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Etiology and Perception of Suicide: Cultural Explanation of Suicide from Javanese Perspective

F.A. Nurdiyanto*[1] Subandi[1]
[1]*Faculty of Psychology, Universitas Gadjah Mada, Indonesia*

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Abstract. The suicide rate in Java is increasingly worrying. Furthermore, there is still a limited exploration of suicide in Javanese culture. This qualitative research intended to explore the perception of suicide in the Javanese with Arthur Kleinman's explanatory model framework. We interviewed 21 Javanese, of which 28.5% had a history of attempted suicide. Grounded theory analysis found that the Javanese have various terms for suicide based on how suicide is conducted, emotional nuances, and influences of taboo. Suicide is believed to be influenced by suffering, loss of hope, alienation, mental frailty, and low religiosity. It is important to consider cultural characteristics in suicide prevention campaigns and suicide management programs. This article encourages cultural sensitivity for clinicians and health authorities to accommodate the Javanese belief in suicide prevention programs as well as the delivery of effective interventions.

Keywords: cultural; explanatory model; Javanese; suicide

The global prevalence of death by suicide is alarming. The suicide rate has reached nine percent and kills more than 703,000 people annually, ranking as the 20th leading cause of death globally, surpassing malaria, breast cancer, war, and terrorism (WHO, 2021). Women are known to have higher suicide attempts due to vulnerabilities (Freeman et al., 2017), but, death by suicide is reported to be higher among men (12.6%) than women (5.4%) (WHO, 2021). Developing and low-to-medium-income countries are known to have higher suicide rates, with 77% of global suicides occurring in developing and third-world countries (WHO, 2021). The prevalence of suicide in Indonesia is quite low, reaching only 2.6% (WHO, 2021), with men (4%) more likely to commit suicide compared to women (1.2%). However, it is believed that Indonesia has an underreported number of suicides (Snowdon & Choi, 2020). In addition to the absence of a suicide registry system, death by suicide is rarely reported by families and authorities due to the stigma. It is challenging to examine the phenomenon of suicide in Indonesia because of socio-cultural factors.

Suicide is a complex phenomenon that demands a comprehensive elaboration without isolating it from the context (Turecki & Brent, 2016). This phenomenon should be understood as part of life's struggles, unique experiences, pains, and suffering. For example, mental disorders are considered strong predictors of suicide, often characterized by the following diagnoses: mood disorders, borderline personality disorder, and anorexia (Gili et al., 2019). However, suicide has different

*Address for correspondence: nurdiyanto@mail.ugm.ac.id

variations based on specific cultures. Lester (2008) described how culture has plurality explanations and is not universally applicable. Suicide should be approached depending on the meaning of the scope in which it exists.

The difference in suicide rates between men and women strongly correlates with socio-cultural aspects. In most countries, suicides among men are two to four times higher than among women. However, in certain countries, such as China, Bangladesh, Morocco, Lesotho, and Myanmar, the prevalence of suicide among women is comparatively higher (WHO, 2019). Vijayakumar (2015) found that women have the shorter end of the stick in social construction and gender roles, causing them to be more vulnerable to psychosocial stressors, leading to suicide. Social environment and family factors; e.g., familial bond, family abuse, social conflict and isolation, along with traumatic or unpleasant experiences; contribute to suicide in women (Li et al., 2012). Meanwhile, high mortality due to suicide among men is related to masculinity values and societal expectations imposed on men (Mac an Ghaill & Haywood, 2012; Xu et al., 2015). In masculine culture, men are not expected to express their emotional distress and vulnerability. They should, instead, display toughness and strength.

Some studies have attempted to link macro non-individual elements with suicide in the Indonesian context. For example, a study conducted in a predominantly-Javanese society showed a high tendency of suicides among the elderly. Using forensic data from the police department, Nurdiyanto and Jaroah (2020) estimated that the elderly constitute the majority of suicide cases in Gunungkidul. In addition, Javanese society stigmatizes and views suicide as a taboo, believing it to be related to a financial crisis, family conflict, and repressed long-term problems (Nurtanti et al., 2020) or supernatural influences (Suwena, 2016). However, there are limited reports of suicide in Indonesia that explain how socio-cultural factors construct and have an impact on local's beliefs about suicide.

