

2016

## I Am Not Thinking About Dying?: Suicide Ideation Among Individualistic and Collectivistic Cultures in a Seventh-Day Adventist University

Reneze Trim

*Southern Adventist University*, trimr@southern.edu

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### Recommended Citation

Trim, Reneze (2016) "I Am Not Thinking About Dying?: Suicide Ideation Among Individualistic and Collectivistic Cultures in a Seventh-Day Adventist University," *Journal of Interdisciplinary Graduate Research*: Vol. 2 , Article 4.

Available at: <https://knowledge.e.southern.edu/jigr/vol2/iss1/4>

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### Abstract

Suicide is the third leading cause of death for 15-24 year olds in the United States of America. Suicide ideation involves having desirability or thoughts of harming or killing oneself. This generally precedes suicide attempts and completions. Any consideration of suicide ideation must be made within the context of culture, and its associated aspects such as gender, since these create a world view that influences all aspects of life. The purpose of this study was to describe and compare cultural and gender differences in suicide ideation in a sample of 140 participants attending a Seventh-day Adventist University in Southeast Tennessee. Specifically, cultural differences in responsibility to family and moral objections in participants representing individualistic and collectivistic cultures were examined. Participants completed the 97 item Life Experience Scale. Although men had higher suicide ideation scores than women, there was no statistical significance in this minor difference, the results are inconclusive. In addition, there are slight cultural differences in family responsibility and moral objections that are inconclusive. Possible reasons for these findings and an agenda for research are discussed.

*Keywords:* suicide ideation, collectivistic, individualistic, culture, Seventh-day Adventists

Suicide is the third leading cause of death for 15-24 year olds in the United States as well as many other countries around the world (Drum, Brownson, Denmark, & Smith, 2009; Park, Im, & Ratcliff, 2014; Kim, Kim, Kawachi, & Cho, 2011). Suicide ideation generally precedes suicide attempts and completions. No people, language, gender, or religion is exempted from suicide ideation, suicide attempts, or completion. Completed suicide is a global and local problem that affects cultures and communities everywhere, yet the phenomenon is misunderstood. This study focused on how culture and suicide ideation are entwined.

Suicide ideation involves *thinking* of harming or killing oneself irrespective of suicidal behavior (Wang, Wong, & Fu, 2013; Goldston, et al, 2008). This ideation is considered by researchers to be an important risk factor and a major indicator of suicide attempts and completed suicides (Chamberlain, Goldney, Delfabbro, Gill, & Dal Grande, 2009; Cheng, et al., 2010; Wang, et al., 2013). Suicidal behavior, according to interpersonal theory of suicide, has two parts: the desire for suicide and the ability to suicide (Gunn, Lester, Haines, & Williams, 2012). The desire for suicide—the reason(s) an individual wishes to die and their belief that they are perceived as a burden to others—plays an important role in suicide ideation (Gunn et al., 2012; Wong, Uhm, & Li, 2012). In light of these findings, the goal of suicide prevention should be early detection, knowing risks and protective factors, and “diminishing self-harming cognitions so as to ensure safety” (Chamberlain, et al., 2009, p. 39). The suicidal thoughts themselves are not the problem, but what constitutes the problem is the ability to harm oneself or kill oneself, after one is continually thinking about taking one’s own life.

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**Risk factors and protective factors.** Risk factors are behaviors that are associated with suicidality, whereas protective factors are “specific factors that may have a protective function against suicide” (Chioqueta & Stiles, 2007, p. 67). Risk factors for increased suicidal ideation include: psychological distress, depression, hopelessness, family history of psychopathology, and family history of suicide attempt or completion (Chamberlain, et al., 2009; Chioqueta & Stiles, 2007). A research-established risk factor for suicide is psychopathology (de Leo & Heller, 2008; Chioqueta & Stiles, 2007). Chamberlain, et al.’s (2009) study showed that men who had very high levels of psychological distress were more likely to have suicidal ideation than women. Hopelessness and depression consistently have been shown to be related as cognitive factors that predict suicide ideation that can lead to completed suicide (Chioqueta & Stiles, 2007). Within the dimension of risk factors of suicide, poor cognitions, inadequate problem solving skills, ineffective coping styles, and some aspects of perfectionism have been associated with higher

levels of hopelessness (Chioqueta & Stiles, 2007; Fortin, Lapierre, Baillargeon, Labelle, & Dubé, 2001).

