# Addiction, Substance Abuse, and Suicide Studies in Judaism

**If you are struggling, you are not alone.**

This post discusses topics like alcohol addiction and suicide that may be distressing for some readers. If you or someone you know is struggling, please know that help is available. Reaching out to a trusted individual—a friend, family member, or professional—can be a vital first step.

In moments of crisis, it's essential to remember that there are resources and people who want to support you through this. For immediate help, consider contacting a local mental health service, crisis hotline, or support group.

Your well-being matters, and taking the step to seek help is a sign of strength.

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## Addiction: Alcohol and Substance Abuse in Judaism by Kate Miriam Loewenthal (MDPI)

**1. Introduction**

What are and what have been the rulings and beliefs about addiction in Judaism concerning alcohol and substance use?

This article will focus on alcohol and substance use and abuse; its net will not be spread to explicitly include the many other forms of addiction and dependency, such as gambling, pornography and the Internet, which are now said to haunt the Jewish community.

We begin by outlining biblical and rabbinic rulings, past and present, and looking at the development of the status of addiction.

Alcohol's appearance in the biblical text places the history of its use to be almost as old as the history of the human race: Noah's drunkenness and its sequelae are significant features of the early part of the book of Genesis (Gen 9: 20–27), and the biblical text has a clearly

condemnatory attitude regarding Ham's role in causing this drunkenness. Subsequent Jewish laws and customs are not difficult to discover. Although excessive alcohol consumption is discouraged (for example, by officiating priests in the Temple) (Lev 10:9), alcohol consumption for religious reasons is prescribed (for example, sanctifying the Sabbath and festivals); wine in moderation is praised as something that "gladdens the human heart" (Psalms 104:15); and drunkenness on selected (very rare) occasions may even be encouraged (for example, for the festival of Purim). Thus, Judaism supports and prescribes the controlled use of alcohol [1]. This has been suggested as an explanation for the overall lower levels of alcohol use and abuse among Jews [1,2,3,4,5].

However, it should be noted that a genetic basis for alcohol intolerance has also been noted among some Jews [6]. The protective genotype is less common than the non-protective genotype, and among older Jews in Israel, among whom alcohol consumption is low, genotype was not related to a measure of anticipated alcohol consumption. Among younger Jews, genotype did have a protective effect, with anticipated alcohol consumption among the genetically unprotected exceeding the threshold for risky and unsafe drinking [7]. This work suggests that environmental influences promoting higher levels of drinking can be modulated by genetic factors. However, where the norms of alcohol consumption are low, genetic factors were unrelated to anticipated alcohol consumption. This implies that Jewish religious rulings, norms and social attitudes about alcohol consumption have probably played at least as important a role in regulating alcoholism as genetic factors. Although genetic protection can have an effect, only a minority of Jews are so protected, and the effect may only be apparent when group norms of alcohol consumption are high. In the past and among the older generation, genetic protection may not have played a role: norms and customs based at least partly from religious sources were the source of Jewish moderation with respect to alcohol [7].

Jewish and rabbinic views on the use and abuse of opiates and other mood- and mind-altering substances have emerged much more recently. These views follow the development of substance abuse in countries with Jewish communities and also the subsequent outlawing of many forms of owning and/or supplying drugs and medicines deemed to be harmful, for recreational and non-medicinal use. There has been some suggestion that Jews have played some role in the scientific and legislative response to substance abuse; this will be described.

There are no biblical references to the use of substances, such as opium and cocaine derivatives, even though these have been used by humanity since biblical times. This is in contrast to alcohol, which is relatively frequently referenced. The possession of opiates, cocaine and many other addictive substances without medical prescription and supervision is now illegal in most countries, and this is a comparatively recent historical development. Opium

use has been known for at least two thousand years and was widespread and problematic in eighteenth-century China, when the substance was controversially imported from India by British merchants to raise funds to buy the tea to which the British had developed a strong attachment [8,9]. Laudanum, diluted opium, was a popular over-the-counter panacea in nineteenth century Western society. It was widely used for pain relief, to sooth cranky babies and cheerfully endorsed as a means of enhancing creativity and literary sensitivity among the educated classes. The best-known of many famous users was Queen Victoria [8,9]. With respect to other well-known substances, Freud was an enthusiastic cocaine user [10]. Mariani wine (diluted cocaine) was said to be endorsed and used by popes in the nineteenth century, and Coca Cola's original secret ingredient was cocaine (removed in 1903). The highly addictive opiate, heroin, was derived from morphine and innocently (or naively) marketed at the beginning of the 20th century by Bayer as a substance that could wean opium and morphine addicts from their addiction. Cocaine was similarly advocated as a cure for "morphinism" by Freud and others [10]. Although there was some strong disapproval of opiate use in some quarters (Gladstone was a noted opponent), generally, opiate use was socially acceptable. However, by the late nineteenth century, there was concern about the effects of both alcohol and opiate use and abuse on the workforce [9]. In the Western world, legislation simply controlled the sale and consumption of alcohol, whereas the ownership and supply of opiates became illegal.

However, the early twentieth century introduction of legislation designed to make the ownership and supply of addictive drugs illegal did not stop the spread of potentially addictive substances. As in China nearly 200 years earlier, the spread was ensured by compulsive demand from addicts, enabling enormous profit margins to providers. It has been suggested [11] that medical scientists played a major role in marginalising and repressing drug addicts in the early twentieth century. German and Russian medical writings in the late 19th and early 20th centuries constructed drug addiction as a social problem related to modernity, capitalism; and Jewishness. These writings had an anti-Semitic tone, making Jews responsible for addiction among other social and economic problems. Jewish scientists attempted to respond to these allegations, addressing the issue of addiction, constructing projects for social change, also for improving Jewish health, and generally trying to reshape Jewish identity. The overall effects were the marginalisation and repression of drug addicts. In Vassilyev's view [11], anti-Semitism and the Jewish scientific response played an important role in developing current policies towards drug addiction, in spite of the lack of effectiveness of these policies.

The above account contextualises current perspectives of drug use as illegal and morally wrong. 120 years ago, although there was some disapproval, the "problem" of drug

addiction was not apparently as serious and as widespread, or normally defined as problematic, or seen to be an issue in the Jewish community. Hence, we cannot meaningfully search for pre-20th century rabbinic opinion.

Current rabbinic opinion centres on two fundamental general principles in Jewish law. First, that life and health must be protected and the saving of life prioritized: *Pikuach nefesh* (Leviticus, 18:5; Talmud Yoma, 83a). The health risks of excessive alcohol consumption and substance abuse mean that no rabbinic authority will be found to condone these behaviours, although medically-sanctioned use for health and life-saving are, of course, rabbinically sanctioned. There is also an important principle that Jews should obey the laws of the country they live in (where these do not conflict with Jewish law): *Dina d' malchusa dina*: the law of the land is the law (incumbent on Jews) (see the Talmud, e.g., Baba Kama 113a, Baba Basra 54b). The importance of self-control has been endorsed by many rabbis and extended into the widespread rabbinic endorsement of Twelve Step programmes [12,13,14].

Among secular professionals, addiction is currently recognised as a mental disorder, for instance by the American Psychiatric Association, which has produced successive versions of the widely-used Diagnostic and Statistical Manual of Mental Disorders [15].

The rabbinic view offers a shift of emphasis: though rabbinic sources regard addiction as something over which control might be achieved, addiction would appear to straddle the divide between wrongdoing and illness: sin/wrongdoing and insanity are both regarded as spiritual illness *(choli nefesh)*.

Parallels have been drawn between Maimonides' laws of repentance (*teshuva*), Rabbi Yonah of Gerona's Gates of Repentance, and the Twelve Steps programme for the rehabilitation of addicts [12]. There are marked similarities, Glass argues. The Twelve Steps and the rabbinic guides to repentance all advocate acknowledging ones failings and taking a careful inventory, asking for forgiveness, making reparation and resolving not to repeat the failings. Faith in divine power is consistent with the Twelve Steps approach and with Judaism and certainly does not mean abandoning free will and personal responsibility [12]. However, there are possible differences between the Twelve Steps and Jewish views on repentance: the Jewish sources take it as given that the Jew is a believer, whereas the Twelve Steps involves becoming a believer. The possible difference might be resolved by the view that belief and faith must be in a continual process of strengthening and development by all people, addicts or not, Jewish or not. As mentioned above, there is general rabbinic endorsement for the Twelve Steps approach to alcohol and substance addiction [12,13,14].

Complementing all of this is a rabbinic view that those who become addicted are (through no fault of their own) particularly prone even before they start to imbibe alcohol or illicit drugs. An

orthodox rabbi, Shais Taub, working with addicts in a Jewish rehabilitation facility, endorses this view, arguing against viewing addiction as the result of moral failing or as a mental illness and strongly supporting the spiritual approach behind [16].

