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Exploring Local Values and Beliefs to Develop School-based Mental Health Anti-Stigma: A Phenomenology Study

Aiyub Aiyub[1,2], Syarifah Rauzatul Jannah[2], Marthoenis Marthoenis[2], Asnawi Abdullah[3], Hizir Sofyan[4]*

[1]Graduate Program, Graduate School of Doctor Mathematics and Applied Sciences (DMAS), Universitas Syiah Kuala, Banda Aceh, Indonesia; [2]Department of Psychiatry and Mental Health Nursing, Universitas Syiah Kuala, Banda Aceh, Indonesia; [3]Department of Biostatistics, Faculty of Public Health, Univesitas Muhammadiyah Aceh, Banda Aceh, Indonesia; [4]Department of Statistics, Faculty of Math and Science, Universitas Syiah Kuala, Banda Aceh, Indonesia

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***Correspondence:** Hizir Sofyan, Faculty of Math and Science, Universitas Syiah Kuala, Banda Aceh, Indonesia. E-mail: hizir@unsyiah.ac.id
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Abstract

BACKGROUND: Students in middle-income countries frequently experience stigma related to mental disorders (MDs). Those with MDs are stereotyped as incompetent, uncontrollable, uncooperative, and dangerous. Stereotypes are predominantly formed and disseminated due to culture and beliefs. Therefore, it is essential to investigate, comprehend, and apply the local values and beliefs to increase the effectiveness of school-based anti-stigma programs.

AIM: This study aims to investigate the local values and beliefs related to mental health anti-stigma as early initiation of school-based anti-stigma development.

METHODS: This is an exploratory phenomenological study. A total of 30 informants were interviewed personally or participated in focus group discussions. Content analysis was performed to identify related sub-themes and themes.

RESULTS: This study identified seven themes and 15 sub-themes. The seventh theme included the importance of school-based anti-stigma, school-based anti-stigma approach, school-based anti-stigma method, media dissemination of school-based anti-stigma information, design of school-based anti-stigma information, the target group of school-based anti-stigma, and collaboration partners of school-based anti-stigma.

CONCLUSION: Adolescents in middle school frequently experience stigma regarding their mental health from their peers. Using both Islamic and mental health approaches, integrating internal and external stakeholders, dispelling unfavorable misconceptions and stereotypes, encouraging students to understand and empathize with others, and reducing the harmful effects of mental health stigma were found to help reduce the stigma of mental illness.

Introduction

Indonesia comprises approximately 1.340 recognized ethnic groups [1] and extends official recognition to seven religions [2]. Every ethnic group has its own culture and religion, while religion consists of many sects and beliefs. Both cultures and religions significantly impact daily human life [3]. Indonesian people regard to culture and religion as fundamental parts of everyday life. The cultural and religious influences are evident in how Indonesian society views people with MDs.

Muslims in Indonesia live in a collectivist culture in which community perspectives are sometimes more valuable than individual existence. As a result, when a family member is diagnosed with a mental disorder, other family members feel a strong sense of shame and try to hide and isolate the affected one by confining or restraining, known as “pasung” [4], [5]. This situation is inextricably linked to negative societal prejudices and stereotypes (stigma).

Mental health stigma is more prevalent in developing countries (31.2%) than in developed countries (20%) [6]. Mental health stigma is not only experienced by adults but also by adolescents. Even stigma is more prevalent during adolescence than adulthood [7], [8]. Adolescents frequently face stigma from their peers [9]. Despite the lack of a national survey, several local studies found that stigma was still prevalent in Indonesian society [10]. Peer stigma is not only experienced by adolescents in Indonesia; but also those in Jordan, Japan, the Philippines, Singapore, India, Lebanon, Nepal, and Thailand [11]. In Jordanian, peer stigma affected approximately 88% of adolescents with depression, due to their peers’ lack of mental health knowledge [12].

Stigma occurs due to negative perceptions of students’ physical or psychological weaknesses (labeling). Labeling triggers grouping toward students with specific weaknesses and builds on negative characters (stereotype). Afterward, the students as the victims are frequently perceived as different and isolated (separation) persons. Consequently, they are considered a marginal group with low social status (status loss) and treated discriminatively (discrimination) [13], [14].