Chioqueta and Stiles' (2007) longitudinal study reported that high levels of life satisfaction, or an individual's judgment of their life's circumstances, is an important protective factor for suicide ideation, despite the severity of depression experienced by the individual. In addition, positive health, stable self-esteem, and perception of family and social support are protective factors as well. The researchers also reported that lower life satisfaction levels were associated with higher risk factor of suicide, thereby indicating that higher levels of life satisfaction are a protective factor against suicide. Past research, for example De Man & Gutierrez (2002) has also shown that higher levels of self-esteem are related to lower levels of suicide ideation. Similarly, the greater the amount of family support the lower levels of suicide ideation in both high school and university students (Chioqueta & Stiles, 2007).

### **Suicide and the Cultural Context**

Culture determines the systematic way people meet and solve universal human needs and problems, and the worldview and value systems in which a person creates meaning in their world during a specific time period (Oyserman, 2011; Triandis & Suh, 2002, Goldston, et al, 2008). How suicide, attempted suicide, and other behaviors are viewed, are largely influenced by culture (Bhugra, 2013). Oyserman (2011) states that "differences in values, relationship focus, self-concept, and cognitive processes are all implicated in distinctions between individualism and collectivism" (p. 170; see also McCarthy, 2005). The simplest definition of collectivism is a society that is built on a foundational unit consisting of a group of individuals, as contrasted with individualism, where the foundational unit is the individual (Oyersman & Lee, 2008).

**Individualistic cultures.** Individualism promotes self-sufficiency, care of and distinction of self, personal-ruling or autonomy, and nuclear family (Bhugra, 2013; Oyserman & Lee, 2008; Vandello & Cohen, 1999; Zhang, Norvilitis, & Ingersoll, 2007), all of which are highly valued in individualistic cultures, and many of which are found in Western countries (McCarthy, 2005; Gelfand, Triandis, & Chan, 1996; Zhang, et al., 2007). The individual prioritizes personal goals and sense of self over the group's collective goals and entity (Lee, et al., 2010; Agishtein & Brumbaugh, 2013). Because groups in individualistic cultures are fluid, separate, and loose from one another (Bhugra, 2013; Oyserman & Lee, 2008), they can be chosen by the individual and are generally momentary (McCarthy, 2005). Yet these individuals can learn to be a part of an 'in-group' for a sustained period of time, to organize and maintain relationships, and to manage individual welfare (Oyserman, 2011). Individualism has been shown to ease friendship-making, forming new in-groups, and interacting with strangers (Oyserman, 2011; Triandis, Bontempo, Villareal, Asai, & Lucca, 1988). Subsequently, conflict is handled openly due to looser relationships in group (Triandis, et al., 1988).

**Collectivistic cultures.** A collectivistic culture views the world as essentially connected to others (Zhang, et al., 2007). Collectivistic societies engrain the need to provide tight, interconnected groups in which sharing of responsibilities, emotional interdependence, group harmony, and respect for authority are valued (Bhugra, 20013; McCarthy, 2005; Lee, et al., 2010). These groups include family, church, school, community, and even country (McCarthy, 2005). There is a sense of duty to the greater good which supersedes the duty to self (Suh, Diener, Oishi, & Triandis, 1998).

Collectivistic individuals adhere to the group norms in order to foster and experience relationships (Oyserman & Lee, 2008; Vandello & Cohen, 1999). Therefore, collectivistic

individuals rank cooperative aims and objectives of the group to which they belong over their own personal goals (McCarthy, 2005; Lee, et al., 2010; Agishtein & Brumbaugh, 2013). This creates a loyalty that protects those of a “strong and cohesive in-group” with social harmony, which is further preserved by the minimization and covert handling of conflict (Bhugra, 2013, p. 221; Agishtein & Brumbaugh, 2013; Triandis, et al., 1988). Additionally, research on protective factors of suicide has also shown collectivistic cultures to be a protective factor (McCarthy, 2005; Zhang, et al., 2007). However, protective factors by themselves are insufficient to prevent suicide ideation or completed suicide.

