PSYCHOSOPHIA
Journal of Psychology, Religion and Humanity

Homepage : ejurnal.lp2msasbabel.ac.id/index.php/psc
E-ISSN : 2721-2564
Issue : Vol. 4, No. 1, April (2022)
DOI : https://doi.org/10.32923/psc.v4i1.1851
Publisher : Department of Islamic Psychology
IAIN Syaikh Abdurrahman Siddik Bangka Belitung, Indonesia

MENTAL HEALTH LITERACY AMONG UNIVERSITY STUDENTS IN SEMARANG CITY

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Abstract: *Increasing mental health problems in Indonesia is not followed by mental health literacy in the community, especially college students. The way people perceive mental health and disorders is closely related to their culture. This study aimed to capture university students' perceptions in the city of Semarang regarding mental health and disorders also attitudes towards psychological help. This study was conducted using generic qualitative methods, with open-ended questionnaires and focus group discussions. The participants of this study were 88 undergraduate university students aged 21-25 years old recruited through accidental sampling. The data analysis used were coding and categorization. The results showed that 1) the participant includes aspects of spirituality in terms of mental health, 2) the word "stress" is associated with crazy or severe mental disorders, 3) depression is perceived as a continuation of stress or mild anxiety, 4) the participant tends to have a negative attitude to professional psychological help and prefer informal source of help such as family and religious to overcome the problems experienced and emphasizing autonomy in solving problems, and 5) low accessibility to psychological services, insufficient knowledge of psychological services nearby, and tariffs of psychological services were external factors that affect the less favorable attitude towards psychological help.*

Keywords*: mental health literacy, university student, religiosity, autonomy, depression, stress*

Abstrak: Meningkatnya masalah kesehatan jiwa di Indonesia tidak diikuti dengan literasi kesehatan jiwa di masyarakat khususnya mahasiswa. Bagaimana seseorang memandang kesehatan mental dan gangguan jiwa terkait erat dengan budaya mereka. Penelitian ini bertujuan untuk mengetahui bagaimana persepsi mahasiswa di kota Semarang tentang gangguan kesehatan jiwa dan sikap terhadap bantuan psikologis. Penelitian ini dilakukan dengan menggunakan metode kualitatif umum, dengan kuesioner terbuka dan diskusi kelompok terfokus. Partisipan penelitian ini adalah 88 mahasiswa S1 berusia 21-25 *tahun* yang direkrut melalui *accidental sampling*. Analisis data yang digunakan adalah pengkodean dan kategorisasi. Hasil penelitian menunjukkan bahwa 1) partisipan memasukkan aspek spiritualitas dalam kesehatan mental, 2) kata "stres" dikaitkan dengan gangguan jiwa gila atau berat, 3) depresi dipersepsikan sebagai lanjutan dari stres dan kecemasan ringan, 4) partisipan cenderung memiliki sikap negatif terhadap bantuan psikologis profesional dan lebih memilih sumber bantuan informal seperti keluarga dan agama untuk mengatasi masalah yang dialami dan menekankan otonomi dalam memecahkan masalah, dan 5) rendahnya aksesibilitas ke layanan psikologis, pengetahuan yang tidak memadai tentang layanan psikologis di dekatnya, dan tarif jasa psikologis merupakan faktor eksternal yang mempengaruhi sikap kurang mendukung terhadap bantuan psikologis.

Kata kunci: *literasi kesehatan mental, mahasiswa, relijiusitas, otonomi, depresi, stres*

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Submitted Date : July 08, 2021
Review Date : July 14, 2021
Revised Date ; February 02, 2022
Accepted Date : April, 04, 2022

Introduction

Mental health problems in Indonesia were increasingly attracting the attention of both public and the government. The prevalence of households with psychotic mental disorders is 6.7% while for non-psychotic mental disorders such as depression is 6.1% and mental emotional disorders is 9.8% (Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI, 2018). Indeed, mental health is an integral part of health, although in many countries it is not yet considered as important as physical health. Although often ignored, mental health problems are common throughout the world (Alemu, 2014).

