Predictor of Mental Health among Survivors of Sexual Violence: The Role of Religiosity Factors

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Abstract: This study examined the role of religiosity factors in mental health, in which religiosity is expected as one of important predictor that affect mental health. Therefore, this study was expected to: 1) examined the influence of religiosity factors in improving mental health, and 2) explored one of the central issues concerning the role of religiosity in individual condition with its relationship to mental health. This study used quantitative method with survey to 47 survivors of sexual violence whom specifically experienced sexual violence by their partners in the context of intimate relationships. Collecting data was used mental health scale (GHQ-12) and religiosity scale (Religiosity Questionnaire). Data analysis used regression analysis technique to examine the relationship between religiosity and mental health. The results of this study showed that religiosity factors affected mental health state of the survivors through positive correlation between religiosity and mental health. Religiosity was positively correlated with mental health ($r = 0.37$; $p > 0.01$; BCA 95%, CI [0.47; 0.28], and religiosity was able to predict mental health improvement ($t = 5.46$; $B = 0.27$; $P < 0.01$; BCA 95% CI [0.23; 0.05]). Thus, implication of these findings are important to build an understanding the predictor of mental health in terms of religiosity both theoretically and practically. Moreover, it can be widely applied by therapist, counselor, health practitioner, and community to improve mental health through intervention in charged with religiosity.

1 INTRODUCTION

The prevalence of sexual violence throughout Indonesia is increasing and is widespread in various areas. In fact, sexual experience can be had by both men and women at any time and in any place, regardless of who is the victim or perpetrator. In general, the results of the General Social Survey (GSS) on victimization in 2009 showed that the average incidence of sexual violence reported through self-reports appeared to be stable, even though the number of the victims increased. It is known that sexual violence is a crime, but unfortunately, it is rarely reported. Since 2009, the GSS results have revealed that 88% of sexual violence, in both men and women, has gone unreported (Brennan, 2012).

The reluctance to report their sexual violence experiences was evident when it occurred in the context of a romantic relationship between the victim and perpetrator, whether they were married or dating. A study demonstrated that sexual partner violence occurred at different levels all over the world (Bergman, 2002). In the United Kingdom, for example, 23% of cases of sexual violence against partners revealed that the victims had received violence from their partners throughout their lives. Similar condition also occurred in some big cities in Mexico (23%), Nicaragua (21.7%), Peru (22.5%), Zimbabwe (25%), Canada (8%), Finland (14.2%), Switzerland (5.9%), and the United States (7.7%). During 1999-2000, there were 765 victims of sexual violence by partners in Indonesia, particularly in the Central Java region, who did not bring their cases to court (Judibicious, 2001). This demonstrated that sexual violence occurred for both men and women, even though cases are generally underreported everywhere.

Survivors of sexual violence showed that mental health problems exist in broad categories, such as the tendency to show anxiety problems, mood swings, psychotic symptoms, personality instability, impulse control difficulties, and so on. People around us might experience erratic thought patterns, a lack of interest in socializing, a lack of empathy, an unstable mood, inability to distinguish between reality and fantasy, and a lack of control in daily life as some symptoms of mental health disorders

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(Sosialita, 2019). Survivors of sexual violence bear their trauma throughout their lives, especially if they have not been able to reconcile and overcome the symptoms. Thus, their condition was exacerbated by external responses from environment.

It has been proven that survivors of sexual violence experienced mental health problems. In fact, it is estimated that one in every five people today has had some kind of mental health problems at some point in their lives. For that reason, it is important to understand the basics of mental health predictors so that we can recognize some aspects of mental health. As it is known, there is no single cause for mental health disorders, but the emergence of mental health problems can be triggered by various factors that contribute to one another.

Understanding the individual factors of the victim to provide a comprehensive description of their psychological dynamics requires seeing the explanation of the sexual violence phenomenon that left a huge impact in physical, psychological, and behavioral aspects. Understanding the psychological dynamics of survivors of sexual violence was expected to allow them to provide appropriate information to their families and communities, allowing them to receive some supports and assistance.

