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Experiences of depression in Yogyakarta, Indonesia

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ABSTRACT

People from different cultural settings may differ in their presentation with depression. Exploration of experiences was assessed through interviews with 20 Javanese adults aged from 18 to 55 years in Yogyakarta, Indonesia, who had mild to moderate depression. Five themes emerged from the interviews as characteristic of Javanese experiences of depression: internalised and externalised emotions, loss of interest in social and religious activities, disturbance in cognition, the presence of physical symptoms, and suicidal ideation. Javanese respondents used particular terms to explain their depression. Attending to how people's expression and experiences of their depression might enhance the capacity of clinicians to understand cultural variation, in order to respond appropriately to their clients.

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Culture; depression; Javanese people; primary health care

Introduction

Questions on the relationship between culture and depression including the social context and local understandings of cause, manifestation and management of depression have received considerable attention in recent decades, following the foundational work of Kleinman and Good (1985) on cultural dimensions of depression. Depression symptoms can include emotional and cognitive change and vegetative symptoms (Alang, 2016; Hitchcock et al., 2016), but also, for some people, physical symptoms of depression are common (Abdul Kadir & Bifulco, 2010; Brintnell, Sommer, Kuncoro, Setiawan, & Bailey, 2013; Kleinman, 2004; Seifsafari, Firoozabadi, Ghanizadeh, & Salehi, 2013; Selim, 2010). Understandings of depression vary within and across cultures in relation to psychological causes, interpersonal pressures, biological explanations, and in some contexts, spiritual explanations (Abdul Kadir & Bifulco, 2010; Bhui, Rüdell, & Priebe, 2006; Juchli, 1991). Below, we explore how Javanese in Yogyakarta, Indonesia, speak about depression and relate their own experiences of it.

Javanese comprise over 40% of the Indonesia population, and although they are dispersed in all 34 provinces of the country, their homeland is in Central Java, the Special Region of Yogyakarta (hereafter Yogyakarta) and East Java (Ananta, Arifin, Hasbullah, Handayani, & Pramono, 2015). Increasing awareness since 2004 of the need to address mental health problems has seen the local government in Yogyakarta integrate clinical

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psychology into the primary health care system. The initial programme involved the assignment of six clinical psychologists at six primary health care centers (PHCs) through collaboration between the Sleman District Health Office and the Faculty of Psychology, Gadjah Mada University. By 2008, clinical psychologists had been allocated to all 25 PHCs in the district. In 2010, the programme was extended to the Yogyakarta City Health Office, with nine clinical psychologists appointed to provide mental health care across 18 PHCs in that district. By 2014, clinical psychologists were located in all PHCs in the district. The integration of clinical psychological and medical services includes their co-location in the PHCs. This co-location stimulates referral and encourages communication between the clinical psychologist and other medical staff, in particular, the GPs (Widiana, Manderson, & Simpson, 2018).

In providing mental health services, clinical psychologists use clinical interviews and clinical observations to assess patients, and then make a diagnosis by following the Pedoman Penggolongan Diagnosis Gangguan Jiwa III (*PPDGJ III: Manual for the Classification and Diagnosis of Mental Disorders*), based on ICD-10 and DSM-IV (Widiana, Manderson, et al., 2018). Javanese use the term *edan* (Javanese) or *gila* (Bahasa Indonesia), meaning "crazy", to refer to mental illness, especially schizophrenia; other terms reflect a nuanced understanding of mental health conditions, pathways, and chronicity (Good, Marchira, Hasanat, Utami, & Subandi, 2010). For example, a study in East Java identified that women described perinatal depression with a variety of terms including *cemas* (anxiety), *banyak mikir* (thinking too much or worrying too much), *kuatir* (worried), *takut* (scared or afraid), *bingung* (confused), *sedih* (sad), *serba kekurangan* (personal and economic inadequacy), and *nelongso* (self-pity) (Andajani-Sutjahjo, Manderson, & Astbury, 2007), with these various terms reflecting women's spread of emotions in relation to practical problems and personal capacity.