Studies related to mental health literacy in Indonesia was considered insufficient. The results of studies also tend to show inconsistent results due to differences in measurement methods. The results of the study by Idham, Rahayu, & As-Sahih (2019) on about 500 participants through the Mental Health Literacy scale showed that about 54% of participants had high mental health literacy, while according to Novianty (2017), out of 89 respondents only about 20% respondents who were able correctly identify psychological disorders described through vignette. Furthermore, according to Afifah (2016) with a qualitative method among 32 health workers including nurses and midwives at primary health care, showed to have low mental health literacy. This can be seen from the lack of ability to recognize symptoms of mental disorders and lack of interest in improving their abilities in mental health literacy. This condition indicates that more research is needed regarding mental health literacy in Indonesian society, especially with the discovery of many mental health problems, the lack of attention and care of people with mental disorders in Indonesia.

Studying mental health literacy was important not only because of the insufficient data, but also the level of literacy will predict number of positive results for society. Kelly, Jorm, & Wright (2007) indicated that high literacy of mental health will enable someone in identifying early signs of mental health problems and knowledge of where to find the available psychological help. Another study by Falasifah & Syafitri (2021) showed that mental health literacy among university students significantly predict favorable attitude towards seeking psychological help.

Theoretical Framework

According to Jorm (2012) mental health literacy is defined as "knowledge and beliefs about mental disorders that help a person's ability to recognize, manage, and prevent". The components of mental health literacy are a) knowledge about preventing mental disorders, b) recognizing the emergence of disorders, c) knowledge about options and available treatments, d) knowledge about self-help strategies for minor problems, and e) first aid skills for those with mental disorders or mental health crises.

On the other hand, understanding related to mental health literacy cannot be separated from culture. Ethnicity influences how help-seeking behavior and preferences for help, (e.g. many Chinese students prefer to get help from pharmacists), beliefs about discrimination and perceptions related to stigma (Am et al., 2007). In general, culture is conceptualized as something that is learned, changes over time, is cyclical, consists of behaviors that can and cannot be done, and is an important part in the process of adaptation and self-preservation.

Cultural norms and traits influence how a person thinks, responds to stress, and how comfortable he or she feels about expressing emotions. Culture includes ethnicity, race, religion, age, gender, family values, and many other features. Culture can also include similarities in physical characteristics such as skin color, psychological characteristics such as aggressiveness levels, and superficial features such as hairstyles and dress styles (Eshun & Gurung, 2009).

World Health Organization (WHO) confirmed that respondents from different countries reported sad mood, anxiety, tension, and lack of energy as the main symptoms of depression. Respondents from the west reported additional symptoms such as feeling guilty while respondents from the west added somatic complaints. The results of this study lead to the conclusion that vegetative symptoms of depression may be universal while feelings such as guilt may be related to cultural factors such as individualism and religion (Eshun & Gurung, 2009).

Culture influences how a person presents symptoms, communicates symptoms, copes with psychological challenges, and is willing to seek help. Furthermore, many experts state that culture and mental disorders are embedded in each other so that understanding the role of culture in mental health is very important to be able to accurately diagnose and intervene against disorders (Sam & Moreira, 2012). Furthermore Castillo (1997) shows several ways how culture affects mental health, namely:

1. A person's personal experience of the disorder and associated symptoms
2. How individuals express their experiences or symptoms in the context of existing cultural norms norma
3. How are the expressed symptoms interpreted and diagnosed
4. How mental disorders are treated and the results

Based on the explanation above, this study aimed to discover how the perceptions of the Indonesian people, in this case specifically university students in the city of Semarang, related to mental health and mental disorders according to their understanding and attitudes towards psychological help. It is important to know the level of mental health literacy and how students' attitudes towards psychological help can be determined in order to determine the most appropriate approach to improve mental health literacy in students.

Research Methodology

The research method employed in this study was generic qualitative approach. This approach was defined as study that has some or all of the qualitative approach characteristics but does not use particular viewpoint (such as case study, phenomenology, or grounded research) and generally focus in capturing experience or event (Caelli et al., 2003)

The data collection method in this study has two stages, the first stage is through an online survey using google forms link that is distributed via WhatsApp messenger to various chat groups with the criteria of non-psychological students. In the second stage, the method used was focus groups discussion (FGD) on three groups of students from three different universities. FGD is a form of qualitative research in which the interviewer (also known as the moderator) asks each participant specific questions related to the topic or issue in the group discussion. In the FGD there is a need for guidelines to provide a framework

for moderators to ask questions and conduct probing (Wong, 2008).