One of the factors that influence mental health is religiosity. A prior study showed that a higher score on mental health scale correlated with optimal mental state. Prior to that, empirical findings from studies of how religion affects mental health outcomes are briefly reviewed, even though the findings of those studies revealed a positive correlation between religiosity and mental health. One study which examined the mental health of sexual violence survivors after narrative therapy in individual and group counseling, showed that there were differences in mental health conditions between highly religious and less religious subjects, that a high level of religiosity tends to be related to good mental health.

Based on the data, survivors who are categorized as having high religiosity got higher scores on mental health than survivors who are categorized as having low religiosity. The result also reported that survivors with high religiosity tend to be more insightful, seeing their experiences as part of God's plan and like a test for them to become better human beings (Joonmo, 2011). The religious background and experiences of survivors may aid the therapist or counselor in better understanding the conflicts that subjects face. Also, we can say that therapists who choose to address religious issues with patients or clients must be conscious of transference and countertransference issues likely to arise when their religious beliefs are similar.

Various research studies with their explanations have been given for the positive association between religiosity and mental health (Levin, 2010). Literature reviews and academic papers have focused attention on the impact of religious indicators on mental health outcomes in population, community, and hospital samples, such as depression and anxiety levels, levels of psychological distress, dimensions of psychological well-being, such as life satisfaction and happiness, patterns of self-destructive behavior, including addictions, and mental health care utilization. The findings, on average and across studies that were reviewed, suggest that religion, however assessed, is generally a protective factor for mental illness.

According to that finding, as follow-up, a comprehensive understanding about the role of religiosity in mental health is needed. Concerning the literature of research on religiosity, with some exceptions, found no evidence for a negative correlation between religiosity and mental health, even though religious subjects are in general more susceptible to mental illness and also report better mental than other psychological constructs.

Moreover, the author intends to find possible evidence that religiosity could, in some cases, attenuate the adaptive effects on interpersonal and intrapersonal functioning of mental health. As a result, this study provided religion-based intervention to survivors of sexual violence. Thus, the results are expected to suggest that religiosity is a factor that can be significant or not for mental health.

Therefore, this research was expected to study an important factor that plays a vital role in supporting mental health specifically survivors of sexual violence. The author hopes that by learning more about the predictors of individual mental health, we will be able to live a better life. Furthermore, understanding mental health predictors can lead us to pursue effective individual and group interventions in mental health. The author hopes many parties can take advantage of the study.

After considering various research findings and the facts in the field, this study examined the role of religiosity factors in mental health, in which religiosity is expected to be one of the most important predictors that affect mental health. Therefore, this study was expected to: 1) examine the influence of religiosity factors in improving mental health, and 2) explore one of the central

issues concerning the role of religiosity in individual condition and its relationship to mental health.

2 METHOD

This research is a quantitative study using a survey method to measure the level of mental health based on the participants' religiosity level.

2.1 Participants

This research was conducted on 47 participants who were survivors of sexual violence and who were specifically victims of their partners in the context of intimate relationships. Participants were obtained through a purposive sampling technique with the following criteria: survivors of sexual violence from partners, aged 18–37 years, living in the Surabaya area, and willing to participate as research participants. The number of samples was estimated by the Slovin formula (95% confidence index). The mean age of the participants was 29.06.

2.2 Instruments

The General Health Questionnaire (GHQ-12) and the Centrality of Religiosity Scale (CRS) were used in conjunction with an in-depth interview to explore the Religion Scale: a 20-item self-report. A questionnaire to test the mental health of subjects was distributed and collected on the first and last days of the study. In addition, subjects self-report the Centrality of Religiosity Scale (CRS) and Religion Scale. An in-depth interview would be given to the participants to explore their religiosity more deeply, so that a clear explanation of religious factors could be understood.