In the PHCs in Sleman District, people who might be diagnosed with depression or related mood disorder typically complain of physical symptoms such as burning in the chest (*dodo rasane kemranyas*), stiffness in the stomach (*wetenge mbesesek*), oesophagus (*ulu ati mbedhedheg*), or heart (*atine mrongkol*), burning in ears (*kuping kemropok*), tension in the neck (*githoke pating creneng*), and headache (*sirahe cenat cenut)* (Retnowati, 2011). However, variations in symptoms that depart from assumed universal presentations are not listed in the PPDGJ III, and accordingly patients are treated for physical ailments as they present them, rather than for possibly underlying mental health problems (Retnowati, 2011). Possible depression or anxiety in patients presenting with a physical complaint might be identified through clinical interviews and clinical observation, particularly when a GP has eliminated other causes for pain. However, when a patient is referred on to a clinical psychologist located in the PHC, he or she uses the Beck Depression Inventory (BDI) either as a self-report inventory or as an interview guide (Widiana, Manderson, et al., 2018), to screen for depression. The BDI does not include physical complaints, but in addition, clinical psychologists reported difficulties in assessing patients with the BDI as they had to explain the meaning of each item and some patients were reluctant to fill out the inventory (Widiana, Manderson, et al., 2018).

The current study sought to explore how Javanese describe experiences of, and the terminology used to convey depression, thus providing a better understanding of its presentation.

Methods

The research we report here was a component of a larger study designed to develop a locally appropriate screening tool. Ethnographic interviews were conducted in the first stage of the larger study, from September to November 2014 in the Yogyakarta City and the Sleman District, Special Region of Yogyakarta, Indonesia. Data on the experiences of depression, presented in this article, were used as the basis for the development of a depression measure.

Ethics approval for the study was received from Monash University Human Research Ethics Committee (CF14/1743 – 201200857). All personal names and place names of PHCs and hospitals, used below, are pseudonyms.

Participants

Clinical psychologists who were treating or had previously treated people with depression invited patients to participate in the study. When potential participants expressed interest, the first author was introduced to them and explained the study in either Javanese or Indonesian, depending on their language, to provide a plain language participant explanatory statement; answered any questions; completed the consent process; and scheduled the interview. Participants gave verbal consent because of unfamiliarity with this process, fear that their signatures could be misused, and/or because of illiteracy. Twenty Javanese (four men, 16 women) participated in the study, aged from 18 to 55 years; all but one was Muslim. The majority of participants in Yogyakarta City had been diagnosed with mild to moderate depression for less than one year, whereas nearly equal numbers of participants in the Sleman District had experienced depression for less than one year or for longer. Most participants in the Sleman District were single; equal numbers of participants in the Yogyakarta City were single and married.

Procedure

The ethnographic interviews started with a casual conversation related to the daily activities of the participant, conducted either in Javanese or Indonesian, or a mix of both, depending on participant's preference. Only two out of 20 participants chose the Javanese language.

Following this introductory phase, questions were asked which derived from the Cultural Formulation Interview (CFI) (APA, 2013), with probing to gain a deeper understanding of particular responses. The CFI is a tool that was developed by the DSM-5 cultural issues subgroup to assist in the diagnosis of people who have mental health problems that may be impacted by cultural factors (Worcester, 2013). The CFI includes questions in four domains: cultural definition of the illness; cultural perception of cause, context, and support; cultural factors affecting previous help-seeking and coping; and cultural factors affecting current help-seeking (APA, 2013). Eight additional questions that allowed further insight into Javanese patients' explanatory model of illness were drawn from the supplementary module 1 of the CFI.

Each person participated in from one to three meetings with the interviewer. When an interview was not possible at the first meeting, a brief conversation was held to begin to

develop rapport. Participants were reassured at this and later interviews that, if they felt uncomfortable, they had the choice not to answer the question, and if they were distressed, the interview could be postponed. Where distress was sustained, the interviewer discussed with the participant whether they would like to meet the clinical psychologist at the PHC, and if they agreed, they could choose to be accompanied to meet the psychologist. All interviews were audiotaped and lasted between 30 minutes to 2 hours, transcribed into Javanese or Indonesian by the first author, and translated into English following discussion among the authors. Translation was discussed with the second author (competent in Indonesian), and discussion about the nuance of language continued to inform analysis.