Mental health stigma is divided into public stigma and self-stigma [15]. Public stigma exists once people encourage stereotypes and contributes to discrimination, social isolation, and violence. Meanwhile, self-stigma is an individual's response to internalizing stereotypes, which leads to low self-esteem and self-efficacy, as well as increased anxiety, fear, frustration, helplessness, low quality of life, lack of empowerment, increase in psychiatric symptoms, and in some cases, it triggers suicidal ideation [16], [17], [18]. On the other hand, low self-esteem and self-efficacy lead to low academic achievement, intelligence, trustworthiness, and attractiveness as romantic partners, which frequently leads to school dropout [18], [19].

Consequently, school-based anti-stigma is required to minimize peer stigma and its negative consequences. This program is reasonable because adolescents spend more time with their peers, especially during school hours. Furthermore, peer stigma has been identified as a common barrier to students seeking healthcare [20]; thus, it potentially triggers severe mental disorders (MDs).

Applying the existing anti-stigma in many cases can be a challenge. There is no evidence that current interventions are effective or acceptable to people of all ages or communities [21]. Some interventions that are acceptable for adults may not be suitable for children. Similarly, interventions that run in developed countries may not necessarily work in developing countries [22]. Therefore, it is beneficial to develop school-based anti-stigma interventions by exploring local values and beliefs to increase their efficacy and acceptability. In this qualitative study, researchers investigated local values and beliefs based on respondents' experiences and perspectives to enrich the scientific evidence in developing anti-stigma interventions.

Methods

Design

This qualitative explorative study used the phenomenological approach to explore and understand the descriptive and interpretative aspects of the respondents' experiences, feelings, and thoughts about peer stigma and anti-stigma. Based on these aspects, the respondents were asked to convey their experiences and perspectives according to their culture and beliefs about mental health stigma and school-based anti-stigma initiatives.

Informants

Respondents were recruited using a convenience sampling method with the following criteria,

1. Junior high school students in Banda Aceh were actively studying.
2. Junior high school teachers in Banda Aceh who have been working for 2 years.
3. Health practitioners with 2 years of experience with school mental health programs.
4. Scholars who have experienced teaching in university for 2 years.

Based on these criteria, 30 respondents with different backgrounds were recruited, including 16 students, five junior high school teachers, six scholars, and three health practitioners. All the informants have lived in the study area (Banda Aceh) for more than 5 years. To meet the desired criteria, researchers also met representatives from universities, educational offices, health offices, principals, and health centers in the target areas to discuss who should be chosen as the informants.

Data collection

Data were collected using focus group discussions (FGDs) among two groups of students and in-depth interviews with junior high school teachers, health practitioners, and scholars. All informants received seven semi-structured questions about peer stigma and anti-stigma initiatives. The interview guide was reviewed by three experts from various backgrounds, including a nurse educator, an Islamic scholar, and a clinical psychologist.

Data analysis

Data were analyzed using the Qualitative Content Analysis by the following stages: (1) Obtain the FGDs and deep interviews transcripts as unit analysis; (2) the transcripts repeatedly to meet the desired meaning units according to the study goals; (3) condense the meaning units without changing the original meaning; and (4) construct the abstraction of the condensed meaning units to generate codes, sub-themes, and themes [23]. The use of qualitative content analysis since this method has been used frequently as a qualitative data analysis tool in nursing research, especially in psychiatric nursing [24].

Ethical considerations

This research has been reviewed and declared feasible by the Ethics Commission of The Faculty of Nursing, Universitas Syiah Kuala, Banda Aceh, Indonesia (reference number = 113005200220). The recruitment of informants used ethical consideration in which respondents' involvement was voluntary, as they all signed informed consent before being a respondent. For the students under 17 years old, the parent's approval was necessary for participant recruitment. Before signing the informed consent, the informants were well explained about the study.

Results

The informants identifier

The informants consisted of 30 participants with different backgrounds. Each of them was assigned a specific code as an informant identifier. The first participant was given a unique code "p1", the second participant was coded "p2", "p3" for the third one, and so on until the 30th participant was set to "p30". The details of the informants' identifiers are shown in Table 1.

