Perception, Knowledge, and Attitudes of Young People about Suicide Behavior

Khansa Fahira Wisdana[1], Margarita Maria Maramis[2], Maramis Lilik Djuari[3]
{Khansa.fahira.w@gmail.com[1]}

Faculty of Medicine, Airlangga University Surabaya, Indonesia[1,2,3]

Abstract. According to WHO, Indonesia's suicide rate in the 15-29 age category is five people per 100,000 population while those aged 30-49 years are 4 people per 100,000 people. Perception, knowledge, and attitudes about suicide have essential factors in depression and suicidal thoughts in an individual. The research method used is a quantitative method through the stigma of suicide scale questionnaire, suicide opinion questionnaire, and attitude towards suicide scale. The findings of this study are the public perception that 96.1% of people with depression have the lowest potential for suicide in loneliness, the community's knowledge of suicidal behavior is relatively high with a Literacy of suicide scale score of 61% with the proportion of women having higher knowledge than men, and simultaneously. The contribution of findings suggests health practitioners, social workers, and the community increase empathy, knowledge of suicidal behavior and prevent the exclusion of depressed individuals from reducing suicide rate.

Keywords: Suicide; Perception; Knowledge; Attitude

1 Introduction

Suicide is an act of ending one's own life, usually due to depression or a mental illness. In the United States, approximately 2% of deaths by suicide, meanwhile the numbers increase in the youth of 15 to 24 years (1) . WHO data show that the suicide rate is approaching 800,000 people per year, which means one person every 40 seconds. In Indonesia, the suicide mortality rate is around five people per 100,000 in 2016 (2). The suicide rate is an essential factor that must be considered to develop healthy and quality Indonesian human resources. Self-injury and suicide are major health problems in society. High self-injury and suicide rates are the second most common causes of death in adolescence (3). Many risk factors can lead to suicide. Mental illness, having had a previous suicide attempt, personal character, family factors, certain life events, the transmission of imitation behavior, and availability of means to people who already have suicidal thoughts (4). Suicidal behavior can be influenced by various factors that affect a person's life, in which external environmental factors and internal factors of the surrounding individual are the most prominent variables. Individual internal factors arise from within the individual, such as perception, personality, and psychology. In contrast, external factors arise from the surrounding environment to respond to the surrounding

ICSST 2021, November 25, Tangerang, Indonesia
Copyright © 2022 EAI
DOI 10.4108/eai.25-11-2021.2318833

community's behavior, influencing individual perceptions. This study focuses on society's external factors. It includes perceptions, knowledge, and attitudes about suicide.

1.1 Internal Factors

Many internal risk factors lead to suicide. Various studies generally suggest a background of mental illness, depression, and personality disorders. The method and tool used in the suicide can help the creation of suicide. Suicidal-imitating behavior can also be one of the reasons people commit suicide. Transmission in mimicking suicide can occur through observations of behavioral models. The imitation of suicidal behavior can occur at the macro-level (mass media reports) or events in the neighborhood (peer group, friends, school environment). The availability of means and tools that help commit suicide plays a vital role in the transition from thoughts to act suicide so that it becomes the method of choice that determines the decision to act suicide (4). In much of the literature, men have a higher suicide rate than women because men are less likely to seek help and express emotional distress, resulting in less contact with mental health services. Men also usually use more lethal methods of suicide because male suicide is even higher (5).

Men tend to use techniques for suicide attempts that are much more fatal than women because men use faster or harsher methods such as hanging themselves, carbon monoxide poisoning, and firearms. In contrast, women are more likely to poison themselves (6). Suicide control bias towards culture, for example, in the culture of hara-kiri suicide in Japan caused by shame or the consequences of defeat. In Eastern cultures, depression and other forms of mental illness are signs of personal weakness that bring shame to the family (7). In suicidal behavior, there are several classifications such as; categories of suicide, attempted suicide, active suicidal ideation, passive suicidal ideation, non-suicidal injury, suicidal experience, acts of preparation for impending suicidal behavior, and self-harm intentionally (8). Also, the methods used for suicide vary (9), divided into three groups, physical, chemical, and other types. Physical suicide methods are usually carried out by hanging yourself, burning yourself, drowning, getting hit by a train, crashing a vehicle, shooting your head, cutting your pulse, and other physical actions. The method of chemical suicide is carried out by ingesting, injecting, and inhaling chemicals such as cyanide, carbon monoxide, and others. Another technique that can be used to commit suicide is by deliberately starving to death or using an electric current.