Data analysis

In the analysis of data, we used a process of inductive thematic analysis (Braun & Clarke, 2006). Authors read transcribed data from the interviews multiple times, and notes were made based on the data. Generation of codes occurred for each interview, with the same process applied across the entire data set. Review of the list of codes occurred from all interviews and like codes aggregated. Code definitions, information on the code's central meaning, and examples of text considered within the code's parameters, were documented in a codebook. Working with and refining these codes, we identified emergent themes, and determined primary themes and subthemes as a means of conceptualising and explaining trends in respondents' experience. These themes and subthemes were assigned to specific sections of text across all interviews for ease of management and searching.

Results

Below, we elaborate on the experiences of depression as described by participants. Most participants reported on five distinct, although interrelated, ways in which depression manifests: (a) emotion, (b) loss of interest in social involvement and/or religious activities, (c) disturbances in cognition and ideation, (d) suicidal ideation and attempts, and (e) physical symptoms either with or without diagnosed illnesses. We describe these as follows.

Emotion

Javanese participants reported that they experienced a broad range of emotions, mostly internalised, including sadness, shame, guilt, fear, and sense of hopelessness, worthlessness, or uselessness. However, participants also experienced anger as an externalised emotion, and often experienced multiple emotions at any one time:

> I was so lonely, sad, no-one understood me, and I did not know who to talk to, no-one … I couldn't find anyone to listen to me … I was sad, but more so, (I was) angry, resentful. I was sad; I couldn't help my friends. I was angry, was there nothing about me that they liked? I felt so sad so lonely … disappointed, grudging, full of hate. (Bintang)

When people talked about depression, they often explained their emotions in relation to a specific trigger or circumstance. Sadness was almost always tied to particular

circumstances. For example, Dian described her sadness as unbearable, and related this to her knowledge that her grandchild had been sexually abused by a neighbour. Citra had a son with schizophrenia, had financial difficulties and problems walking because of an injury. In combination these factors left her feeling hopeless and depressed.

Other than sadness, participants spoke of shame in relation to a particular circumstance or series of events. Five participants spoke of feeling ashamed because of social judgments. Fitri became pregnant while unmarried and her boyfriend refused to marry her:

> I was ashamed, it was dishonorable … I was ashamed because what I had done was not acceptable according to my religion and social norms. I was ashamed, afraid and confused (about) what would happen in the future.

Participants also felt ashamed because they were depressed. Thus, the shame related both to events precipitated their depression as well as their response to the events as depressive illness.

Several participants also experienced guilt. Ningsih said that she frequently made mistakes at work, and she had participated in an illegal activity at her workplace. Nearly half felt deep regret, fear or anxiety as a result of the particular event, and the depth of this emotion had led to depression. Kanti, for instance, was an undergraduate student whose boyfriend, she explained, had forced her to have sexual intercourse:

> I lost it (virginity). It was a thing that I was supposed to be proud of and I lost it. I have lost part of my body that should have been for my husband only. I felt like … like … very useless. It was really … why did I do this? I felt sorry, I wished I had not done that. I wish I had rejected him.

Tuti (26 years) was to have married, but her boyfriend cancelled their wedding. This influenced later relationships and contributed to her depression: "I feel traumatized whenever I start to get involved with a man. I worry that this (being rejected) will happen again."

Thirteen participants also reported that they angered easily; one participant could not control his anger. Sometimes, when participants were unable to express their anger verbally, they expressed their emotions in other ways, such as by hitting a wall or by breaking dishes.

Loss of interest

Emotions were translated into social behaviour that was both internalised and externalised. During depression, participants became self-focused, isolating themselves, and losing motivation. They spoke of self-absorption, reiterating the idea that they did not care for others. Participants were reluctant to engage with others and withdrew from social events, including attending religious activities at the mosque. The most common social symptom was that participants would stay in their room: they wanted to be alone and thought only of themselves. Hermi (50 years), for example, was a homemaker who developed depression after her husband was dismissed from his work place. In response, she explained: "I just slept and was confused … I did not like my husband, I did not like my children. … I just felt sadder and sadder. I only thought about myself."