Table 1: Informants' identification and characteristics

Informants identifier	Gender	Age (year)	Employment	Education level
p1	Male	46	Lecturer in Islamic Study	Master
p2	Male	44	Lecturer in Islamic Study	Master
p3	Male	46	Lecturer in Islamic study	Master
p4	Female	53	Lecturer in Psychology	Doctor
p5	Female	58	Lecturer in Education and Pedagogy	Doctor
p6	Female	39	Lecturer in Nursing	Master
p7	Male	38	Counseling Teacher	Bachelor
p8	Female	35	Counseling Teacher	Bachelor
p9	Male	51	Islamic Religious Teacher	Bachelor
p10	Male	43	Islamic Religious Teacher	Bachelor
p11	Female	54	Subject Teacher	Bachelor
p12	Male	34	Community Mental Health Nursing in Health Center	Diploma
p13	Female	30	Community Mental Health Nursing in Health Center	Diploma
p14	Female	32	Community Mental Health Coordinator in Health Department	Bachelor
p15	Male	15	Islamic Junior High School Students	Student
p16	Male	16	Islamic Junior High School Students	Student
p17	Female	15	Islamic Junior High School Students	Student
p18	Female	15	Islamic Junior High School Students	Student
p19	Female	15	Islamic Junior High School Students	Student
p20	Female	16	Islamic Junior High School Students	Student
p21	Female	15	Islamic Junior High School Students	Student
p22	Female	15	Islamic Junior High School Students	Student
p23	Male	16	General Junior High School Students	Student
p24	Male	15	General Junior High School Students	Student
p25	Male	15	General Junior High School Students	Student
p26	Female	15	General Junior High School Students	Student
p27	Female	16	General Junior High School Students	Student
p28	Female	15	General Junior High School Students	Student
p29	Female	15	General Junior High School Students	Student
p30	Female	15	General Junior High School Students	Student

Informants characteristics

The informants consist of students, teachers, health practitioners, and scholars. Most informants are students (53.33%), with a female predominance (60%), while adolescents comprise approximately 53.33% of the informants. Their ages ranged from 15 to 58 years old, with an average age of 28.23. Detailed data about the characteristics of respondents are shown in Tables 1 and 2.

Table 2: The demographic data of informants

Informants' characteristics	f (%)
Gender	
Male	12 (40.00)
Female	18 (60.00)
Age	
Adolescent (10–19)	16 (53.33)
Adult (20–60)	14 (46.67)
Education level	
Junior High School Student	16 (53.33)
Diploma	2 (6.67)
Bachelor	6 (20.00)
Master	4 (13.33)
Doctor	2 (6.67)
Employment	
Student	16 (53.33)
Teacher	5 (16.67)
Health practitioner	3 (10.00)
Scholar	6 (20.00)

Content analysis results

According to the data analysis, the study discovered seven themes and 15 sub-themes. The details are described,

The importance of school-based anti-stigma

Under this theme, the study identified two sub-themes. Each of which is described in more detail,

Mental health stigma was prevalent.

Some informants mentioned that mental health stigma was prevalent among students. Mental health stigma was addressed for students with MDs and adolescents with behavioral, appearance, and economic weaknesses (p3, p4, p6, p7, p8, p17, p18, p21). Some others stated that mental health stigma is more prevalent in rural areas than urban areas (p6, p4). The following are direct quotes from informants, as can be seen from the excerpts,

Mental health stigma was prevalent among students with MDs. Students with behavioral, physical, and economic weaknesses are also stigmatized, as are students with MDs (p17).

Mental health stigma was more prevalent in rural areas than in urban areas (p6).

A few mental health programs were available in schools.

Today public health centers had mental health programs in schools as an early detection step of MDs. However, they were not evenly distributed across all schools (p6, p7, p8, 12, p13). Aside from early detection programs, informants stated that school-based anti-stigma is also crucial in reducing negative perceptions, attitudes, and myths addressed to students with MDs (p3, p4, p6, p7, 18, p19, p29). In addition, the informants hope that school-based anti-stigma will foster a positive school environment and be free from stigma and bullying (p10, p21). The following statements are direct quotes from the informants,

We have early detection programs, but they are not distributed evenly across all schools due to a lack of financial and human resources (p7).

There are so many negative stereotypes about students with MDs that school-based anti-stigma programs are required (p29).

We strongly believe that when mental health promotion is conducted in school to enhance studenWts' knowledge about mental wellness, it is likely to change the negative perception of ailing peers (p10).

School-based anti-stigma approach

Mental health approach

Informants proposed to use mental health approach in the school-based anti-stigma campaign.

