Jurnal Kawistara
The Journal of Social Sciences and Humanities

Vol. 15, No. 2, Agustus 2025: 158–177
https://doi.org/10.22146/kawistara.101193
https://jurnal.ugm.ac.id/kawistara/index
ISSN 2088-5415 (Print) | ISSN 2355-5777 (Online)
Submitted: 31-10-2024; Revised: 09-07-2025; Accepted: 13-08-2025

Ethical Perspectives on Mental Health Advocacy for College Students at Risk of Suicide: Insights from Buddhist Psychology

Fuji Riang Prastowo[1*]
[1] Indonesian Consortium for Religious Studies
Faculty of Social and Political Sciences, Universitas Gadjah Mada
Kwartarini Wahyu Yuniarti[2]
[2] Faculty of Psychology, Universitas Gadjah Mada
Yulianti[3]
[3] Faculty of Cultural Sciences, Universitas Gadjah Mada
*Corresponding author: fujiriangprastowo@ugm.ac.id

ABSTRACT This study examines the ethical aspects of mental health advocacy for Indonesian university students at risk of suicide, highlighting the constraints of prevailing Western psychological frameworks that emphasize biomedical secrecy and autonomy. These standardized techniques can engender estrangement and overlook Indonesian students' cultural and community realities. This study utilizes an autoethnographic approach rooted in Buddhist psychology and the concept of cognitive justice to demonstrate how academic settings influenced by cognitive capitalism exacerbate mental health issues. The research presents an ethical alternative grounded in Buddhist principles, including *Bodhicitta* (altruistic intention), *Anattā* (non-self), and *Kalyāṇamitta* (spiritual friendship), emphasizing community healing and relational support. Lecturer-counselors are essential figures, delivering non-clinical, culturally relevant support that connects institutional procedures with students' real-life experiences. The study attempts inflexible confidentiality standards in Western mental health procedures, contending that they may heighten suicide risk by isolating peers and family from the support process. It presents a three-tiered structure integrating universal prevention, targeted ethical support, and culturally tailored crisis intervention, harmonizing Buddhist ethical principles with global health standards. This integrative strategy reconceptualizes mental health advocacy as a moral and community pursuit, converting higher education institutions into compassionate ecosystems grounded in ethical solidarity, cognitive equity, and cultural significance. The study ultimately calls for transitioning to ethically inclusive, spiritually coherent, and structurally responsive mental health interventions in Indonesian universities.

KEYWORDS *Buddhist Psychology; Cognitive Justice; Lecturer-Counselors; Mental Health Advocacy; Suicide Prevention.*

INTRODUCTION

Student suicides in Indonesia have emerged as a significant public issue, especially in university settings where competitive pressures, academic isolation, and insufficient institutional support intensify psychological misery. Between September and October 2023, during the formulation of this scholarly work, at least three university students committed suicide (Kartikasari, 2023; Yulisnawati, 2023; Purbaya, 2023). Despite the Indonesian Ministry of Health reporting 826 suicide cases in 2022, a 6.37% increase over 2018 (Sagita, 2023), mental health frameworks in higher education remain heavily reliant on

biomedical paradigms that are insufficiently adapted to Indonesian students' cultural and existential realities.

This study is authored cooperatively by three individuals. The first author, a university lecturer, volunteer mental health advocate, and Secretary of the Department from 2021 to 2023, employs an autoethnographic methodology to examine personal experiences in supporting students with suicidal ideation and emotional distress both within and beyond the academic environment, utilizing institutional authority to promote advocacy at the faculty level. The second and third writers, possessing expertise in clinical psychology and Buddhist studies, offer analytical foundations to evaluate these insights through clinical and philosophical perspectives. This collaborative authorship facilitates a multifaceted comprehension of mental health advocacy that integrates personal experience, psychological understanding, and Buddhist ethical principles.

The initial advocacy of the first author commenced in 2018 at Universitas Gadjah Mada (UGM) and intensified during the COVID-19 pandemic, exposing systemic deficiencies in the institutional mental health response. As department secretary (2021-2023), the first author implemented structural interventions at the faculty level, including establishing safe rooms with oxygen for students undergoing panic attacks and negotiating exam accommodations for impacted students. These initiatives received institutional backing and provided immediate aid to 27 students over two years. After the suicide of a UGM student at a neighboring hotel (Wawan, 2022), these interventions were broadened to incorporate collaborative avenues with professional psychologists, psychiatrists, and community stakeholders.

Simultaneously, the first author launched a non-clinical, spiritually focused program named Selasa Hening ("Silent Tuesdays"), which has been conducted regularly at Karangdjati Vihara in Yogyakarta since July 2023. Grounded in Theravāda Buddhist psychology and bolstered by a partnership of interfaith practitioners, Selasa Hening offers a communal, stigma-free environment where students and community members engage in mindfulness, address mental health issues, and oppose pathologizing labels such as *Orang Gila* (crazy person). Widely attended by students from the first author's university, the program provides a stigma-free space for peer connection among those receiving psychological or psychiatric care—interactions often restricted on campus due to clinical confidentiality. As the standard 1–2 hour biomedical consultation model is perceived as inadequate for addressing crises beyond clinical settings, students seek community-based support. The first author, serving as the program's permanent meditation facilitator, enables continuity of care through relational and ethical presence. This communal approach, unlike academic protocols that prioritize secrecy and psychological diagnosis, promotes open discourse and ethical witnessing, aligning with Buddhist principles such as *Anattā* (non-self), *Karunā* (compassion), and *Kalyāṇamitta* (spiritual relationship). The spiritual and collective interpretation of

suffering contests the binary framework of illness and health seen in biomedical models, positioning mental pain as a communal existential experience.

This disparity illustrates a wider epistemic conflict in mental health advocacy between Western psychological standards—particularly individualism, confidentiality, and diagnostic classification—and non-Western perspectives that prioritize relationality, impermanence, and social resilience. Indonesian universities, shaped by neoliberal educational demands and adopted mental health procedures, frequently replicate Western paradigms that exclude alternative ethical and spiritual understandings of distress. This study positions itself within this contentious domain by employing Shiv Visvanathan's (1998, 2016) notion of cognitive justice, which promotes heterogeneous knowledge systems and contests the dominance of Western epistemologies in delineating mental well-being.

The research employs Independent Mental Health Advocacy (Maylea et al., 2020), a person-centered approach that integrates individual assistance with systemic advocacy within academic settings at the intersection of Western psychology and engaged Buddhism. Buddhist generosity, significant to engaged Buddhism (King, 2023), redefines religious practice as social engagement to foster mental resilience throughout diverse societies. The study question underlying this investigation is: *How may Buddhist psychology enhance mental health advocacy for Indonesian college students, particularly in promoting resilience and mitigating suicide within an academic environment primarily influenced by Western psychological frameworks?*

Literature Review

The study contributes to three important intellectual and practical areas. First, by acknowledging educators and peers as ethical suicide prevention agents through community-based involvement and Buddhist-informed assistance, it redefines mental health advocacy beyond clinical and medical institutions. Second, it makes a unique empirical addition to the discourse on mental health in Indonesian universities by exposing infrastructural limits while simultaneously addressing the epistemic conduct of Western psychological dominance, which frequently marginalizes indigenous knowledge systems. Third, by integrating Buddhist ontology into campus mental health frameworks, the study promotes a culturally resonant paradigm of holistic well-being that views suffering as an ethical and spiritual reality to be compassionately understood and collectively addressed.

