

Religiosity in Malay Patients with HIV/AIDS: Correlation with Emotional Distress

¹Zahiruddin Othman, ²Nor Asyikin Fadzil, ¹Rahimah Zakaria,
¹Sharifah Zubaidiah Syed Jaapar and ¹Maruzairi Husain

¹School of Medical Sciences, Universiti Sains Malaysia Health Campus, Kelantan, Malaysia

²Hospital Raja Perempuan Zainab II, Kelantan, Malaysia

Abstract: Religion promotes better health behavior, including less drug use and safer sexual practices. A total of 100 (60 males, 40 females) Malay Muslim HIV/AIDS patients were recruited in this study. Religiosity, emotional distress and stigma were measured using Hatta Islamic Religiosity Scale (HIRS), Depression Anxiety and Stress Scales (DASS)-21 and HIV Stigma Scale (HSS), respectively. It was found depression, anxiety and stress occurred in 28%, 6% and 2% of all subjects. Female were significantly more depressed than male subjects ($P=0.006$). Islamic practice was significantly higher in male subject ($P<0.001$). The Islamic religious practice was correlated with lower emotional distress; depression ($r=-0.31$, $P=0.016$), anxiety ($r=-0.25$, $P=0.012$) and stress ($r=-0.28$, $P=0.015$). Islamic religious knowledge was fairly correlated with disclosure concern ($r=0.25$, $P=0.003$). In conclusion, lower emotional distress was correlated with Islamic religious practice but not knowledge. Therefore, it is important to ensure improvement of Islamic practice in rehabilitation programs of HIV/AIDS patients.

Key words: Religiosity • HIV/AIDS • Emotional Distress • Stigma • Malay

INTRODUCTION

HIV infection was noted to be a major burden in an infectious disease clinic, affecting as high as 9% of the attendees [1]. As there is still no cure for HIV/AIDS, behavioral prevention remains the most viable option. Religion or spirituality promotes better health behaviors and is associated with less drug use and safer sexual practices in the overwhelming majority of studies that have examined these relationships [2].

A study by Kagimu *et al.* [3], showed Muslim respondents with *sujda*, the hyperpigmented spot on the forehead due to prostration during prayers, were more likely to abstain from sex, be faithful in marriage and avoid alcohol and narcotics. In other studies, *sujda* and fasting were associated with lower HIV infections [4, 5], suggesting the importance of faith-based approach to HIV prevention in the Muslim population.

Malaysia, being a Muslim majority country emphasized spiritual rehabilitation in most of its social, behavioral and correctional programs of HIV/AIDS patients [6,7]. Most of the educators, teachers, counselors

and therapists in government-operated programs are provided by the Department of Islamic Development, Malaysia (JAKIM) and the State Religious Council/Authorities. Additionally, drug rehabilitation centers obtain assistance from local religious leaders (*Imam*) to interact with residents in preparing them to re-enter society [8].

As a rapidly developing country, there are a lot of social problems among Muslims in Malaysia [9]. This raises many questions in relation to Islamic understanding and practice. In addition, the majority of existing studies used religiosity instrumentation grounded in the Judeo-Christian religious worldview, which does not adequately represent the uniqueness of the other non-Judeo-Christian worldviews such as the Islamic one.

Thus, it is high time to conduct more research on religiosity in Muslim HIV/AIDS patients, using an Islamic religiosity scale that would allow easier implementation of the findings. This study aimed to assess the relationship between religiosity and psychological distress in Malay Muslim HIV/AIDS patients.

MATERIALS AND METHODS

Study Setting and Subjects: This cross-sectional study was approved by the USM Human Research Ethics Committee (HREC) and Malaysia Medical Research and Ethics Committee (MREC). It was conducted from July 2012 to February 2013 at the infectious disease outpatient clinic, Hospital Raja Perempuan Zainab II (HRPZ II) in Kota Bharu, the capital city of Kelantan which is situated on the northeastern Malaysia Peninsular. Malay Muslim population constitutes 95% of the population. More than 5,800 HIV/AIDS patient had been treated since its establishment in 1993. Subjects from each gender (60% males, 40% females) were selected according to systematic sampling method. Recruitment was carried on every clinic day until a total of 100 consenting, cooperative and literate Malay Muslim HIV/AIDS patients (18-65 years) were enlisted. Those having physical illnesses too ill to participate, severe mental illness such as schizophrenia or major depressive disorder, learning disability or mental retardation and severe communication problem were excluded from the study.

