BAU Journal - Health and Wellbeing

Volume 1 | Issue 1
ISSN: 2617-1635

Article 5

October 2018

SUICIDE AND CULTURE

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Abstract

The rates of suicidal ideation, attempts and mortality present a large intersocietal variation. This variation is usually attributed to the role of culture, but the issue is still poorly understood. How does culture contribute to the intersocietal or cross-cultural variation of suicidal behavior? How culture might be involved in the onset, maintenance and aggravation of suicidal tendencies? In this paper, I will be discussing possible mechanisms of culture for the onset, maintenance and aggravation of suicidal propensities. Specifically, I will be examining the role of religion, individualistic-collectivistic value orientations, self-construal and survival versus self-expression values for their relevance to suicidal behavior and its intersocietal variation. The article highlights some conceptual and methodological issues together with some future directions for research on the possible role of culture in suicidal process.

Keywords

Suicidal behavior, intersocietal variation, culture, values

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ABSTRACT

The rates of suicidal ideation, attempts and mortality present a large intersocietal variation. This variation is usually attributed to the role of culture, but the issue is still poorly understood. How does culture contribute to the intersocietal or cross-cultural variation of suicidal behavior? How culture might be involved in the onset, maintenance and aggravation of suicidal tendencies? In this paper, I will be discussing possible mechanisms of culture for the onset, maintenance and aggravation of suicidal propensities. Specifically, I will be examining the role of religion, individualistic-collectivistic value orientations, self-construal and survival versus self-expression values for their relevance to suicidal behavior and its intersocietal variation. The article highlights some conceptual and methodological issues together with some future directions for research on the possible role of culture in suicidal process.

KEYWORDS

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1. INTRODUCTION

Suicidal phenomena are a global public health concern and are the cause of many premature deaths. It is a personal and social tragedy not only for the deceased but also for families, friends, neighbours and the society. According to World Health Organization (WHO), 800,000 people die by suicide annually and it is the second leading cause of death among 15-29 year olds (World Health Organisation, 2014). Seventy eight percent of all global suicides occur in low-middle income countries and data indicate that there are 20 attempts for every suicidal death (World Health Organisation, 2014). This means globally 16,000,000 individuals per annum make at least one attempt to kill themselves. Suicidal phenomena therefore constitute significant a burden on national health care systems (Goldman-Mellor et al., 2014). For instance, the annual cost of suicide and suicide attempts are estimated to be 93.5 billion dollars in the United States (Shepard, Gurewich, Lwin, Reed, & Silverman, 2016).

Suicide is not an end in-itself but a result of a process comprising of various cognitive, affective, social, interpersonal and behavioral acts or omissions. Suicidal behavior is an umbrella term used to denote a range of acts related to the process self-annihilation ranging from ideation to self-killing. Suicidal ideation includes thoughts of engaging in behavior intended to end one's life. Suicidal plans involve formulation of a specific method through which one intends to die. Suicidal attempts are comprising of acts in potentially self-injurious behavior in which there is at least some intent to die. Suicidal death is the intentionally ending one's own life (Nock et al., 2008).

1.1 Characteristics of Suicidal Behavior

The research in suicidology has so far delineated several features for suicidal behavior. The first feature of suicidal behavior is that it is a process which starts first with an idea (Kral, 1994). Another feature is that suicidal behavior is a result of psychological pain which exceeds person's

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tolerance threshold (Shneidman, 1998; Verrocchio et al., 2016). The pathways leading to suicidal behavior are multifaceted, including intrapersonal, interpersonal, social, biological and genetic factors. Thus, there is no fixed cause of suicidal behavior. Although there is a strong overlap between mental disorders and suicide this does not imply causality and some claim that suicide is not always a sign of psychopathology (Hjelmeland & Knizek, 2017). Another characteristics of suicidal behavior is that it is a major public health problem and constitute a serious economic burden on national health care systems (Shepard et al., 2016). Another feature of suicidal behavior is that its prevalence rates vary from one sociocultural context to another.

1.2 Intersocietal Variation of Suicide

Table 1 presents the international variations in age standardized suicide rates (per 100 000 population) reported by the member states to the World Health Organization for the year 2015 (WHO, 2015). The table groups member states into quartiles based on their age standardized suicide rates. The quartile 1 contains the states with the lowest and the quartile 4 includes those with the highest suicide rates. As it is seen in the table, suicide rates vary considerably among the nations. Despite this variation, suicides are relatively statistically stable across nations or social groups (Ritter et al., 2008) but individually unpredictable events (Ribeiro et al., 2016) which is called conundrum of suicide.

Why is this variation? What is or are the etiology of this variation? Is it living standards? Is it the widespread poverty? Is it the availability or quality of (mental) health care systems? Is it the abuse of alcohol and the use of illicit drugs? Is it social and personal traumas like war, disasters, robberies, rapes and the like? Is it the social factors such as unemployment, divorce, violence etc.? Is it the prevalence of psychological conditions like depression and anxiety? Or is this variation simply an artifact of misreporting and underreporting?

There may be many more factors that may be related to the variations in suicide rates, but do they really matter? The author has compared gross domestic product based on purchasing-power-parity per capita in US Dollars (GDP) (IMF, 2015), depression, anxiety rates (World Health Organization, 2017) and unemployment rates recorded for the states in the first and the fourth quartiles by means of t-tests. The states in the first and the fourth quartiles did not differ in terms of GDP (first quartile M = 18413,5755, SD = 16974.29786 versus fourth quartile M = 19360,7885, SD = 23420.2358, $t(90) = 0.824$, $p > 0.05$), rates of depression (first quartile M = 4.408, SD = 0.681versus fourth quartile M = 4.427, SD = 0.722, $t(92) = 0.899$, $p > 0.05$), rates of anxiety (first quartile M = 4.145, SD = 1.253 versus fourth quartile M = 3.960, SD = 1.228, $t(92) = 0.472$, $p > 0.05$), and unemployment rates (first quartile M = 10.335, SD = 7.404 versus fourth quartile M = 7.960, SD = 6.044, $t(89) = 0.098$, $p > 0.05$).