The mental health approach can easily increase students' understanding of adolescent mental health issues. (p19, p26, p23, p28, p7, 8, p11, 13, p6, p4). Below is a direct quote from the informant,

The mental health approach can increase students' knowledge of mental health so that students have positive thinking with their friends who have psychological and mental health problems (p11).

Religious approach

The Islamic approach is also crucial in developing school-based anti-stigma. The Islamic approach would improve students' acceptance (p1, p5, p8, p9, p10, p11, p12, 14, p16, p20, p26), as stated in the informant's quote.

Islamic approach is essential in the anti-stigma campaign, aside from the health approach, because during my counseling experiences, the Islamic approach was more acceptable (p14).

School-based anti-stigma methods

Informants believed that applying appropriate methods follow the goals and the target groups can improve anti-stigma effectiveness. Informants proposed three methods with different goals: To increase students' understanding and empathy and minimize the adverse effects of students' stigma. The detailed sub-themes will be discussed,

Method to increase students' understanding

It is critical to improve students' understanding of mental health, MDs, and stigma to reduce mental health stigma. Face-to-face teaching and video were recommended (p1, p2, p4, p6, p7, p8, p10, p13, p14, p19, p27, p29). The following quotes are direct statements from the informants,

The anti-stigma campaign method should be capable of increasing both understanding and empathy so that students have compassion for people with MDs (p6).

Face-to-face teaching is an ideal method to increase student's knowledge, the same as teaching using video is also effective for keeping students entertained and reducing students' boredom. Counseling is also essential for victims to minimize the adverse effects of stigma and for perpetrators to become more aware of and willing to stop stigma (p4).

Methods to increase students' empathy

Empathy is required for the development of social relationships. Empathy can help students understand what another person thinks or feels (p6, p8). Field trips, storytelling, and videos were three methods suggested by the informants to increase students' empathy (p2, p6, p7, p24). The followings are direct quotes from the informants,

Through empathy, students can feel what their friends are feeling. It can stimulate affection for each other (p6).

Sometimes, students need to take a field trip to a psychiatric hospital to witness the conditions of the patients on their own so that it can improve their empathy (p7).

I believe, it is beneficial for students if we tell them how people with MDs and their families struggle to be free from MDs so that they will be more sensitive than those who require assistance and support to get better (p24).

Methods to minimize the adverse effects of stigma

Counseling and self-help groups were recommended as methods to anticipate the adverse effects of mental health stigma (p7, p8, p10, p12, p22, p27). Reducing the adverse effects of mental health stigma will allow stigmatized students to recover from their illnesses and cope with the stigma (p6, p21, p26). Both victims and perpetrators must become the target of school counseling (p6, p8, p10). The followings are direct quotations from the informants,

School counseling and student self-help groups are two effective methods to minimize the adverse effects of mental health stigma (p12).

The adverse effects of mental health stigma will impede the recovery of students with MDs. Thus, it is critical to decrease the adverse effects of mental health stigma (p6).

I counseled stigmatized students on improving their appearance and behavior, contributing to mental health stigma. It will be challenging to prevent perpetrators from stigmatizing attitudes if the victims refuse to change (p8).

Stigma perpetrators must also be counseled to understand that their stigma can make victims feel ashamed and inferior (p12).

Media dissemination of school-based anti-stigma information

We identified two sub-themes under this theme: Printed media and electronic media. Both will be discussed in detail,

Printed media

Informants stated that printed media (i.e., leaflets, booklets, brochures, posters, banners,

pamphlets, and stickers) could be used in disseminating anti-stigma information (p5, p6, p7, p8, 19, p28, p29). The followings are direct quotations from the informants,

To disseminate anti-stigma information, printed media such as leaflets, brochures, posters, and pamphlets can be used (p7).

Booklets, banners, leaflets, and newspapers are printed media that can be used to go against stigma (p28).

Electronic media

Electronic media (i.e., video and social channels) are more effective in disseminating anti-stigma information because it is frequently used by young people today (p3, p4, p6, p10, p21, p22). The following statements are direct quotes from the informants,

Today, using social media, both text, and video, to disseminate anti-stigma information to adolescents is very effective (p3).