This research is an urgent matter, given that previous attempts to explain the suicide phenomenon in Indonesia tend to be monoperspective (Christian et al., 2019; Kurihara et al., 2009b) and did not provide the space needed for the perspectives of survivors, families, or communities in articulating their beliefs. This study sought to fill the gap regarding the cultural explanation of the suicide phenomenon in Javanese society. Although suicide occurs in almost all societies, local understandings will vary across cultural groups. The understanding of suicide in a local context can bridge the differences in knowledge and belief systems between communities (patients and family members) and healthcare providers (professionals, medical experts, and policymakers). To the best of our knowledge, this is the first study to elaborate on suicide from a Javanese psycho-cultural perspective with an explanatory model framework. This study aimed to elaborate on Javanese cultural knowledge and beliefs regarding suicide using Arthur Kleinman's explanatory model.

Explanatory model

The explanatory model was first developed by Kleinman (1980) to understand health systems in non-Western contexts through the common perception of patient attributions and behaviors related to treatment and illness management. The framework is commonly used to understand how people perceive pain and their beliefs about it (Sumathipala et al., 2008). It is also included in the DSM-V

diagnosnic system to help explain pain experiences from differenct culture perspectives (emic). Today, explanatory model studies no longer narrowly focus on patients' perspectives alone but have expanded to caregivers, families, communities (Montesinos et al., 2019), healthcare providers, and traditional or religious healers (Shankar et al., 2006).

Previously, the DSM-IV acknowledged the role of culture by establishing 'culture-bound syndrome' and offered a framework to identify cultural aspects of mental disorders. In short, the explanatory model is formulated as the cultural explanation of illness. Despite recognizing the role of culture in clinical presentation, the DSM-IV essentially failed to recognize psychiatric categories and diagnostics based on cultural interpretation (Littlewood, 1990). On the other hand, the DSM-V (American Psychiatric Association, 2013) shows progress in recognizing cultural aspects in clinical symptoms, diagnosis, and treatment management. The DSM-V adopts this concept as an instrument that clinicians can use as part of a culturally sensitive anamnesis (CFI; Cultural Formulation of Interview). Clinicians can use the CFI to elicit information about cultural aspects manifested in patient's clinical presentations.

Clinicians should understand the explanatory model of each patient and client, as two patients with the same complaint may have different explanatory models. This diversity of explanatory models reflects the dynamics of disorder experiences, social perspectives, and the cultural context of the community (Good & Good, 1980; Kleinman, 1980). For example, an explanatory model study of suicide in India found that suicide is attributed to various socio-cultural characteristics, such as violence, family problems, health problems, and supernatural influences (Parkar et al., 2008; Parkar et al., 2012). Meanwhile, Turkish descents in Germany believe that suicide is caused by social problems, such as discrimination, societal pressure, and the lack of social acceptance that further isolate the suicide attempters from their social world (Montesinos et al., 2019).

Similar to other cultural systems, the health system has a symbolic system that takes form in meanings, values, behavioral norms, and the like. A health system may articulate illnesses or disorders through idioms, beliefs about the causes of illness, expressions of symptoms, patterns of sickness behavior, decisions on treatment, treatment practices, and evaluation of treatment outcomes (Good & Good, 1980; Kleinman, 1980). Both healers and patients are part of cultural and health systems that should be understood concerning one another. Health beliefs and behaviors are governed by a set of culturally approved rules. The explanatory model is intended to be a heuristic qualitative research approach, which aims to consider the narratives and experiences of illness. The model has shown high credibility, demonstrating the alignment of health-sickness perceptions in specific cultural contexts and promoting awareness of cultural variation in any empirical data, especially in health studies.

Mental Health and Suicide among Javanese People

Javanese believes mental health as a system comprising of physiological, psychological, social, and spiritual dimensions; all of which are expected to be in cosmic balance and integral. Muluk and Murniati (2007) explained that Javanese people carefully maintain a harmonious balance in various ways. Social manners (*tata krama*) regulate interpersonal relationships, custom regulates

communal behavior, while religion and mysticism regulate transcendental relationships. Javanese social interactions are based on sympathetic values with attention to the wishes of others, as well as respecting and obeying authority figures (parents, customs, ethics). Instincts and emotions are expected to follow the moral rules of *nrima* (grateful acceptance), *sabar* (patience), *eling-waspada* (mindfulness), *prasaja* (modesty), and *andap asor* (humility).

