Religiosity and mental health stigma among adults in Malaysia

JURNAL ILMIAH PSIKOLOGI TERAPAN
p-ISSN 2301-8267; e-ISSN 2540-8291
ejournal.umm.ac.id/index.php/jipt
2024, Vol 12(2):84–91
DOI:10.22219/jipt.v12i2.32256

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Abstract

This study explored religiosity's impact on mental health stigma among 451 adults of various religions in Malaysia using quantitative methods. Participants, including Muslims, Buddhists, Hindus, and Christians, completed the Centrality of Religiosity and Perceived Devaluation-Discrimination scales via an online Google form. Findings indicated high religiosity and moderate mental health stigma levels overall. Pearson correlations showed no significant relationship between religiosity and stigma across all groups. However, Buddhists demonstrated a small to moderate correlation ($r = 0.27$, $p < 0.05$) between Public Practice of religiosity and stigma, while Hindus showed a similar effect ($r = 0.24$, $p < 0.05$) with Experience of religiosity. One-way ANOVA revealed no stigma differences between religious groups. Addressing mental health stigma is crucial, given its impact on help-seeking behaviors. Future research should focus on fostering inclusive attitudes towards mental illness while respecting religious beliefs.

Keywords

Adults, mental health stigma, multi-religious, religiosity

Introduction

Among many possible reasons for the rise in the prevalence of mental health issues in Malaysia, one highlighted the most is stigma. Stigma is associated with beliefs about specific conditions or situations that result in individuals falling out of socially accepted groups (Koenig & Al-Shuhaib, 2018). Past studies also debunked social stigma as a major component responsible for the remaining 80 percent of Malaysians with a mental disorder who did not seek expert help (Raaj et al., 2021). Even with the best mental healthcare services provided, both self-stigma or stigma directed from people around, including family, friends, and society, can prevent help-seeking behavior through avoidance and social isolation (Berry et al., 2019; Al-Natour et al., 2021). These fears instilled by stigma lead individuals to suppress their flaws instead of ensuring positive changes in behavior (Bharadwaj et al., 2017). If not through suppression, there are also possible traditional care as alternatives provided by unqualified practitioners such as shamans in Malaysia(Raaj et al., 2021).

Religious or spiritual beliefs play a significant part in influencing the view and behavior of a person toward another person (Wesselmann & Graziano, 2010). This means that not only did individuals resort to religion due to being stigmatized, but in most cases, religiosity is also what reinforced stigma in people towards those with mental illness (Peteet, 2019). In some religions, mental health problems are said to be associated with the devil or as punishment from God, hence why it can be stigmatizing. Mental illnesses were often contested as they were considered to be faith-related issues (Al-Natour et al., 2021). Supernatural and religious explanations were also often used in Asian countries (Knifton, 2012). One thing is for sure: the essential constituent of each religiosity is crucial as it governs the act of prejudice (Wesselmann & Graziano, 2010).

According to Malaysia's 2020 International Religious Report, although the official religion of Malaysia is Islam, other religions are still allowed to be practiced in peace and harmony (Shah & Timothy, 2020). Indirectly making Malaysia a multi-religious country, the top four most religious practices are Islam at 60 percent, Buddhism at 20 percent, Christianity at 9 percent, Hinduism at 6 percent, and others at the rest. Religious beliefs are associated with shame and blame (Knifton, 2012). Taking Islam believers known as Muslims as the majority of Malaysians, mental illnesses are usually hidden to protect family nobility, pride, and community approval to avoid being an outsider due to the stigma (Koenig & Al-Shuhaib, 2018). Unfortunately, such a scenario happened in the Islamic context and the other three main religions. Hence, it is essential to understand religiosity and the beliefs that could be associated with mental health stigma in particular.

