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Mental Health Literacy from Moslem Women Perspective

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Abstract

Purpose: This study aims to describe about Moslem women's views of mental health literacy.

Method: Descriptive analysis was applied in this study using depression and schizophrenia *vignette* as the instrument to collect data. Those *vignettes* were consisted of the depression and schizophrenia cases, which followed by some questions to explore the recognition of mental disorder symptoms, the belief about the cause, the help-seeking type, as well as the attitude toward people with mental disorder.

Result: In the aspect of recognition of mental disorder, most participants could not recognize the symptoms of mental disorder with correct psychiatric label on both *vignettes.* In aspect of the belief about the cause of mental disorder, most participants believe the cause was psycho-social factor in both *vignettes.* Most participants also tend to seek informal help, such as a friend, family, and religious healers. Last, most participants are willing to be a friend and close with people in both vignettes, even though some of them stigmatized the people with mental disorder were harmful.

Conclusion: Moslem women in this study to some extent recognize the psychiatric label of mental disorder, and believe the psycho-social factor was one of the causes of mental disorder, yet the attempt to seek help are still rely on informal type of help seeking, mainly to religious leader. It indicated that religion factor in the group of Moslem women in this study plays an important role in help-seeking aspect of mental health literacy.

INTRODUCTION

Mental health is as important as physical health. According to World Health Organization (2014), mental health is a state in which every individual could realize their potential, overcome the normal life-pressure, productive, and able to contribute to their community. When an individual could not develop themselves optimally and make a contribution to their community, they might be considered having mental disorder. Meanwhile, as stated by the American Psychiatric Association (2018), a mental disorder is a condition that involves emotional changes, thought, and behavior. Mental disorder also associated with social, work, or family problems and difficulties.

Globally, about 300 million people affected by depression (WHO, 2018). The national survey shows the prevalence of mental disorders continues to increase every year. According to National Basic Research, the prevalence of severe mental disorder such as schizophrenia reaches 400.000 people or 1.7 out of 1000 population. Prevalence of mental-emotional disorders, such as depression and anxiety aged 15 years and over, reaches 14 million people or 6% of the total Indonesian population (Kemenkes, 2013). At some point, suicidal behavior could be caused by depression. As it found that the ratio of the population who are committing suicide in Indonesia reaches 11.4% from 100.000 total population, which has the highest suicidal rate in ASEAN, by woman 4.9% from 100.000 total population and man 3,7% from 100.000 total population (Gerintya, 2017). Still, anxiety disorder and depression affect more women than men (Kemenkes, 2013).

Depression is a common mental disorder and one of the biggest problems in all of the countries around the world. Globally, there are 300 million people who affected depression and most of them are women (WHO, 2018). According to a survey in a primary health care, depression and anxiety

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are significantly higher on women (31.9%) compared to men with (20.3%) (Douki et al., 2007). According to research with sample of Indonesian teenagers, it showed that mostly symptoms of mental-emotional disorder (such as anxiety, depression, and suicidal tendencies) experienced by women (Mubasyiroh et al., 2017). Women are definitely at a greater risk of developing mental disorders such a depressive, somatoform, anxious, or eating disorder (Douki et al., 2007).

A literature review about psychological intervention in primary health care found that patients with a mental disorder with psychotherapy have fewer relapse events rather than those who did not (Novianty & Retnowati, 2016). Besides, factors which caused mental disorder are social and biomedical. The biomedical factor is indicated by the damage of the structure and function of the brain. Hence in schizophrenia patients, it is found that the temporal lobe disorder is associated with delusions and hallucinations (Frisch & Frisch, 2011). Other than that, religious belief and cultural factor that need to be acknowledged to understand how lay people describe the concept of mental disorder. Moreover, social culture tend to perceive mental disorder such as depression, anxiety, and somatic symptoms as a morality issue or family problem, and did not consider it as mental disorder issue (Novianty & Cuwandayani, 2018)

The important role of religious belief towards the perception of mental disorder cannot be neglected because most of the religion including Islam believe that mental disorder was caused by magic or possessed by spirits (Ally & Laheer, 2008). According to Subandi (2012), religious belief could be one of a factor in a mental disorder through moral conflict that arises from the feeling guilty in breaking the religion rules. The concept of traditional healing of Moslems nowadays, still attached to pray/worship. Subandi (2012) found that healing process conducted by Javanese, most participants (including family of people with mental disorder) use religious coping strategy. There are two kinds of religious coping, namely cognitive and behavior religious coping. Cognitive religious coping is about how a patient with a mental disorder and their family create meaning about the mental disorder that was experienced by them. Whereas behavior religious coping represented when the participants conduct some religious rituals.