As the largest ethnic group in Indonesia, the Javanese community has cultural values that support recovery and protective factors for suicide prevention. For example, *rukun* and *ngemong* contribute to lower expressed emotion and recovery from mental disorders (Subandi, 2011). *Rukun* indicates successful adjustment and integration into warmth and harmonious family relationships (Hawkins, 1996). Integration is achieved by compromising interests; sometimes by prioritizing the interests of others over one's desires (Subandi, 2015). *Rukun* is also achieved through involvement in communal activities, such as neighborliness, tight-knit relationships, and socializing in the community. The success of *rukun* can promote social reconciliation that was damaged by previous crisis experiences.

The value of *nrimo* is the Javanese attitude in facing difficult life problems (Koentjaraningrat, 1985). The *nrimo* attitude can be a collective coping mechanism for relatives in dealing with the pressures of illness and the frustrations of treatment. Patients and families who develop a *nrimo* attitude show self-capacity in managing pain and burden, as well as low expressed emotion (Subandi, 2011).

Term existence or naming system is influenced by the knowledge system and language of the community. Javanese people use *nglalu* to refer to suicide. The Javanese dictionary (Poerwadarminta, 1939) explained that *nglalu* can mean *kêntèkan akal* (losing their mind) and *njarag pati* (challenging death). A person who loses their mind (fainting, coma) because they deliberately took poison, even if it did not result in death, can also be subjected to the term. *Nglalu* has synonyms; *ngêndhat* (to bring death upon oneself) and *nganyut jiwa* (to separate the soul). However, Javanese people also refer to suicide by alluding to popular methods of suicide, such as *gantung* (hanging), *ngulu* (chugging), or *nyuduk* (stabbing).

Suicide crises and psychiatric disorders are often attributed to supernatural influences. The Javanese cosmology considers human beings as only a small part of the universe with its cosmic hierarchy which includes its spirits and supernatural beings (Koentjaraningrat, 1980). This view of spirits underlies how mental disorders are believed to be a supernatural possession or *guna-guna*; which is considered an indication of the weakness in controlling the cosmos (Subandi et al., 2021). Javanese people in Gunungkidul believe that suicide occurs due to the influence of *pulung gantung*, a spirit that can cause suicide (Darmaningtyas, 2002; Suwena, 2016). *Pulung gantung* is described as a light or fireball that falls to the person's house, yard, or field. *Pulung gantung* is seen as a sign of tragic death, but its interpretation only occurs after suicide is completed (post-factum). It is told by neighbors who claim to have witnessed the fireball falling at the suicide location. Through this framework of *pulung gantung*, suicide is a divine fate with signs received from the sky.

Suwena (2016) found that *pulung gantung* contains symbolic meaning in conveying aspirations.

Suicide attempters want to express something to the people around them, but have obstacles in accessing channels and language. The existence of *pulung gantung*, which is an ordinary natural phenomenon, such as a falling star or meteorite, is transformed by suicide attempters into a mystical discourse. They use *pulung gantung* as a form of legitimization for their death, and the act is affirmed by society. People who commit suicide are not viewed as perpetrators, but victims of the *pulung gantung*.

Method

Design

This research is part of a thesis project at Universitas Gadjah Mada, conducted to explore the experience of suicidal behavior and how participants interpret suicide in the context of Javanese culture. A grounded qualitative was chosen to explore and elaborate on the diversity and complexity of suicide, involving participants' perspectives, values, as well as their meanings and experiences. Suicide and suicidal behaviors should be explained by considering the Javanese context while focusing on substantive explanations through the explanatory model. Emergent themes are constructed inductively and then grouped based on the resonance of the explanatory model's domains. The study followed the Consolidated criteria for reporting qualitative studies (COREQ) checklist (Tong et al., 2007).

Participants

We involved 21 Javanese (13 women; $\overline{x}_{age}$ = 36.62) who were selected through snowball sampling. We invited suicide survivors and non-suicide attempters who had provided psychological support in a suicide crisis (e.g., teachers, religious leaders, friends). Participant characteristics can be seen in Table 1. Participant names appearing in this report are pseudonyms and proposed by our participants. The ethical aspects of the study were reviewed and approved by the Research Ethics Committee, Faculty of Psychology, Universitas Gadjah Mada (No. 5396/UN1/FPSi.1.3/SD/PT.01.04/2020).

