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Article

Relationship Between Attitude and Level of Risk of Mental Health Problem Among Indigenous Adolescents Girls

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Abstract

Background: Indigenous teenage girls deal with special mental health issues because of economic difficulties, being excluded from their culture, and not having enough access to healthcare.
Objective: This study aims to assess the relationship between attitudes toward mental health and the level of risk for mental health problems among indigenous adolescent girls in Indonesia..
Methods: A cross-sectional study was conducted among 250 indigenous adolescent girls aged 12–18 years. Participants were chosen intentionally. We measured people's attitudes toward mental health using the Attitude Towards Mental Health Problems Scale (ATMHP) and the Mental Health Risk Screening Tool (MHRST). We used Pearson correlation and multiple linear regression to study the data.
Results: The study found a strong negative relationship between people's attitudes toward mental health and their risk for mental health issues ($r = -0.42$, $p < 0.001$). This means that having a positive attitude toward mental health is linked to a lower risk of problems. The study showed that how people feel about mental health is an important factor in understanding mental health risks ($\beta = -0.37$, $p < 0.001$). This held true even when considering their income status ($\beta = -0.21$, $p = 0.002$) and family support ($\beta = -0.19$, $p = 0.007$). The model accounted for 29% of the differences in mental health risk (Adjusted $R^2 = 0.27$, $p < 0.001$).
Conclusion: In conclusion, how people view mental health has a big impact on the likelihood of mental health issues in indigenous teenage girls. Programs designed for specific cultures that encourage a positive view of mental health and lessen shame can improve mental well-being.

Keywords: Indigenous teens, views on mental health, mental health risks, shame, economic position, family support

INTRODUCTION

Indigenous communities have unique challenges in addressing adolescent mental health, including economic inequality, cultural marginalization, and limited access to healthcare (Kirmayer et al., 2014). Particularly at risk for mental health issues are indigenous teenage girls due to specific experiences such as intergenerational trauma, gender-based discrimination, and cultural identity loss (Gone et al., 2019; Lopez-Carmen et al., 2019). Indigenous teenage girls continue to face a substantial knowledge gap when it comes to the correlation between mental health attitudes and the risk level of mental health difficulties, even though these concerns are becoming more widely recognized.

Adolescents generally suffer from mental health issues including sadness, anxiety, and thoughts of suicide, but indigenous kids suffer from these conditions at much greater rates than non-indigenous teenagers (King et al., 2009; Westerman, 2022). The World Health Organization (WHO) has highlighted the need to reduce inequalities

in mental health among disadvantaged groups; yet, indigenous communities encounter persistent barriers to receiving culturally appropriate mental health services (WHO, 2021). How people feel about mental health has a major impact on how often they seek treatment and how healthy their mental health is overall. Mental health issues are underreported and neglected due in large part to stigma and unfavorable beliefs, despite the fact that positive attitudes are associated with improved results (Corrigan et al., 2009).

Cultural variables have a multifaceted impact on indigenous adolescents' mental health outcomes, according to recent studies. When it comes to indigenous teenage mental health, for example, a research conducted by Gone et al. (2019) found that cultural identification and strong community links serve as protective factors. There has been an increase in mental health risks linked to the collapse of cultural traditions and the long-term repercussions of colonization (Kirmayer et al., 2014). The combination of gender and cultural stresses makes indigenous girls, according to gender-specific research, more likely to suffer from internalizing illnesses like anxiety and depression than males (Leatherdale & Rynard, 2013).

Research concentrating on indigenous teenagers, especially females, is limited, despite the extensive examination of attitudes toward mental health in broader communities. A major obstacle to teenagers getting care for their mental health is the stigma associated with it, according to research by Corrigan et al. (2009). But they didn't look at how indigenous people's cultural norms and gender play a role in shaping their perspectives on mental health. Just as King et al. (2009) did not investigate the impact of views on mental health outcomes, they also found that indigenous kids suffer from a high prevalence of mental health concerns.

There is a significant lack of study on indigenous teenage girls' mental health views and the likelihood that they may suffer from mental health issues, even though there is a growing corpus of literature on indigenous mental health. The majority of previous research has ignored the potential mediating or moderating effects of views on the links between cultural variables and mental health prevalence or prevalence (Gone et al., 2019; Kirmayer et al., 2014). The fact that indigenous girls face additional risks as a result of their gender and cultural marginalization makes this disparity all the more worrisome. Consequently, the purpose of this research is to look at how indigenous teenage girls in Indonesia feel about mental health and how it relates to their risk for developing mental health issues.