Several studies investigated the impact or relationship between religiosity and mental health stigma among adults, and the results were inconsistent (Al-Natour et al., 2021;

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Peteet, 2019; Wesselmann & Graziano, 2010; Koenig & Al-Shuhaib, 2018). Much research suggests that religiosity has a significant negative relationship with mental health stigma (Al-Natour et al., 2021; Adu et al., 2021). However, some stated that religiosity is a medium that improves individuals' mental health and general well-being if they genuinely abide by its teachings (Caplan, 2019; Koenig & Al-Shuhaib, 2018). Another opinion concluded that religiosity and mental health differ according to individuals' religious affiliation due to their complex relationship (Wesselmann & Graziano, 2010; Cinnirella & Loewenthal, 1999).

In addition, the recent Covid-19 pandemic has also left a toll on everyone across Malaysia, regardless of religion. Mental health issues increased as individuals experiencing it became worse; in some cases, those cured had relapsed and who were mentally healthy before experienced no less than emotional disturbances and are mentally fragile, too. As the prevalence of individuals increases, so do negative attitudes and beliefs. In short, discrimination towards this population causes a heavy burden on them (Al-Natour et al., 2021; Mannarini & Rossi, 2019). As most studies were conducted before the pandemic and to reduce the gaps in knowledge on this matter, it has become very crucial to examine the relationship between religiosity and mental health stigma now than ever before. It is also possible to examine if there are any other predicting factors of mental health stigmatizing in adults. Hence, this study aims to examine the relationship between religiosity and mental health stigma among Malaysian adults.

Most adults in Malaysia are believers, regardless of any of the four religions: Islam, Buddha, Hindu, and Christianity. It is not too much to say that many aspects of their life revolve around the element of religiosity, including the way they think and conduct themselves, particularly towards people with mental illness. The integration of religiosity in the act of labeling, stereotyping, prejudice, or any other act of mental health stigma is in urgent need of boundaries (Subu et al., 2021). Unfortunately, the study between religiosity and mental health stigma is, indeed, lacking.

This research study provides information about the role of religiosity, particularly its impact on mental health stigma among adults in Malaysia. Readers can also understand how religiosity within their religion relates to mental health stigma. This information enables people at all levels of society to improve their thinking and behavior, thereby avoiding stigmatization of themselves and others and promoting positive overall well-being among individuals with mental illness. Additionally, it encourages further acceptance and promotes help-seeking behavior.

Based on the topic of this study, the objectives are listed below: (1) to examine the correlation between religiosity and mental health stigma among adults in Malaysia. (2) To examine the correlation between the religiosity of each religion (Islam, Buddha, Hindu, and Christianity) and mental health stigma among adults in Malaysia. (3). Examine the difference in terms of mental health stigma between the four religions (Islam, Buddha, Hindu, and Christianity).

Method

Participants

The sampling frame is Malaysian adults who are typically 18 years old and above, believers in one of the four religions in Malaysia, mainly Islam, Buddhism, Christianity, and Hinduism, able to read, write, and comprehend in English, and fully consent to participate in this study. Quantitative methods were used to examine the relationship between variables. The researcher used a cross-sectional survey to gather data from participants on their religiosity and mental health stigma. The sampling technique used non-probability, purposive sampling. The sample size for this study was calculated using G*Power software version 3.1.9.7. By using the two-tailed test, the significant level at α = .05, and a sampling power value of 0.95, the G*Power software suggested a sample size of 280 participants. To reduce insignificant errors and ensure sufficient sampling, researchers gathered 451 participants for this study.

Research Instruments

For the survey questionnaire, there will be three sections, which are Section A (demographic questions), Section B (Centrality of Religiosity Scale), and Section C (Perceived Devaluation-Discrimination Scale). The informed consent and questionnaires were available online and spread to possible religious target groups across social media. Informed consent and a brief explanation about the study were presented before participants agreed to participate. Participants were informed of their rights as participants of voluntary participation, withdrawal, and anonymity, and that no private information would be shared. Other details, including contact person, email, and a few more information, were also available for participants. Upon agreeing to participate, participants must answer all three sections before submitting it. The estimated duration to answer the questionnaire is 15 minutes to 20 minutes. The questions in both scales will be in English as the only version available.

Participants' demographic information, such as age, race, ethnicity, religiosity, gender, marital status, income, education, and employment, was gathered for this study.

