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LITERATURE REVIEW

Faith and Mental Health: Reconstructing the Religious Narrative in Suicide Prevention Efforts in Indonesia (A Narrative Review)

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ABSTRACT

Suicide remains a largely hidden public health concern in Indonesia, shaped by pervasive underreporting and religion-based stigma that frequently frames psychological suffering as a manifestation of weak faith. This narrative review critically examines the dual role of religion in suicide prevention, acknowledging its capacity to function both as a protective resource and, under certain interpretive conditions, as a factor that may exacerbate risk through stigma and social exclusion. Rather than aggregating empirical evidence, this review adopts an interpretive and theory-building approach, synthesizing interdisciplinary literature from public health, psychiatry, neurobiology, and Islamic theology to develop a conceptual framework for narrative reconstruction. The analysis highlights that religious teachings can foster hope, meaning, and social belonging, while rigid or judgmental interpretations may intensify shame and hinder help-seeking. Building on this synthesis, the article proposes a normative framework that integrates scientific understandings of psychological pain and neurobiological vulnerability with compassionate theological concepts, such as divine mercy and hope, and with the reinterpretation of *ikhtiar* and *tawakal* as supportive of professional mental health care. As a practical illustration, a culturally resonant psychological first aid model—*Ask, Listen, Accompany* (ALA)—is presented as a community-oriented approach aligned with established global principles, without claiming empirical validation. The framework is intended as a heuristic guide rather than an evidentiary model, and its applicability will vary across Indonesia's diverse socioreligious contexts. By repositioning religion as complementary to clinical care, this review aims to inform dialogue, guide future empirical research, and support culturally sensitive suicide prevention efforts.

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Introduction

Suicide remains a significant global public health concern, accounting for more than 700,000 deaths annually worldwide and ranking among the leading causes of mortality across multiple age groups, particularly adolescents and young adults (World Health Organization [WHO], 2023; GBD 2021 Suicide Collaborators, 2024). Contemporary scholarship increasingly conceptualizes suicidal behavior not as a singular outcome of individual psychopathology but as a multifactorial phenomenon shaped by the interaction of psychological vulnerability, social relationships, cultural meaning systems, and access to mental health care (Nock et al., 2008; Van Orden et al., 2010).

In low- and middle-income countries (LMICs), suicide and mental health challenges are further embedded within structural inequities, limited availability of professional services, and sociocultural frameworks that strongly influence help-seeking behaviour (Patel et al., 2018). Indonesia, as a lower-middle-income country with a predominantly religious population, represents a context in which suicide is widely underreported and often framed through moral, spiritual, or religious narratives rather than medical or psychosocial lenses (Nurcahyo & Suryani, 2022; Rahman & Yusuf, 2021). Such framings may simultaneously provide meaning and social cohesion while also reinforcing stigma and silence surrounding psychological distress.

Religion occupies a particularly complex position within suicide discourse. A growing body of empirical and review literature suggests that religious affiliation and engagement are frequently associated with reduced suicide attempts and mortality, potentially through mechanisms such as social integration, moral injunctions against self-harm, and the cultivation of hope and purpose (Koenig, 2012; Lawrence et al., 2016). Neurobiological studies further suggest that spirituality and religiosity may be associated with neural correlates linked to emotional regulation and resilience, offering a potential biopsychosocial pathway through which religious experience influences mental health (Miller et al., 2014).

At the same time, religion cannot be assumed to function solely as a protective factor. Qualitative and cross-cultural studies from Muslim-majority settings indicate that rigid, judgmental, or punitive religious interpretations may exacerbate stigma, intensify feelings of shame, and discourage individuals experiencing suicidal ideation from seeking professional help (Gearing et al., 2013; Mousavi et al., 2020). In such contexts, suicidal thoughts may be interpreted as evidence of weak faith or moral failure, obscuring their clinical significance as manifestations of overwhelming psychological pain (Shneidman, 1993).

From a global mental health perspective, these tensions highlight the need to situate suicide prevention within broader sociocultural and governance frameworks rather than relying exclusively on biomedical models (Patel et al., 2018). Mental health discourse is not value-neutral; it is shaped by dominant narratives that determine how suffering is named, morally evaluated, and responded to within a given society (Rose, 2019). In religious contexts, these narratives may profoundly shape public attitudes toward suicide, influencing whether distress is met with compassion and care or condemnation and exclusion.

Against this background, this narrative review aims to examine the dual role of religion in suicide prevention within predominantly Muslim contexts, with particular attention to Indonesia. Rather than evaluating the effectiveness of

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specific interventions, this article adopts a theory-building and interpretive approach to synthesize interdisciplinary literature from psychiatry, public health, neurobiology, and Islamic thought. By integrating scientific understandings of psychological pain and neurobiological vulnerability with compassionate theological concepts, this review seeks to propose a conceptual framework for narrative reconstruction that reduces stigma and repositions religion as complementary to, rather than competitive with, professional mental health care.