Another suggestion, from a group working in an orthodox Jewish rehabilitation centre, is that addicts suffer from splits, for example between affect and logic: here, there is a divorce between (mis)behaviour and feelings of responsibility [17]; for example feelings—cravings to use illicit drugs—"taking over" even though the individual knows all along that what they are doing is wrong. In the Jewish rehabilitation centre, Jewish teachings are used with the Twelve Steps to enable spiritual awakening, direction and control. Abraham Twerski is an orthodox rabbi and a psychiatrist, working with substance addicts. He also points to splits and contradictions in the behaviour and thinking of addicts, permeating the sense of self-worth, for example the eminent specialist—a substance addict—who was terrified when delivering a public lecture for fear that he would be criticised, even though he was an internationally respected expert in his field [13].

So far, we have seen that traditional Jewish religious sources support the controlled use of alcohol. Since substance addiction is a relatively recent phenomenon, there are no traditional religious sources on this, but there is current widespread rabbinic interest and activity focussed on support and therapy. The most noteworthy feature of this interest and activity is a general endorsement of the Twelve Steps approach to recovery from addiction.

We turn now to the question of the extent to which alcohol and substance abuse have occurred and do occur in Jewish communities.

**2. Prevalence**

There are particular difficulties in discovering the prevalence of alcohol and substance abuse and addiction in the Jewish community. Chief among these is denial. For example, in 1962, it was reported that alcoholism and drug addiction were "entirely absent" in the Jewish community in the USA [18]. Thirty three years later, there was a 1995 report of zero prevalence of alcoholism in an epidemiological study of stress and psychiatric disorder the U.K. Jewish community [19]. These reports may well indicate the existence of some denial.

A further difficulty in estimating prevalence is that studies vary in whether they report point prevalence, lifetime prevalence or prevalence over some other period. They vary on whether they report on use, dependence, abuse or addiction and on which substances are investigated.

Awareness of Jewish alcoholism in the USA began to develop in the 1970s, and the possibility of dual dependency was acknowledged in the 1980s. However, support groups in the 1980s

were finding it near-impossible to book accommodation for their activities in synagogue premises: there was continued denial of the existence of addiction in the Jewish community [12], and there were fears that the use of synagogues for addiction support groups would damage the reputation of the synagogues.

In 1997, massively lower prevalence of alcohol abuse/dependency was reported among Jews in the USA [20] compared to those with other religious preferences. Lifetime prevalence was 11.1% (men) and 3.4% (women) among Jews, compared with 28.7% and 8.5% [20] among those of Christian background. Some recent studies have reported a rise in both alcohol and recreational drug use among younger Jews [7,20]. Some or all of this reflects a genuine increase, which may, in turn, be driving a need to report problems and seek help. This may, in turn, be reducing denial. Nevertheless, denial may be continuing to an unknown extent and having an unknown effect on patterns of abuse. Fifteen or 20 years ago, Jewish users of the U.K. drugsline were peripheral to the main Jewish communities: users were described as marginal individuals [21]. Now, users are reported to come from throughout the community, including the traditionally orthodox and strictly orthodox (*chareidim)*. There may have been Jewish addicts who would not have used a Jewish drugsline for fear of their problems becoming known in the community. This fear may have reduced in the previous two decades.

Few or no studies of substance abuse have been reported among the American Jewish population, with no national prevalence data [22]. However, there are Israeli data: the lifetime prevalence of reported illicit drug use in Israel is 13%, while about 1% of Israelis meet the American Psychiatric Association's diagnostic criteria for drug abuse/dependence, which is similar to that reported in the USA [23]. That is, general prevalence estimates in the USA range from 2%–6% [24]. There are reports of a number of trends and group differences in illicit drug use in Israel. For example, there has been growth in the number of drug-related offences since the 1960s and in reported drug use, a possible decline in "hard" drug use, accompanied by a growth in the use of inhalants. Groups with higher rates of illicit drug use include immigrants, men, the secular and victims of terrorist attacks [23].

Lower lifetime and current rates of substance abuse are reported in Israel than in France among adolescents, but among adults, lifetime prevalence is similar in the two countries [23,24].

These rather variable reports and estimates are the survivors of the methodological difficulties and variations mentioned above. We can provisionally conclude that:

- Alcohol and illicit drug addiction do currently occur in Jewish communities, and the rates are said to be rising.

- Rates may have been lower than in other groups, but it is difficult to be confident about prevalence, since denial is said to have occurred in the past and may still occur.
- Insufficient attention has been paid to possible differences between the *chareidim* (strictly orthodox), traditionally orthodox and the non-orthodox in patterns of alcohol and drug use.

**3. Community Beliefs and Attitudes**

There are about 13 million Jews worldwide, about 0.2% of the world's population. About six million Jews are in Israel, six million in the USA and the remainder mainly in Europe, South Africa, Australia and thinly scattered elsewhere. In Israel and the U.K., about a quarter of affiliated Jews consider themselves (strictly) orthodox (*chareidi)*, about 60% are traditionally orthodox and the remainder non-orthodox. In the USA, the proportions of strictly orthodox *(chareidim)* and traditionally orthodox are lower, and the proportions of non-orthodox (reform and liberal) are higher. Numbers of unaffiliated Jews are hard to estimate, but may be relatively low. Among the *chareidim*, there is strict observance of the dietary, marriage and other laws relating to religious observance. Most *chareidim* live in religious communities and send their children to Jewish religious schools. Exposure to the media is limited; television, cinema, theatre, fiction reading and Internet use are tightly restricted and controlled. Jewish community cohesion is high especially among the orthodox. Community beliefs may be relatively homogenous and the influence of religious leadership relatively strong. Although alcohol and substance abuse have risen in recent years, community boundaries have delayed these trends. Traditionally, orthodox Jews normally have orthodox leaders, but individual religious practice and belief can vary greatly, and community boundaries are much more permeable than among the *chareidim*. Media use is unrestricted by rabbinic prohibitions. Although community boundaries and religious leadership have less impact among traditional and non-orthodox Jews and media use is not restricted, there can be a strong sense of community, with strong social ties, and factors, such as respect, prestige and groups norms, are likely to influence alcohol and drug-related behaviour and its reporting. As described below, denial has been and is much evidenced, so the true extent of alcohol and substance abuse may be higher than even currently estimated.

Until relatively recently, those who initiated and worked on the U.K. drugsline with expertise in the Jewish community (Rabbi Aryeh Sufrin MBE, Chava Sufrin and others [21,25]) reported that community beliefs reflected the conclusion that substance abuse and, indeed, alcohol abuse were denied as problems in the Jewish community, but they were seen as problems in the host society. Jewish community members believe that "we are supposed to be better". Jews hold more pejorative beliefs about alcohol use than do Protestants [26], and excessive

drinking was considered to be an out-group characteristic by the Jewish community [1]. Jews reported negative stereotypes about drinking and drunkenness among the rest of (non-Jewish) society, while people of Protestant background were more likely to say that alcohol enabled relaxation and a reduction of worry and tension [3]:

- "It's something that non-Jews do generally therefore it is frowned upon in the Jewish community" (Jewish man);
- "If you do go to the pub, you expect that there will be a lot of drunk people around and beer flying" (Jewish woman);
- "It can lead to abuse or to violence…it can cause husbands hitting wives…destroying furniture, things like this…attacking wives and children" (Jewish woman);

In contrast:

- "People want to enjoy themselves and perhaps put problems to the side" (Protestant man);
- "I find a drink might relax me" (Protestant woman);
- "It drowns your problems" (Protestant woman).

When the existence of addiction within the community came to the attention of some community social service agencies and leaders, attempts to set up services and to educate children via community schools met with denial that there were problems that needed addressing [21]. Parents were reluctant to allow their children to be exposed to information about the dangers of substance abuse, because it was/is believed by parents that children would not otherwise learn about the existence of recreational drugs; having informative sessions might "put ideas into their heads" [21]. One orthodox rabbi stated that he "would be surprised if parents of teenage kids were willing to admit that there is even a need to teach their children about it" [27]. Rabbi Aryeh Sufrin MBE, working on addiction support, said that recreational drug use probably took longer to penetrate the Jewish community, particularly the strictly orthodox (*chareidi*) section, but that security and stability have been eroded over the past two decades. Alcohol and many or all recreational drugs may be seen as part of an attractive carefree lifestyle and as ways of dealing with boredom and stress, with an accompanying growth in alcohol and recreational drug use and abuse. Moreover, exposure to media is somewhat greater than in the past, and addiction can be conveyed as a glamorous problem in the media. Substance and alcohol abuse, gambling and other addictions are now significant problems [25]. However, denial that the Jewish community has a problem is still apparent. Drunkenness and drinking in pubs, football hooliganism and drunken domestic

abuse are seen as problems that do not exist in the Jewish community. Fear of stigmatisation is evident in this community, and there is reluctance to admit to both communal and individual difficulties, whether these relate to alcohol or drug abuse, mental or even physical health:

- "People can't know I'm struggling" (Drugsline user) [25].
- "I wonder what type of families need this? Is it just those who can't cope? I might feel ashamed to ask for such help?" (Orthodox Jewish woman talking about community support services in general [28].
- "One problem is stigma and the related problem of confidentiality. In a small closed community like this, these are difficult issues" (Co-ordinator of a Jewish community support group) [28].

A salient feature of stigmatisation (for whatever reason it occurs) is that it is believed to affect the chances of all family members gaining admittance to the more prestigious religious educational institutions [25], the marriageability of family members [29] and possibly employability in some religious communal roles.