Thus, social, economic and mental health conditions are unable to account for the intersocietal variations in suicidal mortality. Suicide is multifaceted phenomenon including biological, genetic, social, cultural, philosophical, existential, spiritual and religious variables. Therefore, scholars often refer to culture to make sense of these observed intersocietal variations in suicide rates. But, what is culture and what does it have to do with suicide?

Table 1. International variations in age-standardized suicide mortality rates for the year (The World Health Organization)

Quartile 1		**Quartile 2**		**Quartile 3**		**Quartile 4**	
Country	***Rate***	***Country***	***Rate***	***Country***	***Rate***	***Country***	***Rate***
Antigua & Barbuda	0.0	Macedonia	6.4	Ghana	10.2	Cambodia	12.8
Barbados	0.3	Malaysia	6.5	Liberia	10.3	Ethiopia	12.8
Grenada	0.4	Saint Lucia	6.7	Turkmenistan	10.3	Mozambique	12.9
Brunei Darussalam	1.4	Bahrain	6.9	Australia	10.4	Burundi	13.0
Jamaica	1.4	Samoa	7.0	Canada	10.4	Eritrea	13.2
Bahamas	1.6	Vanuatu	7.0	Namibia	10.4	Trinidad & Tobago	13.2
Pakistan	2.5	Afghanistan	7.1	Cuba	10.5	Lesotho	13.6
S-V & the Grenadines	2.6	Nepal	7.2	Kenya	10.5	Argentina	13.9
Sao Tome & Principe	2.6	Viet Nam	7.2	Mali	10.5	Laos	14.0

Guatemala	2.7	Costa Rica	7.3	Czechia	10.6	Chad	14.2
United Arab Emirates	2.8	Dominican Republic	7.3	Switzerland	10.7	Finland	14.2
Indonesia	3.0	UK & Northern Ireland	7.4	Djibouti	10.8	Kiribati	14.8
Algeria	3.1	Ecuador	7.6	Malawi	10.8	Estonia	14.9
Azerbaijan	3.1	Madagascar	8.0	El Salvador	11.0	Benin	15.0
Egypt	3.1	Kyrgyzstan	8.2	Maldives	11.0	Slovenia	15.0
Lebanon	3.1	Belize	8.3	Tanzania	11.0	Nigeria	15.1
Venezuela	3.1	China	8.5	Ireland	11.1	North Korea	15.2
Greece	3.2	Luxembourg	8.5	Bulgaria	11.2	Uruguay	15.2
Syria	3.2	Niger	8.5	Micronesia	11.2	Japan	15.4
Iran	3.6	Portugal	8.5	Zambia	11.2	Togo	15.4
Albania	3.8	Singapore	8.6	Guinea	11.4	Hungary	15.7
Philippines	3.8	Somalia	8.6	Sudan	11.4	India	16.0
Cyprus	3.9	Turkey	8.6	Gambia	11.6	Belgium	16.1
Jordan	3.9	Montenegro	8.7	Austria	11.7	Burkina Faso	16.5
Saudi Arabia	3.9	Seychelles	8.7	Haiti	11.7	Ukraine	16.6
Tonga	4.1	Mauritius	8.8	Iceland	11.8	Latvia	17.4
Iraq	4.1	Fiji	8.9	Senegal	11.8	Cameroon	17.5
Kuwait	4.1	Chile	9.1	Cabo Verde	11.9	Eswatini	17.9
Honduras	4.2	Denmark	9.1	Congo	11.9	Russian Federation	17.9
Myanmar	4.5	Germany	9.1	Papua N Guinea	11.9	Zimbabwe	18.0
Oman	4.8	Romania	9.2	Bhutan	12.1	Poland	18.5
Tajikistan	4.9	Uzbekistan	9.2	Croatia	12.1	Belarus	19.1
Malta	5.0	Norway	9.3	Serbia	12.1	Cent. African Repup	19.6
Mexico	5.0	Netherlands	9.4	Congo	12.2	Bolivia	20.5
Morocco	5.2	Solomon Islands	9.4	Comoros	12.3	Sierra Leone	22.1
Georgia	5.3	Timor-Leste	9.4	France	12.3	South Korea	24.1
Israel	5.4	Yemen	9.4	New Zealand	12.3	Angola	25.9
Italy	5.4	Guinea-Bissau	9.5	South Africa	12.3	Lithuania	26.1
Tunisia	5.4	South Sudan	9.6	Gabon	12.5	Equatorial Guinea	26.6
Panama	5.6	Mauritania	9.8	Moldova	12.5	Suriname	26.9
Qatar	5.7	Nicaragua	9.8	Botswana	12.6	Ivory Coast	27.2
Bangladesh	6.0	Paraguay	9.9	Rwanda	12.6	Kazakhstan	27.5
Brazil	6.0	Slovakia	9.9	Uganda	12.6	Mongolia	28.1
Colombia	6.0			USA	12.6	Guyana	30.6
Libya	6.0			Sweden	12.7	Sri Lanka	34.6
Peru	6.0			Thailand	12.7		
Spain	6.0						

2. CULTURE

Human beings live in an ocean culture unaware of its presence but once they are out of water its absence is realized immediately. The culture we live in is not recognized unless one gets out of it. What is water for fish culture is for human beings. However, culture is often either taken for granted or not recognized in daily life pursuits.