METHODE

Study design

Using a cross-sectional approach, this research looked at indigenous teenage girls' attitudes and how they correlated with their risk of mental health issues. Because it only requires collecting data at one moment in time, the cross-sectional method is ideal for studying correlations between variables without drawing any conclusions about cause and effect. Examining frequency and correlations within a defined population is where this strategy really shines.

Sample

Girls who are indigenous and live between the ages of 12 and 18 made up the study population. One must be able to affirm their indigenous identity; two must be in the age bracket of twelve to eighteen; and three must be willing to take part in the research in order to be considered for inclusion. Two things that might rule someone out as a participant were(1) a strong reluctance to provide informed permission and(2) a serious cognitive or physical disability that would make participation difficult.

Software version 3.1.9.7 of G*Power was used to estimate the sample size. The necessary number of participants for the study was determined to be 250 using the following parameters: a medium effect size ($f^2 = 0.15$), an alpha level of 0.05, and a power of 0.80. In order to find significant correlations in the regression analysis, this sample size guarantees acceptable statistical power. The recruitment of participants was carried out using a purposive sampling approach, guaranteeing that the sample accurately reflected the target population.

Instrument

The Attitude Towards Mental Health Problems Scale (ATMHP) is was created to measure people's perspectives on mental health. On a 5-point Likert scale, from 1 (strongly disagree) to 5 (strongly agree), 20 items make up the scale. Total scores may be anywhere from twenty to one hundred, with higher values showing more favorable views about mental health. The results are classified as low (20–46), moderate (47–73), or high (74–100). With a Cronbach's α value of 0.92, the first scale version showed remarkable internal consistency. High dependability (Cronbach's $\alpha = 0.89$) was also shown by the Bahasa Indonesia version, which was customized via a thorough proc'ss of translation and back-translation.

The Mental Heal'h Risk Screening Tool (MHRST) is created it to determine the probability of mental health issues. The instrument evaluates behavioral, emotional, and psychological symptoms with a battery of fifteen questions.

Each item is given a score between 0 and 45 on a 4-point scale, where 0 represents never and 3 represents always. Risk levels are categorized as low (0–15), moderate (16–30), and high (31-45) based on the interpretation of the scores. The reliability of the original version was 0.88 according to Cronbach's α, whilst the Bahasa Indonesia version had a reliability of 0.86.

Procedure

Institutional Review Board (IRB) of FITKes UNJANI Cimahi examined and authorized the study's protocol. Community leaders and local officials were consulted before data was collected. All participants were given comprehensive information on the research, including its goals, methods, and participant rights. All participants gave their written informed permission, and for those younger than 18, their parents' or guardians' supplementary consent was sought. The surveys were conducted in a private location by trained research assistants to preserve anonymity. People might choose to fill out the surveys on their own or get someone to help them if they needed it. After the program ended, participants had a debriefing and were given information about mental health options they might use if needed. To make sure it was courteous and suitable for the culture, we asked for feedback from the participants.

Data analysis

The statistical package SPSS (version 25.0) was used for the data analysis. Demographic information, attitude ratings, and levels of mental health risk were summarized using descriptive statistics. A multiple linear regression analysis was carried out to investigate the correlation between attitude and the likelihood of experiencing mental health issues. The levels of mental health risk were input as the dependent variable, while attitude scores were included as the independent variable. As a means of controlling for any confounding variables, the model included age, socioeconomic status, and family support as covariates. We verified and fulfilled all of the regression analysis's assumptions, including that the data was linear, multicollinear, and homoscedastic. A significance level of $p < 0.05$ was used.

RESULTS

Table 1 presents the demographic characteristics of the study participants (N = 250). The mean age of the respondents was 15.4 years (SD = 1.8). The majority of the participants (60.4%) were in the 15–18 age group, while 39.6% were in the 12–14 age group. Most participants (67.2%) came from low socioeconomic backgrounds. Additionally, 72.8% of the participants reported receiving moderate to strong family support, whereas 27.2% had minimal family support.

Table 1. Demographic Characteristics of Participants (N = 250)

Characteristic	n	%
Age Group		
12–14 years	99	39.6
15–18 years	151	60.4
Socioeconomic Status		
Low	168	67.2
Middle/High	82	32.8
Family Support		
Minimal	68	27.2
Moderate/Strong	182	72.8

Table 2 summarizes the descriptive statistics for the main study variables, including attitude towards mental health problems and mental health risk levels. The mean attitude score was 65.3 (SD = 12.1), indicating that most participants had a moderate attitude towards mental health. The mean mental health risk score was 22.8 (SD = 8.4), suggesting a moderate level of risk.