In speaking of their lack of motivation to participate in social activities, participants emphasised their reluctance even to converse with others. They were *malas* (Indonesian); they do not want to do anything. Catur, for example, was bullied by his friends at high

school, and used the term *memeng* (Javanese), the equivalent of *malas,* to speak of his lack of motivation. The English equivalent would be both laziness and reluctance.

A quarter of participants reported that they had lacked enthusiasm. Some participants tried to overcome this, Dedi explained how he tried to get his "spirit" back.

> I have tried to get myself back to being a new person, to be a person with spirit, to have stamina, to be who I am, but I have failed, failed, failed. I have tried. I was so sorry. I cried in my room. I felt sorry, for everything.

There is an expectation within this community that all adults are practicing Muslims, however, participants elaborated on their specific loss of interest in religious activities. They explained changes in religious practices both on an individual level and as community members. Some participants, especially the men who were expected to pray at the mosque, focused on their decreased religious attendance. Participants reported having difficulties in praying, so again their depression manifested in terms of observable behaviour and as an internalised state:

> When I had depression, I spoke incorrectly, I wanted to talk about "A" but "B" would come out from my mouth. So, there was a difference between what I was thinking and what I was saying. This also happened when I was praying. I was praying incorrectly, my prayers were incorrect. I wanted to pray but something else was coming out of my mouth. It was like *konslet* (Javanese; i.e., the electric points that are not well connected). (Ningsih)

Ningsih used Javanese term *konslet* to emphasise her cognitive condition, in which her thought and her speech seemed disconnected. As elaborated below, a number of participants experienced cognitive difficulties.

Cognition and ideation

More than half of the participants reported that they were *bingung* (Javanese and Indonesian: confused). Marni had been living with her husband, her mother-in-law and two younger sisters-in-law. She was extremely unhappy, did not feel comfortable in the house, cried and felt confused. Because of her distress and tension with her in-laws, Marni's husband built her a small house beside his mother's house. But this did not resolve her problem, "I wanted to leave this neighborhood, so I would not be *unteguntegan* (Javanese: pushed around; literally jostled)."

Some participants reported perseveration, and were disturbed by their repetitive thinking. Kanti constantly returned to the time when her boyfriend forced her to have sexual intercourse:

> I would be thinking about it, and then I would cry … I always remember, when he treated me like that (forcing her to have sex) … he treated me like that … and it was like, it was difficult to forget it. Ah … I kept on remembering it. And I often had dreams, having sex with him in my dreams, and I'd dream it again and again. Why, why is it like this?

Participants explained that they could not think clearly when they experienced persistent intrusive thoughts at the centre of their depression. Fitri, for instance, found it difficult to concentrate during her pregnancy, as her boyfriend's wife was always threatening her with violence: "I could not think clearly as before; I just kept thinking about it (the threats)."

Others spoke more generally of their inability to think clearly and to concentrate. "It was like I could not concentrate, like … I was always restless when I was doing something" (Retno). Several participants also reported that they had an "empty mind" and could not engage with the world around them.

Suicidal ideation

Some participants reported suicidal ideation, especially in relation to the depression episode that occurred closest to the interview. However, one participant recounted earlier suicidal ideation, when she was anxious about a relationship:

> When I was a junior high school student, I kept thinking what if I jump from the second floor … so my womb would be broken (and so I could not get pregnant), and then I wouldn't have a boyfriend. I don't know why. I never dreamt of being married … never … It was not because of my boyfriend, I don't know why … I just had this idea. (Bintang)

Two participants had tried to commit suicide, one – Andi – on several occasions:

> I wanted to die when the problem first began. I swallowed eight tablets, then my wife brought me to the primary health center to meet the clinical psychologist. The clinical psychologist asked me why I took so much medicine. I answered honestly: so that I can die.

Marni described her suicide attempt:

> When we moved into this house, my husband moved the chairs without telling me. I was resentful … (So) I ran to the water well, jumped … I felt relieved when I jumped into the well. I had thought about suicide for a long time.

Other participants spoke about suicidal ideation, but had not acted on this, out of concern that others would suffer, that their suicide attempt would not be complete, or that either their parents or Allah would be angry with them.