Participants
The participants in this study were university students chosen with the accidental sampling method, where anyone who met the sample criteria could be a participant in this study.
Participant criteria in this study:
1. Undergraduate students
2. Not a student majoring in psychology

Data Collection Instruments
1. Online Survey
   This survey contains questions related to the identity of the respondents (occupational status, area of origin, domicile, age, and education), then seven open-ended questions related to mental health literacy are as follow: 1) understanding mental health, 2) understanding stress, 3) understanding anxiety, 4) understanding depression, 5) psychological help options, 6) knowledge of where to meet psychologists, and 7) knowledge nearest psychological services
2. Focus Group Discussion
   In focus group discussions, the questions asked were similar to online surveys which were 1) understanding of mental health, 2) understanding of common mental disorders such as stress, anxiety, and depression, 3) knowledge of psychological help options, 4) knowledge of psychological services nearby and deepened in the psychological help aspect, for example knowledge of psychologists' tasks and willingness to get psychological help from professionals.

Data Collection Procedure
The first stage was online survey which distributed through WhatsApp group chats. After that, groups students from three universities which were Semarang State University, University of PGRI Semarang, and Sultan Agung Islamic University were chosen to join the focus group discussion. These universities were chosen due to researcher's convenience and access towards the students.

Data Analysis
The stages of data analysis were using qualitative data analysis sequence, in which first was verbatim transcripts of focus group discussions and then followed by coding and categorization of both survey and verbatim results. The categorization process in this study used word proximity, word associations, and semantic meaning.

Results

Table 1. Demographic Information of Online Survey Participants

Information		Number
Age		
	18-21	60
	22-24	11
Place of Origin		
	Central Java	63
	East Java	1
	West Java	4
	Papua	1

	Padang (West Sumatera)	1
Total		71

Table 2. Demographic Information of FGD Participants

a. University of PGRI Semarang (W1)

Name (initial)	Department	Age	Sex
DT	Early Child hood Education	22	Female
AY	Mathematics Education	22	Female
NG	Elementary Teacher Education	22	Female
NV	Indonesian Language Education	22	Female
ID	Mathematics Education	22	Female
DV	Mechanical Engineering	25	Male

b. Semarang State University (W2)

Name (initial)	Department	Age	Sex
CT	Literature and Art	22	Female
TT	Literature and Art	22	Female
TK	Literature and Art	22	Female
JN	Literature and Art	22	Female
SR	Literature and Art	22	Female

c. Sultan Agung Islamic University (W3)

Name (initial)	Department	Age	Sex
FB	Law	23	L
SH	Communication	22	L
EW	Communication	21	L
AG	Planology	20	L
AL	Planology	21	P
SK	Nursing	20	P

1. Survey Categorization

a. Mental health

Answers	Frequency
Mention other terms (health of soul or psychological health)	27
Religious health	6
The ability to communicate and social skills	5
The condition is free from burdens, calm, and serene	5
The condition of not feeling guilty	4
Inner health	3

Normal behavior	3
Mental condition is good or not	3

b. Stress

Answers	Frequency
Conditions where there is excessive pressure from internal or external	24
The state of mind is chaotic because of a problem/burden of the mind so that it is unable to control the mind or find a solution	15
Experiencing many problems and failures	7
Mental/mental disorders or mental illness	5

c. Anxiety

Answers	Frequency
Fear of things to come which may not necessarily happen	22
Negative feelings in the form of anxiety or worry	17
Too worried	13
Overthinking	7
Physical complaints (tension, heart beat faster)	3

d. Depression

Answers	Frequency
Conditions that are more severe following stress or anxiety	30
Conditions under tremendous pressure	10
Desperate (pessimistic and don't want to live anymore)	5
Loss of interest or excitement	5
Sad for a long time	4
Problems piling up and can't find a solution	3