Methodological Clarification

This article adopts an interpretive narrative review approach rather than a systematic or meta-analytic methodology. The literature reviewed was selected to support conceptual exploration and theory-building regarding the relationship between religion and suicide, rather than to provide exhaustive coverage or a quantitative synthesis. Consequently, the analysis reflects an interpretive perspective shaped by interdisciplinary engagement with public health, psychiatry, neuroscience, and theology, and does not aim to establish causal relationships or generalisable effect sizes. While this approach is well-suited to examining complex sociocultural and ethical narratives, it necessarily entails limitations stemming from selection biases and interpretive subjectivity.

Results

This section summarizes patterns consistently reported in the existing literature regarding the relationship between religion and suicide-related outcomes. The findings are presented descriptively, without advancing causal claims or normative recommendations. Interpretive synthesis and conceptual propositions are addressed separately in the Discussion section.

Religion as a Protective Factor in Suicide-Related Outcomes

Across diverse cultural contexts, religion has frequently been associated with protective effects against suicidal behavior. Systematic reviews and epidemiological studies report lower rates of suicide attempts and mortality among individuals with religious affiliation or engagement, although the magnitude and consistency of this association vary across populations and outcome measures (Lawrence et al., 2016; West et al., 2025). Protective associations appear most robust for suicide attempts and mortality, while findings related to suicidal ideation remain more heterogeneous.

Several mechanisms have been proposed to explain these protective associations. First, many religious traditions explicitly prohibit suicide, establishing moral norms that discourage self-harm. Second, religious belief systems often provide existential meaning, hope, and a sense of purpose, which may buffer against hopelessness—a well-established risk factor for suicide (Shneidman, 1993). Third, participation in religious communities is frequently associated with greater social integration, perceived social support, and reduced isolation, all of which are recognised protective factors in suicide prevention research.

In predominantly religious societies such as Indonesia, these mechanisms are often embedded in everyday social life. Communal worship, shared moral frameworks, and collective religious practices may contribute to social environments that promote endurance and mutual responsibility during periods of psychological distress.

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Religion as a Risk-Enhancing Factor Under Certain Conditions

In contrast to its protective associations, the literature also documents circumstances under which religion may be associated with increased suicide risk or barriers to prevention. Studies on spiritual struggle consistently report that negative religious coping—such as feelings of divine punishment, abandonment by God, or excessive guilt—is associated with higher levels of depression, hopelessness, and suicidal ideation (Pargament et al., 1998; Exline et al., 2014).

Membership in religious minority groups has also been linked to elevated suicide risk, potentially due to experiences of marginalization, discrimination, or reduced social belonging (Cull et al., 2025). These findings underscore that the impact of religion on suicide-related outcomes is contingent on social position, interpretive context, and lived religious experience.

Within Indonesia, qualitative and mixed-method studies describe the presence of religion-based stigma surrounding suicide and mental illness. Psychological suffering is frequently framed as a moral or spiritual failure, commonly expressed through notions of "lacking faith." Such narratives intensify shame, discourage disclosure of suicidal thoughts, and delay access to professional mental health services (Subandi et al., 2018). Qualitative research from Bali further illustrates how moralized interpretations of suicide contribute to silence, social distancing, and stigma affecting both individuals and bereaved families (Valentina & Nurcahyo, 2023).

Discussion

This narrative review highlights the complex and often ambivalent role of religion in suicide prevention, particularly within predominantly Muslim contexts such as Indonesia. Rather than functioning as a uniformly protective or harmful factor, religion emerges as a socially embedded system of meaning that can either mitigate or exacerbate suicide risk depending on how religious teachings are interpreted, enacted, and governed within specific sociocultural settings. This finding is consistent with contemporary suicide theories that emphasise the interaction between individual vulnerability and broader interpersonal, cultural, and structural factors (Shneidman, 1993; Van Orden et al., 2010).

Religion as a Source of Protection and Meaning

Consistent with previous systematic reviews, religious affiliation and engagement are frequently associated with lower rates of suicide attempts and mortality, although associations with suicidal ideation remain more heterogeneous (Koenig, 2012; Lawrence et al., 2016). In Muslim-majority societies, religious beliefs and practices may foster social connectedness, provide moral frameworks that discourage self-harm, and cultivate hope and meaning during periods of psychological distress. These protective functions are particularly salient in low- and middle-income countries, where formal mental health services are often limited and religious institutions frequently serve as accessible sources of emotional and social support (Patel et al., 2018).

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Emerging neurobiological evidence further suggests that spirituality and religiosity may be associated with neural processes involved in emotional regulation and resilience, offering a plausible biopsychosocial pathway through which religious experience influences mental well-being (Miller et al., 2014). Importantly, these protective mechanisms appear to operate less through doctrinal content alone than through lived religious experience, including perceptions of belonging, acceptance, and care within religious communities.

