

# Quantitative Research on Individual and Communal Perspectives on Suicide in the Hasidic Community of Borough Park: Risk Factors, Protective Factors, and Resources

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## Research Article

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# Abstract

The Hasidic community of Borough Park is a distinct religious subpopulation in the United States whose relationship to suicide has never been examined empirically. This study is the first to explore the socio-religious factors, predictors, and resources related to suicide within the community. Using a cross-sectional design, a researcher-created survey administered in English and Yiddish gathered responses from 150 participants (52% male, 47% female; ages 18 to 78, mean 33), analyzed in STATA BE with chi-square tests, t-tests, and binary and ordinal regressions across 21 hypotheses derived from three research questions and the predictors age, sex, affiliation, residence, and self-identification. Findings indicate that the same social and religious elements of the community are perceived as protective by some members and as risk factors by others, depending on the element itself and on the participant's position within the community, a dynamic of conditional protection. The findings also point to a substantial gap in available resources for suicide prevention, intervention, and postvention. Because insular religious and cultural communities with distinct socio-religious norms exist worldwide, and because prevention cannot address culturally specific risk without research that examines such communities on their own terms, this study offers a framework for understanding how social norms, religious belief and practice, and attitudes toward mental health inform a community's understanding of suicide, and for building the culturally responsive clinical practice these populations require.

## Introduction

Suicide is a global public health concern. Each year, approximately 727,000 people die by suicide worldwide, and the burden falls unevenly across populations and settings (World Health Organization [WHO], 2025). Social workers are the largest group of mental health service providers in the United States, numbering more than 200,000 clinically trained practitioners, more than psychiatrists, psychologists, and psychiatric nurses combined, and they are among the professionals most likely to encounter individuals at risk of suicide (Substance Abuse and Mental Health Services Administration [SAMHSA], n.d.). Yet the profession's empirical foundation for this work is thin. In the first comprehensive review of social work's contribution to the suicide literature, Joe and Niedermeier (2008) found that social work researchers had produced limited evidence-based knowledge on the treatment or prevention of suicide over more than two decades. Maple et al. (2017) reached the same conclusion, and Petrakis and Joubert (2013) noted a comparable absence of literature evaluating clinical social work contributions to prevention. The consequence is a workforce that will meet suicidal clients without an adequate evidence base to guide its practice (Jackson, 2019).

This gap is not evenly distributed, and unique and insular populations are the least studied of all. Ortiz and Jani (2010) argue that the methods, theories, and techniques of social work education rest on the assumptions of the dominant culture and, left unexamined, apply poorly to non-Euro-American populations. The pattern has been documented in specific communities: Reed et al. (2021) found that suicide among African Americans has risen while social work research has not kept pace, and Maple et al. (2017) documented the near-total neglect of Indigenous and rural populations despite persistently

high rates. These communities differ from one another, and from the community studied here, in every particular of history and circumstance. The parallel is not one of shared experience but of shared invisibility in the research record, and each population must be studied on its own terms.

## **Religion and Suicide**

The relationship between religion and suicide is one of the oldest questions in the field, and what is known of it begins with Durkheim (1951), who found that Jews historically had among the lowest suicide rates of any group and located the reason not in doctrine but in belonging. Religion protects, he argued, because it is a society, one that binds its members to one another. A century of research has complicated that account without overturning it. Reexamining religious affiliation through network theory, Pescosolido and Georgianna (1989) confirmed that religion continues to shape suicide rates, that Judaism remains protective though unevenly, and that protection is not intrinsic to religion itself, since some traditions confer none.

What has grown clear is that religion moves in two directions at once. On one side it guards against suicide: moral and religious objection is independently associated with lower risk (Gearing & Lizardi, 2009), a sense of meaning in life runs counter to suicidal tendency (Wilchek-Aviad & Malka, 2016), and, in the first study of its kind, religiosity predicted fewer self-injurious thoughts and behaviors among Jewish adolescents (Amit et al., 2014). On the other side, the same religious life can wound. Congregational criticism and negative religious coping forecast poorer mental health outcomes (Sternthal et al., 2010), and an affiliation that draws one person into a network of support can, for another, become the source of isolation, depending entirely on context (Lawrence et al., 2016).

