Buletin Psikologi
Volume 31, Nomor 2, 2023: 231 – 246
DOI: 10.22146/buletinpsikologi.77298
ISSN 0854 - 7106 (print)
ISSN 2528-5858 (Online)

An Indigenous Psychology Perspective for Mental Health Services and Research in Indonesia

Yulius Yusak Ranimpi*[1]
Merv Hyde[2], Florin Oprescu[2]
[1]*Universitas Kristen Satya Wacana Salatiga, Indonesia,* [2]*School of Education, University of the Sunshine Coast-Australia,* [3]*School of Public Health, University of the Sunshine Coast-Australia*

Submitted 25 August 2022 **Accepted 3 February 2023** **Published 18 December 2023**

Abstract. Due to a lack of focus and practice, mental health issues in Indonesia have received little attention. Moreover, cultural, religious, economic, and local factors determine perceptions of mental health and poverty. To examine these issues, Indigenous Psychology was carried out as a perspective and narrative review that accompanies its research methods. To reach the goals of this study, some of the most important results are described in this report, particularly the state of affairs and context of mental health studies and offerings in Indonesia, the intertwining of mental health with a way of life and poverty, the hyperlink between mental health and poverty, how indigenous psychology as a new paradigm in the field of psychology plays a role in reading mental health issues, and the challenges confronted by indigenous psychology in contributing to mental health studies and offerings in Indonesia. In conclusion, this examination indicates that mental health must be viewed as a socio culturally built phenomenon. The praxis consequence is that in public policy making, such as studies in the area of mental health, this locality variable has to be a good consideration.

Keywords: indigenous psychology; mental health; poverty

Introduction

People living in remote and poor areas generally have poor health. Living in such areas is often fraught with limitations regarding accessible medical facilities, food, medical and healthcare professionals, transportation, financial and economic conditions, and the populations level of health knowledge. In his 2001 address to the World Health Assembly, UN Secretary-General Kofi Annan stated, The greatest adversary of health in the developing world is poverty. In addition to conditions that affect physical health, there are major concerns about mental health conditions in developing nations. (GBD 2019 Mental Disorders Collaborators, 2019) discovered that between 1990 and 2019, the global number of

*Address for correspondence: yulius.ranimpi@uksw.edu

Copyright ©2023 The Author(s). This is an Open Access article distributed under the terms of the Creative Commons Attribution License (https://creativecommons.org/licenses/by-sa/4.0/)

DALYs (Disability-Adjusted Life-Years) due to mental disorders increased from 808 million (95% UI 595 – 1,059) to 1,253 million (930 – 1,632), and the proportion of global DALYs attributed to mental disorders increased from 31% (95% UI 24 – 39) to 49% (39 – 61). Age-standardized DALY rates remained generally stable between 1990 (15,812 DALYs [11,709-20,614] per 10,0000 people) and 2019. YLDs accounted for the majority of the mental illness burden, accounting for 1,253 million YLDs (95% UI 930 – 1,632; 146% [122-168] of global YLDs) in 2019. Eating disorders were responsible for 17 361 5 YLLs (95% UI 15 518 5 – 21 4598). On a global scale, the age-standardized DALY rate for mental disorders was 14265 (95% UI 10564 – 18695) per 100000 population for men and 17,033 (12,615 – 22,378) per 100,000 population for women.

In Indonesia, mental health has long been ignored (Polls, 2020). The impacts of the environment (social, political, climatic, ecological, and economic) on a population's mental well-being are complicated. People in many parts of Indonesia have suffered deprivation and misery as a result of social unrest, poverty, or natural calamities for many decades, and also suffer from mental health issues that range from minor psychological distress to major mental diseases (Ministry of Health, 2018).

Method

The research method used in this study was a narrative review. This method is a systematic, explicit, and reproducible method for identifying, evaluating, and synthesizing research results and ideas that have been produced by researchers and practitioners (Snyder, 2019). The objectives of this review are, 1) to provide a theoretical background for indigenous psychology research on mental health issues in Indonesia, 2) to study the depth of mental health issues in Indonesia or the breadth of existing research, and 3) to propose some policy considerations to the Indonesian Government that are related to mental health issues.

The steps taken by researchers in applying this method are 1) selecting topics to be reviewed, that is, research themes that have been identified in Indonesia on mental health issues, and 2) tracking, identifying, and selecting literature that is appropriate to the research topic. 3) analyze the selected literature and 4) apply the results of the analysis to writing. Several keywords were used to search for related research articles, including mental health, mental health services, government policy on mental health, indigenous psychology, and mental health.

Results

Mental Health Services and Research in Indonesia

Despite growing awareness of the importance of mental health among national policymakers, less than one percent of all healthcare funds are spent on mental health services and mental health is not listed as a priority for the country's network of primary healthcare centers (Puskesmas) (Good et al., 2013). From a broader perspective, the issue of mental health in Indonesia has not received attention from

the government or the public. At the legislative level since 1966, Indonesia did not have any specific legislation regarding mental health; however, in July 2014, the Indonesian government passed specific legislation that regulated mental health issues. This shows that there is a long time lag, which can be used as an indicator of the government's lack of attention to mental health issues.