> When I felt that there was no hope, I had those thoughts. But *Alhamdulillah*, I had silly thoughts: What if I did not die? What if I failed to die, and then I was in coma, and I would suffer, and other people would suffer. (Dedi)

> I really thought, it would be better if my life in the world were over. But I was too much a coward to do that. Because I knew, if the suicide was not the end, I would face further punishment from Allah. (Utami)

Physical symptoms

Participants reported physical ailments, particularly headaches, described in Indonesian (*pusing, sakit kepala)* and Javanese (*mumet, nggliyer).* One participant explained:

> I often had headaches. It was so painful, it was like vertigo, the floor was rocking, and then everything was spinning. I could not stand up, it was like I had lost my balance … It was like (my head) was going to explode … I didn't feel strong enough to bear it, I screamed because it was so painful. (Sri)

Other participants reported chest pain (*seseg:* Javanese; *sesak:* Indonesian) and others that their heart beat was faster than normal: "When I was afraid, my heart beat (faster)

deg-deg-deg-deg like that. It frequently happened" (Lastri). One participant had recurrent gastritis.

Nearly half of the participants experienced sleep problems. Normally, in this region, people go to bed around 9 or 10 at night, but participants spoke of lying awake until after midnight, finally falling asleep and then waking up again not long after. One participant explained:

> I haven't been able to sleep, from Ramadan (fasting month) until now. I never sleep at night. I don't fall asleep until around 12am, and then (wake up) a few minutes before prayer call (the early Morning Prayer, 4 am). (Ani)

Participants also reported lack of energy. While they related this to lack of motivation and laziness (above), they also spoke of *lemas* as a physical symptom – having no power to walk, support their head, move their hands, or do anything. Participants used both Indonesian (*lelah, capek*) and Javanese terms (*sayah, kesel*) to speak of their tiredness.

Some participants also reported loss of appetite or explained that they were unable to eat even if they felt hungry. Participants lost weight as a result, reporting between 4 to over 10 kilograms since the onset of depression.

Participants who presented for medical attention explained that no physical cause of their illness could be identified:

> I am not allowed to think too hard. I saw a neurologist as I had a headache. I felt dizzy, as if my head was being beaten with a hammer. But the neurologist said I was healthy, I had no illness. He told me, stop thinking too hard. (Dian)

Endang went to many hospitals and met many doctors before being diagnosed with depression by a psychosomatic specialist:

> I found it difficult to sleep, I could not sleep for months, I just slept a little while only. And then my tummy felt like I had been kicked, my tummy was burning. I was taken to three hospitals. The doctors all said there was nothing wrong with me. You have no illness, they said … then I was referred to a psychosomatic unit in a hospital.

Speaking of depression

While participants experienced various symptoms, they found it difficult to express their feelings directly. Women especially often drew on rich idioms to capture their experience: they spoke of feeling their head was going to explode, that their head was being beaten with hammer or pierced with nails, their chest felt trampled or squeezed, their stomach as if it had been kicked or was burning. Some used metaphors to communicate their feelings and conditions, such as *ngangkat awake wis ra mampu* (could not lift up my body), *otake niku kosong* (empty mind), and *wes jenenge ki kembang-kembange ning dunia* (my problems were the flowers of my life). Others spoke of feeling dirty, that they had destroyed or ruined their future or their future was bleak, their mind or their spirit was ruined, their world dark or without meaning. One woman spoke of hanging onto life by a "thin kite string", with the string at risk of breaking and the kite disappearing at any moment.

One participant illustrated her thinking processes and the sense of crowding she experienced as follows:

> I found it really difficult, difficult to sleep, so it was like … I mean, a normal person was … their brain is partitioned off … I mean, we can usually concentrate on one thing, but (I) could not, I was like … like a computer with all the documents open, like that. Here (in my mind) all the files had opened up automatically. (Ningsih)

Participants also drew on common idioms to explain their condition. Dian (50 years) expressed her physical and mental health, by stating, "I was tired … I was … *peribahasane niku, kulo le muni, sikil nggo sirah, sirah nggo sikil* (as they say, 'my feet for my head, my head for feet')." This expression – the equivalent of the English idiom "to work one's fingers to the bone" – emphasised how hard Dian had worked in the past, and she was exhausted.