For all its reach, this literature shares a blind spot. It tends to treat religion in the aggregate, rarely distinguishing among the subgroups within a faith and seldom reaching its most intensely observant members (Pescosolido & Georgianna, 1989; Tettey, 2014). The Hasidic community has not been examined at all. The result is a striking inversion: the population whose daily life is most fully ordered by religion is the one about which the least is known.

## **The Hasidic Community of Borough Park**

Hasidism is an eighteenth-century movement that, after near-destruction in the Holocaust, was rebuilt by surviving Rebbes (the hereditary spiritual leaders of Hasidic courts) and their followers and has grown to roughly 750,000 adherents worldwide, expanding at a high rate (Biale et al., 2020). Borough Park, a section of Brooklyn, New York, is one of a small number of neighborhoods in which the American Hasidic population is concentrated (Comenetz, 2006). Its 97,340 residents are majority Orthodox and Haredi (NYC Department of Small Business Services [NYC SBS], n.d.), and Jewish households account for roughly 101,000 people (NYC SBS, n.d.; UJA-Federation of New York, 2024). The community is strikingly young: about half of its residents are nineteen or younger, more than double the citywide share, reflecting the high birth rate that drives its rapid growth (NYC SBS, n.d.; UJA-Federation of New York, 2024). Yiddish is the predominant language, spoken at home by most residents who use a language

other than English (NYC SBS, n.d.); Yiddish spoken at home is, in fact, a standard demographic marker used to estimate the American Hasidic population, which clusters in a small number of New York neighborhoods (Comenetz, 2006). Markers of insularity appear in everyday life, including rates of home broadband well below the citywide figure (NYC SBS, n.d.).

Borough Park is well suited to a first study of this kind for a reason internal to the community: its heterogeneity. Unlike more homogeneous enclaves such as New Square or Kiryas Joel, it houses many Hasidic groups, among them Hungarian, Galitzianer, Polish, and Russian, living side by side, distinct in synagogue and custom yet sharing the same streets, groceries, and ritual baths. A community this varied allows a single study to speak to the broader Hasidic world and, beyond it, to the wider class of insular religious communities: the Haredi and Orthodox Jewish world and comparable faith communities worldwide, whose members clinicians encounter without research to guide them. Cultural competence requires more than sensitivity to difference; it requires a substantive understanding of how a community's social and religious structures shape the experiences, behaviors, and help-seeking of its members (Ortiz & Jani, 2010). For this community, that understanding does not yet exist. No empirical study has examined suicide within the Hasidic community of Borough Park, or within any Hasidic community, in any location.

## **The Present Study**

The present study uses a cross-sectional design and a researcher-created survey administered in English and Yiddish to examine how community members' perceptions of risk factors, protective factors, and resources related to suicide vary across five participant characteristics: age, sex, affiliation, residence, and self-identification. In examining one community closely, it also asks a question that reaches beyond it: whether an insular community's social and religious structures are experienced uniformly by its members, or conditionally, according to each member's position within it. Any language or terminology used to describe the Hasidic community is intended strictly to provide context and understanding of its uniqueness, not to condone, condemn, or judge it.

## **Research Questions and Hypotheses**

The study was guided by three research questions, each examining how community members' perceptions of a domain, risk factors, protective factors, or resources, vary according to participant characteristics. Each research question comprises sub-questions organized by characteristic, from which a total of 21 hypotheses were derived. The research questions and sub-questions are stated below; the full set of hypotheses, with their corresponding variables, levels of measurement, and analyses, is presented in Table 1.

### **Research Question 1: How do perceptions of risk factors for suicide in the Hasidic community of Borough Park vary according to participant characteristics?**

1a. According to participant age?

1b. According to participant sex?

1c. According to participant affiliation?

1d. According to participant relationship to individuals who have attempted or died by suicide?

**Research Question 2: How do perceptions of protective factors for suicide in the Hasidic community of Borough Park vary according to participant characteristics?**

2a. According to participant age?

2b. According to participant affiliation?

2c. According to participant residence?

2d. According to participant profession?