Design of school-based anti-stigma information

We identified two sub-themes under this theme: The content and the character of information. The specifics of the sub-themes will be discussed,

Content of information

Informants proposed that anti-stigma information content must include mental health and Islamic guidance. The informants believed that knowledge about mental health, MDs, as well as mental health stigma, and their adverse effects of them based on both mental health theories (p4, p6, p7, p12, p13, p17, p18, p20, p21, p26, p28), and Islamic perspectives, (p2, p4, p5, p7, p8, p11, p20, p27) are critical to raising students awareness and empathy toward people with MDs, as seen from the following quotations from the informants,

Students should be taught the definition, causes, and symptoms of MDs, as well as how to support sufferers and their families to maintain their stable condition and willingness to seek treatment (p28).

Students should be given an understanding of the definition, causes, and adverse effects of mental health stigma, then ask students to empathize and increase support for those with MDs (p6).

I am sure, many students will feel touched when the Islamic cleric teaches how to behave toward people with MDs according to Islamic perspectives based on Al-Qur'an and Hadith (p27).

Character of information

In addition to information content, the informants stated that the character of the information is crucial in increasing the interest, motivation, and awareness of young adolescents. Some of the essential information characteristics in anti-stigma campaigns are: Appropriate with the target group (p4, p6, p12, p20), able to stimulate curiosity (p4, p5, p6), and able to understand (p4, p6, p13, p19, p30), empathy (p6, p13), motivation (p1, p8, p21, p25), and self-awareness (p1, p6, p8, p12). The followings are direct quotations from the informants,

In my opinion, the anti-stigma information content must be appropriate for the target group of the anti-stigma campaign, so the information should be brief and focused on the reality that occurs among adolescents (p4).

Anti-stigma information media should stimulate students' curiosity, as it should be interesting to read (p6).

The focus of the anti-stigma campaign is to increase students' understanding to clarify myths, stereotypes, and other negative perceptions toward people with MDs (p13).

Self-awareness and empathy are two crucial characteristics that must be emphasized in the anti-stigma campaign (p12).

Improving the self-awareness of the perpetrators to stop mental health stigma and increasing the motivation of victims to fight against stigma are essential goals of the anti-stigma campaign (p1).

Target groups of school-based anti-stigma

Two sub-themes are identified based on the target group of the anti-stigma campaign, namely, the internal and external target groups. Both will be discussed in more detail,

Internal target group

Informants proposed that school-based anti-stigma campaigns should be targeted not only at students but also at other internal related stakeholders, that is, teachers, administration staff, and principals (p3, p4, p5, p6, p13, p14, p17) as can be seen from this excerpt,

The short-term target of school-based anti-stigma is a student. However, students change continuously per year. The program should also target relatively permanent teachers, as they will likely become change agents in minimizing mental health stigma. However, in the long-term, it is necessary to enrich the curriculum of prospective teachers to have mental health and anti-stigma competencies (p3).

External target group

Aside from internal stakeholders, the informants also conveyed that external stakeholder, that is, families, school committees, prospective teachers, and educational and health authorities, are essential (p3, p5, p6). This quote is an excerpt directly from the informant,

School committees and educational departments must be the target group of the anti-stigma campaign to encourage them to allocate sufficient money and produce good school policies (p5).

Collaboration partners of school-based anti-stigma

Internal partner

The Informants agreed that school-based anti-stigma was not solely the responsibility of schools. To achieve more effective goals of the anti-stigma campaign, it was necessary to involve and collaborate with relevant internal stakeholders, including students, teachers, and administrative staff (p3, p4, p5, p6, p7, p9, p12, p13, p22). The following statement is a direct quote from the informant,

Counselors and homeroom teachers are responsible for identifying and resolving students' problems and minimizing stigma and its adverse effects (p9).

External partner

External partners (i.e., families, Islamic clerics, school committees, educational authorities, health workers, and government) are also essential to be involved in the anti-stigma campaign (p4, p5, p8, p9, p11, p12, p14) as stated in this excerpt,

Anti-stigma campaign is not only the responsibility of schools but also external stakeholders, that is, families, Islamic clerics, and the government (p4).

The government should also be involved in this program to generate important policies to control media content (both social and mainstream media), which are eligible to stigmatize people with mental health disorders in their comments and news (p9).

