Mental Health Literacy from the Marind Perspective

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Abstract

This study aims to describe mental health literacy components from the perspective of the Marind people in Merauke Papua, Indonesia. The participants of this study consisted of 197 Marind people (110 men and 87 women), ranging from 12-71 years old. The method used was a survey of distributed questionnaires consisting of consent sheets, demographic data, and several open questions based on the vignette of Schizophrenia and Major Depression designed by researchers based on the conceptual framework of Jorm (2000). Data were analyzed with descriptive statistics. Participant responses were categorized into several themes according to the concept of mental health literacy. The results showed that most of the participants' responses were different from the biomedical framework in terms of symptom recognition, belief in the cause of mental disorders, and the way to seek help. Culture-based beliefs contribute greatly to the understanding of mental illness symptoms. The implications of this research can be used as an academic reference as consideration for the provision of community-based interventions that are sensitive to the culture.

Keywords: depression, Marind people, mental health literacy, schizophrenia

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The gap between the increasing prevalence of mental disorders and the access to treatment is of the biggest challenges in mental health care. Some barriers have been identified such as stigma, the lack of knowledge, negative perceived values, discomfort with showing emotions, lack of access, and cultural barriers (Shea et al., 2019). Mental health literacy has been proposed as one of the efforts to fill the gap and tackle those barriers.

Mental health literacy was defined by Jorm (2000) as the knowledge and the belief about mental disorder-related recognition, management, and prevention. This concept gradually changes and develops. In this study, the authors focused on several aspects that were proposed by Reavley and Jorm (2011) including the recognition of mental disorders, the belief in the cause, the belief in self-help, and the belief in professional help, as well as public stigma.

Loo et al. (2012) conducted cross-cultural studies on mental health literacy from the UK, Hong Kong, and the Malay people's perspectives. It was found that UK people have the highest mental health literacy compared to Hong Kong and Malay people. There are also differences in help-seeking recommendations related to mental health, such as the fact that UK people tended to recommend professional help, Hong Kong people tended to rely on self-help, and Malay people referred to social support as the main resource to help. Kurihara et al. (2000) found that Balinese people have a positive attitude toward people with psychosis more than Japanese people do. Nigerians tended to have a negative attitude toward individuals with psychosis as well (Tormusa, 2015). Several studies describing mental health literacy from cultural perspectives found that every culture has its own label/recognition related to a mental health issue. The recognition was related to their belief about the cause, which also had a psychosocial and cultural factor, as well as the type of help-seeking they will refer or be able

to access for related mental disorder issues (Cuwandayani & Novianty, 2019; Fauziah & Novianty, 2019; Santoso & Novianty, 2020).

Previous research has found that there is a mental health literacy gap between developed and developing countries, with developing countries having lower mental health literacy than developed countries. This gap revealed that participants in developing countries were unable to recognize vignettes (depression and schizophrenia) using psychiatry labels, identified the causes as psychosocial factors, and instead sought help informally from friends/family, self-help, religious leaders/community leaders, and so on. It might be inferred that mental problems were not framed from a biomedical perspective in developing countries, even though there is an assumption that the age gap (between adolescents and adults) is causing a shift in mental disorder awareness, in which young people are more aware of mental problems from a biomedical perspective than adults or older individuals are (Cuwandayani & Novianty, 2019).

There are several problems in some parts of Indonesia, such as Merauke, which has limited human resources, access, and mental health care facilities. The ancestors of the Marind people were hunter-gatherers known as *peramu,* and their livelihood was based on natural resources (Boelaars, 1986). Their faith was animism, which holds that nature contains spirits (Haviland, 1988). They believed that the ancestral spirit, known as *Dema,* resides in nature and is represented by natural resources like the sun, plants, and animals. Thus, they still have clans that carry the names of and high regard for nature, particularly the land. They have a local knowledge known as Totemism, which prohibits the use of natural resources as a means of exchange, the killing of pregnant animals, and the hoarding of natural resources. Dumatubun (2002) framed the health concept via literature study for several Papuan tribes, including Marind, as abiding by all taboos, keeping a balance between nature and humans, and not disrupting or purposefully walking through sacred sites.