1.1.1 Therapy

The medical world currently provides two types of therapy for patients who have symptoms or have already committed suicide, psychotherapy and somatic therapy (10). Furthermore, Jacob explained currently, psychotherapy studies have shown its efficacy in treating disorders such as depression and personality disorders associated with an increased risk of suicide. Psychotherapy consists of psychodynamic, psychoanalytic, cognitive-behavioral, dialectical behavior, and other psychosocial interventions. They are useful in clinical trials for treatment. Whereas somatic therapy can use an antidepressant, which is supported by a clinical perspective, there is a strong relationship between clinical depression and suicide with the availability of antidepressants. Another somatic therapy is Lithium. There is consistent and robust evidence in patients with recurrent bipolar disorder and major depressive disorder that long-term maintenance treatment with lithium salts is associated with a considerable reduction in the risk of suicide attempts and suicide action. For suicide, lithium

maintenance treatment was associated with a reduced risk of 80% -90%, and lowering the suicide attempt rate was more than 90%. A third drug that can be used is a mood-stabilizing anticonvulsant agent. Many treatments use antimanic of specific anticonvulsant, anti-psychotic agents (11) increased. In long-term effectiveness to protect against recurrent mood, episodes are less clear. Also, there is no firm evidence of a reduced risk of suicidal behavior with "mood-stabilizing" anticonvulsants.

Other drugs are anti-psychotic agents. It effectively treats delusions and hallucinations and agitation, aggression, and confusion and may also have some beneficial action in major affective disorders. Their potential effect in limiting the risk of suicide in psychotic patients is unknown. The annual suicide rate associated with schizophrenia has not fallen since use. The use of older neuroleptic agents has side effects For example, extrapyramidal side effects and the likelihood of harm, depression resulting from akathisia induction. The use of other drugs that can be used, namely Anti-news agents, to remove/rebound severe, long-acting benzodiazepines may be more short-acting. At the same time, long-acting benzodiazepines may be more likely to cause daytime sedation. Sometimes benzodiazepines could be dangerous can increase impulsivity, especially in borderline personality disorder patients. For patients being treated with chronic disease, stopping benzodiazepines can increase the risk of suicide. And the last drug is electroconvulsive therapy (ECT) to treat patients who are severely suicidal, and available evidence suggests that ECT reduces short-term suicidal ideation. ECT ECT is best established in patients with severe depressive illness. Still, ECT can also be used to treat individuals with episodes of manic or mixed bipolar disorder, schizoaffective disorder, or schizophrenia in specific clinical settings. ECT may particularly be prohibited by patients who are responsible for the life-threatening treatment.

1.2 External Factors

Some people lack empathy for suicide perpetrators and instead make fun of flawed assessments of suicidal behavior. (12). Fear, prejudice, and nationality towards individuals experiencing mental health problems are caused by knowledge, misinformation, and myths. A prejudice of society is difficult to change despite education and training. Many people with depression have wrong preconceptions and perceptions of themselves, so they do not seek help (13). At the same time, suicide has a bad impact on the perpetrator and the surrounding community. Many of the bad effects of suicide occurred on the family or closest people when someone responds to suicide. Harmful effects such as the physical and psychological health of those closest to you can not be affected. Relationships between feeling loss and health, such as reactions to sadness or physical, psychological and psychosomatic health difficulties, can last a long time. The gap in support after suicide also makes responsive people both formal and informal aid. The surrounding environment takes a long time to reconstruct their lives after suicide (14). External factors arise from the surrounding environment due to the surrounding community's behavior that affects individual perceptions. This study focuses on society's external factors, including perceptions, knowledge, and attitudes about suicide.

1.2.1 Knowledge

Knowledge of suicidal behavior is vital for society. It contributes to a lack of empathy, attention, and support for depressed sufferers who have the potential to commit suicide. Media reviews discussing suicide in society are also infrequent. Journalists' understanding of the issue of suicide is still low (15). Although suicide is a widespread social problem, society has

limited knowledge about suicide, and this situation harms individuals seeking help (16). The general pattern suggests that low levels of knowledge about suicidal behavior substantially impact suicide mortality rates (17). Many studies show that groups of individuals who have had suicidal experiences and groups who desire, intend, and think of suicide have insufficient knowledge of suicidal behavior. Understanding suicidal behavior needs to be the primary consideration in reducing suicide mortality. Physical prevention keeps people from committing suicide does not reduce the individual's intention to continue to commit suicide at another time (18). The elements of knowledge about suicidal behavior consist of; mental illness, asking for help, the right to die, religion, impulsivity, norms (everyone has the potential to commit suicide), aggressive behavior, moral crimes (19). These elements are frequently included in a suicide opinion questionnaire (SOQ) in suicide research through the literacy of suicide scale (LOSS).