In terms of facilities, there were only 32 government-owned and 16 private psychiatric hospitals. Not all provinces had psychiatric hospitals. Psychiatric hospitals are usually located in the provincial capital, which is a serious problem for provinces or regions that are isolated or remote in terms of accessibility. Of the 441 government general hospitals, only 15 had service and psychiatric wards, while of the community health centers totaling 9,000, only 1,235 provide mental health services. Similar conditions have occurred in health centers, with only 1,235 health centers providing mental health services for approximately 9,000 health centers (Anna, 2012; Idaiani, 2010; Radiani, 2019). Another significant issue in Indonesian mental health is the availability of human resources. Existing human resources in mental health services remain genuinely concerning. The number of mental health professionals involved is extremely limited. On the one hand, the number of psychiatrists is 616 and about 200 of them live in Jakarta and surrounding areas, on the other hand, the number of clinical psychologists in Indonesia is very low, at about 400 people (Anna, 2012; Idaiani, 2010; Radiani, 2019) compared to 240 million Indonesian people. Most psychiatrists and clinical psychologists live in Java or other large cities.

For the first time, in 2007, the Indonesian Government conducted national research on the health sector, including mental health issues. Based on the respondents compliance and the interviewer's observation, the national prevalence of the severe mental disorder is 0.5%, and seven provinces have the highest prevalence above the national prevalence average: Aceh, West Sumatera, South Sumatera, Bangka Belitung, Riau Islands, Jakarta, and West Nusa Tenggara. Based on the Self-Reported Questionnaire, a mental-emotional disorder in people aged 15 years was 11.6%, and 14 provinces had the highest prevalence above the national prevalence average: Aceh, West Sumatera, Riau Islands, Bangka Belitung, Jakarta, West Java, Central Java, East Java, West Nusa Tenggara, East Nusa Tenggara, Central Sulawesi, South Sulawesi, Gorontalo, and West Papua (Ministry of Health, 2008).

The second national research in the health sector was conducted in 2010, but did not assess mental health conditions in the population, but only reported physical health conditions related to the Millennium Development Goals. This was despite the Nations (2009) publishing a policy note linked to the MDG, which mentioned health as a multidimensional concept, including mental health aspects. Additionally, in 2010, the World Health Organization and Department of Economic and Social Affairs published a UN (DESA)-WHO Policy Analysis, which listed mental health as an emerging development issue that should be integrated into all development efforts, including DG's. Unfortunately, these imperatives do not seem to have attracted the attention of the government, so mental health is still not included as part of the assessment. In 2018, the Ministry of Health conducted another Basic Health Research (Riskesdas), which showed that approximately 9.8% or about 26 million out of 267 million people in Indonesia live with "mental-emotional disorders" or mental health conditions. The prevalence of severe mental disorders in the Indonesian population

is approximately 7% per mile, and the highest number is in Bali, Yogyakarta, West Nusa Tenggara, and Aceh. Meanwhile, mental-emotional disorders with symptoms of depression and anxiety amounted to 9.8% for those aged 15 years and over and were most prevalent in Central Sulawesi, Gorontalo, East Nusa Tenggara, and Maluku (Ministry of Health, 2018). Thus, at least through a snapshot of mental health services and research conducted by the Indonesian government, we can see how little attention the Indonesian government has paid to this issue.

Discussion

Culture and Mental Health

If some people in Indonesia are randomly asked about their mental health, generally, the answer remains the same, which is related to crazy people (orang Gila-Bahasa Indonesia), or a person who cannot think and behave as most people in their environment. In other words, an understanding of mental health is close to insanity, abnormality, disorder, or equivalent to mental disorders (Handayani, 2022). Of that notion, it is reasonable if the handling of mental health issues, both at the individual and community levels, is never proper (WHO, 2001). These circumstances are reasonable because of the lack of knowledge, which leads to a lack of effort to socialize on this issue.

According to World Health Organization, mental health is defined as subjective well-being, self-actualization, emotional stability, perceived self-efficacy, and resilience (WHO, 2001). As cited by the WHO (WHO, 2005), three areas of mental health have been identified. First, mental health involves an individual's self-realization and allows them to fully exploit their potential. Second, mental health includes a sense of mastery of individuals over their environment, and finally, positive mental health means autonomy, as in individuals with the ability to identify, confront, and solve problems. Of the various definitions, it seems that the mental health definition contains relativity or, in David Mechanic terms, internally no clear or consistent meaning (Scheid & Brown, 2010). The WHO further states that the well-being of an individual is encompassed in the realization of their abilities, coping with the normal stresses of life, productive work, and contribution to their community (WHO, 2005). The importance of mental health has been recognized by WHO since its origin and is reflected by the definition of health in the WHO Constitution as not merely the absence of disease or infirmity, but rather, a state of complete physical, mental and social Ill-being (Svalastog et al., 2017; WHO, 2001).

