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The Relationship Between Religiosity, Mental Health and Self-Esteem in Muslim Students at the University of Brunei Darussalam

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Abstract: The purpose of this study was to explore the association between religiosity, mental health and self-esteem among a sample of 143 Muslim Bruneian students (43 males, 100 females) from Universiti Brunei Darussalam (UBD). All participants completed) the religiosity scale, the Mental Health Inventory (MHI) and the Rosenberg Self-Esteem Scale (RSES). Female participants scored significantly higher than the male subjects on the measure of religiosity scale however the effect size is small. No other gender-related differences were detected on all the scales. There is also no age-related differences across all the scales. Correlations were significant between religiosity and the psychological well-being component of MHI and RSES but not with the psychological distress component of MHI. Psychological distress is negatively correlated with psychological well-being and RSES. While Psychological well-being is positively correlated with RSES. Implications of the findings are discussed and mixed-methods research was recommended.

Key words: Religiosity, mental health, self-esteem, coping, Brunei students, RSES

INTRODUCTION

Introduction and background: Recently, the pew research center as part of the pew-templeton global religious futures project, published “the future of world religions: population growth projections, 2010-2050” (PRC, 2015). The report revealed that 83.6% of the world’s population in the year 2010 is religiously affiliated and this number is expected to increase to 86.8% by the year 2050. Such a large figure demands a change in the world of mental health that tends to exclude the role of religion and spirituality in its research and curriculum trainings for mental health professionals due to the view that religious influences are pathological (Ellis, 1980, 1988; Sigmund, 1962).

In the last two decades, however, the attitude towards religion in mental health have begun to change. Mental health professionals are becoming increasingly interested in investigating the influence of religiosity on emotion, mental and physical health, coping, behavior, personality and psychotherapy. In fact, the fourth edition of the Diagnostic and Statistical Manual of mental disorders (DSM-IV) have classified “religious or spiritual problem” as a diagnosis. In line with this in 1995, the American Psychiatric Association (APA) has included gathering information on patient’s religious history and influences as well as performing an evaluation that carefully considers patient’s religious beliefs as part of its guidelines for adult’s psychiatric evaluation (American Psychiatric Association, 1995).

These clearly demonstrate the significance of religiosity/spirituality on mental health and thus the need for mental health professionals to be sensitive to client’s religion when conducting therapy. This is especially more so for a country such as Brunei that has a national philosophy of Melayu Islam Beraja (MIB, Malay Islamic Monarchy) whereby Islam, the country’s official religion, defines the way of life of the population. In other words, Islam, being one of the three elements of the country’s national philosophy is embedded in the daily activities, values, principles and also governance of the people of Brunei (especially the Muslim Malays).

This study, thus will attempt to provide some insights into the extent of the relationships between the religiosity and mental health of the bruneian population, specifically the muslim malays studying at the university brunei darussalam. The component of self-esteem will also be included in this study as past research have shown that it is linked to both religiosity (Bagley and Mallick, 1997; Khalek and Eysenck, 1983) and mental health (Rafat *et al*., 2014).

Over the past century, the world of psychology has always avoided any research involving religion. This is probably due to the views made by prominent psychologists such as Freud whom has referred to religion as an “obsessional neurosis” (Sigmund, 1962) or B.F. Skinner or Albert Ellis who generally found little value in the practice or study of religion and even suggested that it has a harmful effect on human psychological functioning (Ellis, 1988; Skinner, 1987).

However, these negative views regarding religion, were simply based on personal opinions of influential researchers in the academic world of psychology, rather than the outcome of systematic research. Systematic research needs to be done on individuals who have a healthy relationship with religion to determine its actual effect on human psychological functioning. Thus brunei, being a country that is strongly influenced by Islam is a good ground for such research.

A construct that is often associated with mental health is self-esteem (Farshi *et al*., 2013). A study by Brown (2010) have shown that high self-esteem helps to buffer the negative feedback that an individual receives and this in turns helps to lower individual's emotional distress and thus protects the person from the negative outcomes that may be related to the distress.