Buddhist Ontology and Suicide: Reframing Suffering Beyond the Clinical Model

Buddhist psychology's ontology of suicide significantly opposes Western psychiatric paradigms by reconceptualizing suffering as a universal condition associated with delusion (*moha*), yearning (*ta□hā*), and the illusion of selfhood (*sakkāya-di□□hi*). According to the Kyoto School's conceptual integration of Zen and psychoanalysis (Fukui, 2022; Rigsby, 2014; Kato, 2016), Buddhist philosophy perceives the self as an ephemeral phenomenon rather

than a fixed reality. Nishida Kitaro's focus on emptiness (*śūnyatā*) as a philosophical foundation has significantly shaped the perception of mental health crises, viewing them not as deviations to be professionally rectified but as existential thresholds necessitating ethical judgment and spiritual care (Yong, 2013; Hetrick, 2022).

Buddhist viewpoints contend that suicide does not end suffering but rather prolongs it through karmic reincarnation (Attwood, 2003; Delhey, 2006; Promta & Thomyangkoon, 2009). Prominent case studies, including those of Channa and Godhika, are pivotal in this discussion, where moral permissibility depends on mental clarity and intention (Keown, 1996; Delhey, 2006). Nonetheless, suicide is not sanctioned; instead, it signifies spiritual failure when motivated by despair. Delhey's (2006) admonition against moral absolutism and Attwood's (2003) notion of "imaginative empathy" present a balanced approach: suicide should be ethically addressed, neither denounced nor idealized.

Recent research has positioned Buddhist Psychology as a field that delves deeply into the nature of the mind and human consciousness (Gallagher et al., 2023; Kato, 2016; Kelly, 2023; Sahdra & Shaver, 2013). Fundamental Buddhist tenets aimed at alleviating suffering, particularly in the context of suicide prevention, such as mindfulness and meditation, have been progressively incorporated into therapeutic methodologies like Mindfulness-Based Stress Reduction (MBSR) (Gawrysiak et al., 2018; Lengacher et al., 2009) and Mindfulness-Based Cognitive Therapy (MBCT) (Nissen et al., 2020; Tovote et al., 2017). The ontology of suicide in Buddhist Psychology is defined by ideas that contest the permanence of the self and highlight detachment from the ego as a means to alleviate suffering (Attwood, 2003). However, these treatments frequently eliminate ethical and cultural dimensions. This study addresses the deficiency by reintegrating Buddhist soteriology into mental health advocacy as an instrument and an ethical framework.

Integrated Mental Health Advocacy in Suicide Prevention: Toward Holistic, Culturally-Responsive Models in Indonesian Universities

Mental health advocacy is essential for suicide prevention, especially via Psychological First Aid (PFA), which provides rapid, non-clinical assistance to those in distress. Mental health advocacy is not a replacement for professional mental health care (Foley & Platzer, 2007; Koteyko & Atanasova, 2018; Teale, 2017); however, its three fundamental principles—safety, calmness, and connectedness—facilitate emotional support to mitigate the intense feeling of loneliness, a recognized risk factor for suicidality (Brymer et al., 2006; Chou et al., 2006; Stahl et al., 2017).

Advocacy in low- and middle-income settings is often informal and little acknowledged (Hendler et al., 2016). Governments may undertake formal initiatives; however, as Gooding (2017) observes, bureaucratic layers frequently exacerbate rather than resolve the issue. Conventional mental health advocacy is primarily limited to clinical and familial contexts, resulting in inadequate attention

to educational and community-based areas (Hann et al., 2015; McKay & Shand, 2018). The lack of mental health support in Indonesian universities is significant, as existing resources frequently expose infrastructure deficiencies without providing alternative intervention frameworks (Rahvy et al., 2020; Wirasto, 2012).

Students frequently find themselves in a precarious liminality—beyond professional hours, they remain alone and exposed. McKay and Shand (2018) note that individuals who have survived suicide attempts frequently rely on "luck" or "chance" to obtain assistance. The lack of cohesive, culturally relevant support structures underscores the pressing necessity for morally informed and contextually appropriate advocacy measures.

This study fills this gap by offering a culturally grounded model of mental health advocacy, based on the Buddhist concept of *kalyāṇamitta*—spiritual companionship. Lecturer-counselors are conceptualized not solely as gatekeepers, but as ethical companions involved in moral present (Kowalczyk, 2023; Rodríguez & Huertas, 2013). This methodology corresponds with the Holistic Prevention & Intervention Model (HPIM) put forth by Besse et al. (2024), which amalgamates universal education, selective prevention, and specified therapeutic interventions.

The Indonesian Mental Health Act encounters obstacles due to structural fragmentation and societal stigma (Bikker et al., 2021). Irmansyah et al. (2009) assert that legal reforms frequently fail in the absence of culturally informed advocacy. This study addresses the research vacuum by offering an advocacy paradigm that reinstates dignity through relational, spiritual, and educational transformation.

Method

This research used an autoethnographic approach to investigate the ethical aspects of mental health advocacy for Indonesian university students facing suicide ideation. Autoethnography, which combines personal narrative with cultural analysis, was chosen to enable the first author—serving concurrently as a lecturer, department secretary (2021–2023), and mental health advocate—to critically examine the institutional, emotional, and existential aspects of suicide prevention in higher education.

Autoethnography, extensively utilized in health and medical education research (Farrell et al., 2015; Lapadat, 2017; O'Connell, 2023; Walker et al., 2020), enables the examination of the interplay between personal experience and overarching systemic frameworks. This study documented researcher reflections via journaling, field notes, and discussions with students, families, psychologists, psychiatrists, and academic colleagues. These narratives provide a thematic investigation into the ethical dilemmas arising in culturally and institutionally rooted mental health interventions. The study employs Visvanathan's (1998, 2016) idea of cognitive justice to critically contextualize the findings, contesting the epistemic supremacy of Western biological paradigms.

The author's distinctive positionality, especially as a meditation instructor at Karangdjati Vihāra, facilitated culturally attuned initiatives that connected institutional policy with spiritual practice. A significant

intervention in 2023 effectively averted a female student's suicide by leveraging familial and peer support via a Buddhist meditation network. These examples illustrate how Buddhist practices, provided spiritually at the vihāra and in a secular context within the institution, can augment or potentially replace therapeutic care.

Nonetheless, the author's dual function imposed constraints on prejudice. Institutional power provided access and influence not available to other lecturers, highlighting structural impediments to wider advocacy. Furthermore, intimate relationship connections obscured the differentiation between culturally accepted sorrow and severe suicidal thoughts. Some students, particularly those who have experienced religious trauma, responded positively to secularized therapies, needing ethical adaptation. The study was co-authored by a clinical psychologist and a scholar of Buddhist studies to guarantee analytical rigor. Their contributions facilitated interpretive triangulation, merging clinical and philosophical viewpoints to augment the study's validity and analytical depth.

DISCUSSION

Reframing Suffering and Resilience: Buddhist Psychology as an Ethical Alternative to Western Clinical Paradigms

Mental health interventions in Indonesian universities predominantly adhere to Western biomedical ethics, emphasizing clinical detachment, customized diagnosis, and procedural confidentiality (Hann et al., 2015; Wirasto, 2012). In a collectivist and religiously diverse society like Indonesia, where mental health is closely linked to familial ties, moral duties, and spiritual customs, the use of solely biomedical models can lead to ethical discord—simplifying intricate experiences of anguish to isolated symptoms requiring rectification.

Empirical evidence from 27 student interviews, along with the first author's autoethnographic experiences as both department secretary and mental health advocate, indicates a persistent pattern of emotional alienation and procedural exhaustion. Students characterized their interactions with university psychiatric services as bureaucratically limited and emotionally devoid, events that frequently exacerbated their feelings of loneliness. On May 19, 2023, the primary author, acting as Department Secretary, initiated an institutional email network that connected officials from undergraduate programs to the faculty dean level. This communication channel seeks to record procedural responses to mental health crises and to establish mental health as a strategic issue necessitating coordinated focus and morally safeguarded discourse.