Religion, Stigma, and the Silencing of Psychological Pain

At the same time, this review underscores that religion may also function as a risk-amplifying factor when psychological distress is framed through rigid, moralistic, or punitive interpretations. Qualitative and cross-cultural studies from Indonesia and other Muslim-majority settings indicate that suicidal ideation is often interpreted as evidence of weak faith or moral failure, leading to shame, secrecy, and delayed help-seeking (Gearing et al., 2013; Mousavi et al., 2020; Nurcahyo & Suryani, 2022). Such interpretations may inadvertently invalidate psychological pain and obscure its clinical significance.

Contemporary suicide research increasingly converges on the understanding that suicidal ideation reflects an attempt to escape intolerable psychological pain rather than a genuine desire for death (Shneidman, 1993). When religious discourse fails to recognize this distinction, it risks reinforcing stigma and intensifying suffering. In this sense, the problem lies not in religion per se, but in how religious narratives are mobilized to explain and morally evaluate psychological distress.

Governance, Narrative, and the Ethics of Suicide Discourse

Mental health discourse is not value-neutral but is shaped by governance practices that influence how psychological suffering is classified, interpreted, and responded to within society (Rose, 2019). These practices operate not only through formal policy and clinical institutions but also through informal moral frameworks embedded in cultural and religious narratives. In predominantly religious contexts, such narratives may profoundly shape public understandings of suicide, determining whether individuals experiencing distress are met with compassion, silence, or moral condemnation.

From this perspective, stigma surrounding suicide can be understood as a product of narrative governance, whereby specific interpretations of suffering are legitimized while others are marginalized. When suicidal ideation is framed primarily as moral or spiritual failure, psychological pain may be rendered invisible as a legitimate health concern. This framing risks discouraging help-seeking and reinforcing social exclusion, particularly in settings where religious authority strongly influences community norms and values.

Integrating a governance lens into suicide prevention highlights the ethical responsibility to examine dominant narratives that regulate responses to distress critically. Reframing suicide discourse to emphasize psychological pain, vulnerability, and the need for care may help counter stigma without undermining religious values. In this sense, religious narratives can be reoriented toward compassion and responsibility, functioning as ethical resources that support, rather than obstruct, access to mental health care.

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Toward an Integrative and Compassionate Framework

Building on this synthesis, the present review proposes an integrative conceptual framework that bridges scientific understandings of psychological pain and neurobiological vulnerability with compassionate theological interpretations. Rather than positioning religion and psychiatry as competing explanatory systems, this framework emphasizes their potential complementarity. Concepts such as *ikhtiar* (active effort) and *tawakal* (trust in God) may be reframed as supportive of professional mental health care rather than as substitutes for it, thereby reducing perceived tensions between faith and treatment.

From a practical perspective, global suicide prevention frameworks increasingly emphasise the importance of multi-level interventions that integrate individual, community, and systemic approaches (Zalsman et al., 2016). In resource-limited settings, culturally adapted community-based strategies may serve as feasible entry points for early support, particularly when aligned with existing religious and social structures. While such approaches require empirical validation within specific contexts, they may serve as heuristic tools to facilitate compassionate engagement and reduce barriers to help-seeking without prematurely medicalizing distress.

As an interpretive narrative review, this article is subject to limitations arising from selection criteria and analytical subjectivity. It does not provide quantitative estimates of effect or establish causal relationships. In addition, persistent underreporting of suicide in Indonesia constrains epidemiological precision. The proposed framework is conceptual and normative, and its feasibility and effectiveness require future empirical and implementation research.

Conclusion

Suicide is a significant yet largely hidden public health crisis in Indonesia. Practical prevention efforts are currently impeded by a combination of inaccurate official data due to massive underreporting and profound social stigma, often reinforced by judgmental religious narratives that equate psychological suffering with a weakness of faith. This narrative review synthesizes literature from multiple disciplines to demonstrate that the role of religion in suicide prevention is not static; it can be a risk factor when its interpretation fosters judgment and isolation, but it can also be a decisive protective factor if its narrative is deliberately reconstructed.

The answer to the first research question is that religion has a dual role. Inherently, through moral teachings, the instillation of hope, and the provision of community, religion serves as a protective bulwark against despair. However, rigid and less compassionate interpretations can transform it into a source of stigma that exacerbates risk. In answering the second question, an effective narrative reconstruction requires an integrated approach. This involves deconstructing the "lacking faith" myth by leveraging modern scientific understanding of psychological pain, cognitive constriction, and the neurobiological underpinnings of depression. Concurrently, it demands a theological reconstruction that re-emphasizes core Islamic principles of mercy and hope, and reinterprets *ikhtiar* and *tawakal* to embrace professional medical and psychological help actively.

The primary contribution and novelty of this review is the articulation of an integrated and actionable framework for this narrative change. By harmonizing insights from psychiatry, neurobiology, and a compassionate interpretation of Islamic theology, this framework offers a path to transform religion

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from a barrier into a bridge to recovery. Empowering the community through a simple, culturally relevant first aid model like "Ask, Listen, accompany" is a practical step toward realizing this new narrative, turning every individual into a potential agent of prevention and, ultimately, saving lives.

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