1.2.2 Perception

In Indonesia, mental problems are still heavily influenced by perceptions inherent in society. People with mental issues and suicidal tendencies refrain from being honest about their condition. With a country that has a predominantly Muslim population, it also exacerbates the stigma that shapes perceptions. Because in Islam, it is said that suicide is a sinful act, which is why members of suicide victims do not tell the truth because of shame. (Jong, 2014). Attitude stigmatization has a critical factor in individual suicidal behavior, so understanding why people commit suicide needs to be considered in preventing suicide rates (20). Stigma shapes people's perceptions of suicide. The stigma of Indonesian society towards suicidal behavior is still negative. Sufferers of depression and mental health disorders are still reluctant to talk about their problems to other people because they consider it taboo. The more people who fall into depression, the more suicidal thoughts become (21). To measure people's perceptions of suicide, the Stigma of Suicide Scale (SOSS), which consists of Stigma-Isolation-Depression and Neutralization, can be used.

1.2.3 Attitude

The behavior of the surrounding community has an impact on the action that intends to commit suicide. Conducive communication between communities in positive conversation or other communication forms can save someone's life (22). It reflects society's attitude that many studies consider to be a determining factor for making suicide decisions. In a study, it is necessary to measure the attitudes that are thought to contribute to individual satisfaction in thinking about suicide choices. To measure people's attitudes towards suicide can be done with the Attitude Towards Suicide Scale (ATSS), which consists of several essential aspects: attitudes towards suicide, suicide rights, understanding suicide, and an assumption that suicide is contagious, perceived taboo, ordinary actions, the process of suicide, prevention, life satisfaction attitudes, expressions of suicide, demographic data, perceived causes, and ways of prevention (23).

2 Methodology

This research method uses quantitative methods with a cross-sectional descriptive approach that measures the community's variable perceptions, knowledge, and attitudes,

especially young people about suicidal behavior in East Surabaya. The population is a productive age of 15 - 49 years who live in the East Surabaya area consisting of students and non-students, with a sample of 03 respondents. The instrument used to measure the perception variable of the stigma of suicide scale (SOSS) questionnaire, to measure knowledge variables used the suicide opinion assessment (SOQ) instrument, while to measure the attitude variable used the attitude towards suicide scale (ATTS) instrument. Another supporting tool used as a measurement scale is the literacy of suicide scale model LOSS to support the measurement of knowledge related to suicide.

3 Results and Discussion

3.1 Perception

The Following are the results of collecting data on perception variables through the stigma of suicide scale (SOSS), which consists of Normalization, Stigma, and Depression.

Table 1. Distribution of Normalization Perceptions of Suicide Behavior

Items	*Agreement*	Average & Deviation
Fearless	22,4%	2,53(1,21)
Courage	13,6%	2,07(1,05)
Dedicated	13,6%	2,24(1,13)
Commitment	12,7%	2,31(1,13)
Realistics	12,6%	2,06(1,07)
Understandable	12,6%	2,30(0,98)
Strong	9,7%%	1,89(1,07)
Tough	5,9%%	1,81(1,06)
Motivation	4,9%	1,79(0,91)
Noble	4,9%	1,64(0,89)
Rational	2,0%	1,75(0,83)

Table 2. Distribution of Stigma Perceptions of Suicide Behavior

Items	*Agreement*	Average	Items	*Agreement*	Average & Deviation
Vulnerable	90,3%	4,27(0,89)	Mercyless	30,1%	2,85(1,24)
Burden	84,5%	4,22(0,90)	Unforgiven	28,2%	2,80(1,24)
Fail	83,5%	4,20(0,82)	No feeling	25,2%	2,64(1,18)
Shame	78,6%	4,16(1,00)	Stupidity	25,2%	2,64(1,24)
Sad	71,8%	3,57(1,12)	Stricht	24,3%	2,71(1,10)
Coward	50,5%	3,29(1,27)	Inhuman	22,3%	2,59(1,16)
Shallow	50,5%	3,31(1.28)	Amoral	16,5%	2,37(1,15)
Selfish	45,6%	3,20(1,26)	Lazyness	13,6%	2,30(1,09)
Useless	43,7%	3,05(1,41)	Funishment	12,6%	2,37(1,04)
Attention	42,7%	3,06(1,23)	Ignorant	11,7%	2,34(1,17)
Careless	41,8%	3,14(1,21)	Vile	8,8%	2,15(0,98)
Irresponsible	40,8%	3,10(1,24)	Cruel	6,8%	2,06(0,86)
Shame	35,0%	2,94(1,32)	Abusive	2,9%	2,09(0.84)
Vengeful	33,1%	2,97(1,19)	Arrogant	1,9%	1,85(0,80)
Weird	33,0%	2,83(1,32)			