The Centrality of Religiosity (CRS) Scale is a 15-item self-report scale to measure the religiosity of interreligious adults in Malaysia. Three versions of the Centrality of Religiosity Scale (CRS) are available online in English. The first version used was the standard version of CRS for both Islam and Hindu, the second version was the Hindu adaptation, and the version was adopted. The 15-item self-report inventory is made up of five dimensions, mainly public practice, private practice, religious experience, ideology, and intellectual dimensions (Huber & Huber, 2012). The item's responses include a 5-point Likert Scale. High scores on dimensions suggest the degree of religiosity of interreligious Malaysian adults.

Perceived Devaluation-Discrimination Scale (PPD) is a 12-item self-report scale that examines how individuals perceive societal attitudes related to mental illness and possible anticipated rejection associates (Link et al., 1989). The 12-item self-report inventory is a one-dimensional instrument that examines how individuals perceive societal attitudes related to mental illness and possible anticipated rejection associates

or stigma. The item's responses include a 5-point Likert Scale. High scores on the scale suggest more positive perceptions of individuals with mental illnesses among interreligious Malaysian adults (Al-Natour et al., 2021).

Data Analysis Technique

The researcher's gathered data were analyzed using the Statistical Package for Social Sciences (SPSS) version 27. The author used two kinds of statistical methods: descriptive analysis, inferential analysis using Pearson Correlation, and one-way ANOVA. The sample size in this study was large for the descriptive analysis. In descriptive statistics, the researcher practically transformed the extensive data. This includes analyzing the mean, standard deviation, and frequencies of gathered data.

Additionally, for inferential analysis, the Pearson Correlation was used to measure the correlation between religiosity and mental health stigma among adults in Malaysia. The independent variable is religiosity, and the dependent variable is mental health stigma. The normality and skewness will be noted, as well as the probability value, to see if there is any significant relationship or not. Another analysis of the Pearson Correlation was also run to observe the correlation between religiosity and mental health stigma according to each religion. This study reports effect sizes in addition to p-values to provide a more comprehensive understanding of the data. Effect sizes measure the practical significance of findings, which is crucial for interpreting the magnitude of observed effects. While p-values indicate whether a relationship exists, effect sizes quantify the strength of this relationship, offering a more nuanced interpretation of the data.

Furthermore, one-way ANOVA will be conducted to measure the difference in terms of mental health stigma between the four religions (Islam, Buddha, Hindu, and Christianity) among adults in Malaysia. The independent variable is religiosity and the dependent variable is mental health stigma. The normality and skewness will be noted, including homogeneity of variance and the probability value to see if there is any significant difference. The researcher will further determine whether to accept or reject the four hypotheses of this study after running data analysis.

Result

Demographic information explains population-based data statistically, including gender and many other factors. It allowed the researcher to further understand the background of the respondent and facilitate the representativeness of the target population. In this research, gender, race, marital status, academic qualification, income, religion, and age group were addressed by the summarized frequency and the percentage of data collected, as shown in table 1.

Table 2 shows the result of descriptive statistics and interpretation of the mean of the descriptive statistic for independent and dependent variables involved for both the Centrality of Religiosity Scale (CRS) and Perceived Devaluation-Discrimination Scale (PPDs).

The correlation between religiosity and mental health stigma was tested using the Pearson correlation coefficient and the interpretation shown in Table 3.

Table 1. Demographic Information

Variables	n	%
Gender		
Female	341	75.6
Male	110	24.4
Race		
Malay	171	37.9
Chinese	112	24.8
Indian	87	19.3
Others	81	18.0
Marital Status		
Single	406	90.0
Married	45	10.0
Academic Qualification		
SPM	15	3.3
STPM/Matriculation/Diploma	99	22.0
Bachelor Degree	297	65.9
Master	35	7.8
PhD	5	1.1
Income		
B40	270	59.9
M40	156	34.6
T20	25	5.5
Religion		
Islam	183	40.6
Buddha	91	20.2
Hindu	81	18.0
Christian	96	21.3
Age group		
$<$20	37	8.2
21 - 30	362	80.3
31 - 40	24	5.3
41 - 50	20	4.4
51 - 60	5	1.1
$>$ 61	3	0.7
Total	451	100.0