Culture can be defined in many ways. For example it is defined by Kroeber and Kluckhohn as "Culture consists of patterns, explicit and implicit, of and for behavior acquired and transmitted by symbols, constituting the distinctive achievements of human groups, including their embodiment in artifacts; the essential core of culture consists of traditional (i.e. historically derived and selected) ideas and especially their attached values; culture systems may, on the one hand, be considered as products of action, on the other, as conditional elements of future action, (p. 181)" (Kroeber & Kluckhohn, 1952). Culture is also defined as the collective programming of mind which distinguishes the members of one group or category of people from another (Hofstede, Hofstede, & Minkov, 2010). In short culture can be defined as the cognitive, behavioral and affective characteristics of people living in a society or a group.

Another way to conceptualize culture is to distinguish between different levels of social reality. For instance, surveying the previous intellectual work on culture in various scientific disciplines, Buono et al. delineate two aspects of culture. The first one is the integrative concept of custom. This can also be termed as social culture. This aspect includes traditional or regularized ways of doing things. In the second, they make a distinction between objective versus subjective cultures. Objective culture refers to artifacts and material products of a society. The subjective culture is the cultural group's characteristic ways of perceiving the man-made part of its environment (Buono, Bowditch, & Lewis, 1985). The subjective culture includes cognition, values, beliefs and behaviors.

For Oyserman et al. humans need other humans for survival and this requires cooperation which they call as "sticking together". According to the authors' analysis sticking together is both vital and problematic. They argue that culture is a solution to the problems that arise from sticking together: managing relations to avoid conflict, clarifying boundaries and facilitating innovation. They designate culture as situated cognition (Oyserman & Lee, 2008a; Oyserman, Novin, Flinkenflögel, & Krabbendam, 2014).

2.1 Culture Makes People Similar but Different

Culture provides people with some readymade packages of codes, content and timing for what, how, why, when and where to think, like, eat, wear, behave, do things, and feel. The package contains complex scripts and descriptions for behavioral patterns related to the world, others, self, production, reproduction, consumption, life, death and after life. Culture signals people what behaviors are deemed acceptable and desirable in what kinds of situations and what others are deemed unacceptable or undesirable.

As people are born into families whom they cannot choose, likewise persons cannot choose their culture into which they are born. This imperative makes some people/groups resemble one another but different from others. As stated above, culture provides people with ready-made packages containing complex scripts and descriptions to point directions for behavioral patterns. Thus, a person born into a culture reacts to situations and demands originating from the inner and outer world by means of scripts and descriptions made available in that culture.

Culture can be conceived as a within and a between culture variable (Leung & Cohen, 2011; Moorman & Blakely, 1995). Thus, culture can be used to account for variations in interindividual differences within a culture and variations between cultural groups. The relative frequencies of the scripts and descriptions in cultural groups render group members similar to or different from one another. On the other hand, a person's adoption of which scripts and descriptions to follow while responding to those situations/demands makes her/him different from others sharing the same culture. But at the same, time scripts/descriptions being limited/finite makes him/her similar to others sharing the same culture.

2.2 Culture-Person Interplay

There is a reciprocal dynamic relationship between the culture and the person. The nature of this reciprocal interaction renders both the culture and the person to have an impact on one another. Human beings create culture but once created the culture recreates human beings. Human beings are reflexive and abstract thinking meaning makers. As of their nature humans have a natural propensity for a regulated-meaningful existence. As part of the meaningful existence, human beings need others to achieve collective meaning and at the same time need autonomy to establish personal meaningfulness.

2.3 Relevance of Culture to Suicidology

The observation that suicide rates vary between societies is often taken as indication of cultural differences. Many researchers working in suicidology attribute this variation to cultural differences. Societal suicide rates show consistent patterns over time (Hansen & Pritchard, 2008). Like most human behavior, culture exerts an influence on suicide (Kral, 1998; Lester, 2008, 2009; Maharajh & Abdool, 2005). Therefore, for a better understanding of suicidal phenomena, some suicidologists have called for an inclusion of culture in suicide research (Akotia, Knizek, Kinyanda, & Hjelmeland, 2014; Chu, Goldblum, Floyd, & Bongar, 2010; Hjelmeland, 2010). The inclusion of culture in suicide research raises three questions. The first one is: What do we mean by culture, and how do we conceptualize it, to include it in suicide research?" This relates to the

issue of precision. The second question is: How does culture affect suicide? This relates to the issue of mechanisms or processes. The third one is: Do we conceptualize culture at the group level or individual level? This relates to the level of measurement.

2.4 How Culture is Involved in Suicide?

Scientific research on suicidology often compares groups of participants from different nations, countries or social groups and attributes findings to cultural factors. Suicide is a process starting from its onset to the reporting and recording. To achieve precision, the scientific work must specify in what ways culture may affect suicide? This is essential for a better appreciation of the possible role of cultural factors in a suicidal process. Following is a list of the ways in which culture might be involved in a suicidal process:

- Culture might direct or signal what reactions to emit under stressful life conditions: People may behave in various ways under stressful life circumstances. Cultural values and codes may point or prepare individuals how to respond during negative life circumstances.
- Culture may prepare or signal the tolerance threshold for kinds of psychological pain: It usually assumed that people engage in suicidal behavior when experienced level of psychological pain which exceeds their tolerance threshold. For instance, while the psychological pain resulting from cause A for individual X in culture-I may not be a sufficient condition to trigger a suicidal process, but it may be sufficient to trigger it in culture-II.
- Culture may shape help-seeking behavior under stressful life conditions: The suicidal act frequently is seen as personal freedom and choice (Wexler & Gone, 2012; Wiesenhutter, 1971). Consistent with this, most suicidal individuals usually seek neither professional nor nonprofessional help (Bruffaerts et al., 2011; Husky, McGuire, Flynn, Chrostowski, & Olfson, 2009), and perceived stigma, embarrassment, and a preference for self-reliance are the most common barriers to seeking help in young people with suicide and mental health problems (Clement et al., 2015; Curtis, 2010; Gulliver, Griffiths, & Christensen, 2010).
- Culture may shape attitudes towards suicide: Cultural values and codes may shape the nature of attitudes towards controversial topics such as suicide. It is often assumed that prevalent cultural values form peoples' attitudes to suicide and hence account for the intersocietal variation of suicidal behavior. For instance, research suggests that cultural approval of or permissive cultural attitudes towards suicide are associated with increased propensity toward suicidal behavior (Jeon, Park, & Shim, 2013; Lenzi, Colucci, & Minas, 2012; Stack & Kposowa, 2008).
- Culture may shape and determine the social reactions to suicidal persons: Not only to controversial topics themselves but culture may also exert an influence on the nature of social reactions to persons engaging in controversial behaviors like suicidal behavior. Though in varying degrees, all religious traditions forbid self-killing and it is seen as a sin. Societal stigma surrounds suicidal behavior and suicidal individuals.
- Culture may shape attitudes and reactions to persons bereaved by suicide: The death of a close and beloved one is a heavy emotional burden on the person (Cvinar, 2005; Peters, Cunningham, Murphy, & Jackson, 2016). If the death is through suicide the picture becomes even more complicated due to societal reactions. The social stigma introduces a unique stress on the bereavement process. Hence the research show that persons bereaved by suicide are at a greater risk factor for suicide (Peters et al., 2016; Pitman, 2018; Pitman, Osborn, Rantell, & King, 2016; Pitman, Stevenson, Osborn, & King, 2018).
- Culture may influence reporting and recording of suicidal behavior: Cultural values may also have an impact on the mere recording and reporting of suicidal phenomena. The stigmatized nature suicide renders its reporting problematic in several ways. The stigma around suicide stem from different layers of societies. In societies such as Islamic ones where suicide is considered as a major sin, persons who happened to engage in a suicidal behavior may find it difficult to reveal this even to health professionals. Likewise, recording of suicidal behavior is also believed to be influenced by cultural values (de Leo, 2015). Therefore, many

researchers question the validity of suicide statistics with good reasons. For instance, it is a well-known fact that some Muslim nations report and record extremely low suicide rates. But the rates for youthful nonfatal suicidal behaviors in some Muslim societies are comparable to or even higher than the rates in societies with high suicide rates (Eskin, 1995; Eskin, 1999; Eskin, Sun, et al., 2016; Eskin, 2017; Eskin, Palova, & Krokavcova, 2014). This raises the doubts that suicide rates are in fact not as low as officially reported in Muslim countries. There is scientific evidence supporting this view especially for Middle Eastern Arab nations. For instance, it is empirically shown that most suicides are misclassified as Other Violent Deaths in Middle Eastern Muslim Arab nations but not in European Muslim nations such as Albania, Bosnia-Herzegovina or Turkey (Pritchard & Amanullah, 2007).

- Cultural Values May Exert an Influence on Suicide Research: The topic of suicide has a taboo characteristic in almost all social contexts. It causes uneasiness when talking about suicide. Due to its controversial characteristic the topic of suicide touches upon life values such as freedom, restraint, holiness, happiness, human rights, rationality and so on. Ethical presuppositions play a role in the pursuit of suicide research (Mishara & Weisstub, 2005). For some, "ideology, politics, power, and vested interests among influential professionals (p. 1)" play a role in establishing the truth about the relationship between mental illness and suicide (Hjelmeland & Knizek, 2017).

2.5 Culture and Suicide: Methodological Caveats

Almost every researcher acknowledges that culture plays a role in suicidal process. But the way in which this role is played is not clear. It is partly because the term culture is an all-encompassing fuzzy one. If you are comparing groups of people, you simply do not know what you are comparing. Assume that a researcher in a cross-cultural study compared the rates for youthful suicidal behavior in Country A and Country B and found out youthful suicidal behavior rates to be lower in Country B than in Country A. What does this finding mean? What does it say about the role of culture in suicide? In what ways our researcher can explain her/his finding? What the researcher shall attribute to observed differences in suicide rates between the two countries? These and other questions remain unanswered in comparisons between countries or groups.

One way to overcome this issue is to compare countries or cultural groups with known cultural characteristics, i.e., suicide rates, individualism-collectivism, religion or any other cultural feature of interest. It is also known that what is considered as a cultural characteristic of a given sociogeographic region may function as an individual difference variable. In this case one should make sure that the samples taken from two countries differ from one another in cultural characteristics of interest. Another approach might be to compare samples taken from the same country or culture with known cultural characteristics. One should know that findings from all these comparative research designs are prone to ecological fallacy. Therefore, it is difficult to ascribe a causal role for culture in suicidal process. In order claim a causal role for culture in suicide one should make use of creative experimental or longitudinal research designs.