Hence, the present study intends to investigate the relationships between religiosity, mental health as well as self-esteem, a of the muslim malay bruneian students in the University Brunei Darussalam (UBD).

Psychological research on religiosity and mental health in Brunei students: Research that compares religiosity and mental health variables in brunei students is still rare. The current study was probably the first of its kind intended to narrow the knowledge gap in this area. Much of the previous psychology research on Brunei students tended to focus on a wide range of factors such as disability issues and behavioral problems (Bradshaw and Mundia, 2005, 2006; Tait and Mundia, 2012a; Haq and Mundia, 2012; Mundia, 2010a-e; Yusuf and Mundia, 2014; Tait *et al*., 2014). Some studies looked at the mental health status of the students in Brunei schools (Mundia, 2013). There is also an increasing body of research which has examined the challenges and achievement of brunei students in various subjects including mathematics and Japanese (Mundia, 1998, 2010d, 2010, 2007; 2011a, 2012a; Keaney and Mundia, 2014). Teacher preparation and teacher's contributions to student performance in brunei schools have also received a great deal of research attention (Mundia, 2012; Tait and Mundia, 2012b; Tait and Mundia, 2014). Two studies reported on how Brunei students responded to items on English research instruments (Mundia and Abu Bakar, 2010; Mundia, 2011b). None of all the above studies included a measure and discussion of religiosity.

Purpose and significance of the research: The increasing number of research that shows a positive relationship between religion and health prompts the question of whether matters relating to religious values should be completely avoided in psychotherapy especially when dealing with religious and spiritual clients. In fact there is now a growing number of research that specifically addresses when and how should religious matters be approached in psychotherapies (Shukor and Jamal, 2013; Dein, 2004; Plumb, 2011; Post and Wade, 2009).

It is worth to note that most research that documents the positive relationship between religiosity, mental health and self-esteem makes use of western participants, whom are either Protestants or Roman Catholics as their subjects (Joshi and Kumari, 2011; Koenig, 2009, 2012). To the knowledge of the researcher, no research in this area has been done so far using muslim bruneian samples. This research tries to shed light on using bruneian muslims as participants and adding on to fill the gap in the literature.

With regard to the measure of religiosity used in the western studies, most make use of only one question in the form of "How important would you say your religion is to you personally" with possible answers of: very important, somewhat important, not very important and not at all important. Such a simple construct does not give a comprehensive view of individual's religiosity in a Muslim context. Meanwhile other studies often simply translate the terminologies used in the christian religiosity scales into Islamic terminologies. A more specific religiosity scale that measures the religiosity of individuals towards a particular belief/religion (i.e., Islam) is needed to give a better measure of religiosity (Menouar and Stiftung, 2014).

The result from this present study will help to give a better understanding on the role of religion in influencing the mental health of the muslim bruneian population. This information is important as religion is deeply integrated into the way of life of the people in the country. The result of this study would give information to mental health practitioners and counsellors as to whether they should incorporate religion into psychotherapy.

Research questions: Specifically, the study will investigate the following broad research problems:

- Will there be any associations between the measures of religiosity, mental health and self-esteem
- If there are what is the extent or degree of relationship between religiosity, mental health and self-esteem of Muslim Bruneian students in UBD
- Will there be any gender differences on the religiosity, mental health and self-esteem of Muslim Bruneian UBD students
- Will there be any age related differences on the religiosity, mental health and self-esteem of the muslim bruneian UBD students

MATERIALS AND METHODS

Design of study: The present study employed quantitative (i.e., survey questionnaire) method in the collection of the primary data in order to address the research objectives. The quantitative method is used as it maximizes the objectivity, replicability and generalizability of the findings of this study compared to if qualitative method were to be employed (Harwell, 2011).

