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PREFERRED COPING ACTIONS FOR ANXIETY AMONG PSYCHIATRIC OUTPATIENT WAITING ROOM VISITORS

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ABSTRACT
Anxiety and psychological disturbance are commonly managed through coping actions that reflect individual beliefs, social norms, and perceived accessibility of care. Understanding preferred actions in routine service environments such as psychiatric outpatient waiting rooms is important to support culturally sensitive mental health education and referral strategies. This study aimed to describe the most preferred action when experiencing anxiety or psychological disturbance among individuals present in a psychiatric outpatient waiting room. A descriptive cross-sectional survey was conducted in the waiting room of an outpatient psychiatric polyclinic at a mental hospital. Respondents consisted of patients, accompanying family members, and nurses who were present during the data collection period. A total of 100 respondents were recruited using a convenience sampling technique. Data were collected using a self-administered questionnaire that recorded age category, education level, and one most preferred coping action when experiencing anxiety or psychological disturbance. Data were analysed using descriptive statistics. Religious worship and spiritual practices were the most frequently preferred action, selected by 50% of respondents. Ruqyah was chosen by 20%, professional help seeking through psychologists or psychiatrists by 15%, self-management meditation by 9%, and visiting a traditional healer by 6%. Adults represented the largest age category (55%), and senior high school was the most common education level (43%). Preferences for coping with anxiety in this setting were dominated by religious and spiritual practices, while professional help seeking was less frequently prioritised.

Keywords: anxiety; coping strategies; help seeking; ibadah; religious coping; ruqyah

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INTRODUCTION

Anxiety disorders are widely recognised as a major contributor to disability and reduced quality of life, with consequences that extend to family functioning, social participation, and work productivity. Global estimates indicate a very large burden of anxiety disorders and a persistent treatment gap, meaning many people who would benefit from care do not receive it, even when effective interventions exist (Chatterji et al., 2018). These conditions often present with fluctuating symptoms and ambiguous somatic complaints, which can encourage people to interpret distress through nonclinical frameworks and to try familiar coping options before approaching mental health services.

Help seeking for psychological distress is shaped by perceived severity, trust in providers, financial and geographic access, and the expectation of being judged. Stigma remains a central barrier, influencing whether symptoms are disclosed and whether professional care is considered

acceptable, while negative attitudes can also exist among health-related groups, potentially affecting the wider social climate around referral and engagement (Pankey et al., 2023). Religious coping is frequently chosen because it is accessible, socially legitimate, and can support meaning making and emotional regulation. Evidence syntheses suggest religiosity and spirituality can be relevant to prevention and management approaches for anxiety, although study quality is mixed and findings vary by population and setting (Aggarwal et al., 2023).

Waiting rooms in psychiatric outpatient services offer a practical setting to describe coping preferences because patients, accompanying relatives, and healthcare staff share the same space and may carry different assumptions about what counts as an appropriate response to anxiety. Descriptive information about what people prioritise as a first action during anxiety or psychological disturbance in routine service environments remains limited, even though these preferences may shape subsequent care pathways and readiness to accept referral. This study aimed to describe the most preferred action when experiencing anxiety or psychological disturbance among individuals present in a psychiatric outpatient waiting room, including nurses, using a survey of 100 respondents and reporting the frequency distribution across spiritual practices, ruqyah, professional help seeking, meditation based self-management, and use of a traditional healer.

METHOD

Study design

A descriptive cross sectional survey design was applied to capture the distribution of preferred actions when experiencing anxiety or psychological disturbance.

Setting

Data collection took place in the waiting room of an outpatient psychiatric polyclinic at a mental hospital. The waiting room was selected because it gathers patients, accompanying relatives, and healthcare staff in a routine service environment where coping preferences are actively discussed and enacted.

Participants and sampling

Participants comprised individuals who were present in the waiting room during the data collection period and who agreed to participate, including nurses. A total of 100 completed questionnaires were obtained and analysed. Inclusion criteria were age sufficient to understand the questionnaire and willingness to provide responses. Exclusion criteria were inability to communicate effectively at the time of data collection due to acute distress or other conditions that prevented completion of the questionnaire.

Instrument and variables

A brief self-administered questionnaire was used. Respondents reported education level and age category, then selected one action considered most appropriate when experiencing anxiety or psychological disturbance. Five response categories were provided. Category one comprised religious worship and spiritual practices such as dhikr, ṣalat, Qurʾan recitation, khalwah, and doa. Category two comprised ruqyah, understood as Qurʾanic healing recitation. Category three comprised professional help seeking through psychologists or psychiatrists. Category four comprised self-management practices including meditation. Category five comprised visiting a traditional healer. The primary study variable was the selected coping category, recorded as a single choice.

Data collection procedure

Questionnaires were distributed to eligible individuals in the waiting room and completed anonymously. Participation was voluntary, and respondents were informed that responses would be used only for research purposes. No personally identifying information was collected.

Data analysis

Analysis used descriptive statistics. Frequencies and percentages were calculated for each demographic category and for each preferred coping action. Results were presented in tables and supported by brief narrative descriptions focused on observed distributions.