Chava Sufrin, an experienced community support worker, reported that a prevalent belief about causes of addiction among lay members of the Jewish community is that it is self-inflicted, not a disease [25]. However, if a family member is known to be addicted, then family members will feel guilt, shame and self-blame; this is often alongside a paradoxical, but common initial response by the user to blame everyone and everything else. Some users may come to see addiction as a disease, and some may believe that personal control and responsibility are important: different beliefs are helpful for different people. Eventually, with effective support, families will usually assume responsibility for supporting their addicted relative. Of course, many or all of these beliefs may be held in other religious and social groups, but some may be particularly marked in Jewish communities. In particular, denial has been widely noted, although said to be decreasing.

Signs that community denial is being eroded include a recent edition of a popular orthodox-Jewish women's magazine on addiction, which included strong assertions that the Twelve Step programmes for alcohol and substance and other forms of abuse are not only kosher for Jewish use, but are the most effective and appropriate [30]. Other articles gave attention to ways in which "co-dependents" (typically spouses) might alter their behaviour and attitudes [30,31,32,33], and all advocated the importance of strengthening connections to the divine and becoming aware of the spiritual strength that comes from this [33].

In summary, collective beliefs and attitudes are slowly changing from denial that alcoholism and drugs and other addictions are problems for the Jewish community. As it becomes evident

that these problems are apparent (perhaps particularly among the younger generation), denial is becoming less total. Stigmatisation is still a problem and may inhibit help-seeking.

**4. Relations of Religious Rulings to Behaviour in the Community**

There is negligible systematic study of the ways in which religious rulings on alcohol and substance abuse actually affect behaviour. Some of the possible effects have been alluded to, and there are others.

First, there is some evidence that rabbinic rulings are followed by many, with respect to many behaviours. To take some obvious examples, kosher food shops and restaurants, synagogues and religious educational institutions, ritual baths and many other institutions and businesses are well patronized. This indicates that the observance of the dietary laws and prescriptions regarding prayer, religious study and other behaviours are commonly and normatively observed among the orthodox. As noted, over half of the Israeli and U.K. Jewish populations are strictly or traditionally orthodox and well aware of many rabbinic recommendations. Specific examples include the observation that beliefs about the causes and treatment for depression were generally reported to follow rabbinic guidance [29] and the observation that orthodox Jewish women reported strenuous efforts to follow rabbinic guidance to avoid idle gossip and speaking badly of others [34].

Overlying this general tendency (especially among the more orthodox) to follow rabbinic guidance is a marked tendency to develop and maintain a perfect image and reputation. This may help to keep some from doing the right things and might partly account for the possible lower prevalence of addiction among Jews, but it also helps to account for denial.

Denial has been widely noted, and failure to acknowledge addiction issues prevents or delays help-seeking. A facet of denial is the belief that the Jewish community or religion "protects us from the scourge of drugs, alcohol or gambling". As described by one rabbi, this dangerous belief "makes dealing with the issue more difficult as people are lulled into a false sense of security".

Rabbi Aryeh Sufrin, who pioneered Jewish use of the U.K. drugsline, noted enormous difficulty even ten years previously in being allowed to speak to Jewish school children about the dangers of recreational drugs [21]. Initially, many schools and parents felt that to allow such information to be offered would be to put ideas into the heads of children/teenagers. Jewish drugsline workers indicated that to an increasing extent, they were being allowed and welcomed into Jewish schools to improve awareness [21], but this may have come too late to be of use in enabling current Jewish users to make informed choices.

Another very striking effect reported was the lack of distinction made by orthodox Jewish drug users between more and less significant failings. Thus, if one has committed a minor religious transgression, they may be in danger of branding themselves as an outcast, henceforth allowing themselves to enjoy all kinds of forbidden indulgences. Therefore, for instance, one might allow himself to try a non-kosher candy, and from then on, one might-as-well try marijuana and other substances. This can be a common path into substance abuse in the orthodox Jewish community [25].

It can be suggested therefore that observance of rabbinic rulings by many may help to account for the possible relatively low prevalence of alcohol and substance abuse. However, the downside of this is the need to maintain a perfect image and the readiness with which individuals and communities have been practising denial. Stigmatisation is also a feature of community beliefs. The realisation that alcohol and substance abuse do happen in the Jewish community has facilitated the support now generally offered by communal leaders for preventive educational programmes and religiously-appropriate treatments.

**5. Organisations, Centres and Helplines**

It is often acknowledged that minority groups, including Jews, may feel more comfortable in treatment programmes that are sensitive to cultural and religious values [27,28].

A number of helplines and residential and non-residential addiction treatment programmes have sprung up in the last two decades, offering support to Jews (and sometimes to others). These include:

- Norwood (formerly Chabad) Drugsline, London UK [35]; Gateway Rehabilitation Centre Pittsburgh USA [36]; Beit T'shuvah Synagogue Recovery Center, LA, California, USA [37];
- Chabad Residential Treatment Center, Los Angeles, CA, USA [38];
- Jewish Recovery Center, Florida, USA [39]; Jewish Center for Addiction: Prevention, Help and Hope, Chicago, USA [40];
- Addiction helpline, Torah and the Twelve Steps: JewishDrugRehab.org [41];
- JACS: Jewish alcoholics, chemically dependent persons and their families: friends and associates encouraged and supported to explore recovery in a nurturing Jewish environment [42].

Many of these Jewish rehabilitation centres and agencies involve orthodox rabbis as central figures. These rabbis have a strong sense of mission: they do not seek specifically

orthodox Jewish clients; they do offer Jewish spiritual teachings (sometimes Kabbalistic) and some religious practices to clients as appropriate, in the expectation that these will inject a spiritual dimension and sense of purpose into the lives of their clients. *Beit T'shuvah* (literally "House of return"), for example, takes approximately one-third of its clients from those who have been ordered to take treatment somewhere and who have elected to go to *Beit T'shuvah*; one-third are there as an alternative to a prison sentence, and the remaining one-third are entirely voluntary. Spiritual teachings and practices are offered, and as in most Jewish rehabilitation facilities, the Twelve Steps are endorsed and followed. It is suggested that a spiritual awakening can facilitate the process of recovering integrity [17].

Expectations are often said to be fulfilled, but quantitative outcome studies are still awaited.

## 6. Conclusions

Addiction is stigmatised in the Jewish community, as it emerges from decades of denial that alcoholism and drug abuse are Jewish problems. Rapid social change and electronic communication are factors that have contributed to the increased consumption of alcohol and recreational drugs within the Jewish community, including enclave strictly orthodox (*chareidi*) communities. Responses include educational initiatives to alert school children to the dangers of recreational drug use and helplines and treatment programmes, both residential and non-residential. The Twelve Steps approach is widely supported and generally argued to be consistent with Jewish spirituality.

A number of methodological problems and a sheer shortage of research have meant that prevalence data are inadequate. Alcohol and substance abuse probably have been lower in Jewish groups than in many other groups, and this may be a more marked effect among the more religiously orthodox. Prevalence is probably rising, but data are inadequate to be sure of the extent and do not allow estimates of the effectiveness of religious boundaries and the extent to which they resist erosion. The extent of denial of alcohol and substance abuse may be greater among the religiously more orthodox. By definition, there are methodological problems in investigating its extent, but such investigation is needed. Denial may continue to mask true prevalence figures. Other factors contributing to changes in prevalence include changing patterns of media use, including the Internet, and changing depiction of alcohol and substance abuse in the media [43]. Social influence has been under-investigated: for example, we need to assess the impact of the norms of high levels of alcohol use of Russian-Jewish immigrants to Israel [44] and elsewhere on the new host community norms.

There is a need for outcome research on the rehabilitation programmes referred to in this article.

*Religions* **2014**, *5*(4), 972-984; **https://doi.org/10.3390/rel5040972**



# Suicide in Judaism with a Special Emphasis on Modern Israel by Eliezer Witztum and Daniel Stein

**Abstract**

Judaism considers the duty of preserving life as a paramount injunction. Specific injunctions against suicide appear in the Bible, Talmud, and thereafter. Nevertheless, Jewish tradition emphasizes that one should let himself be killed rather than violate cardinal rules of Jewish law. Mitigating circumstances are found for the six deaths by suicide mentioned in the Bible, for example to account for one's sins, or avoid shameful death. Heroic suicide is praised throughout the Jewish history, from the suicide of Samson and the collective suicide in Masada, to the collective readiness of Jews in Medieval times and during the Holocaust to kill themselves rather than succumb to their enemies. Suicide rates for Jews are lower than those of Protestants and Catholics. Similarly, suicide rates in Israel are lower in comparison to

Europe and North America, although being higher than those in most Moslem Asian and North African countries. This low rate of suicide is found in Jewish Israelis of all ages, including in adolescents. Elevated suicidal risk may be found in specific sub-populations, including male Israeli soldiers, immigrants from the former USSR and Ethiopia, in particular adolescent immigrants from the former USSR, elderly Holocaust survivors, and young Israel-Arab women. The meaning of these findings is discussed according to different socio-cultural perspectives.