Another participant explained her condition in terms of overflowing emotion: "I was irritated, irritated, irritated, angry, angry, angry, it was cumulative. It was like water. I was like water in a glass that was so full, it overflowed" (Endang).

Several participants drew on Javanese proverbs, such as *urip nika nek wong Jawa mik mampir ngombe* (Javanese: life is only a passing stop to have a drink, and so on is a mere passer-by), to come to terms with the fact that if they might not fully resolve their problems. Bintang had two younger siblings, a brother and a sister. She was constantly worrying about them, especially after their parents divorced and her mother began a new relationship. She wanted to have enough money to care for her siblings herself. She felt that "life was only a passing by". She explained:

> I was on my campus this one afternoon. I was alone on the third floor, there was a breeze, I was listening to music, and suddenly … hhhhhh. I looked up, oh My God … *life just drifts by* … (laughter). It just drifts by. What a pity I feel so sad when I have problems … It's so hard to reach my dreams. So sad. I wanted to reach them soon, but … I need much more time. I always think about my little brother and little sister. (Bintang)

Discussion

Participants reported classic symptoms of depression, which we have differentiated in terms of emotion, rumination, or perseveration, withdrawal, lack of interest in social activities, and suicidal ideation. However, participants also highlighted symptoms that are not global symptoms of depression, including physical symptoms and loss of interest in religious activities. Therefore, relying only on screening tools based on the symptom of depression listed in the DSM-5 or ICD may not be sufficient for Javanese.

Although an overwhelming sense of sadness was most frequently reported, a wider range of emotions was reported – feeling lonely, hopeless, distressed, guilty, and useless. These emotions are consistent with universally reported experiences of depression. Feelings of shame, regret, fear, and anger were also common for our participants, but are less often reported in the literature or identified in screening tools.

In this study, depression was experienced and displayed both as internalised and externalised. Participants mostly experienced internalised emotions such as sadness, shame, guilt, fear, hopelessness, worthlessness, or uselessness. The trend to internalise may reflect efforts to maintaining harmony, which is typically spoken of as the ultimate goal of life among Javanese (Irawanto, Ramsey, & Ryan, 2011). Conventionally and in historical ethnographies, Javanese are said to disapprove of strong expressions of emotion, and place a strong value on the capacity to contain emotion (Geertz, 1959; Subandi, 2011).

Javanese people often speak of their reluctance to articulate their emotion as they consider this was impolite (Andajani-Sutjahjo et al., 2007), and being quiet is regarded as less stigmatising than externalising distress (Browne, 2001).

Cognitive symptoms were the most prevalent symptoms contributing to depression among these participants (Widiana, Simpson, & Manderson, 2018). The most common cognitive symptom was *bingung* (confused), a state in which people did not know what they should do, did not understand what was happening, and could not think in a focused manner. Rumination was also common, and participants often spoke of thinking about their problems over and over again (cf. Watkins, 2015).

Depression symptoms were generally presented as contextual, with underlying issues seen to trigger their depression. These included conflicts with family members or friends, unemployment, or financial difficulties. Emotions such as shame and guilt also related to underlying issues. Adverse life events could trigger depression and contribute to its continuation (see Serretti et al., 2013). Because of the relationship between symptoms and context, the persistence of problems external to the individual worked to maintain depression: depression did not go away by itself. People with depression continued to feel sad and distressed because of underlying issues, and this prevented them from engaging in other activities.

Consistent with Western experiences, Javanese with depression lacked the motivation to be involved in many activities. As noted, they tended to lose interest in social and religious activities and self-isolated, wanting to stay alone in their room, to think only about themselves, and not to engage with others.

Suicidal ideation was reported, but few had attempted suicide. Religious understanding was a particular deterrent, as for Muslims, death is in Allah's hands. Participants worried that they might not die, but also that Allah would punish them in the afterlife were they to succeed.

Physical complaints were especially salient, although not unique to these participants. Changes in sleep and appetite are well known aspects of depression, and participants reported difficulty in sleeping and in staying asleep, loss of appetite, and weight loss. In addition, they reported physical symptoms such as headache, chest pain, faster heartbeat, and gastritis. These findings support previous reports that depression may present differently across cultures, including in physical symptoms (Halbreich et al., 2007; Kleinman, 2004; Seifsafari et al., 2013; Selim, 2010), especially in primary care settings (Davidsen & Fosgerau, 2014).