This study used the Indonesian version of GHQ-12, which has been translated by MAPI Research Institute, an authorized institution to translate and adapt GHQ-12. Various studies have proven that the GHQ has satisfactory validity and reliability (Sosialita, 2020) with a good GHQ-12 reliability coefficient (=0.892). This study used the GHQ-12, which contains 12 (twelve) questions, each with four (four) answer choices, namely "more," "same," "less," and "very less" than usual. The dimensions measured include anxiety and depression (item numbers 1, 3, 4, 7, 8, and 12); social dysfunction (item numbers 2, 5, 6, and 9); and loss of confidence (item numbers 10, 11).

The purpose of the CRS and the Self-Report Religiosity Scale is to know the level of religiosity at once and explore each dimension of religiosity so that a comprehensive picture of the religiosity of the subjects is obtained. In addition to the theoretical basis and rationale of their construction with different versions of languages with norm values for 21 countries, including Indonesia, the CRS also has specific modifications that were developed for studies with Buddhists, Hindus, and Muslims (Huber, 2012). A self-report scale is also given as an attempt to examine religiosity as a predictor of mental health, and in-depth interviews with subjects are also possible.

Words like “is”, “or”, “then”, etc. should not be capitalized unless they are the first word of the title. The test tool used to measure religiosity is the CRS-15 version of the Islamic religion from Dr. Stefan Huber (a psychologist from Switzerland), which became the CRS-15 TII (the centrality of religiosity scale) for the atmosphere of Islamic religious traditions in Indonesia. The results of the Item Validity Test and the Reliability Test using the calculation of the Cronbach-Alpha coefficient show that the CRS-15 TII is reliable (high reliability) with a value of (0.689) > r (0.088).

2.3 Procedures

The study is strategizing to collect preliminary data on mental health and religiosity mapping. The data collection procedure begins with determining the criteria for the research target subjects. Data collection was carried out through an online form in the form of a Google Form, which recorded participants' responses to the GHQ-12 questionnaire as well as CRS and self-report. At the beginning of the instrument, informed consent was provided to ask about subjects' willingness to become research subjects. During the data collection process, 47 participants agreed to take part in the implementation of the research and complete the research instruments that were distributed.

2.4 Data Analysis

After the data was collected, it was coded and entered the Statistical Package for Social Science (SPSS) by the authors. Data from a total of 47 participants was analyzed using regression analysis to see the effect of religiosity on mental health.

3 RESULTS AND DISCUSSIONS

The following is a description of research participants based on age, gender, and education.

Table 1. Description of Participant by Age.

Age Category (years)	Number of Participants
18 – 22	5 (10.64%)
23 – 27	14 (29.79%)
28 – 32	23 (48.95%)
333 - 37	8 (17.02%)
Total	47 (100%)

Table 2. Description of Participant by Gender.

Sex	Number of Participants
Male	19 (40.43%)
Female	28 (59.57%)
Total	47 (100%)

Table 3. Description of Participant by Educational Status.

Former Education Level	Number of Participants
Junior High School	3 (6.38%)
Senior High School	25 (53.19%)
Higher Education	19 (40.43%)
Total	47 (100%)

The following is the result of inferential analysis.

Table 4. Correlation Matrix for Religiosity and Mental Health.

	Religiosity	Mental Health
Religiosity	1	
Mental Health	0.37***	1

The data shows that there is a significant relationship between religiosity and mental health. Even so, the correlations obtained were weak. It is known that the relationship between religiosity and mental health shows a weak correlation, as indicated by the value of r = 0.37.

Table 5. Regression Analysis Results.

t	B	Sig.	BCA 95% CI	
			LL	LC
5.46	0.27	0.05	0.47	0.48

The results of this study showed that religiosity factors affected mental health state of the survivors through positive correlation between religiosity and mental health. Religiosity was positively correlated with mental health ($r = 0.37$; $p > 0.01$; BCA 95%, CI [0.47; 0.28], and religiosity was able to predict mental health improvement ($t = 5.46$; $B = 0.27$; $P < 0.01$; BCA 95% CI [0.23; 0.05]). Thus, implication of these findings are important to build an understanding the predictor of mental health in terms of religiosity both theoretically and practically.