### **Suicide Ideation and Gender**

Research confirms one phenomenon of culture is gender which influences an individual’s expectations, roles, and behaviors called the “gender paradox of suicidal behavior” (Canetto, 2008). Cultures, worldviews, and value systems from which a person creates meaning in their world during a specific time period, guide gender behaviors, expectations, and roles (Oyserman, 2011; Triandis & Suh, 2002, Goldston, et al, 2008). In industrialized, individualistic, English-language countries such as Australia, Canada, Great Britain, New Zealand and the United States, women (regardless of age) have higher suicide ideation and suicidal behavior rates than men, but lower mortality rates than men (Canetto, 2008). In this paradox, completed suicide is considered a masculine behavior and thus socially viewed and examined through such a lens, while suicide attempts or nonfatal suicide is considered feminine.

However, around the world the opposite paradigm is true, in a 2008 study, Canetto reports that women have higher rates of suicide mortality than men along with higher suicidal non-fatal behaviors. In some cultures, namely China, India, and Papua New Guinea, suicide is strictly considered a feminine behavior. She argues, “suicide is the ultimate strategy available to

powerless people for influencing the behavior of others” or a viable method for powerless individuals to manage the intolerable (p. 262). Many of these, mostly collectivistic cultures adhere to the notion that women suicide under certain conditions, because there are very specific social consequences of a woman’s suicidal act on people around her. The suicide of a woman is often a response to issues that include: conflict with kin, denial of school opportunity, arranged marriage partner, sexual impropriety, or abuse. For married women, conflict and abuse most likely will be from her husband and his family. In this society, when a woman marries into his family and lives among her in-laws, therefore away from her family, she is outnumbered and not supported during disputes with her in-laws. So even the threat of suicide in these societies can give leverage in kin disputes and abusive situations. According to Canetto (2008), when a man in these cultures tries or kills himself, “he is thought of as acting in a womanly fashion” (p. 261). She continues, “suicide is considered a social rather than a private act, a call for retaliation rather than a sign of mental problems” (Canetto, 2008, p. 262).

Suicide and attitudes toward suicide are impacted by individualistic and collectivistic values (Bhugra, 2013; Park, et al., 2014). Research on culture concludes that suicide ideation, “rates, expression, experience, risk and protective factors,” vary across ethnic and cultural groups (Chu, et al., 2013, p. 424). Within cultures, there are gender differences in suicide rates, expression and factors. These nuisances are important to note in aiding with suicide prevention in a culturally appropriate manner. The purpose of this study was to describe and compare individualistic and collectivistic cultures and gender differences in suicide ideation, cultural differences in responsibility to family and moral objections in a sample of convenience representing Seventh-day Adventist young adults.

## **Research Methodology**

### **Research Design and Procedure**

This quantitative, exploratory non-experimental study is descriptive and comparative. Participants were recruited from upper and lower division psychology courses offered at Southern Adventist University (SAU). Volunteers were asked to come to the Psychology Lab to complete the written survey Fall 2015. After reading and signing the informed consent form, the students were then given the Life Experiences Scale (LES). Completion time ranged from 10-30 minutes. After the form was completed participants were thanked for their time and given information via a Tennessee Suicide Prevention Network (TSPN) brochure for young adults. The purpose of giving each participant a brochure was to provide information on suicide and available resources for suicide prevention.

### **Participants**

Participants for this study were at least 18 years of age ( $M = 21.31$ ,  $SD = 4.13$ ) and consisted of 140 volunteers (97 women and 43 men) enrolled as students at SAU. This sample of convenience was recruited from various undergraduate and graduate classes, students from the Wellness Center Library, and Summerour Hall on campus. All participants were treated in accordance with the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2002). The principal investigator and research assistants completed the Collaborative Institutional Training Initiative's (CITI) Responsible Conduct of Research Curriculum and Research Involving Human Subjects courses (Braunschweiger, 2014). Participants were also treated in accordance with the CITI's curriculum and guidelines.

## Materials

The Life Experiences Scale (LES) is comprised of three instruments: (a) the *Reasons for Living Scale*, (b) the *Individualism and Collectivism Scale*, and (c) the *Interpersonal Shame Inventory*. The demographic information of LES included: gender, age, academic standing, place of birth, length of time lived in America, and parents' place of birth.