This study explored the Marind people's perspectives toward depression and schizophrenia vignettes related to their recognition, the belief about the cause, the belief about self-help and professional help, and stigma. Due to local knowledge, restricted access to mental health care, and other obstacles, we (authors) decided to investigate their indigenous perspective on what scientific understanding defines as a mental disorder.

Methods

Research Design

A descriptive study was employed in this study using open-ended questions which derived from several aspects of the mental health literacy concept. This study intended to collect the description related to the knowledge and belief of Marind people regarding mental disorders through depression and schizophrenia vignettes and several open-ended questions. Vignettes were created according to symptoms of major depression and schizophrenia in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). Some expressions of symptoms were constructed like Marind people's life experiences, such as the typical hallucinations. After reading vignettes there are the following open questions to answer that will allow the participants to express their opinions and understanding of the case without limiting them to choose certain responses.

Setting and Context

The setting of this study was schools and the Marind Community in Merauke. The research was conducted in Merauke, Papua. The first author visited Merauke, especially the Marind people's living area, to be able to directly meet people who identified themselves as Marind.

Research's Instrument and Data Collection

The questionnaire consisted of two vignettes (major depression and schizophrenia) following five open-ended questions employed in this study. Vignettes were constructed

according to symptoms of Major Depression and Schizophrenia in the DSM-V. The expression symptoms in vignettes were adapted from the verbal folklore of Marind People, such as the typical hallucination or delusion. Two vignettes were validated by clinical psychologists, including the open-ended questions to explore Marind people's understanding of their knowledge and beliefs about the mental disorder that was provided in vignettes. After that, one local person translated the vignettes and the following questions into the Papuan dialect. Participants were asked to write their answers, or the first author helped them to write in case they had no ability in writing. The first author also was assisted by a research assistant from the local people.

Participant

This study was intended to collect data from Marind people, so in the selection process, the candidate's parents' background (if they identified as Marind) became the determinant to select participants. People who only lived in Merauke, or were even born in Merauke/the Marind's area, but had no lineage in the Marind people, were excluded from this study. Snowball sampling was applied in this study to collect participants. Two hundred nineteen participants were involved in this study, but 22 participants have been eliminated because their data showed they were not originally from the Marind family. After data cleaning, 197 people participated in this study, consisting of 67 participants aged 12-17 years old and 130 participants aged 18-71 years old. Demographic data was collected including gender, age, parents' race(s), educational background, and occupation. A parent's race was used to be a determinant in eliminating data. Most participants' background was an adolescent and young adult (aged 12-28 years old) who were students and descendants of the Marind Family, and almost all of them had religion.

Data Analysis

Data were initially coded to divide it into numerous themes, and then descriptive statistics were used to compute the distribution of data within each theme. There were two stages in data analysis: a) developing several themes in each aspect of mental health literacy and b) calculating the frequency of each theme in every aspect.

Results

Several themes were extracted from the data in each aspect of mental health literacy concepts, including (a) Recognition of mental disorder: correct psychiatric label, incorrect psychiatric label, and incorrect label; (b) The belief about the cause of the mental disorder: biological factor, personal factor, social factor, culture, unidentified; and (c) The type of help-seeking: formal help-seeking, semi-formal help-seeking, and informal help-seeking.

Recognition of Mental Disorder

Most participants in this study could not identify those vignettes in psychiatric labels (See Table 1). For the schizophrenia vignette, the most labels that were given by participants were spirit possession (in the local language called *magu, weimbanggu, kena suanggi*, or *disarung setan*) and having life problems or heavy thoughts. Meanwhile, for major depression vignettes, the labels given most were sadness because of loss, spirit possession, and heavy thoughts. Only 1.5% of participants answered the correct psychiatric label in the major depression vignette, whereas no one gave the correct psychiatric label in the schizophrenia vignette.