"Of all religions, Judaism counts the fewest suicides, yet in none other is education so general . . . But if the Jew manages to be both well instructed and very disinclined to suicide, it is because of the special origin of his desire for knowledge. It is a general law that religious minorities, in order to protect themselves better against the hate to which they are exposed, or merely through a sort of emulation, try to surpass in knowledge the population surrounding them . . . Primitive in certain respects, in others [the Jew] is an intellectual and man of culture. He thus combines the advantages of the severe discipline characteristic of small and ancient groups, with the benefits of the intense culture enjoyed by our great society. He has all the intelligence of modern man without sharing his despair".

## 1. Introduction

It was the French-Jewish sociologist Emile Durkheim who made these optimistic remarks at the turn of the century, in 1897, in his famous work *Le suicide*, which marked the beginning of the scientific study of suicide [1]. Inspired by positivism and a faith in progress, Durkheim set out to probe the relationship between society and the individual, and the social phenomenon of suicide appeared to him the ideal subject, demonstrating the need for establishing sociology as an independent academic discipline.

The universality of suicide as a form of human behavior across all societies and cultures is well documented [2]. Attitudes toward suicide have varied over time and place, reflecting the ideologies of each society to the value of life and the concept of death. Thus, the attitudes toward suicide in some societies of the ancient world, for example the Ancient Egyptians or the Greeks of the Homeric period, could be described as "justifiable in specific situations" and "non-condemning" [3]. In contrast, current Western negative attitudes toward suicide are likely a consequence of Judeo-Christian traditions. St. Augustine's 4th century writings against suicide and the 6th century council of Braga both illustrate Christianity's consistent regard of suicide as the most grievous crime of all [2].

## 2. Suicide in Judaism

### *2.1. Introduction*

In Judaism, the duty of preserving life, including one's own, is considered a paramount injunction [4]. Nevertheless Jewish tradition has constantly emphasized that one should let himself be killed rather than violate three cardinal rules of Jewish law: Commands against idol worship, murder, and incest [4]. In the Bible, although no explicit command forbidding suicide is given, the sovereignty of God and not of man over life and death is repeatedly emphasized: "It is I who put to death and give life" (Deuteronomy 32:39). "The Lord kills and makes alive" (Samuel I 2:6). Job rhetorically asks, "In whose hand is the life of every living thing, and the breath of all mankind?" (Job 12:10). The context supplies the unequivocal answer: God. Although God is equally sovereign over the deaths of all men, those of his people touch him deeply: "Precious in the sight of the Lord is the death of His godly ones" (Psalms 116:15).

Theologically, suicide interferes with human purpose on earth that is to be co-partner with God in recreating another Garden of Eden on this planet. Suicide also supersedes God's role as the judge who decrees who is to be rewarded and who is to be punished. The taking of one's life places man in that supreme role. Further, the suicide is denied reincarnation, a part of traditional Jewish theology. Finally, a phrase that is said when a person dies, epitomizing Judaism's theological posture, is "God gives and God Takes". By killing oneself, one is presuming to be powerful enough to take over a right that belongs to God alone [5].

*2.2. Historical Background*

Six deaths by suicide are recorded in the Bible: Samson, King Saul and his arm bearer, Ahitophel, Avimelech and Zimri. In every instance mitigating circumstances for the suicidal act can be found, for example to account for one's sins or mistakes, or to avoid captivity, unbearable torture, or shameful death. In the case of Avimelech, the Old Testament account of his death, after capturing the city of Thebez and assaulting a fortified tower in the center of the city, reads: "So Avimelech came to the tower and fought against it, and approached the entrance of the tower to burn it with fire. But a certain woman threw an upper millstone on Avimelech's head, crushing his skull. Then he called quickly to the young man, his armor bearer, and said to him, 'Draw your sword and kill me, lest it be said of me, "A woman slew him."' So the young man pierced him through, and he died" (Judges 9:52–54).

The account of king's Saul's is almost identical to that of Avimelech. It reads: "And the battle went heavily against Saul, and the archers hit him; and he was badly wounded by the archers. Then Saul said to his armor bearer, 'Draw your sword and pierce me through with it, lest these uncircumcised come and pierce me through and make sport of me.' But his armor bearer would not, for he was greatly afraid. So Saul took his sword and fell on it. And when his

armor bearer saw that Saul was dead, he also fell on his sword and died with him (Samuel I 31:1–6 and Chronicles I 10:1–6). It seems that these two accounts are virtually identical.

In the case of Ahitophel who was King David's counselor and then betrayed him, David prayed that Ahitophel's advice would be regarded as wrong and foolish, which indeed was the case (Samuel II 15:31). The bible reads: "Now when Ahitophel saw that his counsel was not followed, he saddled his donkey and arose and went to his home, to his city, and set his house in order, and strangled himself; thus he died and was buried in the grave of his father" (Samuel II 17:23). Lastly, the king Zimri gained the throne of Israel by assassination. He lacked popular support and was soon attacked by a rival. "And it came about, when Zimri saw that the city was taken, that he went into the citadel of the king's house, and burned the king's house over him with fire, and died, because of his sins which he sinned, doing evil in the sight of the Lord, walking in the way of Jeroboam, and in his sin which he did, making Israel sin (Kings I 16:18–19).

*2.3. Suicide and Heroism*

Another relevant typology in Judaism relates to heroic suicide, demonstrated, for example, in the story of Samson. Samson's death is thus recorded: "It so happened when [the Philistines] were in high spirits, that they said, 'Call for Samson, that he may amuse us.' So they called for Samson from the prison, and he entertained them. And they made him stand between the pillars. Then Samson called to the Lord and said, 'O Lord God, please remember me and please strengthen me just this time, O God, that I may at once be avenged of the Philistines for my two eyes.' And Samson grasped the two middle pillars on which the house rested, and braced himself against them…and he bent with all his might so that the house fell on the lords and all the people who were in it. So the dead whom he killed at his death were more than those whom he killed in his life" (Judges 16:25–30).

Heroic suicide is particularly materialized in the narrative of Masada, the most famous case of collective suicide in Jewish history [6]. Masada—a fortress built on top of a mountain overlooking the Dead Sea in the Judean desert, was the last stronghold against the Roman Empire at the end of the Jewish revolt of 66–73 A.D. After a long and enduring siege, the Romans succeeded to demolish the walls and it was evident that the invasion of the fortress was inevitable. The leader of the rebels, Elazar Ben-Yair, convinced his people to die. It was a profound religious conviction and an equally strong sense of freedom that led the 960 surviving defenders of Masada to kill their wives and children and then each other rather than surrender to the Romans.

Still, it is of interest to note that although the suicide of Ben Yair and his warriors in Masada has become a symbol of bravery in modern Israel and all over the world, it has never been

mentioned in Judaic rabbinic literature. Moreover, for years, it has been known only through the account of Josephus, a Jewish historian of the Roman times. Any mention of suicide is conspicuously absent in *Yosippon* [7], a later Hebrew account of the Jewish revolt; here the defenders fought against the Romans to the death Some argue that Josephus's story of Masada sheds some insight into his own views on suicide [8]. Thus, while regarding suicide as completely alien to Jewish intellect, spirit, and law, Josephus, has nevertheless, seen it as justifiable, even admirable, as part of the heroic legacy of Judaism in times of persecution and captivity.

Indeed, from the chapter of Masada, voluntary death as an ultimate refuge of persecution [9] can be followed in Jewish history through the High and Late Middle Ages into the modern era. It can be shown that suicides on a mass scale have occurred during the persecutions occasioned by the Crusades, the Black Death, the expulsions from Spain and Portugal, and the pogroms of the Chmelnicki uprisings in Eastern Europe. There is no saying if, and to what extent, memories of those acts of despair and religious fervor have been still alive in Jewish communities of the twentieth century, particularly during the Holocaust [9]. Still, suicide of Jews under Nazi rule is a phenomenon with a historical dimension, that is to say, there are precedents going far back into Jewish history, always connected with particular moments of crisis, persecution and despair [6].

Some authors argue that suicides of Jews during the Holocaust should be regarded as acts of heroism and resistance, for example the readiness of the Jewish warriors in Second World War Polish ghettos to die rather than to be captured by the Germans [6]. This point of view has encountered considerable opposition and has not been widely accepted. Kwiet [9] suggests that during the Holocaust period, Jews, both individually and collectively, have developed a variety of strategies of defense and survival determined by tradition as well as by the prevailing social and personal circumstances. The strategies have varied in form and intensity, ranging from emigration, accommodation and collaboration to protest, escape attempts, politically organized resistance and suicide.

Suicide was the ultimate and most radical attempt to resist Nazi terror. Not surprisingly, the Nazis sought to prevent Jewish suicides. Wherever Jews tried to kill themselves—in their homes, in hospitals, on the deportation trains, and in the concentration camps—the Nazi authorities would invariably intervene in order to save the Jews' lives, wait for them to recover, and then send them to their prescribed deaths [9].

*2.4. Judaic Injunctions against Suicide*

The Biblical basis for the injunction against suicide has been derived from the Noahide laws: "For your lifeblood too, I will require a reckoning" (Genesis 9:5). This statement has been seen

as a prohibition not only against suicide but also against any form of self-mutilation. The Hebrew Bible contains several additional prohibitions with regard to self-mutilation. For example, "Yeare the children of the Lord your God: Ye shall not cut yourselves, nor make any baldness between your eyes for the dead" (Deuteronomy 14:1) [8].