Alienated from their peers because of perceived unattractive personality traits or behaviors. They can also cause anger, fear, sadness, and feelings of helplessness if the person does not know or understand what is happening. In the long-term, mental health problems head to disorders when they not handled properly. Person with mental disorders can drive to commit suicide, as the most severe consequences. According to the National Institute for Mental Health, over 90% of suicides have depression or another mental health disorders as factors (Huber, 2012). Considering this, mental health problems also need to be handled at the religiosity and spirituality context.

Religion has some rules that must be obeyed by its adherents. Religion takes control of a person and makes him or her obedient to God by living the teachings of religion (Huber, 2012). The teachings of religion have a binding nature between human beings and God. As we know, mental health should be nurtured since childhood so that people grow naturally without disturbance. On the contrary, sometimes people are raised by parents who do not understand or are unaware of the importance of mental health. According to the literature, mental health is determined by experiences and habits instilled in children by their parents since childhood. It begins with habituation based on moral values learned from parents and family. Religion plays an important role in mental development, particularly when it comes to moral values that are derived from religion and do not change with time or place. Similarly, religion will serve as a moral controller for adherents who understand, feel, and become acquainted with those norms. To promote mental health, good conditioning must be practiced on a regular basis beginning in childhood (Huber, 2012).

Religion can provide resources to explain and resolve problematic situations; 2) religion increases the feeling of empowerment so that an individual is able to cope with their problems; and 3) religion is the basis for meaningful feelings, a directional life guide, personal identity, and instilling significant events in an individual's life. It is also possible to subject people to improving their religious commitment in religion-based interventions, which has a relationship with one dimension of psychological well-being, which is positive relationships with others. Individuals with better religious commitment have a better level of relationship with others because various religious

activities can increase group solidarity and family ties as informed by participants in this study. Based on the explanation, it can be concluded that there is a relationship between religiosity and mental health, in which the existence of religion leads to meaningfulness and prosperity in individual everyday life.

4 CONCLUSIONS

It showed the differences between survivors with high religiosity and those with low religiosity. Survivors who are categorized as having high religiosity got higher scores on mental health than survivors who are categorized as having low religiosity. They assumed that sexual violence had happened to them for a reason. They also learned to believe that life must go on and stepped forward. They showed an intention to fully trust God. Their religious activities also helped them to be focused on the positive rather than their bad experiences. The result also reported that survivors with high religiosity tend to be more insightful, seeing their experiences as part of God's plan and like a test for them to become better human beings (Joonmo, 2011). The religious background and experiences of survivors may aid the therapist or counselor in better understanding the conflicts that subjects face. Also, we can say that therapists who choose to address religious issues with patients or clients must be conscious of transference and countertransference issues likely to arise when their religious beliefs are similar.

It can be stated that some survivors of sexual violence still had mental health problems, which affected their mental health. They got a lower score on the mental health scale even though they had received the same intervention as the other survivors, who got a higher score on the mental health scale. This condition hampered their ability to cope and survive in daily life and had the potential to progress to more serious disorders (Weiss, 2010). Considering the finding that religiosity factors affect survivors' mental health, this study is part of ongoing research to design a religiosity-based intervention through narrative therapy in individual and group counseling to improve the mental health of the survivors who are categorized as having low mental health. In this study, we will involve subjects from the prior research who had low scores on the mental health scale.

Survivors of sexual violence experienced intense anxiety when they came directly to therapy or mental health professionals. They had a kind of trust issue with other people related to sexual violence that they experienced as a shameful and traumatic event. The advantage of online counseling, both individually and in groups, in this study was reducing the concerns that arose among the survivors.

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