**Research Question 3: How do perceptions of resources for suicide prevention, intervention, and postvention in the Hasidic community of Borough Park vary according to participant characteristics?**

3a. According to participant age?

3b. According to participant sex?

## **Method**

### **Design**

This study employed a cross-sectional design to examine how perceptions of factors related to suicide vary within the Hasidic community of Borough Park across five participant characteristics: age, sex, affiliation, residence, and self-identification. It reports the quantitative findings of a larger mixed-methods investigation whose qualitative findings are reported in full separately; those qualitative findings are drawn on in the Discussion, where noted, only to interpret the quantitative results. As the first empirical study of suicide in this population, the work is exploratory, intended to establish baseline relationships rather than to test a causal model.

### **Participants and Recruitment**

Participants were recruited through purposive sampling from the researcher's contacts and, from there, through snowball sampling, as recipients were invited to forward the survey to others. Solicitations were distributed by WhatsApp, Facebook, Facebook Messenger, text message, and email, and consisted of a brief description of the study, an assurance of anonymity and confidentiality, and links to the English and Yiddish versions of the survey; a single follow-up solicitation was sent two weeks later. Participants were selected on the basis of their affiliation, residence, and self-identification. A total of 150 individuals completed the survey. Two respondents who did not report their sex were excluded from the

multivariable models, which were therefore estimated on 148 participants. An a priori power analysis, specifying an alpha of .05, an anticipated effect size ( $f^2$ ) of .35, and power of .80 across the predictor variables, indicated a required sample of 100; the achieved sample exceeded that threshold. Participant demographics are reported in the Results.

## **Instrument and Measures**

Data were collected through an anonymous online survey built in Google Forms, with a mailed paper version available on request. The survey was offered in English and Yiddish. The Yiddish version was produced by an independent, paid translator, reviewed and edited by a third-party volunteer, and checked once more by the researcher, who is fluent in both languages, so that meaning was preserved across the two versions. The survey combined continuous items (age), dichotomous and nominal items (for example, sex and yes-or-no questions), and ordinal items measured on a five-point Likert scale. The five predictor variables were age, sex, affiliation, residence, and self-identification.

The study operationalized three domains. Risk factors were defined as any factors that increase the risk of suicide, whether direct, such as a previous suicide attempt, or indirect, such as communal alienation that gives rise to depression, isolation, and loneliness. Protective factors were defined as any factors that decrease the risk of suicide, whether direct, such as suicide prevention services, or indirect, such as cultural and religious belief. Resources were defined as the useful information on suicide available to the community, spanning prevention, intervention, and postvention.

## **Procedure and Ethical Considerations**

Participants provided consent by voluntarily opening the survey link, completing the questionnaire, and submitting it. Responses were anonymous, and no identifying information was collected. Completed responses were exported from Google Forms to Excel and assembled into a single dataset for analysis. The study received an exemption from WCG IRB under 45 CFR § 46.104(d)(2) (August 30, 2021).

## **Data Analysis**

The dataset was analyzed in STATA BE. Data were first cleaned, and a missing-data analysis confirmed no missing values. Participant demographics were summarized using descriptive statistics, and the relationships between the predictor and dependent variables were examined using inferential statistics, including Pearson correlation, chi-square tests, independent-samples t-tests, and binary and ordinal logistic regression. Each regression model included the five participant characteristics together, so that the influence of any one could be assessed while controlling for the others. The Pearson correlations, chi-square tests, and t-tests provided unadjusted bivariate comparisons, whereas the logistic regressions served as the primary, adjusted tests, and the two converged. Because the ordinal outcomes were five-point scales, they were treated as interval for the bivariate comparisons, a common convention, and the ordinal regressions, which make no such assumption, corroborated those results. In total, 21

hypotheses, derived from the three research questions and their sub-questions, were tested and are presented with their outcomes in the Results.