Injunctions against suicide continue to appear in the *Talmud* (5), and in later post-Talmudic writings [4]. The prohibition against suicide is clear in Jewish Rabbinic law. It is written that a suicide victim is not given full burial honors. Rending one's garments, delivering memorial addresses, and other rites to honor the dead are not performed for a suicide victim, whose burial is done in a separate place, outside of the cemetery [4]. Only rites respecting mourners are permitted [4]. Still, there are exceptions to the prohibition against suicide even in the Talmud. Thus, according to the Talmud (*Sanhedrin*, 74a) one is obliged to accept death when the alternative is to be forced to commit adultery, murder, or idolatry. It should be nevertheless stressed that this means allowing oneself to be killed under certain prescribed circumstances, not to actively killing oneself.

Some mitigation in the overall restriction of suicide continues to appear in later Jewish codes of law. Thus, the codes of Maimonides from the 12th Century, and the Shulhan Arukh from the 16th Century, distinguish between suicide while of sound mind—to which these restrictions apply, and suicide while of unsound mind (including suicide by minors and people with mental illness), which is forgiven. Still, injunctions against suicide still apply in Modern Judaism, in that official orthodox burial ceremonies are not performed in the case of suicide [10].

Altogether, there seems to be an inherent duality of Judaism in ancient and modern times with respect to suicide. On the one hand, to regard it as a sinful and forbidden act that should be opposed as a paramount Jewish injunction; yet to allow, if not worship, the readiness of the individual to take his/her life when it comes to protect the existence of the Jewish religion, morality, or nation [6,11].

## 3. Suicide in Modern Israel

### *3.1. Introduction*

Israel presents ample opportunities for the study of the association of Judaism with suicide. Nevertheless, other socio-cultural influences are likely of considerable relevance. More than many other countries, Israel is a society in transition, undergoing major socio-economic and socio-cultural changes both before, and since its independence in 1948. This is of particular relevance, as social instability may increase the risk of suicide [12]. Other important socio-cultural factors likely influencing suicide relate to the

considerable ethnic diversity in Jewish Israeli society, the influence of the massive immigration to Israel in the past 60 years from many countries around the globe, and the repeated switches between war and peace conditions within a relatively brief period of time [10,13].

A recent study by Oron [14] analyzes the relations existing between war conditions and suicide rates in Israel from its independence to the recent 2nd Lebanon War. In keeping with studies of other existential wars (World Wars 1 and 2), Oron [14] has shown a reduction in suicide rate during the three existential wars Israel has faced (the Independence War in 1948, the Six Days War in 1967, and the Yom Kippur War in 1973), with an increase in the rate of suicide in the year after, and either a stabilization or a decrease in its rate in the next years. Similar to other researchers, Oron [14] associates the reduction in suicide rates during war conditions with an increase in the national sense of cohesion, commitment and solidarity that decrease once again when the crisis is over. Wars that are not existential (e.g., the Suez War in 1956) have usually a lesser effect on the suicide rate of the population. Still, a decrease in suicide rate has been noted during the 2nd Lebanon War in 2006 in comparison to 2005, the sole conflict-free year since the 2nd Palestinian uprising in 2000. In keeping with this trend, Lester [15] has shown a significant inverse correlation between the number of suicide terrorist attacks/number of people killed in these attacks and suicide rates in Israel from 1983–1999. Lastly, an increase in suicide rate has been found during the 1st Lebanon War, the first controversial war Israel has faced in 1982, in comparison to the years preceding this war [14].

*3.2. Suicide in the General Jewish Israeli Population*

From the early documentation of suicide in Europe by Durkheim in the second part of the 19th century and in North America in the 1920s, the suicide rates for Jews have been consistently lower than those of Protestants and in most, although not all studies, also lower in comparison to Catholics [10,16]. In keeping with these trends, the suicide rates in Israel are also relatively low [17,18]. Thus, of all European countries investigated in the late 1980s, only England and Greece have had lower suicide rates than Israel [19]. In a report of the World Health Organization of suicide rates in 110 countries in the 1990s [20], Israel ranks in the 73rd place for males (10.5/100,000) and the 76th place for females (2.6/100,000). Lastly, in a further report of suicide rates in 25 European countries in recent years, Israel ranks in the 23rd place for males, and the 24th place for females [21]. Accordingly, suicide rates in Israel are consistently lower than those found in most countries in Europe and North America, in the range of many South and Central American countries, and higher in comparison to Muslim countries in Asia and North-Africa. In keeping with these findings, the suicide rates of Israeli Jews are mostly considerably higher than those of Israeli Arabs [10,21,22,23]. These findings

likely reflect the inclination of Judaism to negate suicide to a greater extent than Christianity, but to a lesser extant than the Islam [2,10,22].

Several factors may account for the relatively low suicide rate in Israel, in addition to the influence of Judaism [10,22]. Thus, the tendency towards secularization, likely increasing the risk of suicide, is more pronounced in Western industrialized countries than in Middle-Eastern or North African countries [24,25]. Israel is in this respect less secular than most European and North American countries. Currently, more than a half of Israeli Jewish citizens are of Middle-Eastern or North-African descent. Israelis of this descent likely tend to keep their traditional religious adherence, an inclination potentially associated with reduced suicidal risk [25]. From a different perspective, suicide rates are usually higher in industrialized compared to non-industrialized non-urban societies, reflecting greater psychosocial distress and social alienation in the former [12]. Again, Israel is in this respect in a middle-ranked position between Europe and North America on the one hand and Asia (with the exception of Japan and South Korea) and North-Africa on the other.

Suicide is recorded in Israel since its independence in 1948. The highest rates have been found in the early 1950s (around 18/100,000) decreasing to 11–14/100,000 in the 1960s and 1970s, and to rates between 8.1–8.5/100,000 in the early 1980s. It rose to values of 10.8–11.2/100,000 from the mid 1980s to the mid 1990s. From 1995–2009, the annual Israeli suicide rate has fluctuated between 6.3–9.4/100,000 [17,18,21,23,26,27]. Although the temporal changes in suicide rates in Israel may be influenced by methodological inconsistencies (e.g., the lack of systemized reliable multi-informant medical and forensic recordings before 1974 [10]), they may be nevertheless associated with several important socio-demographic processes: Firstly, the high suicide rates in the early years of Israel might be related to the highly unstable socio-political condition at that time, when the young nation was at a constant threat to its existence, likely presenting a continuous state of alert, coupled with a highly unfavorable economic condition [10,13,17]. Secondly, the increase in suicide rates in the mid 1980s to the mid 1990s may reflect the influence of the massive immigration from the former USSR and Ethiopia to Israel, as will be dealt with later in this chapter.

Thirdly, the majority of the Jewish population in the early years of Israel was of Jewish Ashkenazi, (*i.e.*, Eastern European) descent. By contrast, the immigration in the 1950–1960s brought to Israel mostly Non Ashkenazi Jews from North Africa and Middle Eastern countries, which currently comprise the majority of the Jewish Israeli population [10]. It has been repeatedly shown that Jews born in Europe may have brought to Israel the potential proneness to suicide in many of their native countries, in contrast to the low rate of suicide in

many Muslim North-African/Middle Eastern countries, whereas the heterogeneously constituted group of Israeli-born Jews stands in-between [10]. This indeed has been the condition until the mid-1980s [18]. However, since the mid-1990s, the suicide rates among Jews born in North-African/Middle Eastern countries have reached values close to those of European and American-born Jews [27]. Moreover, since 2000, the highest suicide rate is found in those Israeli-born of Non-Ashkenazi descent [27].

Israeli Jews of non-Ashkenazi descent tend to attempt suicide to a greater extent, particularly with respect to repeated attempts, in comparison to Ashkenazi Jews [10,22,28]. The higher rate of repeated suicide attempts among individuals of Asian/North African descent may reflect their tendency to express emotions and frustrations more openly, including the use of behavioral channels. Accordingly, this pattern may suggest an expression of emotional distress rather than a wish to die [29]. By contrast, guilt feelings, which are positively associated with suicide and death-related wishes, are more common in European than in Middle Eastern cultures [10].

A low suicide rate is also found in Jewish Israeli adolescents [22,27]. The average rate of suicide between 1975–1989 for 15–19 years old Israeli Jewish males (5.3/100,000) and females (1.9/100,000) has been among the lowest in the world [22]. The suicide rate for 15–17 years old for the years 1990–2008, fluctuating between 2.7–5.7/100,000 for males and 1.8–3.0/100,000 for females, is still considered low in comparison to most European countries [21]. Among other likely protective factors in addition to the influence of Judaism, a striking finding is the low rate of suicides in Israeli youth performed under the influence of alcohol and drugs [30,31]. This likely reflects the relatively low rate of substance use in Israeli adolescents in comparison to European and North American countries [32].