e. Knowledge of Available Help for Psychological Problems

Answers	Frequency
Psychologist	40
Psychiatrist	22
Close people (friends/trusted people)	15
Parents	12
Allah	10
Ustadz (Islamic religious figure)	3
Counselor	3

f. Knowledge of Where to Meet Psychologist

Answers	Frequency

Do not know	23
Know	48

g. Knowledge of Nearest Psychological Service

Answers	Frequency
None	19
Yes, I know	26
No, I do not know	26

2. Categorization Results of FGD

The categorization results entailed with code which were S, number, and W. The word S was referred to participant in FGD, for example S2 referred to participant number 2, while number referred to the line number of verbatim transcripts, and W referred to group of discussion which W1 represent University of PGRI, W2 represent Semarang State University, and W3 represent Sultan Agung Islamic University.

Based on the analysis, 8 categories of responses were emerged ranged from the knowledge of mental health and common mental health disorders (stress, anxiety, and depression), help-seeking options when facing psychological problems, knowledge of professional psychologist, knowledge of where to seek for psychological help, and the willingness to seek help to psychologist.

No	*Categories*	*Sub-category*
1.	Knowledge of mental health	1. Mentioning other terms of mental health: a. Crazy (S6, 13, W1) b. Mentally health (S1, A1, 2-3, S2, 10-12, W3) c. Related to mental condition (S4, A1, 8-9, W3) 2. Cognitive Aspects a) Able to think logically, use reason (S5, 31-32, S3, 29-30; W2; S2, 14-16, W3) b) Able to solve problems, realistic (S1, 36-39, 103) c) Positive thinking (S2, 21, W2; S3, 18-21, S5, 23-25, W3) d) Disorders of the mind (S6, 7, W1) 3. Emotional Aspects: 1) Emotions are in accordance with conditions and can regulate the deep of

No	*Categories*	*Sub-category*
		their feelings (S1, 13-19, S2, 22-24, S4, 26, W2) 2) Experiencing positive emotions (S5, 27-29, W3) 3) Inner pressure, has a problem but is kept to himself (S5, 14-17, W1) 4. Behavioral Aspects: Can control behavior when things go wrong (S5, 37-39, W3) 5. Social Aspects: No social barriers (S5, 27-29, W3) 6. Physical Aspects: Physically healthy (S5, 27-29, S3, 18-21, W3) 7. Spiritual Aspects: a) Spiritual health (S3, 18-21, W3) b) Regularly doing prayers (S3, 18-21, W3)
2.	Knowledge of Stress	1. Excessive pressure: thoughts, pressure, a lot of unfinished work, unfinished problems (S2, 39-40, W1; S5, 42-42, W1), (S1, 432; S3, 447; S2, 449, W2), (S3, 444, W3), (S3, 37, W1), (S2, 451-454, W3) 2. Crazy (not dressed properly, never take a shower, not cared for, on the side of the road) (S5, 423, W2), (S2, 461-462; S5, 480-482; S1, 498, W3) 3. Negative responses in social interaction (being quiet, the answer does not match the question, easily irritated) (S1, 496; S6, 484; S1, 440-441; S5, 471-475, W3), (S5, 427-428, W2) 4. Emotional change: Easily angry (S3, 448; S6, 486; S2, 463-467, W3) Sad (S5, 418-419) 5. Unclear activities: Confused (S4, 440, W2) Restless and not focus (S2, 450-453, W2) 6. Barriers in social relationships: a) Lazy to do activities, do not care about the surroundings (S3, 446-447, W2) b) Withdrawing, aloof (S2, 463-467, W3)
3.	Knowledge of Anxiety	1. Feelings of worry/anxiety that arise when faced with certain situations: a) Facing tight situations (S4, 47, W1) b) Facing uncertain, unclear situations (S2, 48, W1; S1, 50, W1), (S5, 539-540, W3)