## Results

### Descriptive Statistics

The sample comprised 150 participants: 78 men (52.0%), 70 women (46.7%), and 2 who preferred not to report their sex (1.3%). Ages ranged from 18 to 78, with a mean of 33 (SD = 11.29); older community members were less likely to respond, and those who chose the Yiddish survey were older, on average, than those who chose the English one. By affiliation, 83 participants identified as currently Hasidic, 29 as formerly Hasidic, and 38 as never Hasidic; by residence, 42 currently lived in Borough Park, 65 had lived there formerly, and 43 never had. Participants could select more than one self-identification, so the percentages below sum to more than 100. The largest group, 65 of the 150 participants (43.3%), identified as a family member or friend of someone who had attempted or died by suicide, followed by “none of the above” (41.3%), mental health professionals (16.0%), askanim (community activists; 4.7%), and rabbis and community leaders (2.7% each). No Rebbe or Admorim (the community’s most senior spiritual leaders) participated. Full descriptive statistics, along with the odds ratios, confidence intervals, and model fit statistics for every regression, appear in the accompanying tables.

### Risk Factors (Research Question 1)

Perceptions of risk varied with age, sex, affiliation, and self-identification; residence showed no significant associations. Age was weakly but significantly related to viewing religion as a risk factor ( $r = -.202$ ,  $p = .013$ ): older participants were less likely to agree that religion increases the risk of suicide, an association that held when the other characteristics were controlled (OR = 0.97,  $p = .042$ ). By sex, women were less likely than men to regard suicide as prevalent in the community (OR = 0.51,  $p = .039$ ), while women were more likely than men to name those with mental illness as the group that suffers the most isolation and loneliness ( $\chi^2 = 4.07$ ,  $p = .044$ ).

Affiliation carried some of the strongest associations. Formerly and never Hasidic participants were more likely than currently Hasidic participants to describe the community as bounded and separate from its neighbors ( $\chi^2 = 8.99$ ,  $p = .011$ ) and less likely to describe it as diverse ( $\chi^2 = 17.08$ ,  $p < .001$ ; OR = 0.31 and 0.30). Formerly Hasidic participants were more likely to regard suicide as prevalent ( $t = -2.99$ ,  $p = .003$ ; OR = 2.62,  $p = .032$ ) and to agree that religion increases risk (OR = 2.38,  $p = .039$ ). The sharpest pattern belonged to self-identification. Participants who were family members or friends of someone who had attempted or died by suicide were markedly more likely to regard suicide as prevalent ( $t = -5.36$ ,  $p < .001$ ; OR = 6.57,  $p < .001$ ), to agree that religion increases risk ( $t = -3.71$ ,  $p < .001$ ; OR = 2.33,  $p = .008$ ), and to affirm that sexual abuse exists within the community (OR = 3.37,  $p = .003$ ).

### Protective Factors (Research Question 2)

Perceptions of protection also varied with age, sex, affiliation, and self-identification. Older participants were more likely to see the community as offering support and care to those struggling with thoughts of suicide (OR = 1.05,  $p = .043$ ) and to name the Tisch (a Rebbe's communal gathering) as protective (OR = 1.03,  $p = .046$ ). A pronounced sex difference ran through these findings: women were far less likely than men to identify the synagogue as a protective setting ( $\chi^2 = 17.93$ ,  $p < .001$ ; OR = 0.19,  $p < .001$ ) and less likely to see the community as offering support and care (OR = 0.15,  $p = .003$ ). In bivariate comparison, formerly Hasidic participants were less likely than currently Hasidic participants to count social activities as protective ( $t = 2.53$ ,  $p = .012$ ), a difference that did not persist once the other participant characteristics were controlled; they were also less likely to regard the synagogue as protective (OR = 0.23,  $p = .006$ ). Once again self-identification marked the clearest divide: participants connected to someone who had attempted or died by suicide were more likely to report that religion does not help prevent suicide ( $t = 3.26$ ,  $p = .001$ ; OR = 0.43,  $p = .008$ ) and that the community does not offer support and care ( $\chi^2 = 5.46$ ,  $p = .019$ ; OR = 0.24,  $p = .018$ ). Figure 1 presents these self-identification effects across outcomes.