### *3.3. Suicide in Specific Jewish Sub-populations*

#### 3.3.1. Suicide in Male Israeli Soldiers

One striking exception to the low rate of suicide in Israeli youth, as shown in data gathered from 1975 to 1994, is the high rate of completed suicides in 18–21 years old males *vs.* both 15–17 and 21–29 years old males [22,23]. As most 18–21 year old males likely serve in the Israeli army, the high suicide rate in this age group likely reflects the considerable psychosocial stress and loss of previous social support networks associated with recruitment and service, combined with the availability of firearms [22,23]. During peace time, suicide is the leading cause of death in the Israeli Army [18]. Moreover, the suicide rate in male Israelis aged 18–21 is higher than in any other age group [27].

In addition, a significant increase in suicide rate has occurred in 18–21 years old males (but not in 15–17 and 21–29 years old males) from 1984–1985 to 1992–1994 (3.9/100,000 *vs.* 18.2/100,000, respectively). This change may reflect an increase in the overall stress associated with serving in the army following the first Palestinian uprising in 1987, as well as a greater availability of weapons during that period due to military requirements [10,23]. Indeed, a dramatic rise in the use of firearms in suicides of 18–21 year old males has been found during this time period (11% *vs.* 77% of all suicides, respectively) [22]. In the same token, a recent analysis in the US army has shown an increase in the suicide rate among 18–24 years old male soldiers from 2004–2008, surpassing comparable civilian rates in 2008 [33]. Among the factors likely associated with higher suicide risk, the authors note the trend toward greater exposure to combat events in Iraq and Afghanistan in soldiers who have later committed suicide.

A well-designed study in Israeli combat soldiers who have killed themselves during service [34] has found a highly distinctive profile of this group. Most have appeared above average in intelligence, physical fitness, and in personality measures predictive of successful adaptation to military service, with no evidence of pre-existing mental health problems, and their motivation and performance during service have been generally more than satisfactory. Their suicide has been unexpected, conceived in psychological autopsies to represent a sense of failure to live up to their expectations, appearing for the first time in their life, and leading to the development of narcissistic insult and concomitant depression [34]. These "good soldiers" have avoided the seeking of professional help, and have usually not communicated their distress and suicidal ideation to significant others [34,35]. These findings stand in sharp contrast to findings in the US army, showing significantly greater prevalence of mental health problems treated on an outpatient basis in soldiers committing suicide [33].

3.3.2. Suicide in Immigrants from the Former USSR and Ethiopia

Whereas high suicide rates have been shown for 18–21 years old Israeli males of all ethnic backgrounds, these rates have been specifically elevated in young male immigrants from the former USSR [23]. Immigration is known to be associated with an increase in suicide risk, particularly among younger immigrants [36]. Accordingly, between 2000 and 2009, a third of all suicides in Israel have occurred in immigrants, a percentage far exceeding their proportion in the Israeli population [21]. The highest suicide rate has been found in former USSR youths aged 15–24 [27]. The elevated suicide risk in young Russian-born immigrants to Israel may be related to identity crises, loss of familial and social support, severe intergenerational conflicts, social isolation, immigration-based difficulties with the Hebrew language, and a sense of

estrangement in the new country [37]. Similar differences between immigrants and Israeli-born individuals have also been shown for attempted suicide [21].

Additional support for the association of immigration with increased suicide risk comes from two Israeli studies assessing temporal trends in completed [17] and attempted [28] suicides during the 1980s and 1990s. Nachman *et al.* [17] have found an overall increase in the rate of suicide from 1987 to 1992, stabilizing thereafter to 1997. Stein *et al.* [28], examining attempted suicide in two cities in Israel (Holon and Bat Yam) have shown high rates from 1990–1992, with a steady decrease from 1993 to 1998. Both studies relate these temporal changes to the massive immigration of around 400,000 Jews from the former USSR to Israel during the late 1980s and the early 1990s. Indeed, Russian-born individuals have been found to be over-represented among suicide attempters in Holon and Bat Yam in comparison to their overall representation in these two cities [28]. Additionally, the suicide rate among Russian immigrants to Israel has been shown to be significantly higher in comparison to that of both Russian-born and Israeli-born individuals [37,38]. This is of special note, as the suicide rate in Russia is among the highest in Europe [21].

Israel has faced a massive immigration also from Ethiopia, occurring in two waves, in the early 1980s and the early 1990s. Elevated suicide and attempted suicide rates have been shown also for Ethiopian immigrants to Israel in comparison to native-born Israelis, especially in 15–24 years old Ethiopian males [21,23,27,39,40], although the findings for Ethiopian immigrants have been usually less striking in comparison to immigrants from the former USSR. Still for the years 2000–2004, young Ethiopian males have had 7.4 times higher suicide rates compared to non-immigrant Israeli Jews, and 2.8 times higher rates compared to former USSR immigrants [27]. This trend, although to a lesser extent, continues in 2007–2009 [21]. Additionally, in Ethiopian males, the average annual percentage of suicides from all suicidal acts (attempted and completed suicides) has been found considerably higher (43%) in comparison to both former USSR immigrants (21%) and native-born Israelis (17%) [27].

Lastly, in a psychological autopsy of 44 of the 49 reported suicides of immigrants from Ethiopia for the years 1983–1992, Arieli *et al.* [41] have found that the male/female suicide ratio among Ethiopian immigrants is twice higher in comparison to the general Israeli population. In addition, only two suicide methods have been used by both Ethiopian males and females—hanging and jumping from high places. The frequent use of violent methods has been replicated also in more recent suicides of Ethiopian immigrants [42]. Interestingly, violent methods are prevalent in both genders also in suicides and attempted suicides occurring in Ethiopia itself [42].

Some suggest that the high suicide risk among Ethiopian immigrants likely reflects their difficulties in adjusting to a completely new culture that does not always accept them as equals [42]. Thus, the high suicide rate of Ethiopian male immigrants may reflect the distress and sense of humiliation associated with the loss of their traditional dominant role at home following immigration in comparison to their homeland [41]. Similarly, suicide in Ethiopian women immigrating to Israel may be associated with the loss of protection from community leaders that have kept them previously safe from domestic violence [41]. Others relate the high suicide risk of Ethiopian immigrants to the difficulties in the diagnosis and management of severe psychopathology by Israeli-born professionals who are often not familiar with the Ethiopian culture [43], as well as to the reluctance of immigrants from Ethiopia to use the Israeli mental health systems [42]. Lastly, suicidal behavior in first-generation immigrants may be related to their exposure to severe traumatic experiences and loss of many family members during the immigration from Ethiopia to Israel [42].

#### 3.3.3. Other Populations of Interest

Three additional points of interest deserve attention. The first relates to the relatively high proportion of suicidal behavior in Holocaust survivors in comparison to the elderly population in Israel [44]. Aging in Holocaust survivors may be associated with reactivation of past traumatic syndromes. This reactivation, coupled with the presence of physical disturbances, some of them unique to the survivors of the concentration camps, and with an increase in psychosocial distress that may occur in any elderly population, may increase the risk of suicide in this population [10,44].

Secondly, the lowest annual suicide rate in Israel as assessed for 2007–2009 has been found among the inhabitants of the Jewish settlements in the Western Bank (3.7/100,000 *vs.* 7.4/100,000 for the general Israeli population, see [21]). A similar trend exists also for attempted suicide [21]. These findings likely reflect the sizable proportion of observant religious Jews living in the settlements, as well as the cohesion and sense of mission and entitlement found in this population, despite, or perhaps even because, of the constant threat it is exposed to [15].

Thirdly, greater religious belief and commitment, and to a lesser extent, greater religious attendance, may be associated with lower suicide rates and less tolerance toward suicide in both Christianity and Judaism [25,45,46,47]. To the best of our knowledge, this issue has not been investigated in Israel. Still, a study assessing attitudes to suicide and suicidal ideation in Jewish Israeli adolescents has shown that lesser religious affiliation is significantly associated with both greater tolerance of suicide and greater suicidal ideation [11,48].

### *3.4. Suicide in Israeli Arabs*

Lastly we address the issue of suicidal behavior among Israeli Arabs, of whom the majority are Muslims, and the rest Arab-Christians and Druze [10]. In general, Islam forbids suicidal behavior [49,50] and its attitude to suicide is more condemning than both Christianity and Judaism [51]. Indeed, suicide is considered illegal in Muslim countries [49]. Although since 1985 no Middle Eastern country has provided data on suicide to the World Health Organization [52], current suicide rates still appear lower in Muslim countries [49,52].

The finding of low suicide rates in many Muslim countries has been replicated also in Israeli Arabs [50]. Similar findings exist also with respect to attempted suicide. Whereas differences may exist between Israeli Jews and Arabs in the disclosure of information about suicide [10,50], the suicide rates of Israeli-Arabs of both genders are consistently lower for all age groups in comparison to Israeli Jews [10,21,22,23,50]. Socio-demographic factors likely reducing the suicide risk in Israeli Arabs in comparison to the Jewish majority include lower rates of urbanization, greater social and religious cohesion, a greater inclination to live in groups (extended families, tribes), and less use of alcohol [10,23,50].