Loss of interest in religious activities and disinclination to observe personal religious practices were dimensions of depression particularly characteristic of the study participants. Participants experienced difficulties in praying and decreased or ceased their attendance at the mosque. Some participants, however, found the turning point of their depression through religious practice.

Despite her initial reluctance to perform religious activities, Endang forced herself to join a "night prayer community" which participants encouraged each other to pray at midnight in addition to observing the five obligatory prayers, particularly by sending text messages to each other. She also tried to increase her understanding of the Qur'an by reading the explanations of each verse, and prayed to ensure those were correct. Endang explained that Islamic values motivated her to change her behaviour and address her depression. This is consistent with a recent study of Indonesian Muslim

adolescents that showed that religiosity was protective for depression (Purwono & French, 2016).

Religion might be used as an entry point to assist Javanese people with depression. Geertz (1960) argued that Javanese spirituality is attached to formal religious observance and beliefs, and a synthesis of these is common (Irawanto et al., 2011). Dian drew on a Javanese idiom of life as "a passing stop to drink", echoing the belief in Islam that people are travellers who stop by (in life) and return home (after death). Dian used this idiom as a way of making sense philosophically of the circumstances of her life.

By using simple religious vocabulary to reach a point of tranquillity or calmness, clinicians working with Javanese with depression might be able to direct some clients to focus on underlying issues associated with depression, as occurred with participants in this study. A religious approach therefore might be useful in treatment if the client has been unable to resolve a problem. As Bintang explained, "life just drifts by", whereby she tried to accept her limitations in taking care of her siblings. Clinicians might use local idioms to assist people in understanding circumstances in which they cannot intervene, are unable to control, or cannot act to address the factors contributing to their depression.

The ways in which people speak about depression, including through their use of specific idioms and metaphors, could be used in counselling and therapy, with clinicians exploring these expressions and using them as a communication bridge (Tay, 2012). Moreover, clinicians may create metaphors as a way for their clients to cope with distressing problems (McMullen et al., 2008). The common presentation with physical symptoms needs to be included in this context. Because of the limits to time in clinical encounters, and the utility of screening tools in general, we advocate the use of a modified Indonesian screen tool.

Given the importance of religion to most Javanese, an integrated assessment and treatment programme incorporating cultural and religious aspects might be better than an approach based on conventional psychology alone. An interview guide to screen for depression, namely the Indonesian Depression Checklist (IDC), was developed to be used by CPs in PHC settings (Widiana, Simpson, et al., 2018). In the development of the IDC, a list of symptoms was developed from the ethnographic interviews, and these were confirmed by CPs, indicating CPs' understanding of how their patients expressed depression. In treating Javanese with depression, clinical psychologist may start with or draw on a religious approach and its values Javanese people might be equipped to resolve their depression. Endang, for instance, improved by integrating religious practices with psychological and medical treatments.

Limitation

The Javanese participants were recruited through collaboration with clinical psychologists at PHCs. Not all people agreed to be participants, and not all people with depression attend these centres. In addition, people with depression less used to the presence of clinical psychologists, for instance, where they have not yet been integrated into primary health care on Java or elsewhere in Indonesia, may find it more difficult to present with or accept care for depression. Consequently, there are limits to the generalisability of these findings.

Conclusion

Participants' experiences and expressions of depression vary. These include emotional responses to mood, self-isolation, rumination, suicidal ideation, physical complaints, and a loss of interest in religious activities. Understanding physical symptoms of depression, as described by the participants, might enhance awareness of the possibility that people who present to the PHCs with physical complaints have depression. Physical symptoms reported in this study emphasise the relationship between bodily discomfort and disturbed mood and distress in PHC settings. We have highlighted that while many symptoms are common and universal, other features are distinctive, especially those related to loss of interest in religious activities. A depression screening tool that includes a question on religious activities might be used in screening. We suggest that an integrative approach combining religious support and counselling with psychological and medical treatments might work best for Javanese. In this study area, the co-location of psychological and medical services within the PHC provide an opportunity for CPs to communicate how patients describe and explain their depression, in the local terms used by patients, to other health providers.

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