Table 1
Participants' Characteristics

	Survivor (n = 6)	Non-suicide attempter (n = 15)
Age (mean, SD)	625 (2.45)	641.27 (16.73)
Sex (n)		
Men	2	6
Women	4	9
Education (n)		
University	4	10
High School	2	5
Residence (n)		

(Table 1 Continued)

Participants' Characteristics

	Survivor (n = 6)	Non-suicide attempter (n = 15)
Rural	3	6
Urban	3	9
Category (n)		
Survivor	6	-
Religious leader	-	5
Close friend	-	4
Caregiver	-	2
Teacher	-	2
Javanese shaman	-	2

Procedures

Data were collected through interviews conducted at participant's houses, campuses, cafes, or via telephone and Zoom meetings from November 2020 to March 2021 in Yogyakarta, Indonesia. Interviews were conducted by the first author three to five times for 60-90 minutes in each session. The interviews were began by asking participants to describe how they experienced (survivors) or provided help (non-suicide attempters) people with suicide crises, then proposed explanatory model questions according to the nuances of the interview dialog. During the interviews, all participants spoke mostly in Bahasa Indonesia but sometimes mixed with Javanese. The same questions were sometimes asked in subsequent encounters for elaboration and achieving information saturation. During the interviews, we avoided psychiatric jargons and probed participants when they used them (e.g., mental, depression, psychotherapy, or psychologist and psychiatrist). Consent was obtained from all participants in the data collection.

The semi-structured interview guide on the suicide explanatory model was developed based on The McGill Illness Narrative Interview (Groleau et al., 2006). The interview was expected to explore the participants' knowledge, concepts, and beliefs related to the etiology and attribution of suicide causes.

Data analysis

Interview recordings were transcribed and reviewed for accuracy by the first author. Transcripts were inputted into MAXQDA for systematic data management and analysis. This study adopted two steps of analysis: the grounded technique (Strauss & Corbin, 1998) guided the steps in coding to themes, and then we mapped the emerging themes to the domains of the explanatory model framework. This analysis made it possible to develop a systematic concept based on categories and use the theoretical

framework to guide the analysis in an inductive-deductive approach.

The first author independently familiarized the data by reading the transcripts and memos repeatedly and applied open coding by separating the transcript information into segments, while comparing similarities and differences. Then, axial coding was performed by grouping the codes into categories which had similar nuances and constructing explanations of interrelationships between codes and categories. Then, potential central categories were determined within each domain of the explanatory model by grouping or moving sub-categories to satisfactorily fit the central categories. The interrelationships of all central categories in each domain of the model were reviewed and labeled by both authors.

Both authors discussed intensively to reach a consensus on the grouping and labeling of categories; as well as the placement of categories into the sub-domains of the explanatory model. For example, for participants who stated that parental divorce was a relevant reason for the suicidal crisis, divorce was labeled as a sub-domain of suicide causes. This grouping also took into account the theoretical construct and enabled saturation to be reached quickly.

Credibility was ensured by triangulation of the participants, where the first author went back to the participants to get their opinions on the results and interpretation of the interviews. Credibility was also achieved through a reflective examination of the research process. Reflexivity enriched and evaluated the various levels of argumentation and logic of the researcher in developing patterns and conclusions. In this process, we reflected on our role and position in constructing analytical and systematic explanations. We also invited peers to review the accuracy and refine the codes and categories to maintain the trustworthiness of the data.

Results

Etiology

Suicide has a variety of names that contain nuances of emotions, thoughts of suicide, how the attempt is executed.

Language

It has been known that Javanese has varying names refer to suicide include *nglalu* (Javanese), *bunuh diri* (Bahasa Indonesia), and suicide (English). These language differences were more pronounced from the perspective of generational differences. *Nglalu* was more commonly used by older participants (>40 years old), whereas suicide (English) was more commonly spoken by younger people (<30 years old). Suicide was considered to contain less negative nuances (horror, taboo, and cruel), compared to *nglalu* and *bunuh diri*. "*When talking about bunuh diri, people immediately share everything, I feel uncomfortable. So I prefer to say 'suicide', like that*" (Yulia, 25 years old). *Bunuh diri* itself is actually a neutral term that is often interchanged with *nglalu* and suicide. Of course, the nuances and meanings of *bunuh diri* will differ, depending on who is saying it and the emotional reactions that accompany it.

Method

Suicide can be articulated through the method of how the act is committed. Popular terms that refer to suicide include *gantung* (hanging), *nyilet* (cutting the artery), and *lumpat* (jumping). These methods are understood as attempts to damage or injure the body. Dayat (male, 51 years old) recounted how people in Gunungkidul talk about suicide by *gantung*, even though the act was not committed by hanging, *"People here when reporting an incident, usually immediately call it gantung. The person was not necessarily died that way"*.