**Suicide Ideation Instrument.** The *Reasons for Living Scale* (RLS) explores beliefs and reasons for not committing suicide (Brown, n.d.). The 48 item instrument is rated on a 6-point Likert scale ranging from 1 (“not at all important”) to 6 (“extremely important”). To be scored, at least 38 of the 48 items must be completed. If criteria are met, the mean of the items is calculated and multiplied by 48, the result is the Reasons for Living Total Score. The highest possible score is 288, the lowest possible score is 48. High internal reliability has been reported with Cronbach's alphas ranging from  $\alpha = .72$  to  $\alpha = .92$  for each subscale and  $\alpha = .89$  for the total scale (Brown, n.d.; Ontario Hospital Association, n.d.). In this study, the total scale for the Reasons for Living Scale was found to be highly reliable  $\alpha = .90$ .

RLS consists of six subscales (a) Survival and coping beliefs, (b) Responsibility to family, (c) Child-related concerns, (d) Fear of suicide, (e) Fear of social disapproval, and (f) Moral objections (Brown, n.d.; Ontario Hospital Association, n.d.). This study focuses on two of the subscales: responsibility to family and moral objections. Responsibility to Family subscale examines in seven statements an individual's concern and perceived importance to their family. The Moral Objections to Suicide Subscale is an interesting aspect of this study because it reflects attitudes about the acceptability of suicide (Richardson-Vejlgaard, Sher, Oquendo, Lizardi, & Stanley, 2009). Three of the four items are religious in nature (e.g., “Only God has the right to end life”) and one non-religious (“I consider it morally wrong”). Research has shown that the

Moral Objections subscale differentiates individuals with suicidal ideation from those without (Richardson-Vejlgaard, et al., 2009).

**Individualism and Collectivism Instrument.** The *Individualism and Collectivism Scale* (INDCOL) is a 32-item scale widely used in research and designed to measure four dimensions of collectivism and individualism: (a) Vertical individualism, (b) Horizontal individualism, (c) Vertical collectivism, and (d) Horizontal collectivism (Singelis, et al., 1995). To score the *INDCOL*, the individualism scores on the basis of the 16 individualistic items were summed, as were the collectivism scores on the basis of the 16-collectivististic items. The highest score indicated collectivism or individualism. The reliability for US samples has been between  $\alpha = .73$  to  $\alpha = .82$  for each subscale (Cozma, 2011). For this study, the Individualism and Collectivism Scale was found to be moderately reliable  $\alpha = .75$ .

### **Data Analysis**

Surveys were stored in confidentiality in a locked room, scored and coded according to the scoring keys, and entered into SPSS Windows 22 for data analysis. For this present study, all listed statistical tests were two-tailed with an alpha level of .05. The following three research questions were addressed in this study:

1. Are there differences in suicide ideation as a function of gender and culture in students representing individualistic and collectivistic cultures?
2. Are there individualistic/collectivistic (cultural) differences in responsibility to family?
3. Are there cultural differences in moral objections to suicide ideation?

## Results

### Descriptive Statistics

The demographics of the participants were found to be as follows: 69% were women and the average age was 21.31 years old ( $SD = 4.13$ ). Five academic standings were represented: freshman, sophomore, junior, senior and graduate students. Of the 140 participants, 69% were born in the United States of America and almost 31% of participants were born outside of the country (See Figure 1 in Appendix A). The percentage of participants with one or both parents born in a different country was 50.7%, with the remaining 49.3% born in USA. Sixty percent of participants' mothers were born in the USA (see Table 1 in Appendix A), while roughly 57% of fathers were born in USA (see Appendix B for Table 2). The Caribbean and Central America made up the next highest parents' country of birth.

Eighty participants (57.1%) were individualistic in culture on the *Individualism and Collectivism Scale* (INDCOL). Fifty-seven participants (40.7%) scored as collectivistic on the INDCOL scale. Three participants were unable to be categorized as individualistic or collectivistic because the score was tied for both individualistic and collectivistic preferences. Suicide ideation was midrange in this study, as many participants had "somewhat important" reasons for living,  $M = 4.40$  ( $SD = .67$ ).