UNIVERSITAS GADJAH MADA
FAKULTAS ILMU SOSIAL DAN ILMU POLITIK
DEPARTEMEN SOSIOLOGI
Jl. Sosio Yustisia No.1, Bulaksumur, Yogyakarta 55281 Telp. +62(274) 563362 Ext.214
Faks. +62(274) 551753, https://sosiologi.fisipol.ugm.ac.id, *E-mail* :sosiologi@ugm.ac.id

Nomor : 02/SLG/VI/2023 9 Juni 2023
Lamp. : 7 Berkas
Hal : **Permohonan Advokasi bagi Mahasiswa dengan Isu Mental yang Mengajukan Kebijakan Afirmasi Fakultas-Departemen**

Yth.
Dekan Fakultas Ilmu Sosial dan Ilmu Politik UGM

Dengan hormat,

UNIVERSITAS GADJAH MADA
FAKULTAS ILMU SOSIAL DAN ILMU POLITIK
DEPARTEMEN SOSIOLOGI
Jl. Sosio Yustisia No.1, Bulaksumur, Yogyakarta 55281 Telp. +62(274) 563362 Ext.214
Faks. +62(274) 551753, https://sosiologi.fisipol.ugm.ac.id, *E-mail* :sosiologi@ugm.ac.id

Nomor : 03/SLG/VI/2023 9 Juni 2023
Lamp. : -
Hal : **Notulensi Audiensi dengan Center for Public Mental Health (CPMH) – Kesehatan Jiwa Masyarakat, Fakultas Psikologi UGM**

Yth. Ibu/Bapak Dosen Departemen Sosiologi

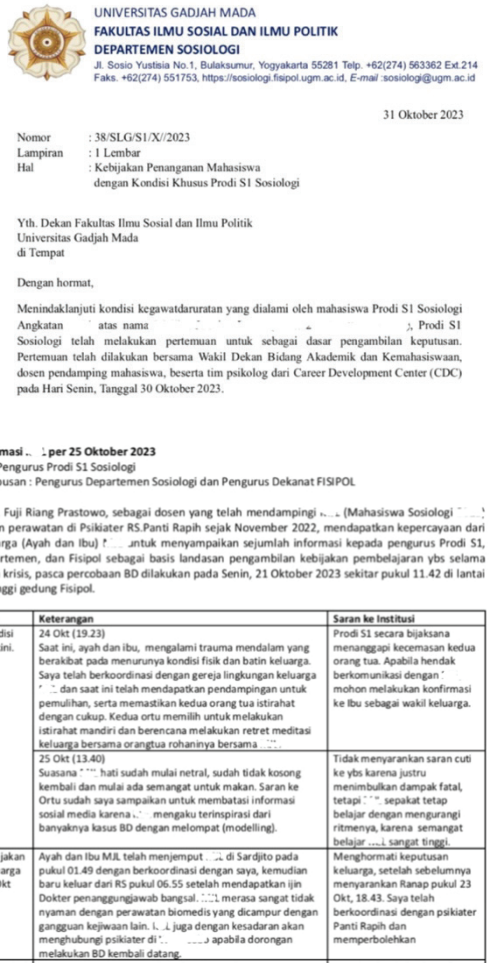
Picture 1 Documenting advocacy for university mental health professionals and students with mental health issues.

Source : Sociology Department, 2023.

On October 21, 2023, a student in the Sociology Department attempted suicide after encountering suicide-related digital content (Kartikasari, 2023), demonstrating how digital influences can aggravate pre-existing psychosocial issues and heighten the risk of suicidal ideation and behavioral relapse (Parrot et al., 2020). Despite the student's prior engagement with psychological support, stringent confidentiality requirements and clinical formalism inhibited family or peer participation, resulting in a deterioration in relational care. These instances underscore the ethical dangers of excessive proceduralism and the inadvertent consequences of impersonal care systems (Nazarzadeh et al., 2016; Petrie et al., 2023).

Incorporating Buddhist psychology concepts into mental health advocacy was executed through direct and ethically guided communication with the student's parents, enabling the prompt application of context-specific, family-sanctioned intervention methods. On the day of the failed suicide attempt, the primary author collaborated with Panti Rapih Hospital and Sardjito Hospital to launch a multi-institutional reaction. A detailed timeline of the case was subsequently assembled to guide policy recommendations focused on suicide prevention and post-crisis recovery, as illustrated in Figure 2, with particular emphasis on protecting peer networks within a student demographic marked by heightened mental health vulnerabilities.

Buddhist psychology provides an ontological and ethical reinterpretation of suffering. Based on fundamental concepts like *moha* (delusion), *taṇhā* (craving), and *sakkāya-diṭṭhi* (false sense of self), suffering is perceived not as a pathological deficiency but as a relational disruption within the network of interdependence (Keown, 1996; Fukui, 2022). Within this perspective, suicidal thought is not merely a symptom to be addressed but an indication of existential disconnection—a plea for *kalyāṇamitta* (ethical companionship), *karuṇā* (compassion), and *bodhicitta* (altruistic purpose to alleviate suffering). Healing necessitates not professional seclusion but morally engaged observation grounded in spiritual and communal support.



UNIVERSITAS GADJAH MADA
FAKULTAS ILMU SOSIAL DAN ILMU POLITIK
DEPARTEMEN SOSIOLOGI
Jl. Sosio Yustisia No.1, Bulaksumur, Yogyakarta 55281 Telp. +62(274) 563362 Ext.214
Faks. +62(274) 551753, https://sosiologi.fisipol.ugm.ac.id, E-mail :sosiologi@ugm.ac.id

31 Oktober 2023

Nomor : 38/SLG/S1/X//2023
Lampiran : 1 Lembar
Hal : Kebijakan Penanganan Mahasiswa dengan Kondisi Khusus Prodi S1 Sosiologi

Yth. Dekan Fakultas Ilmu Sosial dan Ilmu Politik
Universitas Gadjah Mada
di Tempat

Dengan hormat,

Menindaklanjuti kondisi kegawatdaruratan yang dialami oleh mahasiswa Prodi S1 Sosiologi Angkatan atas nama , Prodi S1 Sosiologi telah melakukan pertemuan untuk sebagai dasar pengambilan keputusan. Pertemuan telah dilakukan bersama Wakil Dekan Bidang Akademik dan Kemahasiswaan, dosen pendamping mahasiswa, beserta tim psikolog dari Career Development Center (CDC) pada Hari Senin, Tanggal 30 Oktober 2023.

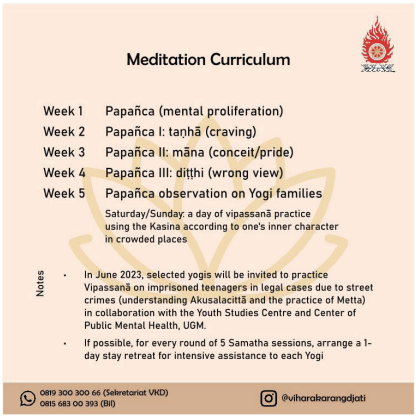
Informasi per 25 Oktober 2023
Yth. Pengurus Prodi S1 Sosiologi
Tembusan : Pengurus Departemen Sosiologi dan Pengurus Dekanat FISIPOL

Saya, Fuji Riang Prastowo, sebagai dosen yang telah mendampingi (Mahasiswa Sosiologi dalam perawatan di Psikiater RS.Panti Rapih sejak November 2022, mendapatkan kepercayaan dari keluarga (Ayah dan Ibu) untuk menyampaikan sejumlah informasi kepada pengurus Prodi S1, Departemen, dan Fisipol sebagai basis landasan pengambilan kebijakan pembelajaran ybs selama masa krisis, pasca percobaan BD dilakukan pada Senin, 21 Oktober 2023 sekitar pukul 11.42 di lantai tertinggi gedung Fisipol.