It is important to recognize that there are two different approaches to differentiating between mental health and mental illness. First, mental health and mental illness fields are in terms of a continuum, with health and illness at opposite ends of the poles with most falling somewhere in between. The latter approach defines health and illness as opposites, forming a dichotomy such that one is either sick or ill, and that one will fit into a specific disease category once specific symptoms are identified (Scheid & Brown, 2010). Measurements such as the International Statistical Classification of Diseases and Related Health Problems (ICD) 10 by the World Health Organization or Diagnostic and Statistical Manual of Mental Disorders (DSM) by the American Psychiatric Association are manifestations of the second approach and are often used to categorize a person experiencing a

mental disorder. The problem is the definition and categorization (which originally came from the Western) do not consider the context, which in this case, is the culture-of person who has a different culture, as argued by Eshun and Gerung, that the assumption of the Diagnostic and Statistical Manual of Mental Disorders Text Revision DSMIV-TR and the International Classification of Diseases ICD-10 categorization of mental illnesses applies to all people also stems from a universalist perspective (Eshun & Gurung, 2009). This notion presupposes that psychological principles derived from research in Western societies can be directly applied to non-Western cultures, which is not necessarily the case. According to Barret et al, much of psychology appears to have produced a deep commitment to the view that behaviors, mental states, and even people themselves are determined by deep and unchanging internal forces, at least in Western psychology to identify mental states, behaviors, and traits as natural entities that "cut nature at their joints," often without considering the influence of the environment (Barrett et al., 2010). In other words, internal variables take precedence over external influences, in this example, the environment, in understanding a person's mental state.

A holistic perspective is required to understand mental health. In general, there are three main factors to consider: biological, psychological, and social. As stated by Danziger the first and second factors have been studied more often than the previous ones. A third factor is still a new approach, although the thesis on the importance of context was put forward by Wilhelm Wundt. He stated that social and cultural context is a necessary contribution to each person's mental life (Danziger, 1983).

In terms of health, culture influences how individuals manifest symptoms, communicate their symptoms, cope with psychological challenges, and are willing to seek treatment (Eshun & Gurung, 2009). As cited by Eshun and Gerung, Castillo identified several ways culture influences mental health, that is 1) An individual's personal experience of the disease and its associated symptoms, 2) How individuals express their experiences and symptoms in light of cultural norms, 3) How to interpret and diagnose manifestations, and 4) How is mental illness treated and what is the eventual course? (Eshun & Gurung, 2009). Therefore, what may be called mental illness (and mental health) by one culture or person may be regarded as natural behavior by another (Thompson, 2007).

Culture and Poverty

The primary objective of some social scientists, particularly economists, is to measure and understand one's status in poverty and illness primarily through income, consumption, and, to some extent, human welfare. According to other social scientists, poverty is an individual's powerlessness to attain a basic level of health, such as being able to obtain an education or becoming healthy, that enables them to attain a fundamental level of personal well-being. However, other social scientists, particularly sociologists and anthropologists, have focused on the social, behavioral, and political underpinnings of human beings (Wagle, 2002).

Brady claims that there are at least three approaches to the concept of poverty, that is 1) Individual actions that are influenced by incentives and culture are the focus of behavioral theories, 2) Structural theories focus on the demographic and labor-market factors that influence behavior and poverty, and 3) According to political theories, power and institutions generate policy, which causes

poverty and modifies the relationship between behavior and poverty (Brady, 2019).

In practice, the most commonly used approach is the one that has standard criteria (as a universal standard), as used by the World Bank or by the Central Bureau of Statistics and Planning Agency of Indonesia. The problem is when standards are used on a group of people who have an understanding of different cultural standards to categorize the poor and non-poor, or those who have no concept of poverty (Friedmann, 2010).

Therefore, the definition of poverty using the subjective poverty approach, which emphasizes one's opinion about the concept and conditions of poverty that they understood and experienced, must be considered. This approach is based on the assumption that poverty is a social phenomenon and its existence is subjective and influenced by context-in this case the culture is a source of meaning, identity, and aspiration, sometimes as a source of oppression and inertia, always as a dynamic, permeable, heterogeneous, incomplete, and contested set of interrelated social structures, practices, assets, and beliefs (Alkire, 2002).

As opposed to challenging the criterion that focuses on basic needs identification, this method would look into what John Finnis refers to as determining the causes of behaviors that do not require further explanation (Alkire, 2002). This identity can be used by any mature individual of any culture, social background, or educational level who asks himself or herself. "Why do I do what I do?" is as important as "Why do other people do what they do." According to this view point, a person reflects on their own life experiences, historical circumstances, connections, projects, hobbies, beliefs, and the lives of people they know in order to comprehend the purpose or value of various activities (Alkire, 2002).

Mental Health and Poverty

Globally, there is a strong link between povertyăand healthăstatus in the least developed countries. Life expectancy is just 49, and 1 in 10 of her children will not reach her first birthday. In contrast, high-income countries have a life expectancy of 77 years and an infant mortality rate of 6 per 1000 live births (WHO, 2002).ăSome studies have shown a link between poverty and the emergence of mental health problems, such as common mental disorders that are about twice as frequent among the poor as among the rich and are also more prevalent for people living in poor and overcrowded housing (Patel, 2001; Patel et al., 1999). Patel and Kleinman (2003), which was also supported by research from Knifton and Inglis (2020) which was also supported by research from (Funk et al., 2012; Knifton & Inglis, 2020) showed an association between poverty and common mental disorders in some developing countries, including Indonesia, as shown in the table below:

Table 1
The Association Between Poverty and Common Mental Health Disorders in Developing Countries (Funk et al., 2012; Knifton & Inglis, 2020; Patel & Kleinman, 2003)

Country	Income group	Sample (n, setting)	Measures of psychiatric morbidity	Prevalence of common mental disorders	Association with indicators of poverty
Brazil (10)	Upper middle	621, Urban	2 stage using SRQ and clinical diagnostic	Not reported	Low education <5 years (OR 3.3, P <0.001); less than ij minimum wage (OR 3.9, P <0.02)
Brazil (11)	Upper middle	1041, Urban	CIDI	Major depression: 8.2%(1 month), 10% (1 year)	No schooling vs >9 years (OR 3.9, P <0.001); not working currently (OR 3.6, P <0.001)
Brazil (12)	Upper middle	1277, Urban	SRQ	22.7% (women 26.5%, men 17.9%)	No education vs school completion(OR 4, P <0.001); low household income (OR 1.76, P <0.001)
Chile (13)	Upper middle	3870, Urban	CISR	26.7% (women 35.2%, men 17.3%)	Primary education vs higher education (OR 3.4, P <0.01); low social class vs highest (OR 2.7, P <0.01); unemployed vs full-time employed (OR 2.5, P <0.01)
Indonesia (14)	Low	1670, rural Sumatra	2-stage design using GHQ and PSE	GHQ case rates: 20%	Less than primary education (OR 1.47, P <0.01); no electricity (OR 2.2, P <0.001); no tap water (OR 1.7, P <0.001)
Lesotho (15)	Low	356, rural	1 stage using DIS	22.7% (women 23.5%, men 14.7%)	No association of education with specific diagnoses (panic disorder, generalized anxiety disorder, major depressive disorder, and education
Pakistan (16)	Low	515, remote rural	2 stage, BSI and clinician diagnostic interview	Women 46%, men 15%; 22% weighted total sample	Literate men and women had lower BSI rates (P <0.05); negative, non-significant correlations with socioeconomic factors

Table 1 (Continued)

The Association Between Poverty and Common Mental Health Disorders in Developing Countries (Funk et al., 2012; Knifton & Inglis, 2020; Patel & Kleinman, 2003)

Country	Income group	Sample (n, setting)	Measures of psychiatric morbidity	Prevalence of common mental disorders	Association with indicators of poverty
Pakistan (17)	Low	664, rural	2 stage with BSI/SRQ followed by clinician interview	Women 66%, men 25%	Inverse relationship with years of education, total household income, and number of electrical appliances (P <0.05)
Pakistan (18)	Low	259, rural	2 stage with SRQ/PHQ followed by PAS	44.4% (women 57.5%, men 25.5%)	Not passed primary school (OR 3.7, P <0.01);experience of financial or housing difficulty(OR 4.4, P <0.01)
Pakistan (19)	Low	269 mothers, urban slum	1 stage locally developed anxiety and depression scale	28.8%	Husband unemployed (OR 4.1, P <0.005);irregular wages (OR 1.8, P <0.02); arguments with husband for economic reasons(OR 10, P <0.001)
Zimbabwe (20)	Low	172 women, urban township	2 stage with a screening questionnaire and PSE	15.7% (1 month), 30.8% (1 year)	Unemployment (OR 2.9, P <0.02); below-average income (OR 2.2, P <0.02); overcrowding (OR 2.1, P <0.02); not passed school (OR 3.4, P <0.01)

That table shows that ten studies showed a statistically significant relationship between prevalence and indicators of poverty, the most consistent relationship being and a low educational level. A few other pointers have been utilized to evaluate destitution, counting low wages, theăneed forămaterial belonging, theăneed forăwork, and lodging challenges (Patel & Kleinman, 2003). Although the majority of research found a substantial link between low income and common mental disorders, we were unable to draw firm conclusions about this trend in the case of income, in part because many of the studies that found links did not employ multivariate analysis. Relative poverty, abrupt income fluctuations, negative life events, and stress related to low income may be better predictors of mental health status than absolute poverty, especially when controlling for other variables. Additionally, this study discovered that people with CMD may be more prone to fall into

poverty because of stigma, less social support, lost jobs, decreased productivity, and increased health costs (Patel & Kleinman, 2003).

Nevertheless, the relationship between poverty and mental health remains questionable (Das et al., 2007). They concluded that poverty itself is not a strong deciding factor in poor mental health and the weakening investment in mental health issues due to the assumption of the serious threat of communicable diseases (Hanandita & Tampubolon, 2014).

Indigenous Psychology and Mental Health

Why it should be universal

As we have seen, social forms have customarily served as a single section in a significant list of phenomena beneath study (Gergen et al., 1996). This claim implies that culture has been treated as an important aspect of understanding the human mind and behavior. In this regard, Gergen et al. (1996) noted that there are two fundamental ways in which culture plays into psychological research reasoning, neither of which supports broad competent conjecture. When viewed as a field of contrasts, culture often serves the same logical function as the study of identity, namely, as a mediator or qualifier for hypothetical propositions with a broader scope. Thus, a vigorous scientist should propose a general theory of learning, motivation, memory, perception, and so on, in which case cultural variations serve only to qualify the character of the processes in varying contexts. Cultural variations were either deemphasized or simply bracketed for later studies. In the second mode of study, culture provides grounds for the universality of general theory. For example, the investigator sought to demonstrate the universality of emotional categories (Gergen et al., 1996). In this idea, culture is a secondary concern because cultural distinctiveness impedes progress toward the wider goal of study. The majority of research focuses on how much more common psychological phenomena, such as perception, cognition, emotion, motivation, self, attribution, conformity, or dissonance, change "across culture (Adams & Markus, 2004).