The 48 item instrument, Reasons for Living Scale, is a rated on a 6-point Likert scale. One: "not at all important," 2: "quite unimportant," 3: "somewhat unimportant," 4: somewhat important," 5: "quite important," and 6: "extremely important." On the subscale responsibility to family, all participants' scores almost reached the category of "quite important" as a reason for living,  $M = 4.68$ ,  $SD = 1.03$ . On fear of social disapproval ( $M = 3.00$ ,  $SD = 1.50$ ) and fear of suicide ( $M = 3.18$ ,  $SD = 1.37$ ), all participants on average reported these fears as "somewhat

unimportant” in their reason for living. Participants from this sample had an average score of  $M = 4.17$  ( $SD = 1.08$ ) or “somewhat important” for moral objections as reasons for living.

### **Culture and Gender Differences in Suicide Ideation**

Are there differences in suicide ideation as a function of culture and gender? In considering the results for suicide ideation, the higher the score for suicide ideation the lower the level of suicide ideation. The collectivistic mean for suicide ideation was 4.35 ( $SD = .74$ ) and the individualistic mean for suicide ideation was 4.44 ( $SD = .63$ ). Both collectivistic and individualistic cultures reported “somewhat important” reasons for living and were virtually identical in suicide ideation. In this study, suicide ideation for collectivistic women resulted in a mean of 4.42 ( $SD = .11$ ) and for the individualistic women the mean was 4.48 ( $SD = .09$ ), indicating slightly lower suicide ideation than for collectivistic women (See Table 3 in Appendix B).

For collectivistic men, the suicide ideation was 4.12 ( $SD = .17$ ), as compared to a mean of 4.37 ( $SD = .13$ ), for individualistic men, which was slightly lower for collectivistic men (see Table 3). These differences were tested with a Two-Way ANOVA, resulting in no significant main effect for gender and suicide ideation ( $F_{(1,132)} = 1.95, p = .16$ ). Although men had higher suicide ideation scores than women, the main effect was not statistically significant between individualistic or collectivistic cultures and suicide ideation ( $F_{(1,132)} = 1.00, p = .32$ ). Considering the similarities between cultural and gender means, no statistically significant interactions were found between gender, culture, and suicide ideation ( $F_{(1,132)} = .28, p = .60$ ). Results were inconclusive.

### **Culture and Responsibility to Family**

Are there individualistic/collectivistic cultural differences in responsibility to family? For the seven questions that addressed responsibility to family, the results showed that collectivistic participants had a mean of 4.74 ( $SD = 1.01$ ) and the individualistic participants had a mean of 4.64 ( $SD = 1.06$ ). Collectivistic participants had slightly higher responsibility to family than individualistic participants. Both collectivistic and individualistic cultures reported “somewhat important” reasons for living because of their responsibility to their family. An independent samples  $t$ -test was used to explore if there were any individualistic or collectivistic differences in family responsibility in participants’ suicide ideation. The results showed no statistical significance in individualistic or collectivistic cultures and responsibility to family ( $t(134) = -.78, p = .44$ ). The results were inconclusive.

### **Culture and Moral Objections**

Are there cultural differences in moral objections to suicide? The results for moral objections were: collectivistic participants had a mean of 3.97 ( $SD = 1.15$ ) and the individualistic participants had a mean of 4.32 ( $SD = 1.04$ ). Interestingly, individualistic participants had slightly higher moral objections to suicide than collectivistic participants. Responses for the former, were “somewhat unimportant” to moral objections while individualistic cultures reported “somewhat important.” An independent samples  $t$ -test was used and results were not statistically significant ( $t(134) = -.78, p = .44$ ), therefore these findings were inconclusive.

### **Discussion**

The purpose of this present study was to describe and compare culture and gender differences in suicide ideation, and cultural differences in responsibility to family and moral objections. Question one addressed if there are gender differences in suicide ideation as a

function of culture. In this study, men had slightly higher suicide ideation than women and individualistic participants had slightly lower suicide ideation than collectivistic participants. Collectivistic women and men had higher suicide ideation means than individualistic women and men. However these differences were not statistically significant; there were no subsequent interactions among gender, culture, and suicide ideation. It may well be that gender differences do exist in suicide ideation, but a larger sample size is needed.

Yet gender differences in suicide ideation and behavior differ from culture to culture. Past research has shown that around the world women have higher rates of suicide ideation and behavior than men (Canetto, 2008). But men have higher rates of suicide completion than women in industrialized, individualistic, English-language countries. This has been described as the gender paradox of suicidal behavior (Canetto, 2008). Interestingly, many countries do not have national data for suicide mortality rates. It could be that men and women's rates of suicide may be similar, but underreported or categorized as an accident or because of cultural conditions that guide what is called suicide.