Info	Keterangan	Saran ke Institusi
Kondisi Terkini.	24 Okt (19.23) Saat ini, ayah dan ibu, mengalami trauma mendalam yang berakibat pada menurunya kondisi fisik dan batin keluarga. Saya telah berkoordinasi dengan gereja lingkungan keluarga dan saat ini telah mendapatkan pendampingan untuk pemulihan, serta memastikan kedua orang tua istirahat dengan cukup. Kedua ortu memilih untuk melakukan istirahat mandiri dan berencana melakukan retret meditasi keluarga bersama orangtua rohaninya bersama	Prodi S1 secara bijaksana menanggapi kecemasan kedua orang tua. Apabila hendak berkomunikasi dengan mohon melakukan konfirmasi ke Ibu sebagai wakil keluarga.
	25 Okt (13.40) Suasana hati sudah mulai netral, sudah tidak kosong kembali dan mulai ada semangat untuk makan. Saran ke Ortu sudah saya sampaikan untuk membatasi informasi sosial media karena mengaku terinspirasi dari banyaknya kasus BD dengan melompat (modelling).	Tidak menyarankan saran cuti ke ybs karena justru menimbulkan dampak fatal, tetapi sepakat tetap belajar dengan mengurangi ritmenya, karena semangat belajar sangat tinggi.
Kebijakan Keluarga 24 Okt	Ayah dan Ibu MJL telah menjemput di Sardjito pada pukul 01.49 dengan berkoordinasi dengan saya, kemudian baru keluar dari RS pukul 06.55 setelah mendapatkan ijin Dokter penanggungjawab bangsal merasa sangat tidak nyaman dengan perawatan biomedis yang dicampur dengan gangguan kejiwaan lain. juga dengan kesadaran akan menghubungi psikiater di apabila dorongan melakukan BD kembali datang.	Menghormati keputusan keluarga, setelah sebelumnya menyarankan Ranap pukul 23 Okt, 18.43. Saya telah berkoordinasi dengan psikiater Panti Rapih dan memperbolehkan

Picture.2 Advocacy documentation on suicide attempts in campus environment with integration of Buddhist Psychology principles with Health Promoting University

Source : Sociology Department, 2023



Picture.3
Extending Mental Health Support Beyond Campus: Meditation-Based Community Counseling for College Students

Source: Vihara Karangdjati, 2023

This ethical perspective has been implemented through community-based initiatives such as Selasa Hening (Silent Tuesdays), a weekly meditation assembly at Karangdjati Vihāra. The Buddhist concept of *Bodhicitta* (Salzberg, 2011)—altruism and compassion for others—illustrates how lecturer counselors engage with students beyond the academic setting. These assemblies served as a spiritual refuge for adolescents grappling with despair, grief, and emotional fatigue. These sessions represented a culturally significant mental health paradigm, incorporating *Sati* (mindfulness), *karuṇā*, and relationship trust rather than serving as mere contemplative exercises—students discovered in these assemblies not diagnosis but togetherness, not symptom management but ethical camaraderie.

Based on empirical experience and autoethnographic reflection, this study attempts to describe the ethical complexities of mental health advocacy in Indonesian higher education. The table below summarizes the structural limitations of dominant mental health paradigms in Western Pyschology and the ethical alternatives offered by Buddhist-informed practice:

Table 1. Comparative Ethical Aspects of Mental Health Approaches

Ethical Aspect	Western Psychology	Buddhist Psychology	Key Differences
View on Suffering and Suicide	Treated as pathological conditions requiring professional intervention.	Understood as outcomes of attachment, ignorance, and misapprehension of self (anattā).	Biomedical pathology vs. existential delusion.
Goal of Mental Health	Promotes personal autonomy and psychological resilience.	Seeks liberation from suffering through non-attachment and communal ethics.	Individual agency vs. collective harmony.
Crisis Intervention	Delivered by trained professionals through structured, confidential sessions.	Offered by trusted community and spiritual companions.	Professional detachment vs. relational engagement.

Ethical Aspect	Western Psychology	Buddhist Psychology	Key Differences
Autonomy and Individual Rights	Centralized around privacy, liberty, and self-determination.	Emphasizes interconnectedness and communal responsibility.	Individual independence vs. interdependent ethics.
Confidentiality	Absolute confidentiality as a professional imperative.	Conditional confidentiality within trusted networks.	Private professionalism vs. shared ethical care.
Cause of Suffering	Attributed to individual psychopathology.	Rooted in existential misconceptions and social disconnection.	Medical etiology vs. spiritual causality.
Therapeutic Relationship	Based on objectivity, professional distance.	Based on ethical friendship (kalyā amitta) and compassionate presence.	Detached care vs. moral companionship.
Compassion and Empathy	Subordinated to clinical neutrality.	Central to healing and ethical development.	Objectivity vs. karu ā.
Community vs. Individual Focus	Prioritizes self-management and individual resilience.	Centers on interdependence and collective well-being.	Ego-based recovery vs. communal healing.

Source: Authors, 2024

This relational paradigm was tested in real-time during the suicide crisis of October 2023 at the researcher's faculty. The student's immediate isolation in a psychiatric ward was mandated by biomedical protocols, as advised by Panti Rapih and Sardjito Hospital in Yogyakarta. Nonetheless, the student's family—excluded from this decision—challenged the intervention and forcibly reclaimed their child. Through lobbying based on relational ethics, the primary researcher achieved a resolution that emphasized family involvement, minimized dependence on medication, and enhanced the student's incorporation into a peer support network. This procedure confirmed an essential principle: Healing is not just adherence to protocol but engagement in a community that prioritizes ethical considerations.

Additionally, students consistently preferred informal and ethically engaged figures—such as lecturers, spiritual mentors, and peers—rather than formal mental health specialists. These partnerships provided what may be termed "ethical intimacy," defined by attentiveness, moral imagination, and cultural proximity. The Buddhist concept of kalyāṇamitta embodies the idea that transformation arises from institutional separation and trust-based companionship. The primary author's dual function as a meditation instructor and departmental secretary facilitated the implementation of these values, merging administrative power with spiritual guidance.

Moreover, institutional actions frequently marginalized families under the guise of confidentiality, resulting in a mismatch between formal regulation and cultural expectations. In a documented instance, as seen in Figure 2, institutional actors adhered to psychiatric protocols without engaging the student's primary support system, resulting in familial opposition and a deterioration of confidence. The lead advocate's technique of engaging the family through informed

consent and collaborative decision-making reinstated relational alignment and student autonomy. The synthesis of these themes is outlined below, encapsulating reoccurring student experiences, relevant Buddhist answers, and implications for institutional reform:

In the Indonesian context, characterized by epistemic plurality, neoliberal educational pressures, and resource disparities, this reframing is both culturally relevant and ethically necessary. It asserts that resilience is not an individual trait but a relational accomplishment, rooted in compassion, interdependence, and ethical observation (Sahdra & Shaver, 2013). As student suicidality reveals deficiencies in institutional care, Buddhist psychology presents a promising approach—prioritizing relational engagement over remote diagnosis and alleviating suffering via communal presence rather than silence.