To ascribe a causal role for culture in suicide three conditions should be fulfilled. First, one should delineate a cultural characteristic or dimension from among a bunch of ingredients or dimensions of culture. Second, this dimension should be able to account as much variance as possible in intersocietal variation. Third, this dimension should be related to suicidal phenomena and the variation in suicide. In the following sections I will survey some ingredients or characteristics of culture for their association with suicidal behavior. In doing this my aim will be to provide evidence for or against the role of culture (if any) obtained from empirical scientific investigations.

3. CULTURAL INGREDIENTS

3.1 Religion

Religion is an important indicator of culture and it accounts for the largest observed cross-cultural differences (Saucier et al., 2015). Religion and religious values are assumed to be related to the intersocietal variation in suicidal behavior. Tarakeshwar and colleagues believes that religion

is an overlooked dimension in cross-cultural psychology research (Tarakeshwar, Stanton, & Pargament, 2003). All religions have explicit or implicit sanctions against self-killing with varying degrees of severity. Among the three Abrahamic religions, Islam has the most explicit sanctions against suicide. Hence, low suicide rates reported by the Muslim countries are often attributed the prohibitive attitude of Islam to suicide. It is believed that religious values determine social attitudes towards self-annihilation.

Why and how does religion protect against suicide? From an evolutionary perspective it has often been asserted that religion as an integral cultural syndrome has evolved to reduce fitness costs and improve the fitness benefits of their fellow members at both individual and group levels along with the cultural evolution (Boyer & Bergstrom, 2008; Pyysiäinen & Hauser, 2010; Wilson, 2005). Religious systems help to increase adaptive capacities of its believers in a constant social, physical, psychological and existential flux (Purzycki, Haque, & Sosis, 2014). As a self-reflecting agent, human beings are aware of their own inevitable death and this is a source of existential anxiety. Research provides empirical support to the view that religious beliefs help people to cope with this existential anxiety (Vail, Arndt, & Abdollahi, 2012).

Then, how does religion help to improve adaptive capacity of its believers? Suicide is an extreme form of desperation. How does religion protect its believers against such desperation? What are the mechanisms by which religion exercise its protective function against suicidal behavior? The suicidology literature has identified three theoretical formulations about the link between religion and suicide (Colucci & Martin, 2008). The first one is the social integration theory (Durkheim, 1951), and the second one is the network theory (Pescosolido, 1990). Both theories argue that religion exercises its protective function against suicide through developing informal relationships and promoting communal ties that increase networking and feelings of integration. On the other hand, religious commitment theory (Stack, 1983; Stark, Doyle, & Rushing, 1983) assumes that core religious beliefs opposing suicide prevent individuals from considering suicide as an option during times of personal crises.

The empirical evidence indicates that religion may be a protective factor against diminished psychological well-being (Kang & Romo, 2011; Moreira-Almeida, Neto, & Koenig, 2006; Smith, McCullough, & Poll, 2003). Findings from a longitudinal study have shown that religious service attendance reduces depressive symptoms significantly (Zou et al., 2014). Note that reduced mental health is one of the strongest risk factors for suicidal behavior. As of theoretical positions about the link between religion and suicide, religion is often assumed to be the strongest deterrent against suicidal behavior and the research provides empirical evidence for this assertion (Dervic et al., 2004; Gearing & Lizardi, 2009; Gearing & Alonzo, 2018; Hsieh, 2017; Lizardi & Gearing, 2010; Neeleman & Lewis, 1999; Norko et al., 2017; Sisask et al., 2010; Stack, 1998; Stack & Wasserman, 1992; Wu, Wang, & Jia, 2015). Further, acceptability of suicide is lower in religious than in nonreligious people (Boyd & Chung, 2012; Eskin, 2004; Stack & Kposowa, 2008, 2011a). Higher levels of suicide acceptability in turn was found to be associated with contemplating, planning and attempting suicide (Eskin, Kujan, et al., 2016; Eskin et al., 2014; Eskin, Voracek, Stieger, & Altinyazar, 2011; Joe, Romer, & Jamieson, 2007). In a recent review, religious affiliation was found to be a protective factor against suicide attempts and suicide but not against suicidal ideation (Lawrence, Oquendo, & Stanley, 2016).

However, other line research indicates that the protective of function of religiosity against suicide may not generalize to some geo-socio-cultural settings and groups (Birkholz, Gibson, & Clements, 2004; Nonnemaker, McNeely, & Blum, 2003; Thanh, Tran, Jiang, Leenaars, & Wasserman, 2006; Young, Riordan, & Stark, 2011; Zhang, Jia, Jiang, & Sun, 2006). The findings from a research with depressed patients have shown that suicide attempts were more common in patients with a religious affiliation. Further, the researchers have found that suicide ideation was greater among depressed patients who considered religion more important and those who attended religious services more often (Lawrence, Brent, et al., 2016). In a recent paper, Lester and Walker showed religiosity to be protective for suicidal ideation in European American students but not in African American students (Lester & Walker, 2017). As mentioned before Islamic scripture prohibits suicide. A recent study involving 5572 students from 12 countries reported the associations of religious affiliation to suicidal behavior in a multinational/multireligious sample. The results showed that an affiliation with Islam was associated with reduced risk for suicide ideation, however affiliating with Orthodox Christianity and no religion was related to increased risk for suicide ideation. While affiliating with Buddhism, Catholic religion and no religion

associated with lowered risk for attempting suicide, affiliation with Islam was related to heightened risk for attempting suicide (Eskin et al., in press).