Ethical considerations

Participation was voluntary and based on informed agreement. Anonymity and confidentiality were protected by avoiding any identifiers and by reporting aggregated results only.

RESULT

A total of 100 respondents completed the questionnaire. Respondent characteristics were summarised by age category and education level, followed by the distribution of preferred actions during anxiety or psychological disturbance.

Respondent characteristics

Age categories showed a predominance of adults. Adults accounted for 55 respondents, followed by young adults with 25 respondents. Older adults and adolescents each accounted for 10 respondents. Education levels showed that senior high school was the most common level, reported by 43 respondents. Junior high school followed with 23 respondents, while 16 respondents reported primary school and 14 respondents reported a bachelor's degree. No formal schooling was reported by 4 respondents.

Table 1.
Respondent characteristics n equals 100

Respondent characteristics	f	%
Age category		
Older adults	10	10
Adults	55	55
Young adults	25	25
Adolescents	10	10
Education level		
Bachelor's degree	14	14
Senior high school	43	43
Junior high school	23	23
Primary school	16	16
No formal schooling	4	4

Preferred actions during anxiety or psychological disturbance

Preferred actions were concentrated in religious worship and spiritual practices. This option was selected by 50 respondents. Ruqyah was selected by 20 respondents. Professional help seeking through psychologists or psychiatrists was selected by 15 respondents. Self-management meditation was selected by 9 respondents. Visiting a traditional healer was selected by 6 respondents. Ranking of preferences placed religious worship and spiritual practices first, ruqyah second, professional help seeking third, self-management meditation fourth, and traditional healer fifth.

Table 2.
Preferred actions during anxiety or psychological disturbance n equals 100

Preferred Action	f	%
Religious worship and spiritual practices	50	50
Ruqyah	20	20
Professional help seeking	15	15
Self-management meditation	9	9
Traditional healer	6	6

Distribution of responses indicated that 70 respondents selected either religious worship and spiritual practices or ruqyah, while 30 respondents selected options outside these two categories. Professional help seeking represented 15 respondents, meaning that formal services were selected less frequently than the combined religious and complementary categories reported above.

DISCUSSION

Religious worship and spiritual practices were the most frequently preferred response to anxiety or psychological disturbance in this study. Prior research has repeatedly described religious coping as a common strategy in settings where religion is socially embedded, partly because it offers meaning making, reassurance, and a sense of agency when distress feels uncertain or hard to control. Evidence synthesis in young people suggests religiosity and spirituality can be relevant to prevention and management efforts for anxiety and depression, while also highlighting that the evidence base is uneven across populations and that higher quality studies from low and middle income settings remain limited (Aggarwal et al., 2023; Alckmin-Carvalho et al., 2025; Francis et al., 2019). These findings support a conservative interpretation of the present result. A high preference for religious coping reflects what feels appropriate and accessible for respondents, yet it does not demonstrate clinical effectiveness or symptom reduction.

Ruqyah was the second most selected option, indicating that Qurʾanic healing recitation is perceived as a legitimate coping route for a substantial portion of respondents. Prior studies in Indonesia have explored ruqyah using quasi experimental designs. A study among health science students reported reductions in anxiety, stress, and depression scores following ruqyah sessions, although the sample was specific and the design limits causal inference beyond the study context (Arifuddin et al., 2018). The present survey did not measure symptom severity, diagnosis, prior experiences, or whether respondents combined ruqyah with other actions, so the current data should be read as preference mapping rather than evidence that ruqyah works better than alternatives. A sceptical reading also matters here. Preference for ruqyah may reflect explanatory beliefs about distress, social endorsement, and expectancy effects, all of which can shape perceived helpfulness even when outcomes are not objectively measured.

Professional help seeking through psychologists or psychiatrists ranked third. This result is compatible with the broader pattern that many people who need care do not receive treatment, despite the availability of effective interventions. Prior Indonesian research on stigma toward mental health problems suggests stigma can negatively shape attitudes and behaviour, including tendencies to hide problems or delay engagement with services (Ariana, 2018; Doll et al., 2021; Radez et al., 2021). A plausible interpretation is that professional care may be positioned as a later option, reserved for situations perceived as severe, persistent, or socially unavoidable. Another possibility is pragmatic barriers such as time, cost, or uncertainty about what professional treatment entails. The presence of nurses among respondents could also influence the distribution, yet the study design did not separate nurses from patients and relatives, so the data cannot clarify whether the 15 percent reflects patient reluctance, staff preferences, or a mixture of both.

Meditation based self-management was chosen by a minority. Prior evidence on mindfulness based interventions, including online delivery formats, suggests modest benefits for anxiety symptoms among adults, although effect sizes vary and adherence is a recurring challenge (Fumero et al., 2020; Haller et al., 2021; Reangsing et al., 2023). Low preference in the present setting may reflect limited familiarity, perceived mismatch with local norms, or lack of guidance, rather than rejection of the underlying idea of self-regulation. Traditional healer visits were the least selected option. A psychiatric hospital environment may prime biomedical interpretations and reduce endorsement of traditional healing compared with community-based samples, so this proportion should not be generalised to wider populations without additional evidence.