Table 2. Empirical Themes, Buddhist Ethical Responses, and Policy Implications

Theme	Empirical Observations	Buddhist Response	Policy/Advocacy Implication
Alienation from confidentiality	Students reported abandonment, lack of follow-up, and procedural coldness	Anattā, Karunā	Rethink confidentiality as flexible, ethically responsive rather than rigidly procedural
Preference for moral companionship	Students turned to lecturers, peers, and spiritual mentors	Kalyāṇamitta	Formalize peer-led and lecturer-mediated support roles within university mental health systems
Family-institutional disconnect	Families excluded from psychiatric decision-making	Bodhicitta, relational ethics	Establish protocols for culturally sensitive, consent-based family engagement in suicide prevention
Digital contagion and post-truth stress	Students influenced by online suicide narratives and misinformation	Sati, Sampajañña, Viriya	Incorporate digital literacy, Buddhist discernment, and mindfulness in campus suicide prevention plans

Source: Authors, 2024

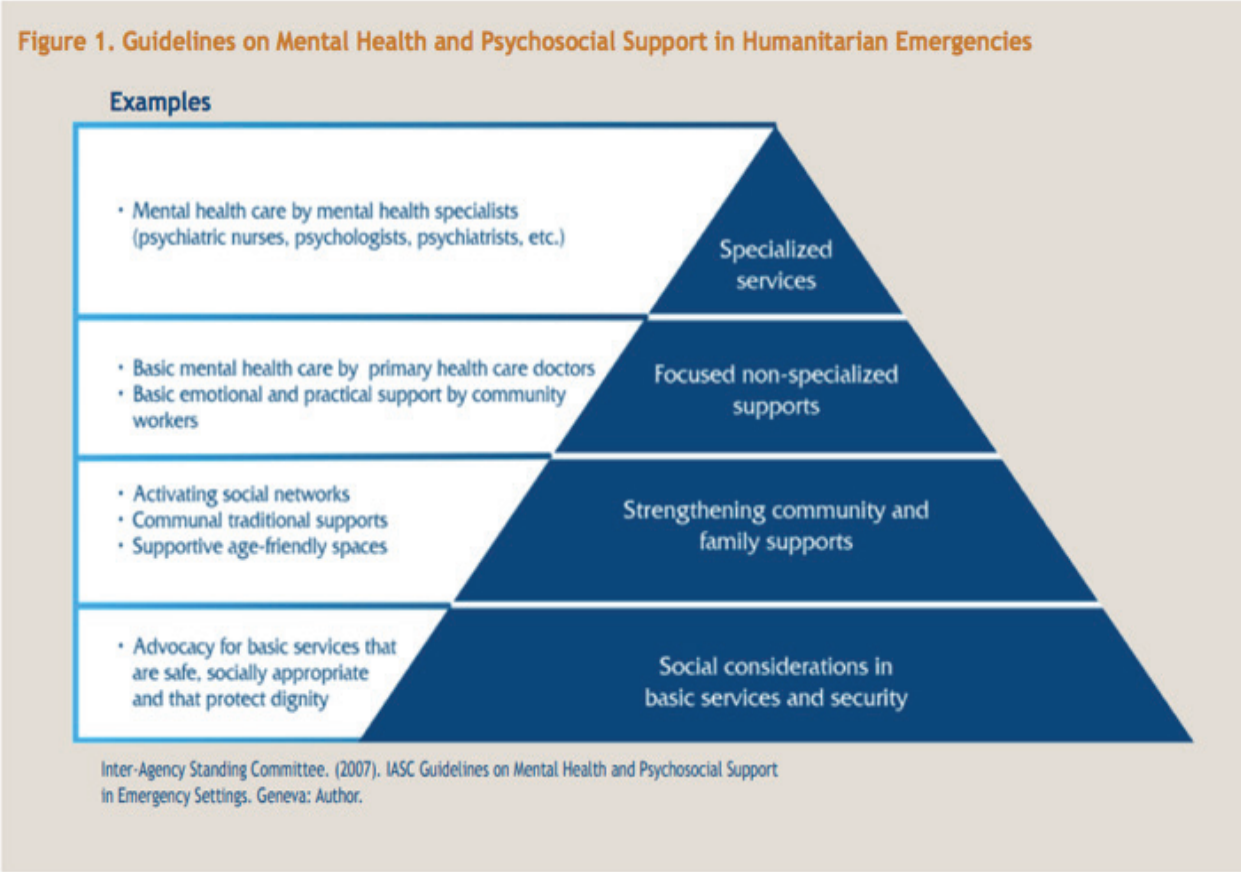
Lecturer-Counselors as Ethical Advocates — Relational Support Beyond the Clinical Model

Modern mental health advocacy in higher education necessitates a thorough reassessment of the individuals recognized as mental health support providers and the framework of ethical care inside academic institutions. In light of the increasing incidence of suicidality and mental distress among college students—aggravated by post-pandemic institutional constraints—a strong argument has arisen for acknowledging lecturer-counselors as primary ethical agents. These individuals, frequently functioning beyond established mental health institutions, have a vital ethical role in student well-being, especially within culturally rooted paradigms like Buddhist psychology.

In contrast to the procedural detachment typically necessitated in professional psychiatric work, Buddhist-informed lecturer advocacy is defined by ethical closeness, contextual attunement, and trust-

based companionship. Students preferred lecturers over professional counselors due to shared cultural contexts, the lack of bureaucratic obstacles, and the relational security these educators offer. This relational concept redefines lecturers as ethical witnesses instead of institutional authority, promoting recovery through treatment programs, moral presence, and dialogical openness. This trust-based relationship dynamic transforms lecturers from passive academic overseers into ethical witnesses and mental health advocates, embodying a model of cognitive justice (Visvanathan, 1998, 2016), wherein diverse epistemologies and healing logic coexist.

This framework also gains prominence when compared to international mental health governance frameworks, especially the Inter-Agency Standing Committee (IASC) Guidelines for Mental Health and Psychosocial Support in Emergency Settings (Garbarino et al., 2015). The IASC framework prioritizes hierarchical, urgent interventions often executed by trained professionals in crisis situations, whereas the lecturer-led approach advocates for preventive, relational, and contextual care within academic environments. The disparity among these models is encapsulated in the table below:



Picture 4

IASC Guidelines on Mental Health and Psychososial Support in Humanitarian Emergencies

Source : Garbarino, et.al, 2015

Table 3. Contrasting Buddhist-Informed Lecturer Advocacy and IASC Guidelines on Mental Health Support

Aspect	Buddhist-Informed Lecturer Advocacy	IASC Guidelines	Key Differences
Primary Focus	Student well-being through ethical care	Crisis response in emergencies	Preventive vs. reactive
Role of Support Providers	Lecturers as ethical companions	Psychologists and aid workers	Non-clinical vs. professional
Confidentiality	Contextual and relational	Strict and legalistic	Flexible vs. rigid
Therapeutic Philosophy	Karuṇā, Anattā, interdependence	Human rights and protection	Ethical intimacy vs. detached professionalism

Source: *Authors, 2024*

The epistemic differences between these frameworks have substantial ramifications for mental health ethics in higher education. The Buddhist-informed paradigm encourages a reconceptualization of care as fundamentally relational, spiritual, and culturally rooted, rather than bureaucratically defined. This stands in contrast to the IASC model's legalistic stance on confidentiality and uniform crisis protocols, which may unintentionally estrange students from marginalized groups that do not view formal counseling environments as psychologically secure. Nonetheless, a binary characterization of these paradigms may be restrictive.