Table 3. Distribution of Depression Perceptions of Suicide Behavior

Point	*Agreement*	Average & Deviation
Lonely	96,1%	4,52(0,68)
Desperation	94,2%	4,60(0,74)
Depression	92,3%	4,50(0,77)
Suffering	92,3%	4,41(0,81)
Hurted	91,3%	4,36(0,79)
Lost	91,3%	4,27(0,74)
Ignored	89,3%	4,36(0,86)
Pain	87,4%	4,20(0,80)
Unconsidered	85,4%	4,17(0,89)
Unfree	83,5%	4,07(0,80)
Gloomy	77,7%	3,89(0,96)
Separated	75,7%	4,00(1,00)
Self-withdrawing	74,7%	3,96(0,97)
Isolated	68,9%	3,83(1,02)
Unpleasant	68,0%	3,66(1,09)
Upset	60,2%	3,55(1,21)

Table 1 shows in the dimension of normalization factor, the highest average value is obtained on the statement fearless with an average value of 2.53 ± 1.219, which indicates that the research subjects consider that people who commit suicide have no fear with agreement 22,4%. Table 2 shows that the highest average value of the stigmatization factor is found in the statement fragile with an average value of 4.27 ± 0.899, which indicates that the research subjects consider that people who commit suicide are vulnerable in agreement score 90.3%. Table 3 shows that the depression factor with the highest average value is the desperation, with an average value of 4.60 ± 0.745. It also indicates that the research subjects feel that most people who commit suicide are alone, with an agreement at 96.1%. Variable perception in suicide behavior means that dominant factors are lonely desperation, vulnerability, burden, fearlessness, and courage. In stigma, dimension reflected that the higher average score means the more elevated stigma against suicide. In depression, the higher the average score indicates, the higher in considering suicide due to being isolated from the environment. In normalization, this dimension means that the higher of average value, the higher in thinking that suicide is considered normal

3.2 Knowledge

The Following are the results of collecting data on the suicide behavior variable's knowledge through a suicide opinion questionnaire (SOQ).

Table 4. Distribution of Knowledge on Suicide Behavior

Characteristics	n (%)	Average	Deviation
Sample Qty	103 (100%)	16,95	(2,50)
Sex			
Male	30 (29,1%)	16,50	(2,76)
Female	73 (73,8%)	17,14	(2,38)
Age			
18	2 (1,9%)	16,00	(0,00)
19	4 (3,8%)	19,75	(0,95)
20	30 (19,5%)	17,37	(2,44)
21	58 (56,3)	16,86	(2,40)

Characteristics	n (%)	Average	Deviation
22	6 (5,8%)	15,50	(3,27)
23	1 (0,9%)	15,00	(0,00)
24	1 (0,9%)	12,00	(0,00)
25	1 (0,9%)	16,00	(0,00)
Profession			
College Student	91 (88,3%)	16,99	(2,54)
Student	6 (5,8%)	16,67	(2,42)
Professional	2 (1,9%)	14,50	(0,70)
Freelance	1 (0,9%)	16,00	(0,00)
Designer			
Civil Servants	1 (0,9%)	20,00	(0,00)
doctor	1 (0,9%)	16,00	(0,00)
Jobless	1 (0,9%)	19,00	(0,00)
Location			
Gubeng	14 (13,5%)	16,36	(2,81)
Gunung Anyar	5 (4,8%)	18,00	(1,87)
Sukolilo	23 (22,3%)	16,43	(2,10)
Tambaksari	28 (27,1%)	17,04	(3,04)
Mulyorejo	19 (18,4%)	17,58	(2,14)
Rungkut	9 (8,7%)	16,67	(2,06)
Tenggilis Mejoyo	5 (4,8%)	17,60	(2,70)
Last Education			
High School	84 (81,5%)	17,08	(2,40)
Bachelor Degree	18 (17,4%)	16,17	(2,85)
Diploma	1 (0,9%)	20,00	(0,00)
Religion			
Buddha	1 (0,9%)	14,00	(0,00)
Hindu	2 (1,9%)	18,50	(3,53)
Islam	90 (87,3%)	16,96	(2,52)
Catholic	5 (4,8%)	16,60	(2,70)
Protestan	5 (4,8%)	17,20	(1,92)