Another plausible explanation is that women in cultures around the world can utilize suicide as a "call for retaliation" (Canetto, 2008). The threat of suicide in some cultures "can give women some leverage in family disputes and abuse situations" (Canetto, 2008, p. 262). In these particular cultures men have more means to resolve family or social problems, especially since it is their own family and not in-laws as in the woman's case. It may be that cultural norms, roles, and expectations have more to do with the perceived gender differences than gender differences themselves.

Expectedly, collectivistic participants had slightly higher responsibility to family reasons to live than individualistic participants. Both collectivistic and individualistic cultures reported

“somewhat important” reasons for living because of their responsibility to their family. A possible explanation for the slightly higher family responsibility in collectivistic participants could be the importance of keeping harmony in relationships at all costs. There is a sense of duty to the greater good which supersedes the duty to self (Suh, Diener, Oishi, & Triandis, 1998). Collectivistic cultures value personal responsibility to their family first and foremost, it may be more important to honor the family, since it is an individual’s first in-group. It could also be that there is no statistical significance because individualistic cultures also value immediate family members which is often overlooked when compared to collectivistic cultures.

An interesting aspect of this study is question three: Are there cultural differences in moral objections? The results indicated that individualistic participants showed slightly higher moral objections than collectivistic participants. The latter reported “somewhat unimportant” moral objections as reasons for living. Individualistic participants reported “somewhat important.” Religion is a subculture that affects all aspects of life. It affects one’s beliefs and lifestyle. Seventh-day Adventism is the unique and powerful religious subculture in this study. Could “religion” supersede the influence of both the individualistic or collectivistic cultures? It could be that the variation in personal practice of religion may reflect cultural differences in moral objections than the culture itself. A study by Stack and Wasserman (1992) found that churches with higher levels of tension with the greater culture, such as the Seventh-day Adventist church, have lower suicide ideology or ideation. Could it be that the belief system of religion interposed with cultural differences creates moral objections? Or is it that religion is so personal that moral objections reflect personal differences rather than cultural differences. This generates more questions to the roles of culture and suicide ideation in religious contexts.

### **Limitations of this Study**

While there are several limitations in this study, the first limitation of this study is one of design flaws that are implicit in quantitative research, numbers exclude the complexity of the topic. Despite the findings of this exploratory study, limited inferences can be made to the stories, reasons, and meanings behind the results. An additional qualitative component could have provided insight to participants' suicide ideation in the form of responsibility to family and moral objections as a function of culture or gender and cultural differences in suicide ideation. Future research should be mixed-methods or quantitative to gather the meaning and reasoning of suicidal ideas in some individuals.

Studies that focus on minority groups yield mixed results, largely due to small sample sizes. Unfortunately, in cultural groups represented in America, there is a lack of cultural sensitivity in risk assessments, the standardization of the instruments and assessments, and knowledge of suicidal presentation in cultural groups, as well as a lack of awareness in suicide acceptability or taboos in cultural groups represented in America (Chu, et al., 2013).

It may be culturally inappropriate to disclose such intimate information to a non-familial person, like a therapist. Therefore culturally appropriate "methods of query" can help decrease stigma or embarrassment and garner the information needed to evaluate risk or hidden suicide ideation (Chu, et al., 2013).

Sample size and selection are other limitations that restrict the generalizability of the results to other populations. The small sample size of convenience represents about five percent of the Southern Adventist University population. Such a small sample precluded other potential participants whose inclusion may have yielded different results. Southern Adventist University is a higher educational institution of the Seventh-day Adventist Church. One of the fundamental

beliefs is the return of the Lord Jesus Christ. This belief focuses on the hope of things to come rather than problems, pain, and death of this world. A limitation of this study is that this sample may not be representative of university populations and cultures in America who may not have such hope and other religious beliefs.

### **Future Research**

The fact that these results were inclusive accentuates the need for future research. There is a need for future research to address cultural sensitivity while discussing suicide ideation; more quantitative research is needed. This present study is specific to a Seventh-day Adventist population and needs to be replicated with public universities and other age groups. Additionally, mixed-methods needs to be utilized to see what aspects of responsibility to family and moral objections lowers suicide ideation. Religion is often forgotten as a culture, the researcher of this study proposes that future research consider the role of religion in general in suicide ideation, as well as the unique culture of religious faiths like Seventh-day Adventist.