In actual campus environments, crises typically develop along a continuum necessitating both preventive measures and immediate action. A hybrid strategy that integrates the relational ethics of Buddhist-informed professor advocacy with the institutional rigor of the IASC framework is essential for scalable and culturally sensitive mental health institutions. The subsequent table presents a cohesive strategy that maintains the spiritual and ethical dimensions of Buddhist caring while conforming to international humanitarian norms of protection and professionalism.

Table 4. Integrated Approach: Merging Buddhist-Informed Lecturer Advocacy and IASC Guidelines

Aspect	Integrated Model	Supporting Literature
Primary Context	Academic and emergency settings; culturally scalable	Rodríguez & Huertas, 2013; Sahdra & Shaver (2013)
Primary Population	Students and vulnerable groups	Koteyko & Atanasova (2018); Wirasto (2012)
Ethical Framework	Buddhist karu ā + Humanitarian dignity	King (2023); Keown (1996); Visvanathan (1998)
Role of Providers	Lecturers and professionals in partnership	McKay & Shand (2018); Farrell et al. (2015)
Focus of Support	Blends resilience and acute care	Besse et al. (2024); Maylea et al. (2020)

Aspect	Integrated Model	Supporting Literature
Confidentiality	Balanced ethical openness	Delhey (2006); Gallagher et al. (2023)
Preventive & Reactive	Long-term support + urgent response	Attwood (2003); Gawrysiak et al. (2018)

Souce: Authors, 2024

This integrated approach emphasizes the need for multi-layered care ecologies on university campuses, where ethical companionship, cultural legitimacy, and crisis preparedness are interrelated rather than mutually exclusive. It anticipates a transition from solitary, expert-led treatments to interconnected networks of trust, wherein students get support through a continuum of care that is both relationally anchored and structurally adaptive. In conclusion, integrating Buddhist psychological ethics into university mental health systems fills service shortages and reinterprets advocacy as a moral, epistemic, and instructional endeavor. When empowered and adequately trained, lecturer-counselors can function as essential intermediaries between the informal and the institutional, the spiritual and the psychological, the preventative and the reactive.

Designing an Integrated, Culturally-Grounded Advocacy Framework

Addressing student mental health in multicultural and spiritually varied cultures, such as Indonesia, necessitates transcending traditional Western psychiatric frameworks. Utilizing the Holistic Prevention & Intervention Model (Besse et al., 2024), this study proposes a three-tiered framework that incorporates Buddhist ethical reasoning into institutional mental health initiatives.

- Tier 1: Universal Prevention : Preventive programs, like Selasa Hening (Silent Tuesdays), mindfulness training, and peer discussion groups, are integrated into weekly campus routines to normalize emotional expression, diminish stigma, and foster spiritual discipline. These activities include Buddhist principles of mindful awareness and impermanence (*anicca*), promoting collective emotional literacy.
- Tier 2: Focused Ethical Support : Trained lecturer-counselors serve as *kalyāṇamitta* (spiritual buddies), providing culturally sensitive and ethically sound support. Instead of functioning exclusively as diagnosticians, these individuals offer ethical companionship grounded in trust, presence, and moral dedication.
- Tier 3: Crisis Intervention : In instances of extreme distress, students are directed to mental health specialists using consent-based protocols that honor individual autonomy while permitting the participation of family, peers, or spiritual advisors. This procedure exemplifies the Buddhist principle of *upāya* (skillful means), guaranteeing attentiveness to clinical urgency and cultural standards.

This triadic framework transcends the individualistic emphasis in several Western paradigms, advocating for a relational and ethically pluralistic perspective on student well-being. To contextualize this

integrated model, it is essential to analyze the ethical underpinnings of Buddhist and Western methodologies on mental health. Table 5 below demonstrates that these paradigms considerably diverge across aspects, including autonomy, secrecy, suffering, and the role of community. This study presents a seven-stage paradigm for suicide risk management to implement ethical integration within Health Promoting Universities (HPUs). This concept integrates curative and preventive aspects from Western and Buddhist traditions, assuring contextual awareness and ethical inclusion.

Table 5. Integrated Curative and Preventive Suicide Risk Management Model

Stage	Objective	Western Psychology Approach	Buddhist Psychology Approach	Integrated Outcome
1. Preventive Mental Health Education	Improve mental health literacy and resilience to prevent suicide.	Activities: Stress-management, self-care, and suicidal awareness workshops.	Activities: Self-focused suffering reduction through mindfulness and meditation on impermanence (Anicca) and non-attachment.	Preventive measures help students understand mental health issues and reduce suicide risk.
2. Early Detection and Community Support	To prevent escalation, identify young people at risk early and provide community support.	Activities: Private screenings, peer support, and mental health professional-led early intervention.	Activities: Create Kalyanamitta (spiritual buddy) groups for compassionate peer assistance and community networking.	Early identification and assistance of at-risk students in a trustworthy, non-judgmental group reduces mental health stigma and isolation.
3. Crisis Intervention and Immediate Support	Respond quickly and compassionately to acute suicidal crises.	Activities: Crisis hotline, on-campus counseling clinics, and expert one-on-one crisis interventions.	Activities: Immediately available peer or mentor help in a non-judgmental place for compassion.	A dual-layered crisis response integrates professional intervention with community-oriented, empathetic assistance to deliver thorough crisis management.
4. Professional Mental Health Care	Organized, discreet treatment with selective community involvement for holistic care.	Activities: One-on-one treatment, psychiatric consultations, and private mental health follow-ups.	Activities: Managing confidentiality and community involvement to promote well-being.	Student suicide risk treatment is structured and professional, with trusted community members providing a helpful, balanced approach.

Stage	Objective	Western Psychology Approach	Buddhist Psychology Approach	Integrated Outcome
5. Reintegration and Ongoing Support	Help the student reintegrate into school and maintain social contact after the catastrophe.	Activities: Continued counseling, campus support, and resiliency training.	Activities: Promote community through Kalyanamitta groups and meditation to reduce isolation.	Professional follow-ups and community connections help students reintegrate into campus life, reducing recurrence.
6. Compassionate Advocacy and Awareness	Create a campus mental health culture to reduce stigma and promote suicide prevention.	Activities: Campus-wide mental health campaigns, empathy and resilience courses, and warning sign training for professors and staff.	Activities: Use Buddhist compassion (Karuna) and connection to encourage student support.	Suicide stigma is reduced and a community ethic of mental health is promoted on campus.
7. Continuous Improvement and Feedback	Modify and enhance the mental health model in accordance with feedback from students, faculty, and mental health data.	Activities: Data-driven modifications, student and faculty feedback sessions, and routine assessments of mental health programs.	Activities: To ensure cultural sensitivity in program improvements and to acquire collective insights, community discussions are conducted.	The mental health paradigm adapts to changing demands, cultures, and needs to prevent suicide.

Source : Authors, 2024

From 2021 to 2023, pilot implementations of this strategy exhibited numerous encouraging results: (1) Enhanced student participation in mental health services, (2) Increased family involvement in mental health processes, (3) More profound integration of spiritual and psychological resources. These findings affirm the efficacy of integrating Western treatment models with culturally embedded spiritual practices, particularly when facilitated by ethical companionship.

Nonetheless, institutional obstacles persist. In Indonesia, higher education professors are required to adhere to the Tri Dharma (teaching, research, and community service), yet, existing academic evaluation systems predominantly favor research output. Consequently, relational labor—encompassing mentoring, emotional support, and ethical presence—is often underestimated or rendered invisible. Smyth (2020) views this occurrence as indicative of the "academic rockstar" culture, which emphasizes performance measurements at the expense of moral and social accountability. To maintain this model, colleges must institutionalize moral labor by acknowledging lecturer-counselors as vital ethical agents, entitled to structural support, professional recognition, and policy incorporation.