The table above shows that people's knowledge of suicidal behavior has an average value of 16.95 ± 2.5 per total sample. The female gender has a higher average value of 17.14 ± 2.38 than men, with an average value of 16.5 ± 2.76. The sample age also shows that the sample aged 19 years has the highest average of 19.75 ± 0.95 while age 24 years of age have the lowest average score with a value of 12. Civil servant jobs show the highest average score of knowledge of personal behavior as much as 20, while professional education jobs show the lowest average score with a value of 14.5. Samples who live in Gunung Anyar Village have the highest average value to determine the community's knowledge of suicidal behavior as high as 18 ± 1.87. In contrast, Gubeng Village has the smallest average value, namely as much as 16.36 ± 2.81. The latest diploma education has the highest average score of 20, and S1 has the lowest average score of 16.17 ± 2.85. The sample with Hinduism has the highest average

value with an average value of 18.5 ± 3.53, and Buddhism the weakest with an average value of 14.

3.3 Attitude

The Following are the results of collecting data on Attitude variables through the Attitude Towards Suicide Scale (ATSS). See Table 5 below.

Table 5. Distribution of Attitudes towards Suicide Behavior

Characteristics	N(%)	ATTS Score Range									
		Factor 1 (1,00-30,00)		Factor 2 (1,00-15,00)		Factor 3 (1,00-15,00)		Factor 4 (1,00-15,00)		Factor 5 (1,00-15,00)	
		Average & Deviation	95% CI	Average & Deviation	95% CI	Average & Deviation	95% CI	Average & Deviation	95% CI	Average & Deviation	95% CI
Total Sample	103(100%)	13,79(4,26)	12-,95-16,62	12,86(1,48)	12,57-13,16	7,48(2,62)	6,96-7,99	10,98(2,11)	10,57-11,39	12,38(1,38)	12,11-12,65
Gender											
Male	30(9,2%)	14,67(4,23)	13,08-16,25	13,07(1,53)	12,50-13,64	7,23(2,41)	6,33-8,14	10,90(2,17)	10,09-11,71	12,53(1,47)	11,98-13,09
Female	73(73,8%)	13,42(4,24)	12,43-14,42	12,78(1,47)	12,44-13,12	7,58(2,71)	6,94-8,21	11,01(2,10)	10,52-11,50	12,32(1,34)	12,00-12,63
Age											
18	2(1,8%)	20,00(2,82)	-5,41-45,41	12,00(0,00)	12,00-12,00	7,00(2,82)	-18,41-32,41	10,00(1,41)	-2,71-22,71	11,50(0,70)	5,15-17,85
19	43(3,8%)	14,00(3,53)	5,48-22,52	12,00(0,81)	10,70-13,30	6,00(2,16)	2,46-9,44	10,25(2,06)	6,79-13,53	12,50(0,57)	11,58-13,42
20	30(19,5%)	14,60(4,72)	12,48-16,36	13,00(1,53)	12,43-13,57	7,60(2,78)	6,56-9,44	10,53(1,97)	9,79-11,27	12,80(1,32)	12,31-13,29
21	58(56,3%)	13,60(3,91)	12,57-14,63	12,72(1,53)	12,32-13,13	7,55(2,62)	6,86-8,25	11,09(2,31)	10,52-11,65	12,14(1,31)	11,79-12,48
22	6(5,8%)	12,00(2,28)	9,61-14,39	13,30(0,51)	12,79-13,88	8,00(2,44)	5,43-10,57	12,00(2,53)	9,35-14,65	12,00(2,09)	9,80-14,20
23	1(0,9%)	8,00(0,00)	-	15,00(0,00)	-	8,00(0,00)	-	11,00(0,00)	-	14,00(0,00)	-
24	1(0,9%)	10,00(0,00)	-	15,00(0,00)	-	6,00(0,00)	-	14,00(0,00)	-	13,00(0,00)	-