## Resources (Research Question 3)

Most participants regarded the community's resources as inadequate: 100 of the 150 (66.7%) disagreed or strongly disagreed that the community holds sufficient resources for suicide prevention, intervention, and postvention, and only 14 (9.3%) agreed ( $M = 2.12$ ,  $SD = 1.11$ ). No hypothesis concerning resources, however, reached significance: neither residence nor any other participant characteristic was associated with these perceptions. The question of resources thus returned a group-level null against a backdrop of broad agreement, a finding whose meaning the Discussion takes up directly.

## Additional Associations

Beyond the three research questions, a few associations among the characteristics themselves are worth noting. Older participants were more likely to identify as Hasidic (OR = 1.04,  $p = .033$ ), and formerly Hasidic participants were more likely than others to identify as a family member or friend of someone who had attempted or died by suicide (OR = 2.61,  $p = .045$ ).

## Discussion

Across risk and protective factors alike, the same finding recurs: the community's social and religious structures are not perceived to bear on suicide in a single direction. Whether a given structure is seen as protective or as hazardous depends on the factor itself and on where the participant stands in relation to the community. The synagogue, communal gatherings such as the Tisch, and the sense that the community offers care were named as protections by some participants and withheld by others, and religion itself was associated with lower perceived risk for some and higher perceived risk for others. Participants named both faces of that duality directly, describing religion as a source of togetherness and belonging and, through strict rules and the shaming of those who differ, a source of harm (Author, 2022). This is the study's central contribution, and it complicates a literature that has long treated

religious affiliation as broadly protective (Durkheim, 1951; Pescosolido & Georgianna, 1989). The present findings align more closely with Lawrence et al. (2016): an affiliation that draws one member into a network of support can, for another, become a source of isolation. In this community, that difference is patterned rather than random.

## **The Conditionality of Protection**

The patterns fall along lines of sex and affiliation. Women were markedly less likely than men to regard the synagogue as protective or to see the community as offering support and care, a difference consistent with a communal life in which the most visible protective settings, daily prayer and public gathering, are more available to men. Formerly Hasidic participants, in turn, were less likely to count social activities or the synagogue as protective and more likely to regard religion as a risk and the community as bounded rather than diverse. The qualitative interviews describe the same divide from the inside: participants portrayed the community's closeness as reserved for those who adhere to its rules, doubted whether that care reached those struggling with mental illness or those who had left, and described the social and religious life of the synagogue as belonging chiefly to men (Author, 2022). Read together, these results suggest that the community's protection is conditional: it extends most fully to those who occupy its center and recedes for those at its margins. For a member positioned outside that center, whether by sex, by conformity, or by having left, the same structures that shelter others may not reach, or may themselves become a burden.

## **Proximity to Suicide**

The clearest divide in the data belonged to participants who identified as a family member or friend of someone who had attempted or died by suicide. They were more likely than others to see suicide as prevalent, to regard religion as increasing risk, to affirm that sexual abuse exists in the community, and to report that the community neither protects through religion nor offers support and care. These are the participants with the most direct experience of suicide in the community. Their divergence most likely reflects that proximity rather than a distinct disposition, and it identifies precisely the population the field is now urged to reach: those affected by suicidal behavior and by loss. That this group emerged as the study's sharpest signal underscores how far the community's response to suicide is felt at the level of family and relationship.

## **The Question of Resources**

No participant characteristic predicted perceptions of whether the community holds sufficient resources for prevention, intervention, or postvention. A null result of this kind is easy to misread. It does not indicate that resources are adequate; on the contrary, two-thirds of participants judged them insufficient. The absence of group differences is most consistent with a perception held broadly across the community, leaving little variation for the predictors to explain. The qualitative strand of this study clarifies why that perception is so widely shared: participants described suicide as a hidden and largely unspoken subject, and some questioned whether resources were needed for a problem the community

does not openly acknowledge (Author, 2022). The quantitative null and the concealment described in those interviews point to the same mechanism: a community that does not name the problem does not build the resources to meet it. The finding is best understood, then, not as the absence of a problem but as the near-absence of disagreement about one.