Instruments: The Depression Anxiety and Stress Scale (DASS)-21 is designed to measure the negative emotional states of depression, anxiety and stress. It consists of three 7-item self-report subscales rated at 4-point severity/frequency scales for each state experienced over the past week. The Malay version (BM DASS-21) has good Cronbach's alpha values for depression, anxiety and stress at 0.84, 0.74 and 0.79 respectively [10].

Hatta Islamic Religiosity Scale (HIRS) is a 27-item scale to measure basic Islamic knowledge and practice of basic Islamic rituals among Muslim adults and adolescents [11]. Basic Islamic knowledge section consists of 15 items based on primary and lower secondary school syllabus. Practice of the basic Islamic rituals section consists of 10 items based on the obligation of practicing Muslim according to the Holy Quran and *al-Hadith*. The third section assesses the level of Quran reading. The last section assesses respondent enjoining good and forbidding evil action which is a responsibility, incumbent on all Muslims. A likert score is used for each item. Inter-rater reliability for total HIRS score was high (0.90). The scale was able to discriminate the religiosity between the *tahfiz* and the delinquent youth groups ($P < 0.05$). However, it must be noted that the HIRS does not attempt to measure the faith (*Iman*) of the

respondent, for the faith of any Muslim or believer is only known to Allah. It is immeasurable by any human inventory or questionnaire [12].

The 40-item HIV Stigma Scale (HSS) is rated on a 4-point Likert scale (Strongly disagree, disagree, agree, strongly agree) to assess stigma experienced by an HIV-positive person across the four domains; personalized stigma (Enacted stigma), disclosure concerns (Enacted stigma), negative self-image (Internalized stigma) and concern with public attitudes (Perceived stigma) [13]. This study used the Malay translated version which was available and used in other studies [14, 15]. The internal consistency reliability 0.92 of the Malay version is comparable to 0.96 of the original English version.

RESULTS

Table 1 shows the socio-demographic variables of the subjects. A total of 100 (60 males, 40 females) Malay Muslim HIV/AIDS patients were recruited with mean age and duration of illness 36.0 ± 7.2 and 5.2 ± 3.7 years, respectively. The majority of the subjects in this study were afflicted with HIV/AIDS during the most productive time of their life, a finding consistent with 2012 national statistics on HIV/AIDS in Malaysia [16]. Most subjects were infected with HIV through sharing needles (48%). Single and multiple sexual partner transmission occurred in 34% and 15%, respectively, similar to finding from a previous study [17]. Almost all subjects (96%) did not disclose their HIV status to family members. More than two thirds (78%) of the subjects were receiving antiretroviral therapy.

HIRS Islamic knowledge and practice scores were 12.46 ± 3.49 and 8.21 ± 3.86 with 27% and 70% of subjects scored low, respectively. Islamic practice was significantly higher in males ($P < 0.001$). Depression, anxiety and stress occurred in 28%, 6% and 2%, respectively as shown in table 2. There was a significant gender difference ($P = 0.006$) for depression where female (2.82 ± 2.96) were more depressed than male (4.60 ± 3.34) subjects. There were no significant differences between gender in anxiety and stress.