According to Ally and Laher (2008), in Islam's perspective mental health issues related to the imbalance between *Qalbu* (feeling), *nafs* (self) and *aql* (mind). Based on the interview to Islamic therapist that was conducted by first author, the therapist believed that mental disorder was caused by a mind that controlled by a spirit. Thus, in solving the problem the therapist tends to recommend the patients into religion rituals to encourage the patients having more faith to God. The definition of health from an Islamic perspective is the balance of mental, physical, and spirit. Therefore, the abnormality state in the human's inner side also affected the physical side. An observation that was conducted by the first author at one of a particular foundation for people with a mental disorder to explore religious treatment towards people with a mental disorder. This foundation is an Islamic boarding school for people with mental disorders and rehabilitation place for drug addicts. The treatment for people with a mental disorder including doing an exorcism /*ruqyah*, consume the self-made special medicine, and the patients need to do pray and recite Al- Qur'an routinely.

According to Jorm (1997), the concept of mental health literacy was known as a knowledge and belief about mental disorder that consisted of several aspects : a) recognition/label towards mental disorder b) knowledge and beliefs about the cause of mental disorder, c) knowledge and beliefs about professional help, and d) stigma towards mental disorder. To measure the mental health literacy somehow we tend to compare the knowledge and belief related mental disorder of lay people toward the concept of mental health from psychiatric field. As a result there is a discrepancy of knowledge and belief about representative symptoms of mental disorder between lay people and psychiatric field.

Novianty & Cuwandayani (2019) found out in Chinese participants, the way of participant in interpreting the symptoms and the way to seek help were affected by their culture. Culture affects how people perceive, explain and believe about the cause of symptoms of mental disorder, even the social stigma (Kirmayer & Schwartz, 2014). The way of lay people in understanding the mental health model in different ethnicities showed similarly result that most indigenous participant in various ethnicities hardly recognize, identify, analyze the cause and seek to professional help (Cuwandayani & Novianty (2019); El-Islam (2008); Kpanake (2018); Novianty (2017); Wang et al., (2013)). One of factors that could be an explanation was the lay people tend to try to access their cultural narrative concept in explaining the issue and seeking traditional healer related mental disorder issue. The purpose of this research is to see the influence of religion aspects towards Moslem women's perspective.

METHOD

Participant

The total number of participants in this study were 102 people (16-25 years old), living in Jakarta, with inclusive criteria : a) aged above 15 years old ; b) female, and c) had lived in a islamic boarding school for 4-8 years.

Instruments

Two vignettes (depression & schizophrenia) were used as instruments in this study. The depression and schizophrenia symptoms in vignettes were developed based on DSM-V and the typical situation, hallucination and delusion were developed by conducting an interview with Islamic-based therapists who treat people with mental disorder. The validation process was carried out on both vignettes with 11 mental health experts, involving clinical psychologists and master psychology students of clinical profession (See Table 1). The object of validation was to verify whether the symptoms described in vignettes were adequate in establishing schizophrenia and depression diagnosis.

Table 1. Aiken's V Value for All Vignettes

Vignette	Aiken-V	Conclusion
Schizophrenia	0,7	Valid
Depression	0,9	Valid

Data Collection

Data were collected by an online questionnaire and paper-pencil based questionnaire. Online questionnaire was applied for participants who already graduated from Islamic boarding school, meanwhile paper-pencil based questionnaire was applied for participants who are living in the Islamic boarding school at that time. The participants were asked to read depression and schizophrenia vignette, then giving their answer by following questions about aspects of mental health literacy by Jorm (1997), such as naming the label of the case on vignette, the cause of the case, where to seek help and the attitude toward person in vignettes.