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Appendix A

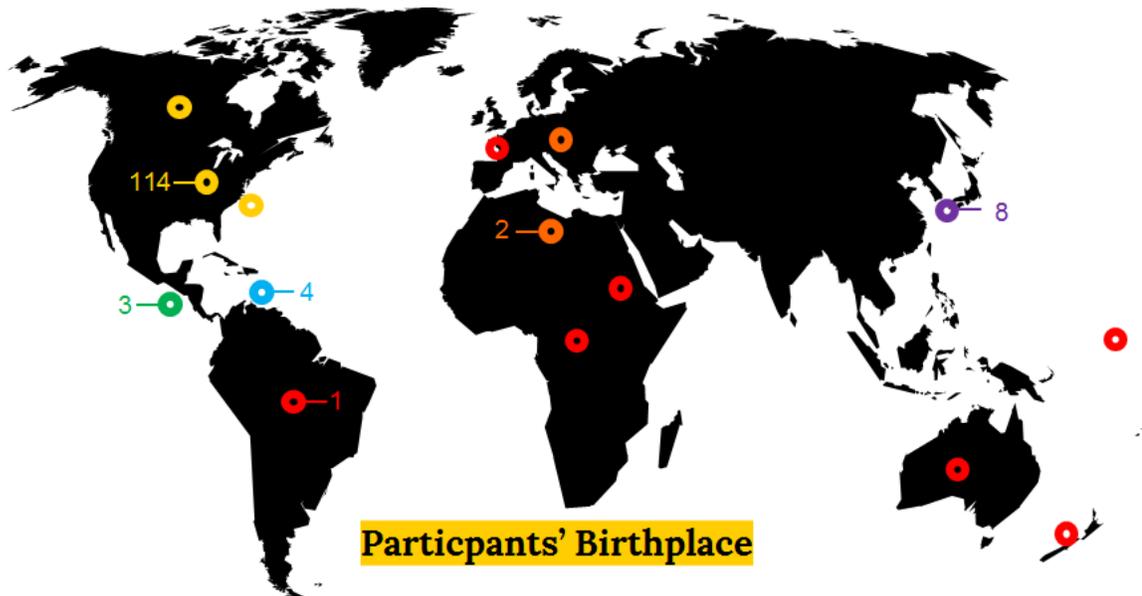


Figure 1. Map of participants' birthplace and how many participants were born in a particular region of the world.

Table 1.

Participants Mother's Country of Birth

Country of Mother's Birth	Frequency	Percent
North America	84	60.0 %
Central America	15	10.7%
Caribbean	13	9.3 %
East Asia	8	5.7%
South America	6	4.3%
South-Eastern Asia	4	2.9%
Northern Europe	3	2.1%
Eastern Europe	2	1.4%
Eastern Africa	2	1.4%
Southern Europe	1	0.7%
Middle Africa	1	0.7%
Northern Africa	1	0.7%
Total	140	100%

## Appendix B

**Table 2.**

Participants' Father's Country of Birth

Country of Father's Birth	Frequency	Percent
North America	80	57.1 %
Caribbean	17	12.1%
Central America	14	10.0%
Eastern Asia	8	5.7%
South America	5	3.6%
South-Eastern Asia	3	2.1%
South-Central Asia	2	1.4%
Eastern Africa	2	1.4%
Eastern Europe	2	1.4%
Northern Africa	2	1.4%
Northern Europe	1	0.7%
Southern Europe	1	0.7%
Western Europe	1	0.7%
Middle Africa	1	0.7%
Australia/ New Zealand	1	0.7%
Total	140	100%

**Table 3.**

Two-Way ANOVA for Gender Differences and Suicide Ideation

Variable	Mean	<i>SD</i>	<i>n</i>	
Women				
Collectivistic	4.42	.69	41	
Individualistic	4.48	.59	54	
Men				
Collectivistic	4.12	.85	15	
Individualistic	4.37	.72	26	
Source	SS	<i>df</i>	F	<i>p</i>
Gender	.89	1	1.95	.16
Culture Type	.46	1	1.01	.32
Gender*Culture Type	.13	1	.28	.60
Error	60.28	132		