Discussion

This study asked informants to convey their thoughts and feelings about mental health stigma and anti-stigma initiatives. The interviews and discussions were designed to elicit information about what the informants were experiencing, feeling, and thinking according to local culture and beliefs viewpoint. The study's findings are expected to provide a professional framework for people interested in developing school-based anti-stigma programs. Exploring local perspectives is critical because the formation of mental health stigma is greatly influenced by geographical, cultural, and belief factors, both positively and negatively [22], [25].

According to the study, mental health stigma is prevalent in Indonesian junior high schools. However, mental health services were limited. Although health centers and the health department have already provided mental health services in schools, such as a program to detect early MDs and drug prevention programs, the services were not distributed evenly across all schools. A recent study found that stigma against people with MDs was widespread in the Indonesian community, while treatment for them is currently insufficient. The country has the lowest psychiatrist-to-population ratio and limited mental health-care facilities [26], [27].

Adolescents have a common understanding of mental health, prone to stress, and potentially experience peer stigma [12]. Students with MDs experience negative personality labeling from their peers, including grumpiness, emotional difficulties, uncooperative, and danger [8], [28]. This situation was often referred to as public stigma [29], and its internalization was risky to violence, fear, exclusion, isolation, rejection, blame, and discrimination [26], as well as was possible to experience severe MDs [8].

To fight stigma, this study suggests not only applying mental health approach based on scientific theory, but it is also accurately combined with the religious approach. This result is consistent with the earlier study. A person correlation test indicated that religiosity negatively correlates with mental health stigma. It implies that the more students become religious and the less mental health stigma [30]. Therefore, the combination between mental health and religious approaches is crucial. This study identified that the mental health theory helps increase students' understanding, while the religious approach increases target group acceptance. In the mental health approach, the students should be introduced to what is mental health disorders, why they happen, what symptoms they have, and how to support them for recovery. This knowledge is expected to be able to clarify myths and stereotypes so that students' thinking about people with MDs will be more positive. While in the Islamic approach, the students should be taught about the Islamic perspectives on people with MDs to increase their awareness and acceptance.

The previous research found that using Western theory alone was insufficient to convince Muslim society to pay attention to their health [31]. Therefore, mixed approaches were considered effective in combating stigma among students. In implementing the mental health approach, involving health practitioners, health scholars, and internal and external stakeholders are

crucial to obtain the optimal result. Moreover, involving Islamic clerics or leaders in the Islamic approach was essential to increase acceptability. This was consistent with a previous study, which found that Islamic spiritual leaders (Imam) played an essential role in shaping the attitudes of families and communities, particularly toward MDs [31], [32], [33].

Aside from anti-stigma approaches, school-based anti-stigma implementation methods are essential in achieving optimal results. The informants in this study proposed three appropriate methods. First is the method for increasing students' comprehension (i.e., face-to-face teaching and video). These ways were both effective methods for increasing students' knowledge and understanding. Face-to-face teaching is most effective when it is appealing, delightful, nonjudgmental, and non-pushy. Meanwhile, the teaching content must be educational, capable of dispelling myths, correcting negative perceptions, increasing students' empathy, and suitable for the target group [34], [35].

Second is the method for increasing students' empathy (i.e., field trips, storytelling, and video). Field trips to a psychiatric hospital are valuable in improving students' empathy. Students will see how the patients were treated firsthand. Discussions with patients and health workers are also considered since they rectify the negative pre-assumptions that people with mental health disorders are dangerous, difficult to talk to and cooperate with, and unable to be cured. Similarly, storytelling and video to describe disease and treatment progression and expose patients' and their families' struggles to recover from MDs will raise students' self-awareness in maintaining their mental health while also improving their empathy. Storytelling was particularly effective in school-based anti-stigma campaigns since it needs a low-cost budget, can use simple messages, easy to adapt to local traditions, and can strengthen the target group's ability to assess their potential for managing better life in the future [36].

The third is the method to minimize the adverse effects of mental health stigma (i.e., counseling and self-help groups). The previous research showed that internalizing stigma led to the loss of self-esteem and self-efficacy, which allowed people with MDs to feel insecure, inferior, withdrawn, avoid social contact, and refuse treatment. However, the externalization of stigma led to marginalization and discrimination [5], [37]. The informants recommended self-help groups (SHG) and counseling to anticipate the internalization and externalization of stigma. SHG has been used widely in mental health services. In the previous studies, SHG was confirmed to help stimulate the involvement and empowerment of people with MDs. The involvement can reduce symptoms and improve quality of life, whereas empowerment can boost self-confidence and self-esteem as a social control group, helps to detect early mental health issues, and protest stigmatizing behaviors among students.