## Implications for Practice, Policy, and Research

For clinical social work, the central implication follows from the conditionality of protection. A practitioner cannot assume that a Hasidic client's community is, for that client, a source of safety. The same synagogue, the same communal bonds, and the same religious framework may protect one client and burden another, and the difference turns on the client's sex, standing, and proximity to loss. Culturally competent practice with this population therefore requires more than familiarity with its customs; it requires assessing where a particular client stands within the community's structures before deciding whether those structures can be enlisted in care (Ortiz & Jani, 2010). At the level of policy, the perceived scarcity of suicide-specific, culturally grounded resources points to a need for services built with the community rather than imported into it, including materials in Yiddish and the endorsement of trusted communal figures (Author, 2022). And because insular religious communities with comparable structures exist worldwide, the framework offered here, in which protection is conditional on one's position within a bounded community, provides a starting point for research and practice in settings well beyond Borough Park.

## Limitations

Several limitations follow from the nature of the study and the population it examined, and each was anticipated in its design. The sample was recruited through purposive and snowball methods rather than probability sampling, because a closed and insular community of this kind cannot be reached through conventional means, and a first study must map the terrain before representative sampling becomes possible. The sample was therefore self-selected and skewed younger than the community as a whole; older members were less likely to respond, and no Rebbe's or Admorim and few communal leaders took part. The findings accordingly describe associations within this sample rather than rates or proportions that generalize to the community at large, and they are reported in those terms throughout.

The survey was created for this study rather than adapted from a validated instrument, and most constructs were measured with single items, so no reliability or validity statistics are reported. This reflects the state of the field more than a preference: no validated instrument for suicide in this population existed, nor could one, before a study of this kind had been conducted. The bilingual design added a measure of rigor, in that the English and Yiddish versions were reconciled through an independent translator, a community reviewer, and the researcher; still, the development and validation of community-specific scales remains essential work for the studies that follow. Sex, moreover, was recorded as a binary category and gender identity was not assessed, a distinction future instruments should capture, particularly given the salience of identity in this community.

The analysis carries the cautions proper to exploratory work. Twenty-one hypotheses were tested without correction for multiple comparisons, so individual results are best read as directions for confirmation rather than as settled conclusions; the strongest associations, those significant at  $p < .001$ , withstand correction and anchor the findings most securely. The a priori power analysis was framed in terms suited to linear rather than logistic models and assumed a large effect, and although the achieved sample exceeded its target, several subgroup models remain underpowered, yielding odds ratios that fall within wide confidence intervals and are best read as directional. The cross-sectional design, finally, establishes association rather than causation and cannot speak to how these perceptions arise or change over time. These are the expected costs of first-of-its-kind research, and together they set the agenda for the confirmatory studies that should follow.

## Conclusion

Culturally responsive suicide prevention must contend with a fact this study makes visible: within a bounded community, the same social and religious structures do not carry the same meaning for every member. What shelters those at the center can, for those at its margins, recede from reach or become a burden, and which it is depends less on the structure itself than on the member's position within the community, along lines of sex, conformity, and proximity to loss. This study names that pattern conditional protection, and the Hasidic community of Borough Park is the first population in which it has been examined. A second finding carries comparable weight: where a community does not openly name suicide, it does not build the resources to meet it, and that scarcity registers as broad agreement among its members rather than as dispute.

For clinical social work, the implication is exact. Cultural competence with an insular community requires more than familiarity with its customs; it requires locating a particular client within the community's structures before deciding whether those structures can be enlisted in that client's care. And because insular religious and cultural communities, bounded, self-governing, and ordered by shared belief, exist throughout the world and remain among the least studied populations in the suicide literature, the framework advanced here extends well beyond a single neighborhood. Each year roughly 727,000 people die by suicide, many of them in communities that population-level approaches struggle to reach. Conditional protection offers a way to study such communities on their own terms, and offers prevention a way to attend not only to who a person is but to where that person stands within the community that shapes them.

## Declarations

## Author Contribution

D.H. conceived and designed the study, developed the survey instrument, and collected the data. D.H. and S.P. designed the analytic strategy, selected the regression models, and conducted the statistical

analyses in STATA. D.H. and S.P. interpreted the results. D.H. led the writing of the manuscript, and S.P. critically reviewed it. All authors reviewed and approved the final manuscript.