Data Analysis

Descriptive analysis was applied in this study to describe the knowledge and belief of participants on each aspect of mental health literacy. At first, raw data were code into several themes in each

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aspect according previous studies, unless there are uncommon responses emerged and new themes were required. Then, descriptive analysis by calculating the frequency in each aspect was applied.

RESULT

Recognition of Mental Disorders

In the aspect of recognition of mental disorders, most participants could not recognize the symptoms in both *vignettes* with correct psychiatric label (See Table 2). In schizophrenia vignette, most participants (61.7%) recognized the symptoms with incorrect psychiatric label, such as ADHD, stress or common label such as, mental illness. Whereas in depression vignette, most participants (47%) recognize the symptoms with incorrect label which related to mystics and religion. Religion labels that emerged in both vignettes such as exploring inadequate teachings, receive a miracle, or lack of worship.

Table 2. Recogniton of Mental Disorders

Theme	Vignette	
	Schizophrenia (%)	Depression (%)
Correct Psychiatric Label	6,8	19,6
Incorrect Psychiatric Label	61,7	29,4
Incorrect Label	27,4	47
Not Know	3,9	3,9

Knowledge and belief about the cause of mental disorder

The themes that used to categorize data in this aspect were adopted from previous study by Jorm and Reavley (2014). In the aspect of knowledge and belief about the cause of mental disorder, most participants believe psycho-social factor as the cause of mental disorder in schizophrenia (80.3%) and depression (83.4%) vignette (See Table 3), such as unemployment, bullying, lack of socialization, lack of attention from parents, etc. Religious factor believed as the cause of schizophrenia is higher than depression vignette, such as following heresy, misleading in believing miracle, having no faith, etc.

Table 3. Knowledge and Beliefs about the Cause of Mental Disorder

Theme	Vignette	
	Schizophrenia (%)	Depression (%)
Physical Factor	0,9	5,8
Psycho-sosial Factor	80,3	83,4
Biological Factor	1,9	0,9
Religious Factor	15,6	3,9
Not Know	0,9	5,8

Knowledge and Beliefs about Professional Help

Self-Help

Self-help becomes profoundly essential when only a few people seek formal help when encountering mental disorder issue. In schizophrenia vignette, participants (31.3%) believed that

schizophrenic people could not heal themselves, while approximately (50%) participants believed schizophrenic people could heal by treating themselves with religious coping such as doing *ruqyah*, getting closer to God, reading holy book (*Al-Quran*), dhikr, praying and increasing their worship, including the other sunnah worships. Whereas in depression vignette, Participants (22.5%) believed depressed people could not heal themselves and (44.1%) participants believed the depressed people could heal themselves by religious coping, which was not much different from schizophrenia vignette. Meanwhile, (7.8%) participants in schizophrenia vignette and (12.7%) participants in depression vignette choose the type of general self-help, such as sharing with significant person, taking herbal medicines, doing activities, being more open to others, and improving their lifestyle.

Type of Help-seeking

Formal mental disorder related help-seeking was defined as the attempt of adaptive coping process of individuals to seek external assistance, such as health professional care to deal with mental disorder issues (Novianty & Hadjam, 2017). There are two type of help-seeking, including formal help-seeking and informal help-seeking (Rickwood et al., 2012). Most participants in this study tend to seek help informally in dealing with depression (70.5%) and schizophrenia (79.4%) vignette, such as providing support by a close friend and family, or treated by religious coping such as visiting religious leaders (kyai/ustad), doing ruqyah, and praying.

Tabel 4. Aspect of Professional Help

Theme	Vignette	
	Schizophrenia (%)	Depression (%)
Formal	17,6	28,4
Informal	79,4	70,5
Not Know	2,9	2,9

Attitude towards People with Mental Disorder

In this aspect, we want to explore the views of participants towards individuals with mental disorders. In schizophrenia vignette, (95%) participants still want to be close with schizophrenic person with some reasons, such as familial bonding (35.2%), the belief that nobody should be rejected by others (14.7%), the belief that person needs to be supported and guided (27.4%), and the belief that person is not dangerous (4.9%), while the rest did not want to be close because of feeling scared (3.9%). In depression vignette, 95% of participants still want to be close with depressed person (95%) by giving similar reasons with schizophrenia vignette. In contrast to schizophrenia vignette, 87.25% participants believed people with depression are not dangerous.