In addition to SHG, counseling was recommended to eliminate the adverse effects of stigma. School counseling was necessary because students with MDs often refused professional help due to stigma [38]. School counseling in Indonesia has focused solely on academic issues without paying attention to students' mental health issues. However, the British Association for Counselling and Psychotherapy stated that counseling for students had some goals, such as solving developmental problems, increasing knowledge, resolving personal conflicts, and improving interpersonal relationships. Psychodynamic counseling based on psychotherapy was an excellent method to achieve the goals identified to strengthen academic identity while promoting students' welfare. The main emphasis in psychodynamic counseling was the students' early experiences, which were important in solving current problems. Through this condition, the counselor helped students understand their conflicts and what relates to the current situation. Furthermore, they discussed with the students what appeared to be happening and what was done to solve the problems. Furthermore, this type of counseling has been confirmed to have effective results in several previous studies [39], [40], [41].

In addition, it is also essential to pay attention to the anti-stigma information dissemination media. The informants recommended both printed (leaflets, brochures, booklets, posters, banners, pamphlets, and stickers) and electronic media (video and social media) as the tools. The previous research has also stated that leaflets, audio-visuals, brochures, booklets, posters, banners, and social media were effectively used in various fields of health promotion [42], [43], [44], [45], [46]. However, care must be taken in producing and conveying anti-stigma messages because psychological reactance was identified as one of the obstacles. This occurred when these messages threatened autonomy and created hostility [47], especially information related to culture and beliefs, such as using religious guidance in anti-stigma interventions. Discussions with religious leaders or experts should be carried out with great care to avoid misunderstanding or harassment. Therefore, anti-stigma messages are crucial to educate, increase understanding, and be persuasive and flexible by not threatening identity, culture, and beliefs. In addition, there is always an opportunity for the target group to make their own decisions freely and independently.

School-based anti-stigma interventions are not only aimed at students. Internal and external stakeholders related to the school should be identified as the target group for the anti-stigma campaign while also being asked to participate in fighting mental health stigma. Targeting principals, teachers, and administration staff as the change agents in the fight against stigma were critical. They must function as both educators and social control. However, the informants

proposed families, religious leaders or Islamic clerics, school committees, prospective teachers, and the education and health authorities as external targets and partners in implementing school-based anti-stigma. Therefore, cooperation between internal and external stakeholders is crucial in fighting against students' stigma.

Since families are a source of stigma, their targeting and involvement in intervention programs are essential. Stigma caused by families against students with MDs was often shown in the form of excessive worry, paternalism, and humiliation because these attitudes were considered to interfere with the development (maturity) and self-control (mastery) of adolescents (Moses, 2010; Winters *et al*., 2018). However, targeting and engaging school committees, education, and health authorities were also essential to encourage them to make good policies and allocate adequate funds to support school-based anti-stigma programs.

Given that mental health stigma still exists among students, very important for schools and other relevant stakeholders to take appropriate and effective actions in combating student stigma. The selection of anti-stigma information content based on the target group is also critical, such as the selection of information that can dispel myths and stereotypes. Similarly, using appropriate methods to implement school-based anti-stigma programs is critical to optimizing outcomes. Furthermore, a cross-sectoral and cross-program collaboration involving internal and external stakeholders is an effective strategy for stigma reduction. Therefore, researchers need to make anti-stigma interventions based on local culture and beliefs and conduct experiments to assess the efficacy of interventions.

The study's limitation is that the participants did not clearly distinguish between Islamic teaching methods and doctrine. While they are both different. The Islamic teaching methods refer to the methods used to disseminate anti-stigma interventions from an Islamic perspective, whereas the doctrine refers to the Islamic beliefs about their god.

Conclusion

Adolescents with MDs are frequently stigmatized by their peers. Schools, as places where adolescents spend the majority of their social time, must be aware of the issue and take proactive steps to reduce peer stigma. School-based anti-stigma with health and religious approaches is crucial for increasing effectiveness and acceptance. This initiative must be directed to debunk myths, raise awareness and empathy, and reduce the harmful effects of stigma. The target group, collaboration partner, information contents, and implementation methods are some important factors must be considered in program implementation.

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