Sample: For the purpose of the research only Muslim students, whom can easily be recognised from their attire in UBD were randomly approached and asked to participate in the study. The questionnaires were given out around the university's compound such as the library, dining area, lecture halls and classrooms. Prior to answering the questions, participants were requested to give their written consent.

Initially there were 150 students who participated in the study. However as the study focuses on muslim bruneians, data from 7 participants (namely participant number: 38, 99, 106, 107,108, 121 and 137) have been excluded from the analysis of this study as they were either permanent residents of the country or a foreigner. Thus the remaining 143 participant's demographic information are presented in Table 1.

Instruments: Three instruments are used in the current research. There are:

The religiosity scale: Religiosity is measured using the five items religiosity scale developed by Shukor and Jamal (2013). This scale includes two important aspects of Islamic religiosity namely the concept of "Hablum minallah" which reflects one's relationship with Allah (God) and "Hablum minannas" that refers to a person's relationship with other people in accordance to the teachings of Islam. Each item is rated on a seven point Likert scale ranging from "1" item (strongly disagree) to "7" (strongly agree). The total score of respondents can range from a low of 5 to a high of 35 with higher scores representing higher level of religiosity.

The 38-items Mental Health Inventory (MHI): The 38 items mental health inventory is used to assess psychological health where respondents are asked about the frequency or intensity of a psychological symptom during the past month. The 36 of its items are accompanied by a six-choice forced response scale while 2 items use a five-choice forced response scale. The questions on MHI is aggregated in to two global scales to obtain the two scores of psychological distress (24 items) and psychological well-being (14 items). The scores on

Table 1: Demographic information (N = 143)

Variables	Group	Frequency	Percentage
Gender	Male	43	30.1
	Female	100	69.9
Nationality			
	Bruneian	143	100
Age	$16 \geq x \geq 20$ y.o.†	58	40.6
	$21 \geq x \geq 25$ y.o.	69	48.3
	$26 \geq x \geq 35$ y.o.	16	11.2

†y.o. = years old

Table 2: Descriptive statistics and reliability of the instrument (N = 143)

Scale	Items	Mean	SE mean	SD	Alpha
Religiosity	5	27.55	0.388	4.639	0.799
MHI: psychological	24	71.91	1.278	15.286	0.896
MHI: psychological	14	51.85	0.887	10.610	0.888
RSES	10	31.38	0.348	4.157	0.839

the psychological distress and psychological well-being scales represent the negative and positive states of mental health, respectively.

The Rosenberg Self-esteem Scale (RSES): The Rosenberg Self-esteem Scale (RSES) is widely used to measure individual's feelings of self-wort or self acceptance. It is a ten item Likert scale with items answered on a 4-point scale ranging from 1 (strongly agree) to 4 (strongly disagree). The RSES has been widely used as a self-esteem measure and has been translated to many languages in different countries across the globe (Schmitt and Allik, 2005). The scale consist of 10 items that require the respondents to report their feelings about the self directly. The total score of the respondents can range from the lowest of 10 to the highest of 40. The descriptive statistics and reliability of the three instruments are presented in Table 2.

The correlation Table 3 shows the low and non significant correlations between paired scales which suggest that each paired scales are assessing different constructs and are not replicating each other. In other words, the discriminant validity of each paired scale is high. The low but significant correlations between paired scales which imply that the scales (to a small extent) might be overlapping and measuring the same construct but the amount of duplication or common variance is little and negligible. The paired scales can thus be said to have satisfactory discriminant validity and low convergence validity. The high and significant positive correlations (0.500-0.700 and above) suggest that the scales concerned have good convergence/concurrent validity.