Overall, indigenous psychology has been considered as a counterpoint to mainstream psychology, which has assumed Western psychology (Allwood, 2002; Allwood & Berry, 2006) because it contained individualism, while this was a bias branded (Danziger, 2006). Indigenous psychology, according to Allwood and Berry (2006), has been produced in many countries and continents over the last 30 years and stands up to mainstream psychology in seeking and reflecting on the social, political, and cultural character of people all over the world. This method should be distinguished from other types of culture-oriented psychology, such as cultural and cross-cultural psychology. The primary distinction between indigenous psychology and the other two is the resolve of indigenous psychology to employ cultural resources in the development of psychological science.

Based on the assumption that understanding human beings rely on their ability to perceive and construct the world as a strategy to survive, indigenous psychology places humans in interaction with their environment as the main actors that construct their world. This approach posits that human beings can construct their world. This ability allows humans to develop constructs during their existence. Knowledge and reality are psychological and social phenomena constructed by humans. As

psychological perspectives evolve, social institutions also evolve (Raskin, 2008). Raskin (2008) added that people's knowledge is constructed based on their experience, and the external world of the real is presupposed, but never truly known.

In this line of thinking, research on poverty and mental health (especially in a multicultural setting such as Indonesia) must be conducted in terms of local people's knowledge of their particular environment. In terms of knowledge, indigenous psychology wants to claim that the truth is contextually owned, experienced, believed, and lived by a human being.

The Challenge of Indigenous Psychology in Indonesia

Psychology emerged in the Western world under a positivist worldview. Theories and their proponents have originated in the Americas and Europe throughout the history of psychology. As a result, positivism is a popular strategy for investigating mental health issues and poverty (Wieser, 2020). This method requires that social phenomena are sufficiently precise and widespread. Many indigenous, local, or community groups in poor nations find the technique problematic since it may not be relevant to health policy or understandable among indigenous cultures. As a result, indigenous psychology believes that it is critical to explore the complex connections between sociocultural contexts, poverty, and mental health. According to this point of view, mental health is inextricably linked to economic, social, cultural, spiritual, and anthropological factors such as hunger, impoverishment, malnutrition, social transformation, violence, and dislocation.

Indigenous psychology, according to Kim and Berry (1993), brings established psychological theories into question and aims to identify psychological universals in social, cultural, and ecological contexts. Indigenous psychologists examine people's knowledge, abilities, and beliefs about themselves and how they function in familial, social, cultural, and ecological contexts. As psychological and social phenomena, mental health and poverty serve as jumping-off places for generating ideas, concepts, and approaches to address the thesis's issues.

Some research, for example, Buckner et al. (2004), and Fitzpatrick et al. (2005), have looked at the connection between mental health and poverty or other socioeconomic problems. The indigenous psychology perspective can account for the diversity and variances observed across communities in developing countries, as well as better describe poverty and mental health and their relationships in an indigenous setting and environment. In this context, Indonesia has drawn strength from its cultural diversity. The contributions of various racial and ethnic groups have covered all aspects of contemporary life. Diversity has made a country a more open society, blazing amazing ideas, perspectives, and innovation. However, the full potential of this diverse, multicultural society cannot be realized until the most marginalized Indonesians, including those of diverse racial and ethnic origin, from remote areas and in endemic poverty gain access to quality health care that meets their well-being needs. Through indigenous psychology, cultural aspects regained attention in understanding human beings in their particular context.

Indigenous Psychology and Mental Health Services and Research In Indonesia

As explained above, the development of indigenous psychology in Indonesia is a form of ontological critique that mistakenly places multicultural Indonesian humans into the container of universalismin this case, the paradigm of positivism. Positivist approaches often presuppose social phenomena as being relatively exact, measurable, or universal. Based on their powerful political, economic, and cultural influences, Western nations would seem to promote the widespread acceptance of Western psychiatry and psychology, frequently fostering a pseudo-global and relatively homogenous approach within these disciplines (Marsella & Yamada, 2010).

This plural context is the basis for the construction of Indonesian human entities with multiple identities. This can be seen in marriages between different cultures or religions (Faturochman, 2008). Therefore, it is not surprising that in Indonesia, there are many individuals with multiple identities, which ultimately contribute to shaping the distinctiveness or uniqueness of Indonesian people.

Departing from this uniqueness, the development of indigenous psychology has specific implications, namely sharpening doubts about the significance and implementation of the universal discipline of psychology. Thus, the multiple cultures in Indonesia should be a context that needs to be given special attention, which is not only local or emic but also placed in the Indonesian context. For example, research conducted by Oetami and Yuniarti (2011) examined the happiness orientations of male and female high school students. From the perspective of indigenous psychology, this research can question how happiness orientation can be a representation of Indonesian society, considering that the research was conducted in the context of the Javanese culture. Another study conducted by Ranimpi (2008) on the conflict between mining companies and local communities in Papua showed how an indigenous understanding of the local community's way of thinking can be an entry point for the construction of contextual conflict resolution.