Euphemism

Suicide is a sinful act, forbidden (*haraam*), and against religious values, and it brings sorrow and the burden of stigma to relatives. Interestingly, Javanese did not mention suicide vulgarly and expressed it in softened terms to reduce or neutralize the nuances of grief and taboo. In this case, suicide is referred to in softened terms to reduce or neutralize the nuances of grief and taboo. Some of the terms used include *pegat nyowo piyambak* (taking one's own life), liberation, giving up, shortcut, or ending life. Adi (male, 31 years old) said *"...the shortcut. I know the term because it tends to be subtle, in the sense that I soften the term suicide more, yes with a shortcut"*. Laras (female, 25 years old) even admitted that she did not have a specific term for suicide and did not agree with the various popular terms used by the community. In fact, she was not very comfortable with the use of unvulgar suicide terminology. For her, softening the term suicide still cannot remove the true horror and suffering. Laras believed suicide should not exist, nor should any terminology exist to express it. *"I don't have a word for it (suicide). I'm not comfortable expressing that word, even if it's softened"* (Laras).

Table 2
Cultural Meaning of Suicide in Javanese People

Domain	Category	Sub-category
Etiology	Language	a) *Nglalu, ngendat*
		b) *Bunuh diri*
		c) Suicide
	Method	a) Hanging
		b) Harming or damaging one's physique
	Euphemism	a) Ending life
		b) Giving up
		c) Liberation
Causes	Suffering	a) Chronic illness, complicated life problems, traumatic experiences, violence, financial issues, loss
		b) Psychosocial stressors (intimate partner relationships, familial conflict, societal and cultural pressures, and embarrassment)
	Hopelessness	a) Repeated failures
		b) Unrealistic expectations
		c) Disappointment, fear of expectations

Table 2 (Continued)
Cultural Meaning of Suicide in Javanese People

Domain	Category	Sub-category
	Isolation	a) Loneliness
		b) Low social support
		c) Lack of appreciation, neglect
	Mental frailty	a) Impulsive thinking, poor emotional management
		b) Overthinking, moody
		c) Low endurance
	Low religiosity	a) Sin, forbidden act
		b) Weak faith, distant from God
		c) Lack of religious understanding
		d) Non-compliance with religious practice

Perception of Causes

Suffering

A person who is driven to commit suicide is believed to experience severe life suffering, known by Javanese speakers as *katiwasan*. This suffering can arise from complicated life problems, chronic illness, violence, financial crisis, and loss. Psychosocial stressors are also often mentioned as causes of suffering, arising from domestic conflicts, failure to meet social demands, intimate partner problems, and violations of general societal rules that can cause *wirang* (intense shame due to violation of moral codes). One survivor, Vale (female, 23 years old), often experienced verbal and physical violence from her father that changed her view to life as suffering. In the same words, Rahayu (female, 77 years old) said, *"Violence in the family, it really destructs our realtionship. Violance makes our life miserable."* Sasa (female, 28 years old), who had assisted several students with suicidal crises, said, *"People who commit suicide are those suffer in life, because they experience violence. What I have encountered so far is either physical or mental violence. Including those who suffer socially, because they try to please many people."*

Hopelessness

This condition is a form of frustration, which imparts a pervasive sense of minimal to no hope towards an individual's life. Hopelessness leads to the lack of expectations and the fear of regaining hope. Losing hope means losing orientation and meaning in life. Laras recounted how her best friend attempted suicide due to hopelessness, *"I know she became very down and increasingly frustrated. She could no longer see a way out of her problems."* The suffering experienced earlier can be fatal if the candles of hope are blown out. Sasa also said, *"Despair, either because of the suffering or all sorts of unsatisfactory efforts. Because there is so much despair and no hope, suicide is often the way out."*

Alienation

This category refers to a form of disconnection from one's social world. A person who commits suicide is believed to experience chronic loneliness, failure to establish relationships and build trust with others, low quality of social support, and increasing experiences of neglect. Dayat, a Catholic priest, believed that loneliness is the main cause of suicide among the elderly in Gunungkidul, *"When they are old, they live alone at home or with their equally old partner. Loneliness is a deadly disease. Before the body dies, loneliness kills the psyche first."* Alienation is also common in people who are denied of enough social attention or recognition. Hana (female, 26 years old), a suicide survivor shared this, *"I thought all this time I was not yearned. Even my parents and family didn't want me. All I know is that I feel alone living in this world."*