It is of note that the difference in the rate of attempted suicide in Israeli Jews *vs.* Israeli Arabs has considerably decreased in recent years [21,29,50]. The highest rates of attempted suicide among Israeli-Arabs are currently found among 15–29 years old women [21,29,50], who tend to live in a highly patriarchal society where women's rights are relatively few [53]. Attempted suicide in the Arab population may represent a means to convey emotional distress, rather than a wish to die [29]. Thus, the rise in deliberate self-harm behaviors in young, likely married, Arab women in recent years may constitute one of a few means they have to convey, albeit indirectly, their distress, as well as their wish not to have to accept anymore their problematic life conditions [29,53].

Another interesting finding relates to the relatively high suicide rate among 15–24 years old Israeli-Arabs, being higher in this cohort than in any other age group [21,52]. More than a third of all suicides among Israeli Arabs in recent years occur in 15–24 years old individuals in comparison to less than 20% in the case of Israeli Jews [21,52]. This finding may reflect the ever growing stress in which young Israeli Arabs may find themselves particularly in recent years, torn between their relations with the Jewish Israeli majority that does not always accept them as equals, and their ambivalence towards their Palestinian neighbors.

A third exception to the low suicide rate among Israeli Arabs is the high rate of suicide found in young Druze males. This finding may reflect the greater exposure of Druze youngsters to the influence of the mainstream Jewish Israeli lifestyle, particularly as male Druze do serve in the Israeli army [22]. Still, the absolute numbers of completed suicides in the Druze population are too small to draw definite conclusions [10].

## 4. Concluding Remarks

Historically, Judaism presents firm negative attitudes towards suicide [4]. The impact of this religious socio-cultural construction is expressed in the low rate of suicide found in Modern Israel Jews in comparison to Christian Protestants and Catholics. An interesting support for the assumption about the importance of religious attitude in suicide comes from the authors' own study assessing attitudes to suicide and suicidal ideation in Jewish Israeli adolescents [11,48]. This study shows that lesser religious affiliation is associated with both greater tolerance of suicide and greater suicidal ideation.

Exceptions to the overall low suicide rate in Israeli Jews are the high rates of suicide found in male Israeli soldiers, new immigrants to Israel, and Holocaust survivors. Other at risk populations include young Israeli Arab women. These specific populations, necessitate early identification of distress associated with lack of adjustment to their specific circumstances, and tailoring of specialized adequate culture-sensitive interventions.



*Religions* **2012**, *3*(3), 725-738; **https://doi.org/10.3390/rel3030725**

# Suicide, Jews and Judaism by Kate Miriam Loewenthal

Introduction: Jewish law on suicide

The World Health Organisation (2017) estimates about 800 000 completed suicides worldwide, accounting for 1.4% of all deaths. Suicide was the 17th leading cause of death in 2015, and the second leading cause of death among adolescents and young adults. There are about 20 attempted suicides for every completed suicide, with incomplete suicide a strong predictor of later completed suicide. How do religious factors relate to suicide? This article will focus on the question in the Jewish community. There are approximately 14 million Jews in the world, about 5 million in Israel, 6 million in the USA, with the remainder scattered in communities in Europe, South Africa, Australasia, the former Soviet Union, and South America, and in tiny groups or in isolation elsewhere. Strictness of adherence to Jewish law varies. Jewish groups are often categorised by strictness of adherence expected or recommended by the synagogue which forms a centre of religious and social life: strictly orthodox, traditionally and modern orthodox, reform and other non-orthodox groups, non-observant and nonaffiliated. In Israel a common categorisation of religious grouping is strictly orthodox, traditional and secular. Within these very broad groups there are many sub-groups but it will not be helpful to describe them here. It is useful to bear in mind that while Jews may vary in adherence to and knowledge of Jewish religious law (Halacha) we cannot make firm predictions about adherence and knowledge from group identification. Nevertheless we can ask in this paper whether and how identification as a Jew, and as a Jew of particular degree of religiosity, might relate to suicide beliefs and behaviour. There is striking ambivalence in Jewish law about suicide, and related attitudes and behaviours.g ambiguity. On the one hand the “duty of preserving life, including ones own, is considered paramount”; saving life is valued above all else (Jacobs 1995). Suicide is regarded as a grave sin, worse than murder. Life is owned by Gd, it is not seen as a human possession. The individual does not have the right to wound his/her own body, and certainly not to take his/her own life (Bailey and Stein 1995; Schwartz and Kaplan 1992). There are serious spiritual consequences to suicide in Judaism. When an individual commits suicide, the soul has nowhere to go (Kaplan and Schoenberg 1988; Gearing and Luzardi 2009). It cannot return to the body, nor can it enter any afterlife. It

has lost opportunities to correct wrongdoings by actions in the physical world. However in Jewish law suicide is not a punishable crime, and is legal in Israel. By contrast, following Shariah (Islamic law) which is also negative about suicide, suicide is illegal in many Muslim countries. In Jewish religious law, the physician has permission to heal, but not to shorten or terminate life. In the case of a terminal illness, regular healing procedures must be maintained. Rabbinic advice must be sought in cases of uncertainty, for example whether it is obligatory to introduce "heroic measures" such as resuscitation or intubation if the illness is terminal (Loewenthal 2016). On the other hand, in periods of religious persecution, suicide may be seen as meritorious: Kiddush HaShem: lit “Sanctification of the name (of G-d)”: dying to prevent transgression (Shulchan Aruch Yoreh Deah, a). In times of religious persecution it is ruled to be meritorious to kill oneself or allowed oneself to be killed rather than transgress Jewish law. A Jew should also choose death rather than commit (in public) murder, idolatry or adultery.

The best-known example of this is an account by the historian Josephus of the mass suicide of nearly 1000 Jewish defenders of the fort of Masada by the Dead Sea, against Roman invasion (Schwartz and Kaplan 1992). The archaeological evidence for this is said to be controversial, but the heroism of the mass suicide continues to be held up as inspirational. There are therefore two contrasting positions in Judaism regarding the moral and spiritual status of suicide.

Suicide rates

Jewish communities have been reported to have low suicide rates. Early reports included Dubin (1963), and Miller (1976). More recently, suicide rates in Israel were still reported lower than those of other countries, including America (Levav and Aisenberg 1989; Maris et al 2000; Gearing and Lizardi 2009). Kohn et al (1997) among others have concluded that suicide rates amongst both youth and adults in Israel are amongst the lowest in the world. For example in 2015 the suicide rate in Israel was 9.9 per 100,000, compared to 12.6 in the USA and 11.9 in Europe (WHO ). Suicide rates among young adult male Jewish Israelis climbed in the 1980s (Bursztein and Apter 2009), but rates broadly stabilised in 1990s, and with some fluctuation, overall Jewish suicide rates in Israel generally continued low compared to those in other countries. Comparative studies suggest that suicide rates are generally lower amongst Jews than the general population in predominantly Protestant communities (Danto and Danto 1983; Goss and Reed 1971; Levav et al. 1988; Williams 1997). Other countries with suicide rates lower than the Israeli rate include most Muslim countries. But, comparisons with Muslim countries and communities are more difficult. In many Muslim countries (e.g. Pakistan, UAE, Lebanon, Syria) suicide attempts are illegal, and punishable by imprisonment or other

penalties. This might be the reason for the low suicide rate in these countries (WHO 2017). Also, there is likely to be under-reporting of suicide. In these countries the ratio of male to female suicides (2:1 or less) is generally much lower than in most other countries - including Israel, where the rate of nearly 4:1 male:female is comparable with that in most other countries (Lubin et al 2001; WHO 2017). In Israel, the suicide rate among Muslims is lower than that among Jews, and this is not an effect of Israeli law, which allows suicide, but is likely to be an effect of a strong cultural-religious veto against committing and indeed acknowledging suicide. This effect may also exist in the Jewish community, but the veto may be less strong than among Muslims. There are some in the Jewish community who favour openness on the issue (Kremer 2015). Bursztein and Apter (2009) remind us that suicide may not necessarily be defined similarly between countries, coroners and doctors. For example in Israel, death of a cancer patient who kills themselves will be recorded as caused by cancer, and many causes of death such as suffocation or falling from a height, are classified as undetermined causes. Some countries (e.g. Antigua, Nepal, Haiti) with very low or zero suicide rates on record may be inadequately resourced for keeping records of causes of death. Such factors must be born in mind when comparing suicide rates between countries. Similarly demographers vary in definition of the term "Jew" - for example self-definition, definition by synagogue or other organisational membership, or surname. This is another factor which may be considered in estimates of Jewish suicide rates.

Suicide and self-harm: precursors and risk factors

A small amount of research has examined cultural-religious differences in beliefs about suicide (Ellis et al 1991., Kamal and Loewenthal 2002, Loewenthal et al 2003) The Reasons For Living Inventory (RFLI) (Linehan et al 1983) has generally been employed, together with some other measures such suicide ideation. The RFLI has been found to predict lesser suicidal ideation and fewer reported suicide attempts (Bakhiyi et al 2017; Laglaoui et al 2017). Only one of these studies on suicide beliefs included Jews (Loewenthal et al 2003). This limited evidence suggests that Jewish beliefs about suicide may reflect the generally low suicide rates reported among Jews: high scores on the Reasons for Living Inventory (RFLI), especially on moral and religious objections to suicide; Jews also thought suicide less acceptable under certain circumstances, for example incurable disease, than did those of Protestant background.