Procedure: The religiosity scale, MHI and RSES were randomly administered to the participants. Before giving their responses to the instruments, participants were explained on the purposes and objectives of the study. Participants were also informed of the confidentiality of

Table 3: Convergent and discriminant validity of the instruments and the pearson correlation coefficients between the scales (N = 143)

Scale	Religiosity	MHI: psychological distress	MHI: psychological well-being	RSES
Religiosity	1.000			
MHI: psychological distress	-0.124	1.000		
MHI: psychological well-being	0.314**	-0.515**		1
RSES	0.287**	-0.615**	0.527**	1

**Correlation is significant at the 0.01 level (2-tailed)

any information that was given and were asked to sign a consent form once they have given their agreement to participate in the study. As among the entrance requirement to study in UBD is a credit 6 in English Language at GCE "O" Level Examination or a grade "C" in IGCSE English (as a Second Language) or an IELTS score of 6.0 or a TOEFL minimum overall score of 550, it is therefore considered not necessary to translate the three instruments into Bahasa Melayu (Brunei's official language). This is reflected by the fact that a majority of the participants were able to complete the instruments in 15-20 min and none of them have reported having difficulties in completing them.

Data analysis: The Statistical Package for the Social Sciences (SPSS) Version 22.0 was used for the statistical analysis of the data to obtain both the descriptive statistics namely frequencies, percentages, mean, standard deviation and standard errors as well as inferential statistics (i.e., t-test for independent samples incorporating ANCOVA F, Pearson's correlation and One-Way ANOVA including Eta squared values). Cronbach's alpha reliability was also computed for all the three instruments. The justification and rationale for using these techniques are: the data obtained is drawn from a random sample thus the chosen techniques are deemed appropriate to address the research objectives. As the data obtained is from a sample rather than the entire population of Muslim Bruneian UBD students, inferential statistics is appropriate to be used as it takes into account measurement error which is mostly present in the data.

RESULTS AND DISCUSSION

The findings are presented below under separate subheadings.

Differences by gender: The scores between the male and female participants are not significantly different in all the variables except for on the religiosity scale as shown in Table 4.

Differences by age groups: According to Tukey HSD, there is no significant differences on the factor of age groups as shown by Table 5.

Correlations between variables: Table 1 shown earlier presents the correlation between the three variables which indicates that there are positive correlations between religiosity and the following variables: psychological well-being ($p<0.01$) and self-esteem ($p<0.01$). No significant correlation was found between religiosity and psychological distress.

Psychological distress is found to be negatively correlated with both psychological well-being and self esteem (both $p<0.01$). While psychological well-being is positively correlated with self-esteem.

The last few decades have seen a steady growth of interest in religiosity, mental health and its mediating factors. However, samples from the South East Asian countries such as brunei are still under-represented in the literature and thus the present study was carried out to fill this gap.

The study found that there were no significant differences between the male and female muslim bruneian UBD students in terms of their mental health as well as self-esteem. In comparing the religiosity of the two groups it was found that the female students had a significantly higher score than the male, however the effect size is considered small.

The results of the mental health means of the Muslim Bruneian sample is unlike the Arab's samples (Abdel and Lester, 2013) whereby both the Egyptian and Kuwaiti male students scored significantly higher than the female in the mental health scale. In fact, the male Kuwaiti sample also scored significantly higher than their female counterparts in the self-esteem as well as self-ratings of happiness and life satisfaction scales.

Abdel and Lester (2013) attributed the differences in the mental health of men and women of the Arabs to the child-bearing and gender role practices in the two countries where by the Arab women generally have less authority, power and responsibilities than the men which according to the author is associated with higher levels of anxiety, fear and neuroticism for the Arab women (Ahmad and Alansari, 2004).