Table 3 shows the results of the Pearson Correlation Coefficient at a significance level of 0.01 (2-tailed) between Religiosity and mental health stigma. The Pearson correlation results indicated no significant relationship between overall Religiosity and mental health stigma with a correlation coefficient of less than 0.1 respectively [Intellect dimension; $r(449) = 0.04$, $p = 0.434$, Ideology dimension; $r(449) = 0.03$, $p = 0.570$, Public practice dimension; $r(449) = 0.06$, $p = 0.196$, Private practice dimension; $r(449) = 0.06$, $p = 0.202$, Experience dimension; $r(449) = 0.06$, $p = 0.224$, Religiosity; $r(449) = 0.06$, $p = 0.190$]. In short, there was almost no correlation between Religiosity and mental health stigma among adults in Malaysia.

The purpose of this study is to examine the correlation between the Religiosity of each religion (Islam, Buddha, Hindu, and Christianity) and mental health stigma among adults in Malaysia. Table 4, on the other hand, shows the Pearson Correlation Coefficient between Religiosity and mental health stigma by religion at the significance level of 0.05 (2-tailed).

According to the data of Islam religion, the correlation between all the five dimensions of Religiosity as well as Religiosity in general towards mental health stigma suggested by Pearson Correlation Coefficient to be negligible with

Table 2. Descriptive Statistics

	N	Mean	Std. Deviation	Level
Centrality of Religiosity Scale (CRS)				
Intellect Dimension	451	3.59	0.86	Moderate
Ideology Dimension	451	4.34	0.85	High
Public Practice Dimension	451	3.81	0.92	High
Private Practice Dimension	451	4.11	0.96	High
Experience Dimension	451	3.73	1.12	High
Religiosity	451	3.92	0.75	High
Perceived Devaluation-Discrimination Scale (PPDs)				
Mental Health Stigma	451	2.92	0.58	Moderate

Note: Low (M = 1.00), Moderate (M = 2.36), High (M = 3.67)

Table 3. Pearson Correlation Coefficient

	r	P
Intellect Dimension	0.04	0.434
Ideology Dimension	0.03	0.570
Public Practice Dimension	0.06	0.196
Private Practice Dimension	0.06	0.202
Experience Dimension	0.06	0.224
Religiosity	0.06	0.190

Note: Weak correlation (r = 0.1), Moderate Correlation (r=0.3), Strong Correlation (r=0.5)

coefficient of less than 0.1 respectively [Intellect dimension; r(181) = 0.00, p = 0.965, Ideology dimension; r(181) = -0.02, p = 0.783, Public practice dimension; r(181) = 0.00, p = 0.996, Private practice dimension; r(181) = 0.00, p = 0.953, Experience dimension; r(181) = -0.06, p = 0.406, Religiosity; r(181 = -0.03,p = 0.729]. The existing value of correlations was not significant, as shown by the effect size indicating no linear relationship between Religiosity and mental health stigma among Islam believers in Malaysia.

Meanwhile, according to the data of the Buddha religion, the correlation between the Intellectual dimension [r(89) = 0.06, p = 0.604] and Private practice dimension [r(89) = 0.07, p = 0.485] towards mental health stigma suggested by Pearson Correlation Coefficient to be negligible with a coefficient of less than 0.1. On the other hand, the Ideology dimension[r(89) = 0.15, p = 0.165], Experience dimension [r(89) = 0.11, p = 0.285], and Religiosity [r(89) = 0.15, p = 0.151] in general were found to have positive weak correlation towards mental health stigma, but the existing value of correlations was not significant. However, there was a significant positive correlation between the dimension of Public Practice of Religiosity and mental health stigma in the Buddhist religion, r(89) = 0.27, $p < 0.05$, indicating a small to medium effect size. This suggests that approximately 7% (r^2 = 0.07) of the variance in mental health stigma can be explained by the public practice of Religiosity. According to the results, higher dimensions of religious public practice were associated with higher mental health stigma among Buddha believers.