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## References

1. Amit, B. H., Krivoy, A., Mansbach-Kleinfeld, I., Zalsman, G., Ponizovsky, A. M., Hoshen, M., ... Shoval, G. (2014). Religiosity is a protective factor against self-injurious thoughts and behaviors in Jewish adolescents: Findings from a nationally representative survey. *European Psychiatry*, 29(8), 509–513.
2. Author. (2022). *Individual and communal perspectives on suicide in the Hasidic community of Borough Park: Risk factors, protective factors and resources* [Doctoral dissertation]. [Institution omitted for blind review].
3. Biale, D., Assaf, D., Brown, B., Gellman, U., Heilman, S., Rosman, M., & Sagiv, G. (2020). *Hasidism: A new history*. Princeton University Press.
4. Comenetz, J. (2006). Census-based estimation of the Hasidic Jewish population. *Contemporary Jewry*, 26(1), 35–74. <https://doi.org/10.1007/BF02965507>
5. Durkheim, E. (1951). *Suicide: A study in sociology* (J. A. Spaulding & G. Simpson, Trans.). Free Press. (Original work published 1897)
6. Gearing, R. E., & Lizardi, D. (2009). Religion and suicide. *Journal of Religion and Health*, 48(3), 332–341.
7. Jackson, K. (2019). Suicide prevention is every social worker's business. *Social Work Today*, 19(1), 10–13.
8. Joe, S., & Niedermeier, D. (2008). Preventing suicide: A neglected social work research agenda. *British Journal of Social Work*, 38(3), 507–530.
9. Lawrence, R. E., Oquendo, M. A., & Stanley, B. (2016). Religion and suicide risk: A systematic review. *Archives of Suicide Research*, 20(1), 1–21.
10. Maple, M., Pearce, T., Sanford, R. L., & Cerel, J. (2017). The role of social work in suicide prevention, intervention, and postvention: A scoping review. *Australian Social Work*, 70(3), 289–301. <https://doi.org/10.1080/0312407X.2016.1213871>
11. NYC Department of Small Business Services. (n.d.). *Commercial district needs assessment: Borough Park*. City of New York. <https://www.nyc.gov/assets/sbs/downloads/pdf/neighborhoods/aveny-cdna-boroughpark.pdf>

12. Ortiz, L., & Jani, J. (2010). Critical race theory: A transformational model for teaching diversity. *Journal of Social Work Education, 46*(2), 175–193.
13. Pescosolido, B. A., & Georgianna, S. (1989). Durkheim, suicide, and religion: Toward a network theory of suicide. *American Sociological Review, 54*(1), 33–48.
14. Petrakis, M., & Joubert, L. (2013). A social work contribution to suicide prevention through assertive brief psychotherapy and community linkage: Use of the Manchester Short Assessment of Quality of Life (MANSA). *Social Work in Health Care, 52*(2–3), 239–257.
15. Reed, D. D., Stoeffler, S. W., & Joseph, R. (2021). Suicide, race, and social work: A systematic review of protective factors among African Americans. *Journal of Evidence-Based Social Work, 18*(4), 379–393. <https://doi.org/10.1080/26408066.2020.1857317>
16. Sternthal, M. J., Williams, D. R., Musick, M. A., & Buck, A. C. (2010). Depression, anxiety, and religious life: A search for mediators. *Journal of Health and Social Behavior, 51*(3), 343–359. <https://doi.org/10.1177/0022146510378237>
17. Substance Abuse and Mental Health Services Administration. (n.d.). *Behavioral health workforce*. U.S. Department of Health and Human Services. <https://www.samhsa.gov/>
18. Tettey, G. E. (2014). *Exploring the role of religiosity on suicidal ideation: A study among a population-based sample of adolescents in the United States* [Doctoral dissertation, East Tennessee State University]. Electronic Theses and Dissertations. <https://dc.etsu.edu/etd/2393>
19. UJA-Federation of New York. (2024). *Jewish community study of New York 2023*. <https://communitystudy.ujafedny.org/>
20. Wilchek-Aviad, Y., & Malka, M. (2016). Religiosity, meaning in life and suicidal tendency among Jews. *Journal of Religion and Health, 55*(2), 480–494.
21. World Health Organization. (2025). *Suicide* [Fact sheet]. <https://www.who.int/news-room/fact-sheets/detail/suicide>

## Tables

Tables 1 to 13 are available in the Supplementary Files section.