Consequently, it appears relevant from the position of indigenous psychology, a relatively recent science, to explore the interrelationships among many socio-cultural circumstances surrounding the issues of poverty and mental health. According to this viewpoint, economic, social, cultural, spiritual, and anthropological circumstances such as poverty, famine, and malnutrition; societal transformation; violence; isolation; and displacement are intrinsically linked to mental health. Therefore, indigenous psychology is well-placed to promote evidence-based and culturally contextualized research within its theoretical and practical framework. For example, in poverty alleviation and healthcare management, it would seem appropriate if policy and care delivery leaders and planners could spend some time in a remote community using some of the methods described here to develop their understanding of the community involved (Shepherd, 2000). They could then enter into forms of planning and service delivery that are better integrated with local traditions and understanding. Improved efficacy was anticipated, local traditions were respected, and knowledge capital was retained. In addition, to develop a more comprehensive understanding of health issues in traditional communities, efforts should be made to integrate a variety of sociocultural values and medical and psycho-medical techniques (Igboanusi, 2014). Medical workers must be able to comprehend the potential impact of cultural influences on health reporting, as well as the social, cultural, and spiritual contexts in which

health and well-being are meaningfully constructed, enacted, and responded to (Ipa et al., 2020).

In this case, the writing of (Mustika, 2016) on elderly health policy based on local wisdom, suggests that the government re-evaluate and or conduct several alternative policies regarding the development of elderly health by paying attention to local wisdom in each region that they may live in well-being and not become a burden in the development of the nation. On the contrary, Massie (2009) reminded us that many decision-makers in the health sector do not use research results as empirical evidence because they are often based on other considerations, including the culture and politics of the community. Therefore, in health policymaking, it is necessary to combine the opinions and expectations of the community with those of policymakers. The opinions and expectations of the community towards the policyholder or decision-maker ensure that the community is not confused by the policy that will be issued. Confused by the policy that will be issued, and may not be beneficial.

It is the responsibility of the government to ensure that pertinent issues are prioritized for action, including how resources are allocated, which strategies are chosen, andmost cruciallywhich local stakeholders retain or share authority over decisions and their implementation.

Conclusion

Currently, as in other non-Western countries, applied approaches to psychology are substantially rooted in Western cultures. This approach is not always adequate for explaining human characteristics, particularly in certain esoteric Indonesian cultural contexts. Even the most appropriate of these psychological approaches, cultural and cross-cultural psychology, do not seem able to provide comprehensive explanations of the phenomena under study. Therefore, a different approach was applied in this article to indigenous psychology to better understand the responses of a remote indigenous community to the challenges of poverty and mental health. Based on its potential to better reveal and analyze human cultural characteristics and their influences on behavior and life patterns, indigenous psychology seems to play an important role in Indonesia for the development and implementation of appropriate policies and practices that are informed by the contexts of the local communities. Such an approach could contribute to strengthening ties among Indonesia's diverse cultural communities and provide potential solutions for social conflict and dissonance.

In conclusion, indigenous psychology requires at least two main points to gain a holistic understanding of mental health issues and their relationship to poverty. First, this concept should be put into cultural framing and will be treated not only as a psychological phenomenon but also as a social phenomenon. Second, as social phenomena, mental health, and poverty are socially constructed by people within their interactions with the worldview. This understanding will not be stable or fixed, but it can change depending on people's abilities as meaning-makers.

The perspective of indigenous psychology seems to have the capacity to account for the diversities and differences found among communities in developing countries and to better identify the conceptions of poverty and mental health and the relationships between them in indigenous contexts and social and organizational settings. The research that has produced this article has

been approved by the Human Research Ethics Committee of the University of the Sunshine Coast (A/14/660).

Recommendation

This studi recommends the following things. 1) Healthcare workers could seek to recognize and acknowledge cultural diversity and increase their awareness of and sensitivity to cultural values that are held both within their own culture and other cultures. They can spend time in remote communities and improve their understanding of affected communities. This will help introduce forms of planning and service delivery that are better integrated with local traditions and ideas. Effectiveness can be improved; local traditions are respected, and knowledge capital is preserved. 2) There ought to be attempts to integrate a range of sociocultural values, and medical and psycho-medical methods to gain a more holistic understanding of health issues in traditional communities. Healthcare workers need to be able to understand the potential that cultural influences may have on health reporting and how health and well-being are meaningfully constructed, enacted and responded to socially, culturally, and spiritually, and 3) Training and professional development should include some grounding in indigenous psychology principles and also provide healthcare workers with research models that are sensitive to the understanding of the social, cultural, and spiritual values and practices of people living in remote and traditional communities.

Declaration

Acknowledgment

The authors would like to express their gratitude to all who have supported the publication of this paper: the Indonesian Government (DIKTI), the Rector and Dean at Universitas Kristen Satya Wacana, the University of the Sunshine Coast, and our family.