Alongside religious affiliation, belief, importance and attendance, religiosity has also been conceptualized in motivational terms. For instance, Allport and Ross differentiated between intrinsic versus extrinsic motivations for religious belief. Individuals with an intrinsic orientation toward religion were described as wholly committed toward their religious beliefs and that religiosity was evident in every aspects of their life. On the other hand, those with an extrinsic orientation use religion as a means to provide participation in a powerful in–group protection, consolation and social status (Allport & Ross, 1967). The empirical evidence indicates that intrinsic motivations for religious belief as opposed the extrinsic orientation may be protective against suicidal behavior (Lew et al., 2018; Nonnemaker et al., 2003; Stroppa & Moreira-Almeida, 2013). Evidence also indicates that extrinsic religious orientation has a negative impact on psychological well-being (Doane, Elliott, & Dyrenforth, 2014).

Still another line of research conceptualizes religiosity as coping (Pargament, 1997). Pargament defines religion as "a process, a search for significance in ways related to the sacred" (p. 32) and religious coping as "a search for significance in times of stress' (p. 90). Pargament conceptualized religious coping in two dimensions: Positive and negative religious coping. Accordingly, positive religious coping involves a secure relationship with a transcendent force, a sense of spiritual connectedness with others, and a benevolent world view. On the other hand, negative religious coping involves underlying spiritual tensions and struggles within oneself, with others, and with the divine (Pargament, Feuille, & Burdzy, 2011). The research indicates that positive religious coping is related to positive whereas negative religious coping is related to negative psychological adjustment to stress (Ano & Vasconcelles, 2005). In a similar fashion, positive religious coping methods like looking to God for strength, comfort and guidance was found to be protective against suicidal attempts and ideation (Taylor, Chatters, & Joe, 2011).

3.2 Individualism-Collectivism

Cultural or cross-cultural psychology has identified individualism-collectivism as a meaningful dimension along which cultures and/or cultural groups can be compared (Hofstede et al., 2010; Kagitcibasi & Berry, 1989). Cultures emphasizing individualism value personal autonomy, self-reliance, uniqueness and independence while those emphasizing collectivism value person-other relatedness or interdependence and person as being part of a collective (Triandis, 2001). The scientific literature indicates that individualism and collectivism as two world views (Oyserman, 1993) influence an array of psychological variables such as self-concept, motivation, affect, cognition, cognitive processing style, attribution, emotion regulation and social support provisions (Cross, Hardin, & Gercek-Swing, 2011; Kitayama & Uskul, 2011; Kühnen & Oyserman, 2002; Matsumoto, Yoo, & Nakagawa, 2008; Oyserman, Coon, & Kemmelmeier, 2002; Oyserman & Lee, 2008b).

The influence of individualism and collectivism on suicidal behavior has long been debated in suicidology. For instance, the seminal work of (Durkheim, 1951) situated the cause(s) of self-killing within the relationship between the person and the collective. Basically, the individualism and collectivism refer to the nature of the relationship between the individual and the collective. Individualism places emphasis on self-reliance, personal uniqueness, independence and a priority on personal goals whereas collectivism places an emphasis on interdependence, relatedness and a priority on group goals (Triandis, 2001). Although the cultural dimension of individualism-collectivism provides important source of information about intersocietal and interindividual differences they nevertheless have not been fully integrated into the science of suicide.

Durkheim has situated the causal mechanism for suicide within the interplay between the person and the culture. Individualistic-collectivistic values relate to the relationship between the person and the collective. Being situated at a certain point on this dimension may involve advantages or disadvantages for both the collective and the person. Researchers seem to hold conflicting views about the benefits and harms of being situated on a certain point on the individualism-collectivism dimension with regards to mental health and well-being.

Some researchers are of the opinion that cultural factors such as materialism and individualism are health hazards for population health and well-being (Eckersley, 2006) but for others individualism exerts a positive effect on mental well-being via its potentials for creating a context for freedom and choice (Fischer & Boer, 2011; Veenhoven, 1999). One should however note that these findings stem mostly from ecological studies. From a methodological point of view, findings

from ecological research designs are prone to a variety of confounders. A third line of inquiry has argued that what matters for a better mental health is the level of person-culture match or fit (Fulmer et al., 2010). This line of reasoning assumes that persons at the extreme ends of the individualism-collectivism dimension, which, when incompatible with the societal values, have disadvantages for personal adaptation. The data seem to support this view (Caldwell-Harris & Ayçiçegi, 2006; Ogihara & Uchida, 2014).

Eskin has argued that individualism and collectivism might be involved in the onset, maintenance and aggravation of a suicidal process in two ways. First, when confronted with or under the influence of negative life circumstances individuals with individualistic value orientations may feel personal responsibility for what happened and blame themselves. This may further aggravate the feelings of anger, unhappiness and hopelessness which are the predominant affective states in suicide (Ellis & Rutherford, 2008). On the other hand, in a similar state, individuals with collectivistic value orientations may attribute responsibility to others or situations and this may diminish the impact of feelings of anger, unhappiness and hopelessness on him/her (Eskin, 2013).

Second, individualism and collectivism may exert an influence on the social attitudes towards suicide as a phenomenon and suicidal persons. The defining features of individualism include independence, freedom, choice, personal responsibility and competition (Bryerton, 2016; Waterman, 1981). The act of self-killing is frequently depicted as involving personal freedom and choice (Wexler & Gone, 2012; Wiesenhutter, 1971). In line with this, most suicidal individuals usually seek neither professional nor nonprofessional help (Bruffaerts et al., 2011; Husky et al., 2009) and perceived stigma, embarrassment, and a preference for self-reliance are the most common barriers to seeking help in young people with suicide and mental health problems (Clement et al., 2015; Curtis, 2010; Gulliver et al., 2010). Within such a value matrix, it is reasonable to assume that people with an individualistic world view will see suicide as a regular act compatible with their personal world view. Subsequently, they will show higher levels of acceptance for suicide than those with a collectivistic world view. Since individualistic values were associated with context-independent information processing (Kühnen & Oyserman, 2002) persons with an individualistic mind set may see the causes for a suicidal act as situated within the person and hence blame her/him for what happened. On the other hand, since collectivism was associated with context-dependent information processing style (Kühnen & Oyserman, 2002), persons with a collectivistic mind set may see the doer or agent of a suicidal act as a victim and hence blame the situations or others for what happened. Thus, persons who attempt suicide and live in social contexts where individualistic values prevail may not receive the help they cry for. On the contrary, persons who attempt suicide and live in social contexts where collectivistic values prevail may receive the help they cry for (Eskin, 2013).