People who experience alienation perceive that others cannot understand them nor providing assistance in alleviating their predicaments. Suicide attempters are considered lacking in quality social relationships. Anto (male, 61 years old), a local Christian preacher, recalled how a woman he used to aid had very poor family relationships, *"If she was in a family that could give her space to express her problems, the suicide attempt would not have happened, for sure. Unfortunately, she was raised by a family with a very strict father, who didn't want to know about his child's situation."*

Mental Frailty

Mental frailty refers to a person's psychological vulnerability in the face of crisis, including: 1) low toughness, 2) non-constructive thinking and persistent rumination on problems, and 3) low emotional control. This frailty is also associated with low endurance in dealing with various problems. Nesi (female, 31 years old), for example, summarized how her boyfriend could have a suicidal crisis after a career failure, "*He was not strong enough to accept such failure, he only had 'weakness' in his mind."* Our participants described suicidal people as being unable to think thoroughly and reflectively, having poor emotional control, and being impulsive. Suicide attempters were described as having a "small heart." Slamet (male, 56 years), a Javanese shaman, suggested, *"I understand these people are mentally weak, unable to withstand the burden of problems. These problems affect their resilience, but they are unable to think constructively. As a result, the mind is dark and cannot see the light of the future."*

Low Religiosity

Suicide attempters are generally perceived as people lacking in understanding of religion, being sinful, having weak faith, and having a distant relationship with God. We summarize that a lack of faith is associated with a loss of hope in divine grace and the promise of salvation behind every suffering. People who have suicidal thoughts are often associated with disobedience in performing acts of worship. Ahmad (male, 52 years old), an official of the Islamic religious office explained *"Suicide is committed by people who are weak in faith. Those who have suicidal thoughts are people who are not devout. Only people who are not devout can think of suicide."* People who have weak faith are considered vulnerable to hopelessness and are easily influenced by Satan to commit suicide. Ahmad added, *"Satan will rule in them. However, Satan will continue to try to harm people."*

Discussion

This study elaborated on emic information attributed to suicide risk factors that ranged from individual problems, family issues, to social relations. Our findings are in line with previous reports showing that suicidal behavior cannot be separated from psychosocial motives and cultural context (Parkar et al., 2012). This illustrates that the phenomenon of suicide encompasses multiple explanatory dimensions and reflects the viewpoints of distinct cultural communities. We highlight that the presence and connection with others are central motives as well as a fundamental meaning of existence in Javanese culture and society. In fact, connectedness with others is a source of happiness and hope, which can be a protective factor against suicidal crises (Nurdiyanto, 2020).

There is a diversity of terms used to refer to suicide. For example, according to the methods used, such as *gantung*, *nyilet* (cutting), or *minum*. *Gantung* is popularly associated to suicide, given the high rate of suicide incidents committed by hanging (Nurdiyanto & Jaroah, 2020). This study also found differences in etiology in explaining suicide, including *nglalu* (Javanese), *bunuh diri* (Bahasa Indonesia), and suicide (English). Adult participants (>35 years old) frequently mentioned *nglalu*, which represents horror, cruel, taboo, and forbidden. On the other hand, the word *suicide* was articulated more frequently by younger participants. As a foreign term, suicide is believed to be more neutral and does not contain negative nuance expressions like *nglalu*. The conscious selection of the word suicide is more indicative of exposure to mental health information and campaigns, especially those accessed through social media content in English. In addition, the difference in terms between the two generations suggests different aspirations and values regarding views of suicide and mental health issues.

We highlight that the domain of social relationships is the dominant cause of suicide, even though social relationships are a paradoxical domain between a protective factor and a relational reason for committing suicide. Previous studies have revealed that violence and social conflict are common causes of suicide for Asians (Chen et al., 2012; Peltzer et al., 2017), even in Javanese society, social conflict can be associated with the emergence of mental disorders (Browne, 2001; Good. et al., 2007). Relationships between husband-wife, parent-children, between friends, intimate partners, or significant others are sources of stressors that connects to anxiety and distress (Subandi, 2011). These relationship issues if amassed is able to cause mental conditions like restlessness, anxiety, and depression (Nurtanti et al., 2020; Subandi et al., 2021), such as family problems, interpersonal conflicts, and social expectations. Socio-cultural issues contribute to high suicide rates in Asian societies, such as social conflict and isolation, low socio-economic status, job loss, and poverty (Parkar et al., 2008). Suicide in Eastern societies is believed to be closely linked to issues concerning interpersonal relationships, religiosity, and socio-cultural aspects (Kurihara et al., 2009a).