Next, according to the data of Hindu religion, the correlation between the Ideology dimension[r(79) = 0.00, p = 0.980], Public practice dimension[r(79) = 0.05, p = 0.659], and Private practice dimension [r(79) = 0.09, p = 0.407] towards mental health stigma suggested by Pearson Correlation Coefficient to be negligible with a coefficient of less than 0.1. On the other hand, Intellectual dimension[r(79) = 0.18, p = 0.109] and Religiosity [r(79) = 0.16, p = 0.145] in general were found to have positive weak correlation towards mental health stigma but were not significant. Interestingly, a significant positive correlation was found between the dimension of Experience of Religiosity and mental health stigma in the Hindu religion, r(79) = 0.24, $p < 0.05$, indicating a small to medium effect size. This suggests that approximately 5% (r^2 = 0.05) of the variance in mental health stigma can be explained by experience of Religiosity. This suggests that higher dimensions of religious experience were associated with higher mental health stigma among Hindu believers.

According to the data of Christian religion, the correlation between all the five dimensions of Religiosity as well as Religiosity in general towards mental health stigma suggested by Pearson Correlation Coefficient to be negligible and not significant with a coefficient of less than 0.1 respectively [Intellect dimension; r(94) = -0.03, p = 0.746, Ideology dimension; r(94) = -0.05, p = 0.611, Public practice dimension; r(94) = -0.06, p = 0.561, Private practice dimension; r(94) = 0.09, p = 0.368, Experience dimension; r(94) = 0.08, p = 0.450, Religiosity; r(94) = 0.02, p = 0.878]. Shortly, the Religiosity of Christian believers was not related to their mental health stigma, suggesting no substantial effect in this context as well.

Table 5 presents a one-way ANOVA analysis comparing mental health stigma across four religions—Islam, Buddhism, Hinduism, and Christianity—at a 0.05 significance level (2-tailed). The results show no significant differences in stigma levels among Islam (M = 2.90, SD = 0.63), Buddhism (M = 2.87, SD = 0.52), Hinduism (M = 2.91, SD = 0.46), and Christianity (M = 2.99, SD = 0.61) [F(3, 447) = 0.83, p = 0.478]. Overall, young adults in Malaysia exhibit a moderate level of mental health stigma, regardless of religion.

Based on the results, there was no significant correlation between religiosity and mental health stigma among adults in Malaysia in general. However, upon closer investigation, two different dimensions of religiosity were found to have significant correlations to mental health stigma in each Buddha and Hindu religion, indicating a small to medium effect size. No observed difference in mental health stigma among adults of different religions.

Discussion

The objective of this research was to examine the correlation between religiosity and mental health stigma among adults

Table 4. Pearson Correlation Coefficient by Religion

Religion	Factor	r	P
Islam (N = 183)	Intellect Dimension	0.00	0.965
	Ideology Dimension	–0.02	0.783
	Public Practice Dimension	0.00	0.996
	Private Practice Dimension	0.00	0.953
	Experience Dimension	–0.06	0.406
	Religiosity	–0.03	0.729
Buddha (N = 91)	Intellect Dimension	0.06	0.604
	Ideology Dimension	0.15	0.165
	Public Practice Dimension**	0.27	0.009
	Private Practice Dimension	0.07	0.485
	Experience Dimension	0.11	0.285
	Religiosity	0.15	0.151
	Intellect Dimension	0.18	0.109
Hindu (N = 81)	Ideology Dimension	0.00	0.980
	Public Practice Dimension	0.05	0.659
	Private Practice Dimension	0.09	0.407
	Experience Dimension**	0.24	0.028
	Religiosity	0.16	0.145
Christian (N = 96)	Intellect Dimension	–0.03	0.746
	Ideology Dimension	–0.05	0.611
	Public Practice Dimension	–0.06	0.561
	Private Practice Dimension	0.09	0.368
	Experience Dimension	0.08	0.450
	Religiosity	0.02	0.878