Table 2. Descriptive Statistics of Study Variables (N = 250)

Variable	Mean	SD	Min	Max
Attitude towards Mental Health	65.3	12.1	32	95
Mental Health Risk Level	22.8	8.4	5	42

Pearson correlation analysis was conducted to examine the relationship between attitude and mental health risk levels. As shown in Table 3, a significant negative correlation was found between attitude towards mental health and mental health risk ($r = -0.42$, $p < 0.001$). Higher attitude scores were associated with lower mental health risk levels. Additionally, socioeconomic status and family support were significantly correlated with mental health risk, suggesting their potential role as confounders.

Table 3. Pearson Correlation Analysis

Variable	1	2	3	4
1. Attitude towards Mental Health	1			
2. Mental Health Risk Level	-0.42***	1		
3. Socioeconomic Status	0.18*	-0.30**	1	
4. Family Support	0.22**	-0.25**	0.31**	1

*p < 0.05, **p < 0.01, ***p < 0.001

A multiple linear regression analysis was conducted to determine whether attitude towards mental health remained a significant predictor of mental health risk after controlling for socioeconomic status and family support. As shown in Table 4, attitude towards mental health remained a significant negative predictor of mental health risk ($\beta = -0.37$, $p < 0.001$). Socioeconomic status ($\beta = -0.21$, $p = 0.002$) and family support ($\beta = -0.19$, $p = 0.007$) also significantly predicted mental health risk, indicating that better socioeconomic conditions and stronger family support were associated with lower risk levels.

Table 4. Multiple Linear Regression Analysis Predicting Mental Health Risk

Predictor	β	SE	t	p
Attitude towards Mental Health	-0.37	0.05	-5.62	<0.001
Socioeconomic Status	-0.21	0.07	-3.09	0.002
Family Support	-0.19	0.06	-2.73	0.007
Constant	29.42	2.34	12.58	<0.001

$R^2 = 0.29$, Adjusted $R^2 = 0.27$, $F(3, 246) = 33.75$, $p < 0.001$

DISCUSSION

This study shows that there is a strong link between how indigenous teenage girls feel about mental health and their chances of having mental health issues. When their views toward mental health are more negative, their risk of developing problems is higher. Teenagers who have positive views about mental health are less likely to experience mental health problems. This study highlights how important people's views and opinions about mental health are in affecting their well-being in this group. Having a positive view of mental health can help people be strong in tough times, motivate them to ask for help, and lessen feelings of shame. These are all important ways to protect against mental health problems.

Our results agree with previous research that shows how views about mental health affect people's willingness to seek help and their general mental health. For example, Goetz et al. (2022) found that indigenous people often have special challenges in getting mental health services. These challenges include feelings of shame and traditional beliefs that can prevent them from finding the help they need. Stigma is a major obstacle because it can make people feel ashamed or afraid of being judged. This can stop them from recognizing their mental health issues or seeking help (American Psychiatric Association, 2022). A study from the American Psychiatric Association in 2022 found that negative attitudes towards mental illness and getting help are common in indigenous groups, making it harder to improve mental health results. This negative view comes from past suffering, social injustices, and ignorance about mental health (Gone et al., 2019).

Having a good view of mental health can lower the chances of having mental health issues. This means that programs designed to improve how people think about mental health might help. Education programs that are respectful of culture and tackle shame can help indigenous teenage girls understand the benefits of mental health care, making them more likely to ask for help when they need it. Studies show that combining traditional recovery methods with Western mental health treatments can help build trust and involve tribal communities more effectively (Gone et al., 2019). Adding mental health services to places that indigenous people know well, like schools or community centers, can make it easier for them to receive these services and stay involved. Involving elders and traditional leaders in mental health programs in the community has been found to make these programs more acceptable and successful (Kirmayer et al., 2020).

Study Limitations

While this study provides valuable insights, it is not without limitations. The cross-sectional design limits the ability to infer causality between attitudes toward mental health and the risk of mental health problems. Additionally, the study's focus on indigenous adolescent girls may limit the generalizability of the findings to other populations or age groups. Future research employing longitudinal designs and including diverse populations would enhance the understanding of these relationships.

CONCLUSION

In conclusion, this study highlights the significant role that attitudes toward mental health play in influencing the risk of mental health problems among indigenous adolescent girls. The findings advocate for culturally tailored interventions that aim to improve perceptions of mental health and address broader social determinants, such as socioeconomic status and family support, to enhance mental well-being in this population.

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