Several limitations help explain why the discussion should remain descriptive. Convenience sampling in a single waiting room limits representativeness. Respondents were heterogeneous and included nurses, which likely introduced role-based differences in beliefs and knowledge that cannot be disentangled here. The questionnaire used a forced single choice response, whereas real world coping is often multi component, such as praying while also seeking professional support.

Symptom severity was not assessed, making it impossible to test whether certain preferences cluster among those with higher clinical need. Social desirability is also plausible, since reporting religious coping in a public setting may feel safer and more socially valued than reporting other options.

The findings still carry practical relevance for service delivery. Waiting rooms can become a site for brief mental health literacy messages that acknowledge religious coping as meaningful, while clarifying when professional assessment is indicated, for example persistent impairment, panic like episodes, comorbid depressive symptoms, or thoughts of self-harm. Referral communication that frames professional care as complementary rather than competing with religious practices may reduce perceived conflict and increase acceptability, especially when stigma and uncertainty remain barriers to care seeking.

The results of the study showed that most respondents chose worship and spiritual practices as the main action when experiencing anxiety or psychological disorders. These findings align with literature showing that religious coping remains a primary reference point in highly religious socio-cultural contexts. In various Muslim groups, practices such as dhikr (remembrance of God), prayer, and Quranic recitation are chosen because they are easily accessible, non-stigmatizing, and aligned with collective norms. They also provide a sense of calm, meaning, and divine protection amidst the stresses of daily life and severe crises (Bukhori et al., 2022; Rutledge, 2025).

Ruqyah as the second most dominant option illustrates the strong belief in a complementary religious healing approach, which is understood to work alongside modern medical therapy, not replace it (Rachman et al., 2025). Within the framework of Islamic belief, anxiety disorders and psychological problems are often interpreted not only as medical problems, but also as indications of spiritual imbalance or the presence of non-physical disorders, so that ruqyah is positioned as an effort to restore the spiritual dimension while seeking inner peace (Sarwar, 2025). Experimental and case studies have indeed reported a decrease in anxiety scores or psychological symptoms after ruqyah intervention, both in the context of patients attending ruqyah clinics and students and students who underwent ruqyah as Islamic psychotherapy (Fadilah, 2019).

The choice to seek professional help through a psychologist or psychiatrist came in third place, with a relatively lower proportion compared to religious practices. This pattern is consistent with literature showing that stigma, the assessment that symptoms are not severe enough, and limited mental health literacy and understanding of professional service pathways are key barriers to seeking formal help (Renwick et al., 2024). Berbagai kajian menjelaskan bahwa rasa malu, takut dinilai negatif, keraguan terhadap manfaat layanan, serta rendahnya pengetahuan tentang di mana dan bagaimana mengakses bantuan membuat individu lebih memilih koping mandiri atau bantuan non-profesional meskipun mengalami gejala yang signifikan (Elshaikh et al., 2023).

Self-management through meditation was chosen by a small percentage of respondents. This low preference is likely related to limited knowledge, lack of exposure to mental health-based meditation practices, or a perception that the method is less aligned with local values and customs. Multiple studies have shown that mindfulness-based interventions consistently contribute to reduced anxiety symptoms across diverse populations, including cancer patients, adolescents and young adults, and adults in the general community (Zhou et al., 2020).

Visiting traditional healers was the least preferred choice in this study. This finding may be influenced by the data collection location, which was within a mental hospital, which indirectly shaped respondents' mindsets toward medical and religious approaches over traditional practices. This distribution of preferences cannot be generalized to the broader community population without considering the context of the location and the characteristics of the respondents.

Several limitations should be considered when interpreting the results of this study. The use of convenience sampling and data collection at a single location limited the representativeness of the sample. Furthermore, respondents came from a heterogeneous group, including patients, family caregivers, and caregivers, making it impossible to analyze differences in background knowledge and experience separately. The instrument's single-choice approach also fails to capture the complexity of coping strategies, which in practice may be implemented simultaneously. Nevertheless, the results of this study provide a relevant baseline for developing a culturally and religiously sensitive approach to mental health communication and education.

CONCLUSION

This descriptive survey identified that religious worship and spiritual practices were the most frequently preferred action when respondents experienced anxiety or psychological disturbance in a psychiatric outpatient waiting room, followed by ruqyah, professional help seeking, meditation based self management, and visits to a traditional healer. The pattern is consistent with prior literature suggesting that religiosity and spirituality can shape coping and may be integrated into anxiety related prevention and management efforts, although the quality and context of evidence vary across settings. Low preference for professional help seeking should be interpreted cautiously, because stigma and social attitudes have been shown to discourage engagement with mental health services in Indonesia. The findings support the use of culturally sensitive mental health literacy and referral communication in outpatient environments, acknowledging religious coping while clarifying indications for timely professional assessment.

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