**Weak correlation but significant at P<.05

Table 5. Oneway ANOVA

Variable	Religion	N	Mean	Std. Deviation	F	P
Mental Health Stigma	Islam	183	2.90	0.63	0.83	0.478
	Buddha	91	2.87	0.52		
	Hindu	81	2.91	0.46		
	Christian	96	2.99	0.61		

in Malaysia. Religiosity was assessed from two perspectives, first according to the five domains of religiosity and second, on religiosity as a whole or referred to the centrality of religiosity. In addition, both perspectives of religiosity and mental health stigma were also examined separately based on the four religions involved: Islam, Buddha, Hindu, and Christianity. This was one of the few studies in Asia that utilized the existence of a multi-religious community to address the issue of mental health stigma among adults.

Religiosity and Mental Health Stigma

In line with the first objective, results indicate that there was no significant relationship between all five domains of religiosity and mental health stigma among adults in Malaysia. In simple words, adults' religiosity does not have any influence on stigma towards mental health. Consistent with the literature review, religiosity, in fact, was related to less mental illness due to its coping mechanism effect (Koenig & Al-Shuhaib, 2018). However, a study of the interaction between religious beliefs and mental health stigma revealed significant results as mental health was viewed from the perspective of sin and morality (Caplan, 2019). One possible explanation for this mixed result might be that because current research consists of variation in the background, there was no pattern of association yet detected between past and current studies to explain more about religiosity and mental health stigma.

To address the second objective, religiosity by religion and mental health stigma initially was expected to have a certain degree of association based on each religion studied. Contrary to expectations, the Islam religion did not find a significant influence on mental health stigma in all dimensions of religiosity. This was very much in contrast with a strong relationship between Islam religiosity and mental health stigma reported in the literature among 338 Muslim believers (Al-Natour et al., 2021). The same goes for the Christian religion; it was found all domains of religiosity were not significantly related to mental health stigma. This finding is in contrast with the study involving 64 Christian believers, who reported religiosity as a factor in instigating mental health stigma (Caplan, 2019).

Furthermore, two anticipated findings were found in the Hindu and Buddhist religions. The effect sizes found in this study indicate that while the correlations are statistically significant, the magnitude of these relationships varies. For instance, the correlation between Public Practice of religiosity and mental health stigma in the Buddhist religion suggests a moderate effect, indicating a practically meaningful relationship. The Public Practice dimension of religiosity is associated with a sense of belonging, especially towards religious communities, which can be observed through

social involvement in activities, events, or rituals (Huber & Huber, 2012). Results yield potentially as a result of cultural influences on attitudes towards mental health and religiosity. This is in line with one of the earliest inter-religious studies on mental health stigma, involving 9 Hindu believers in qualitative research (Cinnirella & Loewenthal, 1999). A thematic analysis later suggests that fear of how the community views individuals and affected families was one of the factors instilling mental health stigma, as supported by this current research. Hence, this study suggests that Hindu believers in Malaysia who were actively involved in religious communities or activities were prone to have higher mental health stigma.

On top of that, the study also demonstrates another statistically significant effect size between Experience dimensions of religiosity towards mental health stigma in Buddha religion suggesting another practically meaningful relationship. The Experience dimension of religiosity was associated with a pattern of religious perception, which also involved the emotional aspect of individuals as they perceived themselves or their surroundings in contact with God (Huber & Huber, 2012). Such a result is consistent with earlier studies showing that public religious expression might occasionally support traditional or conservative viewpoints that heighten stigma. This finding is also in line with a study involving the majority of Buddha believers from 2425 adults, which debunked different levels of religiosity that directly influenced the willingness of individuals to associate with mentally ill people (Wang et al., 2019). Although this study was more focused on the act of discrimination against the mentally ill population, it also visualized the stigma towards mental health embedded through the action of discrimination. The willingness to associate, on the other hand, also visualized their difference in perceptions according to different religiosity exactly as shown by the result of the current study. In short, this study suggests Buddha believers in Malaysia with stronger religious emotional perceptions have a higher tendency to have higher mental health stigma.