What is known about the sociodemographic correlates and precursors of suicide among Jews? In Israel, overall suiciderates have fluctuated but are relatively low. However rates higher among Jews than among Arabs especially Muslim Arabs: here rates may appear to be low due to under-reporting. Israel is the only country in the Middle East that reports suicide

figures to the WHO, so comparisons between rates for Jews in Israel and Arabs outside Israel cannot be made reliably.

Among Jews in Israel, the high risk groups (Bursztein and Apter 2009) are - young men in the army. Israel exercises compulsory conscription for both men and women, though Arabs are not liable for conscription. Israel is a relatively tiny country with a population of about 8 million , surrounded by hostile countries - Israel's immediate neighbours are Egypt, Jordan, Lebanon and Syria, all hostile Arab countries, with populations totalling about 129 million (http://worldpopulationreview.com/countries 2017). They are normatively set on the destruction of Israel, and military attacks on Israel are frequent. Young Israeli men face a high likelihood of severe combat stress. Other countries in the west often do not practice conscription and may not be so often in a state of conflict. Comparisons with young men from countries with lower exposure to combat could be of interest. - Immigrant groups in Israel, particularly Ethiopians and those from the former Soviet Union. Immigration is known to be a source of significant stress: economic hardship, family separation, cultural adaptation, loss of status in the community and/or in professional practice. Suicide risk may be affected by the cultural background of the two high-risk immigrant groups, in whose countries of origin Jewish norms are not generally religious, and reasons for living may not be as compelling as in mainstream Jewish or orthodox communities elsewhere. - the elderly: recognised stress factors among the elderly include loss of social support, loss of occupation, loss of status, failing health and poor mobility. A particular factor in Israel can be the resurgence and rise in post-traumatic stress symptoms in holocaust survivors following retirement. - depression may not be risk factor for suicide and self-harm thoughts and behaviours for Jews (Wilchek-Aviad and Malka 2016): in other groups of people suicide risk is greater among those suffering from mental illnesses, with depression carrying the highest risks of suicide. This section should include at least a brief allusion to the effects of anti-semitism, for example and notoriously during the holocaust period (1933-1945): there have unfortunately been many other times and places in which severe Jewish persecution has occurred. Larson (2011) evokes the early years of the holocaust period in Germany. With the massive increase in Jewish suicide as anti-semitic persecution increased in virulence and intensity many individuals lost all hope of anything to cling to. Larson cites a report that in 1932-4 the suicide rate in Berlin was a massive 70.2 per 100,000. This likely became much higher as persecution and deportation increased, but conditions became impossible for keeping records. Some Jews determined not to kill themselves: Frankl (1986) suggested the importance of feeling purpose in life, enabling some individuals to refrain from suicide when deported to concentration camps. Religiosity may be a protective factor against suicide and some work suggest that this may be the case among Jews. A recent study in Israel compared the strictly (ultra-orthodox) and orthodox with

non-practicing Israelis and found that suicide and self-harm thoughts and behaviours in the non-practising groups to be twice the rate in the religious groups (Amit et al 2014). Another study (Wilchek-Aviad and Malka 2016) however found that although the religious were less depressed than the secular, there were no differences in suicide rates between the two groups. A media report (Kremer 2015) suggested high rates of suicide among those leaving the more religious sectors of Jewish society, particularly perhaps when substance is involved both as a causal factor in defection, and an effect. Therefore the effects of religiosity is unclear and further research would be useful.

Post-suicide

According to strict Jewish ruling, individuals who commit suicide may not receive traditional post-death rituals such as a proper burial (Kaplan and Schoenberg 1988), although in current times this is not strictly applied. The current rabbinic view allows burial in a regular Jewish cemetery, on the grounds that a person would only kill themselves when the mind is disturbed, and therefore could not have committed suicide deliberately. Therefore in the current period and in the cultures in which Jews live, suicide is the result of a disturbed mind therefore not regarded as halachically culpable. As mentioned, in the past a person who committed suicide was said to be buried in a separate part of the cemetery; relatives did not sit shiva (Shulchan Aruch Yoreh Deah). Shiva is a 7-day period in which close relatives wear torn clothes, sit on low seats, and receive consolatory visits. In current times, shiva is normally observed by relatives following a suicide. It is worth noting that in modern Israel, suicide is legal - euthanasia and physician assisted death are not; however suicide in the context of terminal illness such as cancer is recorded as death due to the illness. Cases of possible suicide may be described in the community as death due to illness, not suicide; this may spare relatives' additional pain. Suicide does cast many extra burdens on family and friends, in addition to the burdens already born by the bereaved. Grief and mourning are complicated by feelings such as horror in envisaging the suicidal state of mind, anger at the circumstances that provoked this disturbance, frustration and perhaps self-blame that the desperation was not shared and that something might have done to prevent the suicide. These burdens are not unique to Judaism. What may be unique is the shiva, which is often suggested to be helpful for the mourning process, but which may be complicated by the shadow cast by knowledge of the stigma placed (by Jewish law and custom) on suicide in the past, and which may still remain.

Jewish prevention services

A study reported in 2004 (Loewenthal & Brooke-Rogers) examined the psychological support services provided by some of many culturally and religiously-appropriate Jewish support groups and helplines. These directly or indirectly address suicide. The Jewish community is

well provided with such services. Many of the members of the Jewish public who were interviewed had not heard of or were poorly informed about many of these services, but where they had been used, reports were generally positive and their cultural and religious sensitivity was appreciated. There were said to be several ways in which the services could be improved: organisations need to be vigilant over confidentiality, to improve the dissemination of information, particularly among statutory sector professionals who deal with the community, and improve the reliability of funding. Work is needed demonstrating that the Jewish support groups and helplines are meeting demonstrable needs effectively. A recent press report on the UK Jewish helpline Miyad (Galbinski 2014) said that about 2,000 calls a year are received. There are about 60 trained volunteers. Miyad's work corresponds to the work of Samaritans, but it is culture-specific. Angela Kamiel, Jewish Helpline's vice-chairman said "We're a Jewish helpline, so there's a context their story fits into that we understand. We understand the issues people are dealing with; there's a lot that doesn't need to be explained... Indeed, the charity takes its Jewish principles a step further. "We're not a religious organisation, but we are bound by halachic principles and we try to preserve life...We would try to get a suicidal person through until tomorrow, to stay with us step by step."

Psychotherapy in its early years was predominantly practiced by Jews. There was however some hostility from some strictly orthodox: for example Freud and his cohorts were described as charlatans by one orthodox rabbi (see Loewenthal, 2007). Nevertheless in recent years Jewish communities of all degrees of religiosity have developed counselling and support services that are seen to be culturally and religiously appropriate. Nowadays it is possible to find a Jewish psychotherapist - even a strictly religious Jewish therapist if wished: clients fear that otherwise their religious behaviour and feelings may be misunderstood and misinterpreted as sign of mental illness, and it has been reported that Jewish clients feel better understood by a Jewish therapist. However they prefer anonymity and prefer to choose a therapist from outside their own social circle (Loewenthal and Brooke-Rogers 2004) Many - indeed most or all - forms of psychotherapy may reduce the risk of suicide, though suicide measures are not always included in studies of effectiveness. Most of the original practitioners of psychotherapy were Jewish: when young I remember being told by my head of department that a psychotherapist is a Jewish doctor who can't stand the sight of blood.

Recent examples which have demonstrated the effectiveness of psychotherapy in suicide prevention include the following studies of people at very high risk of suicide: deliberate self-harmers, and people with medication-resistant psychosis - these studies did not explicitly involve Jews but are cited as examples of some of the forms of therapy likely to be adopted by Jewish support services: Erlangsen et al (2015) in a large Danish study examined people who had deliberately self-harmed. They followed them up over 20 years. 5,768 recipients of

psychosocial therapy were compared with 17,034 people who did not receive therapy. There was a lower risk of repeated deliberate self-harm and general mortality in recipients of psychosocial therapy after short-term and long-term follow-up, and a protective effect for suicide after long-term follow-up. Avatar therapy is specifically for those with medication-resistant psychosis (Leff et al, 2013). Using specific software, patients with medication-resistant Sz designed faces to match the voices they hear. With therapeutic support, patients converse with the voice(s) and convert them to become supportive. In some cases the voices disappear altogether. Apart from the effects on voices, this therapy improves mood, and diminishes suicide risk.

Conclusion

Jewish law and custom and social attitudes generally converge on maintaining the tradition of placing a massive positive value on human life and its sanctity. There is a little empirical work to support the impact of these values on actual beliefs held by Jews. Although there is a tradition which may allow suicide under specific circumstances, particularly when religious observance is threatened, the weight of Jewish tradition does not condone suicide. This may account for systematic effect observed since records began to be kept, that Jewish suicide rates are low compared to other religions and cultures. There is very limited work on the question whether, within the Jewish community, suicide rates are lower among the more religious. As well as religiosity, other possible risk factors are reviewed. The Jewish community offers a range of support services for those at risk of suicide, and the Jewish community has also been a source of therapies and other services available outside the community.

https://www.preprints.org/manuscript/201712.0020/v1

Loewenthal, K.M. Suicide, Jews and Judaism. Preprints 2017, 2017120020. https://doi.org/10.20944/preprints201712.0020.v1