Suicide crisis has complex consequences for survivors, both in intrapersonal and interpersonal relations. We found that when survivors were asked to describe the impact of their suicide experience, they described problems in building quality interpersonal relationships. They were frustrated with external expectations that they could not fulfill and expressed discomfort when they were around

people who did not accept them for who they were. This is compounded when survivors felt they fail to understand expectations and how to communicate them to others. The demands and pressures from their family or community (e.g., excessive demands, rejection, and overprotection) forced them into social isolation and other risk factors that could become psychological distress. Isolation places people with suicidal crises into a lonely and solitary confinement, which can lead to doubts about their existence. Isolation and withdrawal have been consistently reported to be predictors of suicide and depression (Hunt et al., 2017).

We also revealed that hopelessness is a common reason for suicide, as is loss of hope, failure to achieve expectations, and disappointment and fear of being let down. Hopelessness in this study is not simply despair, but also the inability to construct new hope. Hopelessness can occur when desires are not fulfilled and there is an inability to change or control the situation (Oyekcin et al., 2017). It is important to note that not every hopelessness can lead to suicide, but if accompanied with continuous failure becomes enough to make hopelessness fatal (Abramson et al., 2006). The finding is in line with Klonsky and May (2015) opinion that suffering and isolation are consistent causes of suicidal ideation and desire. The experience of suffering will be increasingly fatal in individuals who experience hopelessness syndrome; a higher level of hopelessness can be associated with repeated suicide attempts that can be fatal (Tsujii et al., 2020).

This research also linked mental frailty, an individual characteristic, with suicide vulnerability. Previous studies have positively linked mental resilience to emotion regulation; with high aggressiveness and impulsivity being diatheses of suicide (Cáceda et al., 2014). In fact, studies suggest that mental disorders can be a fatal suicide risk when combined with psychological vulnerabilities such as impulsivity, aggressiveness, and maladaptive coping capacity (Franklin et al., 2017; Stein et al., 2010). On the other hand, Ellis and Range (1989) suggested that non-adaptive cognitive capacities, such as rigid thinking, impulsivity, and pessimism are characteristics of suicide attempters because they can lead to failure to find alternative solutions. Mirkovic et al. (2015) found that suicide attempts tended to utilize ineffective coping (e.g., bottling up problems, worrying, and ignoring). The ability to perform positive coping strategies is part of an individual's protective factor against suicide ideation.

With the religious characteristic of the Javanese society, this study also captured that suicide is believed to be a forbidden, sinful act, and there is an emphasis on religious values in explaining why someone commits suicide. Studies of suicide in the context of Western societies would argue against this idea, but it is important to consider the religious aspect in understanding the etiology of suicide in religious societies. This study underline that the suicide crisis is understood to be related to a weakness of faith, disobedience to religious teachings, or a sense of spiritual detachment. Our findings diverge from and challenge the conclusions drawn by Febriawan (2020), who regarded this as a stigmatization of suicide. Faith in this finding takes the form of belief, religious knowledge, and perseverance in carrying out religious practices that can be a source of inspiration in resisting suicide. In line with Lawrence et al. (2016), this study emphasized that religion can build protective factors and prevent suicide. Religious affiliation contributes to connecting suicide-prone individuals to social groups as support systems. In addition, religious activities can also improve psychological well-being,

strengthen social networks, and encourage more positive expectations by providing interpretation and meaning to suffering. Hope and reconstruction of meaning are built through religious advice and teachings, such as God's mercy, *pahala* (rewards), and eternal life (Gearing & Lizardi, 2009). In this sense, religiosity and the frailty of faith have relevance in connecting people in crisis into webs of safety and support.

Javanese people believe that suicide is a fate-defying act, that threatens the sacredness of life and disrupts cosmic harmony. It is a forbidden act and contains a taboo value that is inappropriate to think about, say, let alone do. In this case, the labeling of suicide contains an effort to soften the taboo value of suicide. Subandi et al. (2021) elaborated that Javanese people tend to explain and name mental disorders with subtle idioms (e.g., odd, lost of mind, error) to reduce stigmatization and offensive psychological effects. We argue that the stigmatization of suicide also constructs the etiology and naming of suicide in Javanese society, even with a variety of subtle terms. Those who experience the adverse effects of stigma are likely to face challenges in seeking support and be labeled as weak (Gilchrist & Sullivan, 2006). Such views can inhibit help-seeking, as no one wants to be perceived as weak and instead seeks to present themselves as tough.