The lack of a significant correlation between mental health stigma and religiosity in general is worthy of mention. Findings from this research indicate that the component of religiosity, when not categorized into dimensions, may not directly highlight the impact it has on mental health stigma. Based on results from the Buddha and Hindu religions, perhaps it is much more practical to understand mental health stigma from a multifaceted nature of religiosity rather than a broad concept for the betterment of the future, especially in shaping positive attitudes towards people with mental health issues.

Religion and Mental Health Stigma

Next, this study also set out with the aim to examine the difference in terms of mental health stigma between the four religions, mainly Islam, Buddha, Hindu, and Christian. Contrary to expectations, this study did not find a significant difference between the four religions on mental health stigma. In general, the level of mental health stigma among adults in Malaysia was at a moderate level. Based on the findings, Christian believers have the highest score of mental health stigma, followed by Hindu believers, Islam believers, and Buddha believers with the lowest score of mental health stigma. Although moderate, mental health stigma still needs to be addressed properly in order to avoid negative effects such as avoidance of help-seeking behavior, especially among young adults. These findings broadly support the work of other studies associated with mental health stigma, such as one study in which 36.5 per cent of participants in the study chose not to report their mental health illness rather than 11.0 per cent of physical illness (Bharadwaj et al., 2017). Additionally, another study also debunked mental health stigma to be affecting individuals' quality of life and encouraging social withdrawal (Gierk et al., 2018).

The study's limitations raised significant questions about religiosity's complexity, challenging the understanding of its impact on mental health stigma. However, these findings should be considered a valuable addition to the limited literature on religiosity and mental health stigma. They also offer insights for designing interventions to reduce mental health stigma among Malaysian adults.

The scope of this study was also limited due to the sensitive nature of religiosity, which involves community practices and individual beliefs. Despite these limitations, the study enhances our understanding of the relationship between religiosity and mental health stigma, contributing to the growing body of literature on this topic.

Recommendations for future research include conducting similar studies targeting leaders from all four religions. This approach is justified because adults often prioritize aspects of religiosity less as they age, potentially affecting their attitudes toward mental health stigma.

Researchers can develop a more versatile religiosity assessment tool to address the limitation of using three versions of the same questionnaire. This new questionnaire should be designed to accommodate the diverse religious beliefs and practices found in Malaysia, aiming to improve the accuracy and reliability of data collection. A more flexible religiosity questionnaire could be developed to better suit the needs of Malaysia's diverse religious landscape. Additionally, future studies should strive for a balanced and larger sample size across demographics to obtain more accurate and comparable results.

Conclusion and Implications

This study expanded upon existing literature by providing a comprehensive examination of the relationship between religiosity and mental health stigma. Overall, religiosity does not significantly influence mental health stigma. However, specific dimensions of religiosity were found to influence stigma among Hindu and Buddhist believers, challenging previous assumptions. Further research on this complex topic is strongly recommended.

Implications of the research are significant for future practices and theories. While some studies have explored mental health stigma, few have examined religiosity within an inter-religious context and its profound impact on overall well-being. Therefore, the findings of this study can inspire a deeper understanding of the severe effects of mental health stigma on individuals with mental illness and facilitate the development of targeted interventions.

The study's key findings include the influence of the Public Practice dimension of religiosity on mental health stigma

among Hindu believers and the influence of the Experience dimension on mental health stigma among Buddhist believers. Given the lower research attention historically given to Hindu and Buddhist communities in Malaysia, these insights serve as crucial benchmarks for future studies.

Declaration

Acknowledgement

We would like to thank all lecturers from the Department of Psychology, Faculty of Human Development, Universiti Pendidikan Sultan Idris.

Author contributions

All authors contributed to this article and approved the final version.

Conflict of interest

The authors declare no conflict of interest regarding the contents of this manuscript.

Funding

There is no funding for research implementation.

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Article history

Submissions: 2024-02-09
Review Process: 2024-02-17
Revised: 2024-07-15
Accepted: 2024-07-17
Published: 2024-08-09

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