Funding

This research received external funding from DIKTI (444/E4.4/K)

Author Contribution

Conceptualization: YYR; methodology: YYR; writing original draft preparation: YYR; supervision: MH, FO; review and editing: YYR, MH, FO

Conflict of interest

This article has no potential conflict of interest with any person or institution. All the researchers agreed with the final manuscript.

Orcid ID

Yulius Yusak Ranimpi https://orcid.org/0000-0001-9336-1144

Merv Hyde https://orcid.org/0000-0001-6402-8334

Florin Oprescu https://orcid.org/0000-0003-1342-3566

References

Adams, G., & Markus, H. (2004). Toward a conception of culture suitable for the social psychology of culture. In M. Schaller & C. Crandall (Eds.). Lawrence Erlbaum Associates, Inc. Publishers.

Alkire, S. (2002). Dimensions of human development. *World Development*, *30*(2), 181–205. https://doi.org/10.1016/S0305-750X(01)00109-7

Allwood, C. M. (2002). Indigenized psychologies. *Social Epistemology*, *16*(4), 349–366. https://doi.org/10.1080/0269172022000064621

Allwood, C. M., & Berry, J. W. (2006). Origins and development of indigenous psychologies: An international analysis. *International Journal of Psychology*, *41*(4), 243–268. https://doi.org/10.1080/00207590544000013

Anna, L. (2012). *Gangguan jiwa masih diabaikan [Mental disorders are still ignored*. Retrieved February 11, 2012, from http://regional.kompas.com

Barrett, L. S., Mesquita, B., & Smith, E. R. (2010). The context principle. In B. Mesquita, L. S. Barrett, & E. R. Smith (Eds.), *The mind in context*. The Guilford Press.

Brady, D. (2019). Theories of the causes of poverty. *Annual Review of Sociology*, *45*(1), 155–175. https://doi.org/10.1146/annurev-soc-073018-022550

Buckner, J. C., Beardslee, W. R., & Bassuk, E. L. (2004). Exposure to violence and low-income children's mental health: Direct, moderated, and mediated relations. *American Journal of Orthopsychiatry*, *74*(4), 413–423. https://doi.org/10.1037/0002-9432.74.4.413

Danziger, K. (1983). Origins and basic principles of wundt's völkerpsychologie. *British Journal of Social Psychology*, *22*(4), 303–313. https://doi.org/10.1111/j.2044-8309.1983.tb00597.x

Danziger, K. (2006). Comment. *International Journal of Psychology*, *41*(4), 269–275. https://doi.org/10.1080/00207590544000031

Das, J., Do, Q.-T., Friedman, J., McKenzie, D., & Scott, K. (2007). Mental health and poverty in developing countries: Revisiting the relationship. *Social Science Medicine*, *65*(3), 467–480. https://doi.org/10.1016/j.socscimed.2007.02.037

Eshun, S., & Gurung, R. A. R. (2009). Introduction to culture and psychopathology. Blackwell Publishing.

Faturochman. (2008). Model-model psikologi kebhinnekatunggalikaan dan penerapannya di Indonesia [Psychological models of diversity and their application in Indonesia].

Fitzpatrick, K. M., Piko, B. F., Wright, D. R., & LaGory, M. (2005). Depressive symptomatology, exposure to violence, and the role of social capital among African American adolescents. *American Journal of Orthopsychiatry*, *75*(2), 262–274. https://doi.org/10.1037/0002-9432.75.2.262

Friedmann, J. (2010). Rethinking poverty: Empowerment and citizen rights*. *International Social Science Journal*, *48*(148), 161–172. https://doi.org/10.1111/j.1468-2451.1996.tb00070.x

Funk, M., Drew, N., & Knapp, M. (2012). Mental health, poverty and development. *Journal of Public Mental Health*, *11*(4), 166–185. https://doi.org/10.1108/17465721211289356

GBD 2019 Mental Disorders Collaborators. (2019). Global, regional, and national burden of 12 mental disorders in 204 countries and territories, 19902019: A systematic analysis for the Global Burden of Disease Study 2019. *The Lancet Psychiatry*, *9*(2), 137–150. https://doi.org/10.1016/S2215-0366(21)00395-3

Gergen, K. J., Gulerce, A., Lock, A., & Misra, G. (1996). Psychological science in cultural context. *American Psychologist*, *51*, 496–503. https://doi.org/10.1037/0003-066X.51.5.496

Good, B., Good, M. D., & Grayman, J. (2013). *New model for mental health care. In Indonesia*. http://www.insideindonesia.org/a-new-model-for-mental-health-care-2

Hanandita, W., & Tampubolon, G. (2014). Does poverty reduce mental health? An instrumental variable analysis. *Social Science and Medicine*, *113*, 59–67. https://doi.org/10.1016/j.socscimed.2014.05.005

Idaiani, S. (2010). Kesehatan jiwa di Indonesia dari deinstitusionalisasi sampai desentralisasi [Mental health in Indonesia from deinstitutionalization to decentralization]. *Kesmas: National Public Health Journal*, *4*(5), 203. https://doi.org/10.21109/kesmas.v4i5.170

Igboanusi, H. (2014). The role of language policy in poverty alleviation in west africa. *International Journal of the Sociology of Language*, (225). https://doi.org/10.1515/ijsl-2013-0066

Ipa, M., Puji Astuti, E., Ikawati, B., Wijayanti, T., Yulidar, Y., Ramadhan, N., Nurdjana, M. A., Rahayu, N., Yunarko, R., & Dwilaksono, A. (2020). Indigenous perspective of lymphatic filariasis in endemic region indonesia. *BALABA: Jurnal LITBANG Pengendalian Penyakit Bersumber Binatang Banjarnegara*. https://doi.org/10.22435/blb.v16i1.2648

Kim, U., & Berry, J. W. (1993). *Indigenous psychologies: Experience and research in a cultural context*. SAGE Publications Ltd.