Our findings are consistent with a suicide study in Bali that emphasized the paradox between suicide, social, and religious values (Valentina & Nurcahyo, 2023). Suicide is an act against God's will and has bad karma as a consequences not only on the attempter, but also the family and neighboring community. More specifically, the Balinese believe that an unclean cosmic environment create a bad influence to those who occupy it. It is necessary to perform a Hindu cleansing ceremony at the location where the suicide occurred. Similarly, in Javanese mysticism, the suicide location will be cleansed and even remodeled with a new structure through ceremonies such as *ruwatan* and *slametan* (Suwena, 2016; Woodward, 2011). These rituals aim to restore relational, social, and supernatural harmony due to the chaos and terror caused by suicide; it is a collective coping effort (family and community) as well as a cultural mechanism in reintegrating the bereaved family into the society.

This research has important implications for the development of suicide prevention management studies and practices. In designing suicide interventions, it is important for practitioners and authorities to be sensitive to common knowledge and the local cultural context. Clinicians that are culturally sensitive can reduce future biases that can arise due to: 1) medical-clinical jargon that is not widely adopted by folks, 2) miscommunication between professionals and patients, 3) patients' fear of asking questions or consultation, 4) clinicians' assumption that patients already know, and 5) differences in cultural, social, and economic backgrounds (Kleinman, 1980; Weiss & Somma, 2007). Suicide prevention can be delivered by considering the symbols believed by the patient and the community, for example related to religiosity or expressions of passiveness. This study advocates for cultural competence training for mental health practitioner candidates, given that cultural competence has not been elaborated in widely clinical practice, particularly in the Javanese context. Cultural competence refers to the awareness, knowledge and skills, and processes required by clinicians and systems that can work effectively in cultural diversity (Kirmayer, 2012). Clinicians can understand the clinical representations inherent in the identity, cultural and social values of patients who are

culturally different from them. As an example, a psychologist in a community health center may not understand why their patients are embarrassed to share experiences of life crises and prefer to express them figuratively. Cultural competence can be achieved by translating individual or group knowledge into mental health service practices and policies (Gopalkrishnan, 2019). The application of cultural competence can create mental health services that can provide optimal treatment or care to each client without the barriers of certain cultural symbols.

We need to address some of the limitations of this study. The participants did not represent other more diverse characteristics, such as bereaved families or low-educated groups. The survivor participants were all relatively young, and therefore future investigations should consider survivors from other age groups (e.g. adults, elderly). In addition, this study was limited to the context of Yogyakarta, which may pose challenges for application in other regions.

Conclusion

In conclusion, this study identified the cultural meanings of suicide that are perceived as causes of suicide in the context of Javanese society: suffering, hopelessness, alienation, mental frailty, and low religiosity. We underline that cultural factors have relevance in the meaning, actions, and consequences of suicide, while offering how the dynamics of suicide can be understood through a contextual framework. This study also reveals that the social domain is a paradoxical dimension; it is a causal reason but can also be a potential preventive factor in the Javanese suicide crisis. This study contributes to address suicidal behavior in the context and meaning of Javanese culture, as well as providing cultural binoculars in suicide prevention efforts. Locally relevant patterns of suicidal behavior should be considered in planning specific programs to ensure culturally sensitive mental health services by considering the various cultural attributes of suicide. Ignoring cultural aspects will only lead to bias.

Recommendation

We suggest three suicide prevention strategies that can be carried out considering the social domain: 1) individual preventive interventions focused on efforts to increase adaptive coping capacity, openness to seek help, and resilience; 2) group and community interventions by strengthening family and community as a support system; and 3) mental health promotion is carried out by including de-stigmatization of suicide, while emphasizing sensitivity and empathy, considering that suicide can happen to anyone. This study recommends the development and implementation of suicide prevention management by considering cultural meanings and symbols related to the local explanatory model. Authorities need to provide cultural competency skills training to every mental health clinician in order to have cultural sensitivity in identifying patients' clinical presentation and improve the efficacy of interventions.

Declaration

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Conflict of Interests

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Author Contributions

FAN: Conceptualization, Methodology, Analysis, Writing – original draft, review and editing. S: Writing – review and editing, Supervision.

Orcid ID

F.A. Nurdiyanto https://orcid.org/0000-0003-4353-2501

Subandi https://orcid.org/0000-0001-6655-0038

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