Thus, this is probably why no gender-related differences was found in the mental health and self esteem of the Bruneian sample as the women in the country experience an almost equal opportunity as men in

Table 4: Differences by gender (N = 143)

	Male (N = 43)		Female (N = 100)		ANCOVA			
Factors (scales)	Mean	SD	Mean	SD	F-values	t (df = (141)	p-values (2-tailed)	ES
A	30.33	4.664	31.84	3.855	4.791	2.019	0.045	0.028*
B	72.86	18.650	71.59	13.680	5.533	0.454	0.650	0.001
C	52.30	12.760	51.65	9.603	6.436	0.336	0.737	0.001
D	27.02	5.684	27.78	4.121	6.094	0.894	0.373	0.006

*Small effect size (A-religiosity scale, B-MHI: psychological distress scale, C-MHI: psychological; well-being scale, D-RSES)

Table 5: Differences by the age groups (N = 143)

	Age groups					
	16≥x≥20 (N = 58)	21≥x≥25 (N = 69)	26≥x≥35 (N = 16)			
Factors (scales)	Mean (SD)	Mean (SD)	Mean (SD)	F-values (df = 2)	p-values (2-tailed)	Eta
A	30.90 (4.145)	31.91 (3.471)	30.88 (6.417)	1.079	0.343	0.015
B	73.34 (14.128)	71.00 (16.072)	71.19 (16.437)	0.391	0.677	0.006
C	50.60 (10.787)	52.41 (10.928)	53.94 (8.386)	0.802	0.450	0.011
D	26.62 (4.720)	28.01 (4.635)	28.94 (3.907)	2.265	0.108	0.031

A-religiosity Scale, B-MHI: psychological distress scale, C-MHI: psychological well-being scale, D-RSES

education and job opportunities as well as earned income. Indeed, according to the Global Gender Gap Report 2015 by the World Economic Forum (WEF) Brunei Darussalam ranked number 88 out of 145 countries in the overall ranking of gender-based gaps compared to Kuwait (Rank No. 117) and Egypt (Rank No. 136). In fact Brunei Darussalam, ranked number 1 in the subcategory of estimated earned income with women's average salaries equal to that of men compared to Rank 9 for Kuwait and Rank 133 for Egypt. The country also ranked first together with Kuwait and other countries in the subcategories of enrolment in secondary and tertiary education compared to rank 86 and 108, respectively for Egypt. Thus, the higher level of authority and responsibilities that the women in Brunei have compared to the arab women may contribute to the non-significant differences in the mental health level between men and women in the country.

In the present study, the participants were divided into three age groups (16-20, 21-25 and 26-35) and it was found that there is no significant differences in the scores of religiosity, mental health and RSES across the three groups. This is perhaps not surprising as all the participants were raise to value and practise the same national ideology of Melayu Islam Beraja (MIB) which in many ways may have influenced their religiosity, mental health and self-esteem in the same direction.

With the exception of the pearson correlation coefficient between religiosity and the psychological distress component of mental health, the rest of the Pearson correlation coefficients between the study scales were statistically significant at the 0.01 level and above. This shows that there is a covariation between religiosity, the psychological well-being component of mental health and self-esteem.

Consistent with the results of this study were previous findings on 499 Muslim Kuwaiti adolescents where positive correlation were found between religiosity and self-esteem (Khalek, 1994, 2000, 2011, 2012). In fact, the significant and positive association between religiosity and self-esteem was compatible with a previous study on samples from 11 countries (N = 187, 957, M_{age} = 37.49 years, SD = 12.22) where it was found that religiosity is positively correlated with social self-esteem and psychological adjustment and the correlation between religiosity and social self-esteem is stronger in countries that are religious compared to those that are less religious (Gebauer *et al*., 2012).

This goes to show that being religious in a country that values religion has psychological benefits to the religious individuals. Belonging to a group that values the same values that one does increases the likelihood of social support during difficult times. This is especially true for religious groups that highly encourage pro-social behaviors among its members. The social support that is received can positively influence mental health by diminishing negative emotions such as stress, anxiety and depression which in turn promotes positive mental health. This view is in line with the theoretical model of causal pathway for mental health proposed by Koenig *et al*. (2012) mentioned earlier in this study.