As shown in Table 3, there was no significant correlation found between religious knowledge and three components of emotional distress. There were significant, albeit fair, negative correlations between religious practice and the three components of emotional distress; depression ($r = -0.31$, $P = 0.016$), anxiety ($r = -0.25$, $P = 0.012$)

Table 1: Socio-demographic and clinical characteristics of subjects

	Frequency
Age (years)	35.97±7.23
18-29	20
30-39	40
40-49	32
≥ 50	3
Gender	
Male	60
Female	40
Marital status	
Single	30
Married	43
Divorced	14
Widow	13
Education level	
Nil	30
Primary	43
Secondary	14
Tertiary	13
Employment	
Self-employed	39
Government servant	13
Private sector	19
Housewife/unemployed	29
Income per month (RM)	
≤ 1,000	57
1,001-2,000	19
≥ 2,000	24
Living partner	
Alone	8
Spouse	39
Friend	13
Parent	49
Circle of confidentiality	
Not disclosed	96
Disclosed to people	4
Duration of illness	5.18±3.74
Source of HIV infection IDU	48
Sexual (multiple partner)	15
Sexual (single partner/spouse)	34
Other	3

Table 2: Emotional distress level of subjects

	No (%)	Mild (%)	Moderate (%)	Severe (%)
Depression	72	9	16	3
Anxiety	94	3	3	0
Stress	98	1	1	0

Table 3: Correlation between Islamic religiosity and emotional distress

Depression, Anxiety and Stress Scale (DASS)			
	Depression r (P-value)	Anxiety r (P-value)	Stress r (P-value)
Knowledge	0.14 (0.151)	0.02 (0.864)	0.04 (0.696)
Practice	-0.31 (0.016)	-0.25 (0.012)	-0.26 (0.015)
Pearson correlation			

and stress ($r = -0.28, P = 0.015$). There was no significant correlation between religiosity and stigma, except for Islamic knowledge which was fairly correlated with disclosure concern ($r = 0.25, P = 0.003$) as shown in Table 4.

DISCUSSION

The prevalence of depression (28%) in this study was higher compared to findings from Nigeria (23%) [18] and Uganda (17%) [19], but lower than that in Sweden (35%) [20]. More than two thirds (73%) of Malay Muslim HIV/AIDS subjects scored high in religious knowledge. However, less than a third (30%) of subjects scored high in religious practice. High religious knowledge scores were likely due to a ceiling effect since the construct used in this study was based on Malaysian lower secondary school syllabus [21] for which majority of the participants had completed secondary school education. Nonetheless, the religious knowledge among HIV/AIDS subjects was only superficial and not sufficient to prevent risky behaviour causing HIV infection and the development of emotional distress.

The findings that concern religious practice in male was higher compared to female subjects in this study could be due to men as head of the family pay the *zakat* (alms) and attend weekly Friday prayer which was measured by the scale. Another possible explanation was a higher prevalence of depression among women, causing them to be less involved in organized religious activities.

In conclusion, HIV/AIDS subjects with emotional distress in all 3 categories of depression, anxiety and stress had significantly lower Islamic religious practice but not knowledge. Thus, religious leaders or teachers must not stop at teaching Islamic religious knowledge to HIV/AIDS patients only. They must ensure the knowledge lead to behavioral changes, i.e., better Islamic practice. Indeed, the manifestations of an individual's faith are evident in his daily commitments and undertakings.

However, it should be noted that relying solely on spiritual practices to overcome problems such as addiction is often inadequate. This is known as spiritual bypass, a psychological defense mechanism in which underlying emotional issues is avoided by focusing solely on spiritual beliefs, practices and experiences [22]. Therefore, applying religious values and principles, while ignoring the necessary psychological development and work, will most likely continue to create internal disarray and discord. A skilled therapist can effectively work with individuals who demonstrate spiritual bypassing, which likely will undermine the recovery process [23].

Table 4: Correlation between Islamic religiosity and HIV stigma

HIV Stigma Scale (HSS)				
	Personalized stigma r (P-value)	Disclosure concerns r (P-value)	Negative self-image r (P-value)	Concern with public attitude r (P-value)
Knowledge	0.14 (0.176)	0.25 (0.003)	0.17 (0.085)	0.15 (0.060)
Practice	-0.04 (0.695)	-0.52 (0.133)	-0.51 (0.625)	-0.05 (0.622)

Pearson correlation

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