Is there any empirical evidence supporting these anticipations? Research suggests that, for both societies and individuals, having individualistic values are associated with increased rates of completed suicide and suicidal behavior. Some ecological (group-level, or geographic) studies yielded positive associations between individualism and suicide mortality (Eckersley & Dear, 2002; Lenzi et al., 2012; Rudmin, Ferrada-Noli, & Skolbekken, 2003) while others did not find such an association (Lester, 2000, 2003, 2005).

Except Lester's findings, the results from individual-level studies seem to confirm group-level effects. In one study, individualism was identified as a risk factor for suicidal ideation among second-generation immigrant adolescents in France (van Leeuwen, Rodgers, Régner, & Chabrol, 2010). A study with Australian university students found that participants with strong individualistic values (idiocentrism) to be less satisfied with, and less inclined to seek social support, and presenting higher levels of hopelessness and suicide ideation (Scott, Ciarrochi, & Deane, 2004). Another study with Turkish adolescents and young adults found out that suicidal thoughts and attempts were more common among participants with individualistic than among those with collectivistic tendencies (Mehmet Eskin, 2013). Still another study with Chinese participants showed individualistic orientation to be associated with increased hopelessness and substance use, along with reverse associations for collectivistic orientation (Du, Li, Lin, & Tam, 2014). Another study with the US and Chinese college students found that high levels of suicide ideation were correlated with more idiocentrism (individualism) in women only but more allocentrism (collectivism) were related to less suicidal ideation (Zhang, Norvilitis, & Ingersoll, 2007).

Scholarly work on the associations of individualistic and collectivistic cultural orientations to suicidal attitudes seem to support a relationship between individualistic values and permissive attitudes to suicide and suicide related phenomena. For instance, among US college students, individualistic value orientations were found to be associated with the approval of physician assisted suicide (Kemmelmeier, Burnstein, & Peng, 1999; Kemmelmeier, Wieczorkowska, Erb, & Burnstein, 2002). With Turkish young adults and adolescents, Eskin has demonstrated that participants appraising individualistic values over the collectivistic ones displayed more approving and permissive attitudes to suicide however, they were less accepting of a suicidal close friend than those with collectivistic tendencies (Eskin, 2013).

Another line of evidence for the likely role of individualistic values in suicide process comes from gender distribution of suicidal behavior. In suicidology it is a well-known fact that more women think and attempt suicide, but more men kill themselves (Schrijvers, Bollen, & Sabbe, 2012). Characteristics of masculinity whether hegemonic or not include characteristics such as striving for power and dominance, aggressiveness, courage, independency, efficiency, rationality, competitiveness, success, activity, control and invulnerability (Connell & Messerschmidt, 2005; Möller-Leimkühler, 2003; Schippers, 2007). As one may note, the attributes of masculinity overlap largely with the defining characteristics of individualistic world view. For Möller-Leimkühler equipped with an individualistic world view people attribute reduced life chances such as loss of work and long-term unemployment to personal failure rather than as a social problem which result in identity problems, loss of control, helplessness and depression. Accordingly, the author concludes “Males respond to this with maladaptive coping strategies, triggered by norms of traditional masculinity or confusion resulting from gender-role conflict: emotional inexpressiveness, lack of help-seeking, aggressiveness, risk-taking behaviour, violence, alcohol and drug abuse and suicide (p. 7) (Möller-Leimkühler, 2003).

3.3 Self-Construal

Self-construal refers to how individuals define and make meaning of the self. Basically, self-construal is about to what extent people define themselves by incorporating others into their selves. People may define their selves on a scale from a complete incorporation of others into their selves to an absolute exclusion of others. Hence Markus and Kitayama coined the terms independent versus interdependent self-construals. The research indicates that independent and interdependent self-definitions influence basic psychological processes such as motivation, cognition, emotion, social and the like. (Cross et al., 2011; Markus & Kitayama, 1991).

There is a close link between individualism and collectivism dimensions and self-construal. People in collectivistic societies define themselves by incorporating others into their self-concepts and hence when enquired they sample relational aspects of their selves. On the other hand, people in individualistic societies or cultural settings define themselves as autonomous entities disconnected from others and hence when enquired they sample independent aspects of their selves. In this way, interdependent versus independent self-construals are not static self-qualities but dynamic self-processes. Thus, as with individualism-collectivism, self-construal can be thought of a between-culture (Oetzel & Ting-Toomey, 2003), within-culture (Suh, Diener, & Updegraff, 2008) and a within-person (Gardner, Gabriel, & Lee, 1999) variable. In this way, as a cultural ingredient or syndrome self-construal may account for cross-cultural, interpersonal and intrapersonal variations.