25	1(0,9%)	7,00(0,00)	-	15,00(0,00)	-	4,00(0,00)	-	14,00(0,00)	-	15,00(0,00)	-
Profession											
College student	91(88,3%)	13,57(4,07)	12,90-14,60	12,84(1,46)	12,53-13,14	7,38(2,62)	6,84-7,93	10,96(2,11)	10,51-11,40	12,43(1,39)	12,14-12,72
Student	6(5,8%)	14,38(7,05)	7,43-22,24	12,83(2,13)	10,59-15,08	8,17(2,31)	5,74-10,60	11,17(2,63)	8,40-13,94	12,00(0,89)	11,06-12,94
Proefessional	2(1,8%)	13,50(2,12)	5,56-32,56	12,50(0,70)	6,15-18,85	8,50(0,70)	2,15-14,85	10,50(2,12)	-8,56-29,56	11,50(0,70)	5,15-17,85
Designer	1(0,9%)	10,00(0,00)	-	13,00(0,00)	-	13,00(0,00)	-	12,00(0,00)	-		-
Civil Servant	1(0,9%)	18,00(0,00)	-	15,00(0,00)	-	6,00(0,00)	-	10,00(0,00)	-		-
Doktor	1(0,9%)	7,00(0,00)	-	15,00(0,00)	-	4,00(0,00)	-	14,00(0,00)	-		-
Jobless	1(0,9%)	18,00(0,00)	-	12,00(0,00)	-	9,00(0,00)	-	10,00(0,00)	-		-
Location											
Gubeng	14(13,5%)	13,93(4,98)	11,05-16,82	12,86(1,40)	12,05-13,67	7,00(2,98)	5,28-8,72	12,21(2,00)	11,06-13,37	12,50(1,55)	11,60-13,40
Gunung anyar	5(4,8%)	16,80(4,76)	10,88-22,72	10,00(1,87)	7,68-12,32	7,00(2,73)	3,60-10,40	9,60(1,51)	7,72-11,48	12,00(1,41)	10,24-13,76
Sukolilo	23(22,3%)	13,70(4,44)	11,77-15,62	13,13(1,39)	12,53-13,73	8,22(2,06)	7,32-9,11	10,61(1,75)	9,85-11,37	12,57(1,47)	11,93-13,20
Tambaksari	28(27,1%)	13,69(3,89)	12,17-15,19	12,96(1,26)	12,48-13,45	7,50(2,96)	6,35-8,65	11,04(2,31)	10,41-11,93	12,36(1,36)	11,83-12,89
Mulyorejo	19(18,4%)	12,89(4,82)	10,58-15,22	13,21(1,35)	12,56-13,86	7,26(2,40)	6,11-8,42	10,47(2,17)	9,43-11,52	12,53(1,07)	12,01-13,04
Rungkut	9(8,7%)	15,11(2,31)	13,33-16,89	12,67(1,41)	11,58-13,75	7,44(2,78)	5,30-9,69	11,56(1,66)	10,27-12,84	11,22(0,97)	10,48-11,97
Tenggilis	5(4,8%)	12,40(3,36)	8,32-16,57	13,00(1,22)	11,48-14,52	6,60(3,05)	2,81-10,39	11,20(2,86)	7,64-14,76	13,20(1,64)	11,16-15,24
Last Education											
SMA	84(81,6%)	13,81(4,42)	12,85-14,77	12,82(1,45)	12,51-13,14	7,54(2,70)	6,96-8,12	10,93(2,18)	10,46-11,40	12,40(1,36)	12,11-12,70
S1	18(17,4%)	13,44(3,53)	11,69-15,19	12,94(1,66)	12,12-13,77	7,28(2,35)	6,11-8,44	11,28(1,87)	10,35-12,21	12,39(1,42)	11,68-13,10
Diploma	1(1,0%)	18,00(0,00)	-	15,00(0,00)	-	6,00(0,00)	-	10,00(0,00)	-	10,00(0,00)	-
Religion											
Buddha	1(1,0%)	19,00(0,00)	-	13,00(0,00)	-	11,00(0,00)	-	8,00(0,00)	-	11,00(0,00)	-
Hindu	2(1,9%)	13,50(6,36)	-43,68-70,86	14,00(1,41)	1,29-26,71	7,50(6,36)	-49,68-64,68	11,50(3,54)	-20,27-43,27	13,50(2,12)	-5,56-32,56
Islam	90(87,4%)	13,76(4,06)	12,91-14,61	12,88(1,46)	12,57-13,18	7,41(2,49)	6,98-7,93	11,03(2,07)	10,60-11,47	12,43(1,41)	12,14-12,73
Catholic	5(4,9%)	17,80(5,63)	10,81-24,79	12,20(1,10)	10,84-13,56	9,80(2,95)	6,14-13,46	10,60(2,97)	6,92-14,28	11,40(0,55)	10,72-12,08
Protestan	5(4,9%)	9,40(1,95)	6,98-11,82	12,80(2,49)	9,71-15,89	5,60(2,19)	2,88-8,32	10,80(1,92)	8,41-13,19	12,20(0,84)	11,16-13,24