The positive correlation between religiosity and psychological well-being in this study is consistent with previous findings on Pakistani Muslims sample where it was found that religiosity was correlated with three facets of psychological well-being namely anxiety (negative) loneliness (negative) and general life satisfaction (positive) (Ismail and Desmukh, 2012). Although, analysis of the psychological well-being facets of the present data is beyond the scope of this study, the consistent findings between these two samples seem to point to the psychological relief that the religion of Islam itself brings to its followers. In Islam, Muslims are taught to always

turn to Allah during difficult times and to be patient as help is always near. The Quran, the holy book of the Muslims, repeatedly mentioned this concept in many verses. Examples of such verses are “O believers Seek help with patience and salat (prayers) and Allah is with those who keep patience” (2:153) and “For indeed with hardship (will be) ease. Indeed with hardship (will be) ease” (94:5-6).

Non-significant correlation between religiosity and psychological distress was observed in the present study. It is interesting to see that when religiosity is measured in terms of the individual’sown subjective opinions of religiosity, “What is your level of religiosity in general” and “What is the strength of your religious belief when compared to other persons” such as in the study by a negative correlation is seen between religiosity and components of psychological distress such as anxiety. However when religiosity is measured in terms of religious adherence (such as “I always perform my duty as a Muslim (e.g., pray five times a day, fasting during the month or Ramadhan, pilgrimage to Mecca) to Allah”) as measured by the present study or in terms of religious commitments (for example, “How frequent do you attend religious services”) as measured in the study by Williams *et al.* (1991) no significant correlation was found between religiosity and psychological distress. Such differences in findings when using different types of religiosity scale put emphasis on the need to measure religiosity using an instrument that captures the different aspects of in the case of the present study, Islamic religiosity. This would give a more accurate understanding on the influence of Islamic religiosity on mental health specifically psychological distress.

The positive correlation between psychological well-being and RSES is expected. This is because having a high level of self-esteem is a necessity in order to have a healthy level of mental health (Khalek, 2012; Abdel and Lester, 2013). Furthermore as shown by Ahmad *et al.* (2013) self-esteem increases in domains that are deemed as important to the individual. The MIB ideology greatly influences the lives of the Muslim Bruneians where by it greatly encouraged the practice of Islam in almost every aspect of the life of the muslim Malays in the country (Ahmed and Alansari, 2004). Thus following the teachings of Islam which is highly encouraged in the country, should increase the self-esteem of the muslim bruneian and thus, according to previous studies (Abdel and Lester, 2013) should also increase mental health. It is important to note however, the causal-relationship between psychological well-being and RSES cannot be determined from the findings of this study alone.

CONCLUSION

From the basis of the results of the present study, it could be concluded that participants, both men and women with higher scores on religiosity regard themselves as having a good mental health, self-esteem and an optimistic outlook towards life in general and felt happier than those with lower scores of religiosity.

LIMITATIONS

As the main findings of this research is based on correlation statistics, it is not possible to determine the causal connections between the variable. That is to say, the positive correlation between religiosity and psychological well-being as well as between religiosity and self-esteem are neither interpreted as causal effect of religiosity on psychological well-being nor self-esteem and vice versa. In order such inferences to be made, a longitudinal design of the research would need to be employed.

Secondly, due to the broad meaning of religiosity, it is very difficult to compile all aspects of religiosity into one measurement. Thus, the religiosity measurement used in this study although is an improvement from a single question scale used by previous studies, might still be an inadequate measure of an individual’s true level of religiosity.

Thirdly, the sample of the study was restricted to muslim bruneian UBD students only with age range of between 16-35 years old. In order for findings to be more representative of the overall bruneian muslim population, participants from other samples such as the working class group, the less privileged or pensioners should also be include.

IMPLICATIONS

Furthermore, the findings of the research study implies the important role that religion has on the mental health of the bruneians. It also implies the possibility of incorporating religion into psychotherapy especially in interventions that aims to enhance the self-esteem and well-being of the client. Research and curriculum trainings for mental health professionals should also take into account the influence and role that religion may have in promoting mental health.

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