CONCLUSION

This study has highlighted the pressing necessity for culturally informed and ethically inclusive mental health advocacy models for Indonesian university students at risk of suicide. This research integrates Buddhist psychological principles to challenge the constraints of prevailing Western clinical models that prioritize confidentiality, individualism, and procedural detachment. These systems, although conventional in international mental health treatments, may inadvertently exacerbate student isolation and impede prompt assistance.

This study elucidates how institutional cultures influenced by cognitive capitalism and Western epistemologies frequently limit relational and spiritual care approaches, utilizing autoethnographic insights and multidisciplinary collaboration. Buddhist-informed advocacy conceptualizes suffering as a universal existential condition and fosters healing via ethical companionship and communal presence. Initiatives such as Selasa Hening demonstrate how mindfulness, compassion, and non-pathologizing assistance may be integrated into academic life in culturally and spiritually resonant ways.

Lecturer-counselors serve as key ethical agents within this paradigm. They provide relational support between students and formal institutions that connect emotional, spiritual, and institutional gaps. In contrast to clinical specialists constrained by strict protocols, these individuals offer trust-based, context-sensitive assistance. Their participation confirms that suicide prevention is not merely a clinical duty but a moral one shared by educational and community networks.

The research presents a three-tiered approach integrating universal prevention, targeted ethical assistance, and culturally attuned crisis intervention. This paradigm integrates Buddhist principles with practical processes from global health systems, providing a framework for more inclusive and responsive campus mental health solutions. It endorses the overarching demand for cognitive fairness by recognizing many epistemologies and healing practices inside academic institutions.

In conclusion, suicide prevention in Indonesian universities must transcend standardized interventions to adopt ethical plurality and relational depth. When carefully integrated, Buddhist psychology offers therapeutic insight and a moral framework of care founded on compassion, interdependence, and community involvement. Institutional improvements must acknowledge and assist lecturer-counselors, incorporate spiritual resources, and promote peer-based support structures. Future research must assess these integrated models' scalability and enduring effects across various cultural and educational contexts.

BIBLIOGRAPHY

Attwood, M. (2003). Suicide as a response to suffering. *Western Buddhist Review*, 4.

Besse, S., Kaniuka, A., Zabelski, S., Mennicke, A., Meyer, K., & Cramer, R. J. (2024). The Holistic Prevention & Intervention Model: A public health approach to college mental health and suicide prevention. *Journal of American college health*, 72(9), 3079-3083.

Bikker, A. P., Lesmana, C. B. J., & Tiliopoulos, N. (2021). The Indonesian Mental Health Act: psychiatrists' views on the act and its implementation. *Health policy and planning*, 36(2), 196-204

Brymer, M., Jacobs, A., Layne, C., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E. and Watson, P., 2006. *Psychological first aid: Field operations guide*. 2nd ed. *National Child Traumatic Stress Network*. Available at: www.nctsn.org and www.ncptsd.va.gov

Chou, K., Ho, A.H.Y. and Chi, I., 2006. Living alone and depression in Chinese older adults. *Aging & Mental Health*, 10(6), pp.583-591. https://doi.org/10.1080/13607860600641150

Delhey, M. (2006). Views on suicide in Buddhism: Some remarks. In M. Zimmermann (Ed.), *Buddhism and Violence* (pp. 25–63). Lumbini International Research Institute.

Farrell, L., Bourgeois-Law, G., Regehr, G. and Ajjawi, R., 2015. Autoethnography: Introducing 'I' into medical education research. *Medical Education*, 49(10), pp.974-982. https://doi.org/10.1111/medu.12761

Foley, R. and Platzer, H., 2007. Place and provision: Mapping mental health advocacy services in London. *Social Science & Medicine*, 64(3), pp.617-632. https://doi.org/10.1016/j.socscimed.2006.09.014

Fukui, N., 2022. Compassion as our origin: Examining a Kyoto school approach. *Knowledge Cultures*, 10(1), pp.123-140. https://doi.org/10.22381/kc10120227

Gallagher, S., Raffone, A., Berkovich-Ohana, A., Barendregt, H.P., Bauer, P.R., Brown, K.W., Giommi, F., Nyklíček, I., Ostafin, B.D., Slagter, H., Trautwein, F. and Vago, D.R., 2023. The self-pattern and Buddhist psychology. *Mindfulness*. https://doi.org/10.1007/s12671-023-02118-3

Garbarino, J., Governale, A., Henry, P. and Nesi, D., 2015. Children and terrorism: Sharing child and youth development knowledge. *Social Policy Report*, 29(2). Available at: https://files.eric.ed.gov/fulltext/ED569207.pdf

Gawrysiak, M.J., Grassetti, S.N., Greeson, J.M., Shorey, R.C., Pohlig, R. and Baime, M.J., 2018. The many facets of mindfulness and the prediction of change following mindfulness-based stress reduction (MBSR). *Journal of Clinical Psychology*, 74(4), pp.523-535. https://doi.org/10.1002/jclp.22521

Gooding, P., 2017. The government is the cause of the disease and we are stuck with the symptoms: Deinstitutionalisation, mental health advocacy and police shootings in 1990s Victoria. *Continuum*, 31(3), pp.436-446. https://doi.org/10.1080/10304312.2016.1275146

Hann, K., Pearson, H., Campbell, D., Sesay, D., & Eaton, J. (2015). Factors for success in mental health advocacy. Global health action, 8(1), 28791.

Hendler, R., Kidia, K., Machando, D., Crooks, M., Mangezi, W., Abas, M., Katz, C., Thornicroft, G., Semrau, M. and Jack, H., 2016. We are not really marketing mental health: Mental health advocacy in Zimbabwe. *PLoS ONE*, 11(9), e0161860. https://doi.org/10.1371/journal.pone.0161860

Hetrick, J., 2022. Deleuze and the Kyoto school: Onto-logics. *Philosophy East & West*, 72(3), pp.717-738. https://doi.org/10.1353/pew.2022.0055

Irmansyah, I., Prasetyo, Y. A., & Minas, H. (2009). Human rights of persons with mental illness in Indonesia: more than legislation is needed. *International journal of mental health systems*, 3, 1-10.

Kartikasari, B., 2023. Fakta-fakta mahasiswa bunuh diri di kamar kos daerah Pogung Sleman, ini pernyataan kampus. *Jogja. Tribunews.com*, 18 September. Available at: https://jogja.tribunnews.com/2023/09/18/fakta-fakta-mahasiswa-bunuh-diri-di-

kamar-kost-daerah-pogung-sleman-ini-pernyataan-kampus

Kato, H., 2016. The relationship between the psychology of religion and Buddhist psychology. *Japanese Psychological Research*, 58(S1), pp.70-84. https://doi.org/10.1111/jpr.12121

Kelly, B.D., 2023. Beyond mindfulness: Buddhist psychology and the Abhidharma. *Journal of Spirituality in Mental Health*, 25(1), pp.71-82. https://doi.org/10.1080/19349637.2022.2081952

Keown, D. (1996). Buddhism and suicide: The case of Channa. *Journal of Buddhist ethics*, 3(8), 8-31.

King, S.B., 2023. Mindfulness, compassion and skillful means in engaged Buddhism. *Mindfulness*, 14(10), pp.2516-2531. https://doi.org/10.1007/s12671-022-01847-1

Koteyko, N. and Atanasova, D., 2018. Mental health advocacy on Twitter: Positioning in Depression Awareness Week tweets. *Discourse, Context & Media*, 25, pp.52-59. https://doi.org/10.1016/j.dcm.2018.04.007

Kowalczyk, A. M. (2023). We are their hope: addressing mental health barriers through advocacy. *Journal of psychosocial nursing and mental health services*, 61(9), 3-4.