Table 5 shows Factor 1 means suicide as a right, Factor 2 means preventability - cognitive component, Factor 3 means suicide as a solution concerning self; Factor 4 means incomprehensibility-comprehensibility, and Factor 5 means orientation towards suicide prevention - instrumental part. Overall, Table 5 shows that the subject's attitude towards suicidal behavior has the highest average value on factor 1, namely suicide as right with an average value of 13.79 ± 4.26. It indicates that the majority of research subjects believe that suicidal attitudes are the right of each individual. Meanwhile, the lowest average value is found in factor 3, namely suicide as a solution concerning self, with an average value of 7.48 ± 2.62. It indicates that only a small proportion of research subjects believe that suicide is a solution for themselves. In perception carriable, Table 1,2,3 above shows that the perception variable consisting of dimensional stigma, depression, and normalization is dominated by ten factors with the highest value: vulnerability, burden, failure, loneliness, desperation, depression, suffering, fearlessness, courage, dedicated. These perceptions are harmful characteristics to direct suicide thinking and act.

In the attitude variable, the highest score for men and women is a factor 1, which indicates that the majority believes that suicide is a person's right. When viewed from the sample's age, the aged 18-21 years had the highest value for the first factor, indicating that most of the old 18-21 years believed that suicide was a right, while samples aged 22-25 produced the highest factor two. It means that most of the population thought that suicide could be done as a preventive measure. The statement of "feeling alone" from the isolation/depression factor is the most widely agreed factor of the community's perception of suicidal behavior. The sample's knowledge of suicidal behavior also has a reasonably high value. It has led to an assessment of most people who believe that suicide is a person's right. In General, Table 5 shows that men and women have values that are not much different. This similar pattern occurred in most of all categorized such as age, profession, location, education, and religion. There is the highest score in every factor and every category, but not indicating the dominant factor in general. There is no pattern or tendency that suicide behavior attitude directs to one characteristic or group category.

The knowledge variable indicates suicide between the male and female samples in this study does not have a large difference in value. The same is the case with primary other research (Kennedy et al., 2018). This study confirmed a statement that some fewer men answered questions with correct choices than women, while overall, women answered the option of not knowing more often than men (Oliffe et al., 2016). It was also stated that men's knowledge insight was lower than that of women because most men were reluctant to get professional treatment to treat depression (Johnson et al., 2012). The aged 19 years have higher knowledge than the others, with an average score of 19.75. In the study conducted by Kennedy in 2018, the highest average was found in the 18-24-year-old group as high as 8.20. The sample working as a civil servant has higher scores for knowledge than the other occupations. The people who lived in the Gunung Anyar village had a higher knowledge value than the others. The sample with the last diploma education scored the highest in the knowledge of suicide. From this study, it was found that the Hindu sample had higher experience compared to other religions.

4 Conclusions

There is a highlight that needs to pay attention to this research regarding perceptions, knowledge, and attitudes regarding suicidal behavior that need to be considered to reduce the suicide rate among young people. Perception of suicidal behavior consists of loneliness, desperation, depression, suffering, vulnerability, burden, failure, fearlessness, courage, and dedication to suicide. It shall be an essential characteristic for the practitioner, academics, social worker, psychiatric, and mental health worker to perform diagnosing and analysis to prevent suicidal behavior. In the attitude of suicidal behavior, most youths in the demographic category believe that suicide is an individual right. The consequences are detrimental to people prone to suicidal behavior, which are treated, as usual, assuming that suicide is an ordinary event without special treatment. The knowledge regarding suicidal behavior indicates that males and females do not have a large difference in value and other categories.

Further research is required to improve the results of this study. Necessary improvements include adding and variations in variables such as age, religious work, recent education, and others to represent the research subject's characteristics. For providing accurate results and more favorable conditions, the questionnaire data collection and information can be

completed by a qualitative approach by observing behavior, interviewing face-to-face so that subjects, environments, background, and other essential factors can be clearly captured and understood.