Table 1

Recognition of Mental Disorder

Themes	Major Depression Vignette (%)	Schizophrenia Vignette (%)
Correct psychiatric label	1.52	0
Incorrect psychiatric label	2.54	6.93

Themes	Major Depression Vignette (%)	Schizophrenia Vignette (%)
Incorrect label	95.94	93.07

The Belief About the Cause

Myths such as cultural norm violation, ghosts, landlord *suanggi* possession, or *guna-guna* were mostly believed by participants to be the origin of schizophrenia symptoms in the vignette. In the case of major depression vignettes, most participants felt that social factors such as intimacy relationship problems, the loss of a significant person, and workplace challenges were the source of the symptoms stated in the vignette (See Table 2).

Table 2

The Belief About the Cause

Themes	Major Depression Vignette (%)	Schizophrenia Vignette (%)
Biological Factor	3.04	6.09
Personal Factor	29.95	16.24
Social Factor	42.64	27.92
Culture	13.20	44.67
Unidentified	11.17	5.08

Types of Help-Seeking

The result of this study showed self-help was advised by 6.6% of participants for schizophrenia and 22.84% for major depression in this study. For schizophrenia and major depression, self-help recommendations include meditating, positive thinking, avoiding thinking about the problem, and taking care of the body, as well as forgetting/addressing the problem. A different point of view also pointed out that some participants also believed people with major depression (77.16%) and schizophrenia (93.40%) cannot help themselves,

which means they need to ask for help from family/friends or religious leaders, as well as do religious activities, ask for help from community/traditional leaders, or visit a doctor in the hospital.

There are several types of help-seeking. Individuals who have adequate and officially certified knowledge and skill in health care (doctor, psychologist, psychiatrist, etc.) or formal health care (hospital, primary health care, etc.) are defined as formal help-seeking. Individuals who have enough and officially approved knowledge and expertise in a specific area, but not in health care, are considered semi-formal help-seeking. On the other hand, neither definition includes informal help-seeking.

Informal help-seeking was mostly referred by participants for major depression and schizophrenia vignettes. The forms of informal help-seeking for schizophrenia included conducting a traditional ceremony which is called *apmonguap* or *mabura*, or visiting *dukun/orang pintar.* Whereas for major depression, the forms of informal help-seeking participants recommended were things such as praying, visiting *dukun*, and searching for entertainment. In both vignettes, participants recommended the forms of semi-formal help-seeking such as visiting religious leaders and community/traditional leaders.

Table 3

Types of Help-Seeking

Themes	Major Depression Vignette (%)	Schizophrenia Vignette (%)
Formal help-seeking	4.57	4.57
Semi-formal help-seeking	1.52	3.05
Informal help-seeking	93.91	92.38

Public Stigma

This aspect investigates how people with schizophrenia and major depression are perceived by the public. Participants believed people with schizophrenia and depression were

"crazy," "stressed," "useless," or "abnormal." Some of them also said that people with schizophrenia are viewed as being under the influence of spirit possession (24.37 %), whereas people with major depression will be perceived as having problems with interpersonal relationships or losing significant people (26.40 %).

Discussion

This study found out that most participants, who are Marind people, did not recognize symptoms of major depression and schizophrenia through vignettes with psychiatric labels. It turned out they have a local term for describing people with major depression and schizophrenia symptoms. Some local terms that are used in describing people with schizophrenia symptoms are *ramesaf, avada vetokti, wavia anemka, weimbanggu, yawar,* and *magu,* which mean losing one's mind, spirit possession, and crazy. Whereas some local terms for describing people with major depression are *erer naek erekmaora, irumbu, merk gawa-gawa, weimbanggu, wabuma,* and *etokolokombear,* which mean experiencing great sadness, missing closer family, memory loss, or having trauma.

They also tend to believe the cause of major depression is related to social factors, whereas cultural norm violations or spirit possession are the cause of schizophrenia. In terms of help-seeking, most participants would choose informal help-seeking such as family/friend support, religious leader, or traditional leader in their community. Participants recommended self-help for both situations, such as praying, religious activities, and so forth. The participants had an unfavorable perception of people with major depression and schizophrenia in the public.

