors. *Psychological Trauma: Theory, Research, Practice, and Policy* 11: 137–46. [CrossRef] [PubMed]
- Shannonhouse, Laura R., Jordan D. Snyder, Mathew Fullen, Edward B. Davis, Stacey E. McElroy-Heltzel, Mize C. B. Mize, Jamie D. Aten, Don E. Davis, Joshua N. Hook, and Daryl R. Van Tongeren. 2020. Resource loss, religious coping, and suicide predictors/outcomes during the COVID-19 pandemic: A prospective study of U.S. racially diverse older adults. *The Journal of Psychology and Christianity* 39: 313–27.
- Stain, Helen J., Brian Kelly, Vaughan J. Carr, Terry J. Lewin, Michael Fitzgerald, and Lyn Fragar. 2011. The psychological impact of chronic environmental adversity: Responding to prolonged drought. *Social Science & Medicine* (1982) 73: 1593–99. [CrossRef]
- Suresh, Micheal E., Stacey E. McElroy-Heltzel, and Laura R. Shannonhouse. 2020. Predicting suicide risk in older homebound adults during COVID-19: The role of religious coping. *Journal of Psychology & Christianity* 39: 301–12.
- Teismann, Tobias, Thomas Forkmann, Julia Brailovskaia, Paula Siegmann, Heide Glaesmer, and Jurgen Margraf. 2018. Positive mental health moderates the association between depression and suicide ideation: A longitudinal study. *International Journal of Clinical and Health Psychology* 18: 1–7. [CrossRef] [PubMed]
- Tix, Andrew P., and Patricia A. Frazier. 1998. The use of religious coping during stressful life events: Main effects, moderation, and mediation. *Journal of Consulting and Clinical Psychology* 66: 411–22. [CrossRef] [PubMed]
- U.S. Census Bureau. 2020. Older Population and Aging Data. Available online: <https://www.census.gov/topics/population/older-aging/data/tables.html> (accessed on 30 June 2022).
- Van Orden, Kimberly A., Tracy K. Witte, Kathryn H. Gordon, Theodore W. Bender, and Thomas E. Joiner Jr. 2008. Suicidal desire and the capability for suicide: Tests of the interpersonal-psychological theory of suicidal behavior among adults. *Journal of Consulting and Clinical Psychology* 76: 72–83. [CrossRef] [PubMed]
- Van Orden, Kimberly A., Tracy K. Witte, Kelly C. Cukrowicz, Scott R. Braithwaite, Edward A. Selby, and Thomas E. Joiner Jr. 2010. The interpersonal theory of suicide. *Psychological Review* 117: 575–600. [CrossRef] [PubMed]
- Van Orden, Kimberly, and Yeates Conwell. 2011. Suicides in late life. *Current Psychiatry Reports* 13: 234–41. [CrossRef] [PubMed]
- VanderWeele, Tyler J. 2017. Religion and health in Europe: Cultures, countries, context. *European Journal of Epidemiology* 32: 857–61. [CrossRef]
- Vieten, Cassandra, Shelley Scammell, Ron Pilato, Ingrid Ammondson, Kenneth I. Pargament, and David Lukoff. 2013. Spiritual and religious competencies for psychologists. *Psychology of Religion and Spirituality* 5: 129–44. [CrossRef]

-
- Wand, Anne Pamela Frances, Bao-Liang Zhong, Helen Fung Kum Chiu, Brian Draper, and Diego De Leo. 2020. COVID-19: The implications for suicide in older adults. *International Psychogeriatrics* 32: 1225–30. [[CrossRef](#)]
- Whitehead, Brenda R., and Cindy S. Bergeman. 2020. Daily religious coping buffers the stress-affect relationship and benefits overall metabolic health in older adults. *Psychology of Religion and Spirituality* 12: 393–99. [[CrossRef](#)]