Do we have empirical work relating self-construal to suicidal mental well-being and phenomena? The empirical evidence of a role for self-construal on these issues comes from research on self-construal and social support-help seeking process, subjective well-being, psychopathology. Compared to those with independent self-construal, people with an interdependent or relational self-construal perceive their important relationships as more closer and committed (Cross, Bacon, & Morris, 2000); levels of social support are more important for their self-esteem (Cross & Vick, 2001), life satisfaction (Heintzelman & Bacon, 2015) and socially oriented subjective well-being (Suh et al., 2008; Yamaguchi & Kim, 2015); seek help more (Shea & Yeh, 2008) and they seek socially (dependency) oriented help (Komissarouk & Nadler, 2014) and present lower levels of posttraumatic stress disorder (Mordeno, Nalipay, Sy, & Luzano, 2016). However, in Asian American and African American college students it was shown that distress was positively related to interdependent self-construal and negatively associated with independent

self-construal (Christopher & Skillman, 2009) however, these findings can also be accounted for by a culture-clash perspective. Further, the research also shows that interdependent self-construal mitigates the fear of death (Orehek, Sasota, Kruglanski, Dechesne, & Ridgeway, 2014) which is a crucial factor in the interpersonal psychological theory of suicide (Joiner, 2007; Van Orden et al., 2010) but this effect could not be replicated in an independent sample (Lester, 2015).

From above mentioned findings one can deduce that self-construal may be an important variable in a suicidal process. Since individualism-collectivism and self-construal cultural conceptualizations overlap we can assume that the proposed mechanisms for individualistic-collectivistic values in suicide process apply to self-construal as well. Unfortunately, there is a dearth of empirical work investigating the role of self-construal in suicide.

The interpersonal psychological theory of suicide (IPTS) assumes that a sense of thwarted belongingness and perceived burdensomeness make suicide as a desirable option but unless coupled with reduced fear of death do not translate into action (Van Orden et al., 2010). From an IPTS perspective research have examined the relationships among self-construal, thwarted belongingness, perceived burdensomeness and suicide ideation in Asian American college students. It was found out that interdependent self-construal and independent self-construal both weakened the link between perceived burdensomeness and suicide ideation and between thwarted belongingness and suicide ideation (Wong, Koo, Tran, Chiu, & Mok, 2011). It seems that independent and interdependent self-concepts provide beneficial effects against suicide desire in times of perceived burdensomeness and thwarted belongingness in Asian American college students.

One thesis research [conducted under the supervision of the author] with Turkish high school students investigated the relationships of self-construal to nonfatal suicidal behaviors and suicidal attitudes (Yavuz Yaren, 2013). The results have shown that students with suicidal ideation and attempts were characterized by high scores on autonomous self-construal whereas those without such behaviors were characterized by high scores on relational self-construal scale. The results also revealed that while the autonomous self-construal scale scores were related to suicide acceptance positively, relational self-construal scale scores were related to accepting attitudes to suicide negatively. Thus, the findings from this investigation converge with the findings from some others on the relationships of individualistic-collectivistic values to suicidal behavior and attitudes.

3.4 Other Cultural Ingredients or Dimensions

Researchers have investigated the associations of other value dimensions to suicidal behavior and attitudes. In one study, it was found out that while intellectual autonomy and secular-rational values were associated with higher suicide rates, characteristics of postmodern societies such as self-expression values and egalitarian commitment were associated with lower suicide rates (Schwarzenthal & Milfont, 2016). In another study, self-expression values were found to be associated with higher and survival values with lower suicide acceptability (Stack & Kposowa, 2011b).

The scientific work so far has shown that approval for suicide and social acceptance of suicidal persons are inversely correlated and societies differ on these attitudinal dimensions (Eskin, 1995; Eskin, 1999; Eskin et al., 2014, 2011). In a study with multinational samples of young adults from 12 countries (Eskin, Kujan, et al., 2016) it was found that participants with accepting attitudes towards suicide but rejecting attitudes towards suicidal persons reported more suicidal behavior and psychological distress, and they were more often from high suicide rate countries and samples than their counterparts as if they are caught in a fatal trap in which most predominant feelings of suicidality such as hopelessness or helplessness are likely to occur. It seems that high suicide rate countries are characterized by high suicide approval but a stigmatized view of suicidal persons.

4. CONCLUSIONS

The survey of the results from the empirical work presented here allow for some tentative conclusions. The conclusions drawn from this brief survey may be summarized as follows:

- It is interesting to note that although many scholars acknowledge the role of culture in suicide very few empirical works have been done so far. Therefore, more scientific work in suicidology research is warranted.

- The scientific studies involving country and/or group comparisons of suicidal behavior and attitudes reveal that countries, cultures or groups differ from or resemble to one another. But there are methodological caveats in terms of uncontrolled confounding variables regarding these findings. Thus, the results from these kinds of comparisons, whether aggregate or individual level data, include serious threats to validity.
- The survey reveals that some cultural ingredients or syndromes may be related to suicidal process. Among them are religion and person-collective interface are the most promising variables. Scholarly work indicates that although religion may be a protective factor against suicidal behavior its protective function does not seem to generalize to some geosociocultural contexts and groups. In a similar fashion, the limited scientific work suggests that individualistic value orientations may be a risk factor for and collectivistic value orientations may be a protective factor against suicidality, but these findings do not generalize to some geosociocultural contexts and groups as well.
- More scholarly work with methodological vigor is needed to explore the possible role of cultural factors in suicide. For instance, future work may benefit from making explicit what is meant by culture. Therefore, future research designs should explicitly define what the culture is and develop a measuring approach accordingly. This entails a strict operational definition of cultural variables of interest.
- Future scientific investigations may also benefit from making use of research designs uncovering the conditions under which cultural constructs might be a risk, facilitator for or a protective factor against suicidal behavior.

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