References

[1] American Psychological Association. Suicide. apa.org/suicide. 2019.

[2] WHO. Mental health? Vol. 13, Revista Mexicana de Neurociencia. 2016. p. 168–9.

[3] Hawton K, Bergen H, Kapur N, Cooper J, Steeg S, Ness J, et al. Repetition of self-harm and suicide following self-harm in children and adolescents: Findings from the Multicentre Study of Self-harm in England. J Child Psychol Psychiatry Allied Discip. 2012;53(12):1212–9.

[4] Bilsen J. Suicide and Youth: Risk Factors. Front Psychiatry. 2018;9(October):1–5.

[5] Cupina D. Life events, gender and suicidal behaviours in the acute community setting. Australas Psychiatry. 2009;17(3):233–6.

[6] Schrijvers DL, Bollen J, Sabbe BGC. The gender paradox in suicidal behavior and its impact on the suicidal process. J Affect Disord. 2012;138(1–2):19–26.

[7] Thapa RK, Thapa P, Parajuli-Baral K, Khan GM. Disease proportions and drug prescribing pattern observed in a free health camp organized at Dhorphirdi Village Development Committee of Western Nepal. BMC Res Notes. 2015;8(1):4–9.

[8] Turecki G, Brent DA. Suicide and suicidal behaviour. Lancet. 2016;387(10024):1227–39.

[9] Palimar V, Arun M, Bhagavath P. Paediatric fatalities due to trauma. Medico-Legal Updat. 2006 Oct;6:109–12.

[10] Jacobs., Rodgers TS. Understanding and implementing the CLT (Communicative Language Teaching) Paradigm. RELC J. 2003;34(1):5–30.

[11] Casey DE, Daniel DG, Tamminga C, Kane JM, Tran-Johnson T, Wozniak P, et al. Divalproex ER combined with olanzapine or risperidone for treatment of acute exacerbations of schizophrenia. Vol. 34, Neuropsychopharmacology. 2009. p. 1330–8.

[12] Amindoni. Wabah difteri di 20 provinsi Lima hal yang perlu anda ketahui - BBC News Indonesia. 2017.

[13] Henderson C, Evans-Lacko S, Corker E, Williams P, Thornicroft G. Effect of the time to change anti-stigma campaign on trends in mental-illness-related public stigma among the english population in 2003-13: An analysis of survey data. The Lancet Psychiatry. 2013;1(2):121–8.

[14] Spillane A, Larkin C, Corcoran P, Matvienko-Sikar K, Riordan F, Arensman E. Physical and psychosomatic health outcomes in people bereaved by suicide compared to people bereaved by other modes of death: A systematic review. BMC Public Health. 2017;17(1):1–16.

[15] Manewus. Survei_ Pengetahuan Jurnalis Terhadap Isu Bunuh Diri Masih Rendah _ Into the Light Indonesia. intothelightid.org. 2019.

[16] Calear AL, Batterham PJ, Christensen H. Predictors of help-seeking for suicidal ideation in the community: Risks and opportunities for public suicide prevention campaigns. Psychiatry Res. 2014;219(3):525–30.

[17] Öztürk, Münir, Volkan Altay, Khalid Rehman Hakeem and EA. Liquorice: from botany to phytochemistry. 2018.

[18] Muslimah. Pria Bunuh Diri Lompat dari Atas Transmart, Ini Kesaksian Saksi Mata _

jejamo. 2019.
[19] Ghasemi P, Shaghaghi A, Allahverdipour H. Measurement Scales of Suicidal Ideation and Attitudes: A Systematic Review Article. Heal Promot Perspect. 2015;5(3):156–68.
[20] Batterham, P. J., Christensen, H., & Calear AL. Anxiety symptoms as precursors of major depression and suicidal ideation. Depression and Anxiety. Gend Behav 17(2), 2019, 13007-13015. 2013;17(1):1–19.
[21] Octama. Angka Prevalensi Cacingan di Indonesia Mencapai 28, 12 Persen. Berita Satu. 2015.
[22] Bennett, N. J., & Satterfield T. Environmental governance: A practical framework to guide design, evaluation, and analysis. Conservation Letters. 2018.
[23] Ghasemi M, Brown RH. Emerging mechanisms of molecular pathology in ALS. J Clin Invest. 2015;125(5):1767–79.