## Figures

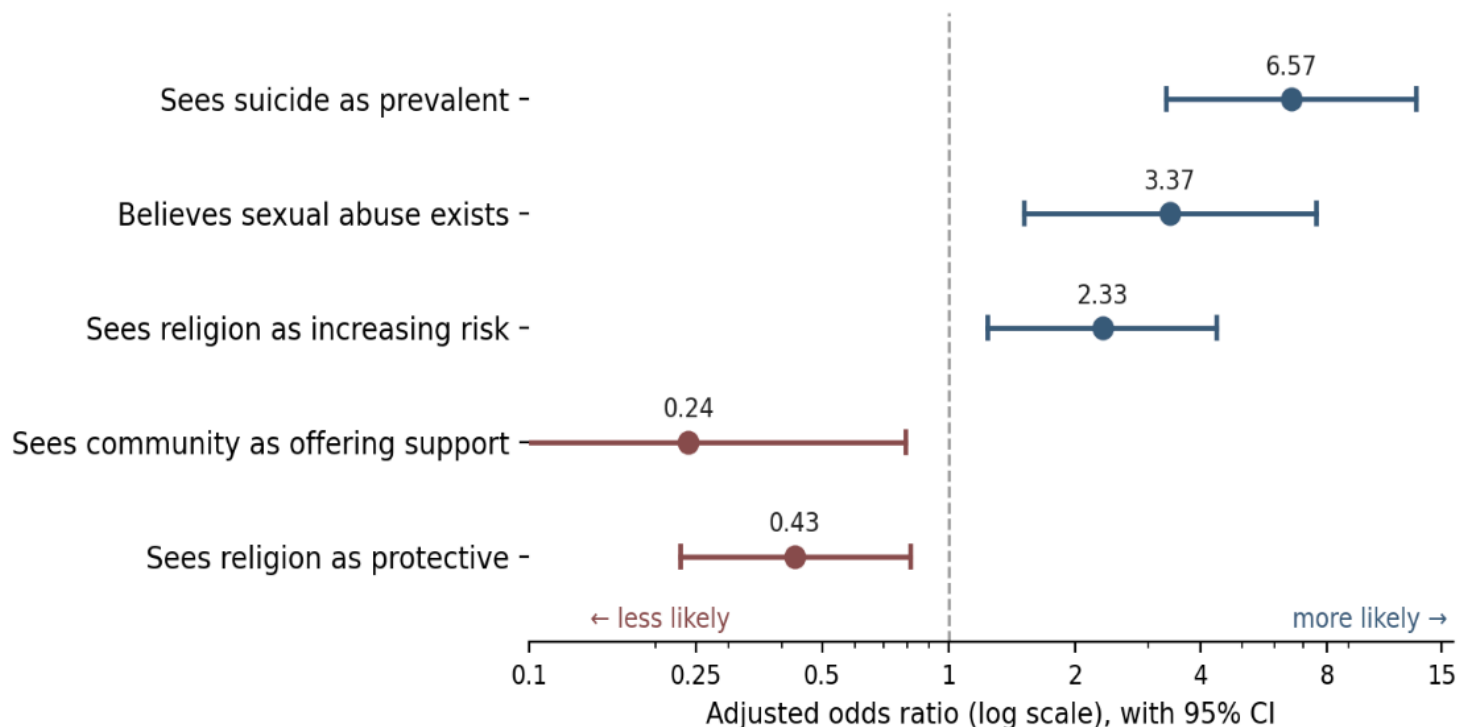


**Figure 1**

*Perceptions of Participants Close to a Suicide, Relative to Others*

*Note.* Adjusted odds ratios, with 95% confidence intervals, from separate logistic regression models predicting each outcome for participants who identified as a family member or friend of someone who attempted or died by suicide. Values to the right of 1.0 indicate greater likelihood; values to the left indicate lower likelihood. All models controlled for sex, age, affiliation, residence, and self-identification.

## Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [CSWJTables.docx](#)