The results of this study revealed that the Marind people's perceptions of mental disorder symptoms differed from the psychiatric label which belonged to the DSM-V. They are more likely to associate symptoms of major depression and schizophrenia with a cultural framework than with a biomedical one. They have their own phrase for the signs and

symptoms of mental disorders that they encounter. The way they seek to help appears to be influenced by their beliefs about the cause.

This finding confirmed research by Patel (2014) which argued there is a paradigm gap between community and psychiatry professionals in addressing the type and symptoms of mental disorders. Marind people in Merauke have limited access to mental health professionals and facilities, which appears to exacerbate this disparity. This result also supports the findings of other studies that sought to understand the meaning of health in some races in Papua, namely, the harmony between humans and nature, as well as the avoidance of violence against ancestral sites and spirits (Dumatubun, 2002). It seems aligned with findings from Kermode et al. (2010) in India, where individuals believe that the quality of human-environment relationships, rather than individual quality, determines the cause of mental disorders.

Most of the participants in this study were original members of the Marind who continue to execute communal performances/activities, such as religious practices, as seen by the first author while collecting data. This endeavor aims not just to preserve indigenous wisdom, but also to maintain the Marind people's bond. Collective culture, according to Mills and Clark (as cited in Triandis, 2001), tends to create individual actions in groups to prioritize collective aims, interdependence with others in groups, and actions by group social norms. Marind people were one of the groups that possessed collective value. This could be seen in the way they seek help, which said people with major depression and schizophrenia are unable to help themselves and require assistance from others, such as traditional leaders or healers (such as *dukun*/*orang pintar*).

According to Loo et al. (2012), Malay and Asian people appreciate collective value, hence they use social support as their primary resource for seeking help and making suggestions for mental disorders. Spirituality and traditional values, on the other hand,

influence their preference for obtaining aid. In developing countries, informal help-seeking was highly common; some of them believed that mental disorders were caused by spirituality or traditional beliefs and that the best way to treat the problem was to engage in religious rites or activities (Reese, 2016). The community's attitude and general belief system will have a considerable impact on help-seeking behavior (Angermeyer et al., 1999). It could be the reason why, for Marind people, the concept of belief in a cause and seeking help are dependent not only on the individual's quality and skill but also on the community's belief and competency.

There is a comparable scenario among Marind people and Indigenous peoples in Africa, as well as Aboriginal people in industrialized countries, where the culture and traditional customs were gradually and systematically overshadowed by modern values as a result of colonization and monotheistic religion (Boelaars, 1986; Corbey, 2010; Kirmayer et al., 2000; Kpanake, 2018). As a community with shared values, they adjust by prioritizing the principles of social relationships, which is equally true in the case of mental health issues.

However, the concept of mental health literacy continues to focus on mental disorders from a biomedical standpoint, which contrasts with preconceived knowledge and value in various communities and cultures. Even the term mental health literacy also focuses on mental disorders. When the construct of mental health literacy instruments is only derived from the knowledge and beliefs of developed countries, it will result in a gap when applied to the middle to low-income countries, which includes not only economic factors, but also social, political, and cultural factors.

Conclusion

There are gaps related to aspects of mental health literacy from a biomedical perspective and a cultural perspective. Certain cultures have emic viewpoints on how they recognize and classify mental disorders, the belief about the cause of the mental disorder, and

the type of help-seeking. From a western perspective (which dominantly uses a biomedical framework), the level of mental health literacy in developing countries will appear to be poor, yet there are specific cultural paradigms that need to be understood related to mental health issues.

Theoretically, we should begin to uncover local wisdom to promote mental health. Cultural competence is a crucial topic in mental health practitioner education, especially when working with clients from various cultural backgrounds. In future research, investigating the label and the cultural expression of symptoms through in-depth interviews could help practitioners develop cultural competence.

More research is needed to recognize local terms of Indigenous people for identifying their mental health states, as well as their local wisdom that could promote the improvement of their mental health. Even though the intersection of biological, personal, and social factors is the cause of mental disorders, there is still a lack of understanding of cultural aspects. Globalization, the advancement of technology, and the dissemination of knowledge have accelerated cultural interaction, and mental health practitioners should be aware of the shifting paradigm in mental health phenomena across cultures.

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