Lapadat, J.C., 2017. Ethics in autoethnography and collaborative autoethnography. *Qualitative Inquiry*, 23(8), pp.589-603. https://doi.org/10.1177/1077800417704462

Lengacher, C.A., Johnson-Mallard, V., Post-White, J., Moscoso, M.S., Jacobsen, P.B., Klein, T.W., Widen, R.H., Fitzgerald, S.G., Shelton, M.M., Barta, M., Goodman, M., Cox, C.E. and Kip, K.E., 2009. Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer. *Psycho-Oncology*, 18(12), pp.1261-1272. https://doi.org/10.1002/pon.1529

Maylea, C., Makregiorgos, H., Martin, J., Alvarez-Vasquez, S., Dale, M., Hill, N., Johnson, B., Thomas, S. and Weller, P., 2020. Independent mental health advocacy: A model of social work advocacy? *Australian Social Work*, 73(3), pp.334-346. https://doi.org/10.1080/0312407X.2020.1725076

McKay, K., & Shand, F. (2018). Advocacy and luck: Australian healthcare experiences following a suicide attempt. *Death studies*, 42(6), 392-399.

Nazarzadeh, M., Bidel, Z., Ranjbaran, M., Hemmati, R., Pejhan, A., Asadollahi, K. and Sayehmiri, K., 2016. Fatal suicide and modelling its risk factors in a prevalent area of Iran. *Archives of Iranian Medicine*, 19(8), p.571.

Nissen, E.R., O'Connor, M., Kaldo, V., Højris, I., Borre, M., Zachariae, R. and Mehlsen, M., 2020. Internet-delivered mindfulness-based cognitive therapy for anxiety and depression in cancer survivors: A randomized controlled trial. *Psycho-Oncology*, 29(1), pp.68-75. https://doi.org/10.1002/pon.5237

O'Connell, L., 2023. Being and doing anorexia nervosa: An autoethnography of diagnostic identity and performance of illness. *Health*, 27(2), pp.263-278. https://doi.org/10.1177/13634593211017190

Parrott, S., Britt, B.C., Hayes, J.L. and Albright, D.L., 2020. Social media and suicide: A validation of terms to help identify suicide-related social media posts. *Journal of Evidence-Based Social Work*, 17(5), pp.624-634. https://doi.org/10.1080/26408066.2020.1788478

Petrie, K., Spittal, M., Zeritis, S., Phillips, M., Deady, M., Forbes, D., Bryant, R., Shand, F. and Harvey, S.B., 2023. Suicide among emergency service workers: A retrospective mortality study of national coronial data, 2001–2017. *Psychological Medicine*, 53(12), pp.5470-5477. https://doi.org/10.1017/S0033291722002653

Promta, S., & Thomyangkoon, P. (2009). A Buddhist perspective on suicide. *Oxford textbook of suicidology and suicide prevention*, 28-36.

Purbaya, A.A., 2023. Mahasiswinya tewas di kos dengan sepucuk surat, Udinus Semarang berduka. *Detikjateng*, 12 October. Available at: https://www.detik.com/jateng/berita/d-6978315/mahasiswinya-tewas-di-kos-dengan-sepucuk-surat-udinus-semarang-berduka

Rahvy, A., Habsy, A., & Ridlo, I. (2020). Actual challenges of mental health in Indonesia: Urgency, UHS, humanity, and government commitment. *European Journal of Public Health*, 30(Supplement_5), ckaa166-1023.

Rigsby, C.A., 2014. Three strands of nothingness in Chinese philosophy and the Kyoto school: A summary and evaluation. *Dao: A Journal of Comparative Philosophy*, 13(4), pp.469-489. https://doi.org/10.1007/s11712-014-9398-6

Rodríguez, M. D. C. F., & Huertas, I. B. (2013). Suicide prevention in college students: A collaborative approach. *Revista interamericana de psicologia= Interamerican journal of psychology*, 47(1), 53.

Sagita, N.S., 2023. RI darurat kesehatan mental, Kemenkes ungkap kasus bunuh diri naik terus. *Detikhealth*, 13 October. Available at: https://health.detik.com/berita-detikhealth/d-6979625/ri-darurat-kesehatan-mental-kemenkes-ungkap-kasus-bunuh-diri-naik-terus

Sahdra, B.K. and Shaver, P.R., 2013. Comparing attachment theory and Buddhist psychology. *The International Journal for the Psychology of Religion*, 23(4), pp.282-293. https://doi.org/10.1080/10508619.2013.795821

Salzberg, S., 2011. Mindfulness and loving-kindness. *Contemporary Buddhism*, 12(1), pp.177-182. https://doi.org/10.1080/14639947.2011.564837

Smyth, J., 2020. The neoliberal toxic university: Beyond no is not enough and daring to dream a socially just alternative into existence. *Educational Philosophy and Theory*, 52(7), pp.716-725. https://doi.org/10.1080/00131857.2019.1654370

Stahl, S.T., Beach, S.R., Musa, D. and Schulz, R., 2017. Living alone and depression: The modifying role of the perceived neighborhood environment. *Aging & Mental Health*, 21(10), pp.1065-1071. https://doi.org/10.1080/13607863.2016.1191060

Teale, J., 2017. Independent mental health advocacy: The right to be heard - context, values and good practice. *Routledge*. https://doi.org/10.1080/09638237.2017.1294746

Tovote, K.A., Schroevers, M.J., Snippe, E., Emmelkamp, P.M.G., Links, T.P., Sanderman, R. and Fleer, J., 2017. What works best for whom? Cognitive behavior therapy and mindfulness-based cognitive therapy for depressive symptoms in patients with diabetes. *PLoS ONE*, 12(6), e0179941. https://doi.org/10.1371/journal.pone.0179941

Visvanathan, S., 1998. A celebration of difference: Science and democracy in India. *Science*, 280(5360), pp.42-43. https://doi.org/10.1126/science.280.5360.42

Visvanathan, S., 2016. The pluriverse of failure in Indian science. *Social Research*, 83(3), pp.723-747. https://doi.org/10.1353/sor.2016.0051

Walker, E., Shaw, S. and Anderson, J., 2020. Dyspraxia in medical education: A collaborative autoethnography. *Qualitative Report*, 25(11), pp.4072-4093. https://doi.org/10.46743/2160-3715/2020.4352

Wawan, J.H., 2022. Penjelasan Hotel Porta soal kasus mahasiswa UGM lompat dari lantai 11. *Detikcom*, 9 October. Available at: https://www.detik.com/jateng/jogja/d-6337958/penjelasan-hotel-porta-soal-kasus-mahasiswa-ugm-lompat-dari-lantai-11

Wirasto, R. T. (2012). Suicide prevention in Indonesia: providing public advocacy. *Jpn Med Assoc J*, 55, 98-104.

Yong, A., 2013. Christianity and the notion of nothingness: Contributions to Buddhist-Christian dialogue from the Kyoto school by Mutō Kazuo. *Buddhist-Christian Studies*, 33(1), pp.209-213. https://doi.org/10.1353/bcs.2013.0024

Yulisnawati, E.A., 2023. Mahasiswa Unnes tewas diduga bunuh diri di Mall Paragon Semarang, tinggalkan surat wasiat bikin nyesek. *Jawapos.com*, 11 October. Available at: https://www.jawapos.com/berita-sekitar-anda/013064680/mahasiswa-unnes-tewas-diduga-bunuh-diri-di-mall-paragon-semarang-tinggalkan-surat-wasiat-bikin-nyesek