In schizophrenia vignette, 39.2% of participants believed that other people would think individuals in vignette were crazy and insane, mentioning the label of mental disorders in general, such as mental disorders, stress, and depression (32.3%), 10.7% of participants believed that other people would make fun of schizophrenic person (1.9%), some participants also believed others would think the person was possessed by Djinn (1.9%). Whereas in depression vignette, the participant believed others would think the person in vignette were crazy and insane (13.7%), having stress (47%), and some of them think the person just tired, experiencing life pressure (16.7%).

DISCUSSION

Mental health literacy consisted of recognition of mental health disorder, the knowledge and

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belief about the cause of mental disorder, the way to seek help, and stigma. The result of this study showed that most participants did not recognize the symptoms of depression and schizophrenia with correct psychiatric label, most of them believe the psychosocial factor was the cause of mental disorder, and the way to seek help is rely on family, friends, and religious leader. Negative stigma attached to schizophrenia rather than depression was they were believed as a weak person or just having life pressure, so it was perceived as less dangerous than schizophrenic person.

The interesting finding could be found in the aspect of recognition of mental disorder. It seems most participants recognize the symptoms of depression and schizophrenia as mental disorder issue, yet they tend to fail to label them with correct psychiatric label. As previous studies found that there was a correlation between mental health literacy and community attitude toward intention to seek formal help (Novianty & Hadjam, 2017), which means when people able to recognize the symptoms of mental disorder as well as the positive attitude from their community toward people with mental disorder, they possibly seek help from mental health professional. In contrast, Moslem women in this study somehow aware the person in schizophrenia and depression vignette has mental health issues and psychosocial factor could be the cause of mental disorder, yet they try to access informal help, especially from religious leaders. Some previous studies also acknowledged religion as one of factors that affected how people perceive and access the help related mental disorder issue (Subandi (2012); Ciftci et al. (2013)). This result indicated religion should be acknowledged in discussing about mental health care, especially in the sample of religion-identity based group.

Type of help-seeking that was accessed by moslem women in this study by ask a help from religious leader and doing religious rituals. Some participants believed *ruqyah* could heal mental disorder. Other participants also believed rituals such as dhikr, pray, wudhu, and reading Al-Quran could heal mental disorder as well. Informal help-seeking was accessed by Moslem women because they believe Islam teaching is essential to lessen their burden in handling life problem, including mental health issue (Kaloo & Laher, 2014).

Negative stigma by Moslem women was found out, mainly in schizophrenia vignette. Stigma could be a significant obstacle to access mental health care because they are ashamed to open personal and family matter to stranger (Youssef & Deane, 2006). The presence of stigma toward people with mental disorder usually happened in a society that supported negative stereotype thinking about mental disorder and decide to act with this stereotype thinking (Ciftci et al., 2013). For Moslem women, traditional gender role in Moslem community probably affects their life significantly (Graham et al. (2008); Haque & Kamil (2012); Turkes & Habibovic (2011)). There are some limitations from parents, husband, and extended family in their activity because of the differences of culture interpretation about women role in Moslem (Ahmed & Aboul-Fotouh (2012); Daneshpour (2012)). A study of mental health care of Moslem women found that they were experiencing difficulties in accessing mental health care because of stigma, family restrictions, and gender roles. Family is a main aspect of their psychosocial well-being, thus family (especially father) and husband opinion are matter to them (Saleem & Martin, 2018)

CONCLUSION

In conclusion, the findings in this study showed that most of Moslem women in this study to some extent recognize the psychiatric label of mental disorder, and believe the psychosocial factor was one of the causes of mental disorder, yet the attempt to seek help still relies on informal type of help seeking, mainly to religious leader. It indicated that religion factor in the group of Moslem women in this study plays an important role in help-seeking aspect of mental health literacy. Religious

leader and rituals are perceived essential in handling mental disorder issue. Religion perceived as a source of help. Unfortunately, the limitation of this study was the absence of information about the mental health care facilities around participants in this study. Further study should consider to include this background information to examine the possibility of religious type of help-seeking that was accessed by participant was related to the absence of mental health care facilities around them or independently related to their own concept about mental health.

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