Knifton, L., & Inglis, G. (2020). Poverty and mental health: Policy, practice and research implications. *BJPsych Bulletin*, *44*(5), 193–196. https://doi.org/10.1192/bjb.2020.78

Marsella, A. J., & Yamada, A. M. (2010). Culture and psychopathology: Foundations, issues, directions. *Journal of Pacific Rim Psychology*, *4*(2), 103–115. https://doi.org/10.1375/prp.4.2.103

Massie, R. G. A. (2009). Kebijakan kesehatan: Proses, implementasi, analisis dan penelitian [Health policy: Process, implementation, analysis and research]. *Buletin Penelitian Sistem Kesehatan*, *12*(4), 409–417.

Ministry of Health. (2008). *Report on national health research (2007)*.

Ministry of Health. (2018). *Report on the results of the National Health Research (RISKESDAS 2018)*.

Mustika, I. W. (2016). Membangun kebijakan kesehatan lansia berbasis kearifan lokal [Building an elderly health policy based on local wisdom]. *Jurnal Skala Husada: The Journal of Health*, *13*(1). https://doi.org/10.33992/jsh:tjoh.v13i1.70

Nations, U. (2009). *Policy note on implementing the millennium development goals: Health inequality and the role of global health partnerships*.

Oetami, P., & Yuniarti, K. W. (2011). Orientasi kebahagiaan siswa SMA, Tinjauan psikologi indigenous pada siswa laki-laki dan perempuan [Happiness orientation of high school students, a review of indigenous psychology for male and female students]. *HUMANITAS: Indonesian Psychological Journal*, *8*(2), 105. https://doi.org/10.26555/humanitas.v8i2.458

Patel, V. (2001). Inequality and mental health in developing countries. In D. Leon & G. Walt (Eds.), *Poverty inequality and health: An international perspective*. Oxford University.

Patel, V., Araya, R., de Lima, M., Ludermir, A., & Todd, C. (1999). Women, poverty and common mental disorders in four restructuring societies. *Social Science & Medicine*, *49*(11), 1461–1471. https://doi.org/10.1016/S0277-9536(99)00208-7

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Health Organization*, *81*, 609–615.

Polls, H. (2020). *The future of mental health care in Indonesia*. https://www.insideindonesia.org/the-future-of-mental-health-care-in-indonesia-6

Radiani, W. A. (2019). Kesehatan mental masa kini dan penanganan gangguannya secara Islami [Contemporary mental health and Islamic treatment of disorders]. *Journal of Islamic and Law Studies*, *3*(1). https://jurnal.uin-antasari.ac.id/index.php/jils/article/view/2659/pdf

Ranimpi, Y. (2008). The meaning of land from the amungme peoples perspective in indonesian modern life. *KRITIS: Jurnal Studi Pembangunan Interdisiplin*, *20*(1).

Raskin, J. D. (2008). The evolution of constructivism. *Journal of Constructivist Psychology*, *21*(1), 1–24. https://doi.org/10.1080/10720530701734331

Scheid, T. L., & Brown, T. N. (2010). Approaches to mental health and illness: Conflicting definitions and emphasis. In *Handbook for the study of mental health, social contexts, theories, and systems* (2nd). Cambridge University Press.

Shepherd, A. (2000). Governance, good government and poverty reduction. *International Review of Administrative Sciences*, *66*(2). https://doi.org/10.1177/0020852300662004

Snyder, H. (2019). Literature review as a research methodology: An overview and guidelines. *Journal of Business Research*, *104*, 333–339. https://doi.org/https://doi.org/10.1016/j.jbusres.2019.07.039

Svalastog, A. L., Donev, D., Jahren Kristoffersen, N., & Gajovi, S. (2017). Concepts and definitions of health and health-related values in the knowledge landscapes of the digital society. *Croatian Medical Journal*, *58*(6), 333–339. https://doi.org/https://doi.org/10.3325/cmj.2017.58.431

Thompson, M. (2007). *Mental illness*. Greenwood Press.

Wagle, U. (2002). Rethinking poverty: Definition and measurement. *International Social Science Journal*, *54*(171), 155–165. https://doi.org/10.1111/1468-2451.00366

WHO. (2001). *Mental health: New understanding, new hope*.

WHO. (2002). *Dying to change poor peoples experiences of health and ill health*.

WHO. (2005). *Promoting mental health: Concepts, emerging evidence, and practice*.

Wieser, M. (2020). The concept of crisis in the history of western psychology. Oxford University Press. https://doi.org/10.1093/acrefore/9780190236557.013.470