No	*Categories*	*Sub-category*
		c) Facing something scary in the future (S1, 458-462; s4, 498-490; s4, 502,W2) 2. Emotion Aspect: a) Feeling anxious (S1, 53, W1; S6, 57, W1) b) Not confident (S1, 467, W2) c) Worried, afraid, afraid of being wrong, afraid of saying the wrong thing (S1, 510, W3; S6, 546-551; S5, 539-540, W3; S2, 481, W2) 3. Cognitive: a) Not thinking clearly (S1, 466; S3, 488, W2) b) Confused about choosing (S3, 524-532, W3) 4. Physical: a) Cold sweats (S1, 469-474, W2; S5, 539-540, W2) b) Raised voice pitch (S1, 469-474, W2) 5. Behavior: a) Unable to control themselves (S1, 505-509, W3) b) Restless (S5, 490, W2) c) Hastily making decisions (S5, 490, W2)
4.	Knowledge of depression	1. Too many thoughts (S6, 61, W1) 2. Continuation of accumulated stress The pressure that is higher than stress, anxiety, and excessive stress (S2, 65-66, W1; S2, 558-560, W3; S5, 529, W2) 3. The condition of not being able to achieve the desired outcomes (S5, 71-73, W1) 4. Emotions: a) Feeling useless (S5, 75, W1) b) Feeling hopeless (S1, 519; S2, 526, W2) c) Feeling sad (S2, 524; S5, 529, W2) d) Mood disorders (S4, 577-580, W3) 5. Social barriers: a) Self-isolation (S3, 510, W2) b) Often daydreaming, absent-minded (S3, 506-508, W2) c) Communication difficulties (S4, 513-514, W2) d) Lazy to do activities (S3, 582-584, W3) 6. Cognitive: Can't think clearly, can't think logically, can't make the right decisions (S4, 513-514, W2; S3, 591-592, W3; S2, 558-560, W3)

No	*Categories*	*Sub-category*
		7. Self-destructive and suicidal behavior (S3, 582-584, W3; S2, 564-566, W3; S4, 577-580, W3)
5.	. Help-seeking behavior when experiencing psychological problems	1. Share (venting): Tell stories to the closest people (parents, family, friends, friends, relatives) (S5, 100, W1; S1, 105, W1; S3, 114, W1; S6, 136, W1); (S3, 171-175, 177, 184-185; S4, 202-203; S1, 259, W2); (S1, 274-278; S3, 336-342; S6, 402-418, W3) 2. Trying to solve the problem alone: a) Being alone (S2, 116, W1); (S5, 292, W2); (S5, 390-393, W3) b) Introspection (S6, 402-418, W3) c) Self-affirmation and self-talk that can solve problems (S2, 374-378, W3); (S5, 390-393, W3) d) Trying to solve it yourself (S6, 133, W1) 3. Catharsis: Crying (S5, 112, W1); (S4, 342, W2) 4. Passive activities: Sleep (S5, 112, W1); (S5, 390-393, W3) 5. Active activities: a) Doing some activities (S2, 119, W1) b) Watching humor show (S1, 272, W2) c) Reading positive content on social media, reading books (S4, 202-203, W2) d) Face the problem head-on (S4, 311, W3) 6. Religious help: a) Doing prayers (S5, 121, W1) b) Ask Allah for help (S4, 202-203; S4, 214; S1, 250; S5, 290-291; S2, 336), (S3, 317-324, W3) c) Draw closer to Allah (S2, 374-378, W3) d) Meet the ustadz (S3, 317-324, W3)
6.	Understanding the psychologist professional	1. Solving problems: Solve problems/help solve problems (S4, 142, W1), (S6, 606; S4, 618, W3), (S1, 579; S2, 567-568; S4, 554-556, W2) 2. Provide service: a) Listening to clients (S4, 149, W1) b) Identify problems, understand clients, provide solutions (S1, 151-152, W1)

No	*Categories*	*Sub-category*
		c) Dealing with psychiatric problems/disorders (S2, 596-600, W3), (S5, 576; S1, 581, W2) d) Giving test (S2, 559-560, W2) e) Providing consultation (S2, 570, W2) f) Expert in the field of psychology/psychologist (S5, 604; S3, 609, W3), (S5, 549, W2) 3. Understand the differences between psychiatrists and psychologists: psychiatrists from medicine and psychologists from psychology graduates (S2, 596-600, W3), (S2, 559-560, W3)
7.	Knowledge of where to look for psychological help	1. Don't know (all, W1, W3) 2. Difficult to find a psychologist (S1, 584, W2) 3. In Counseling Guidance Study Program (S5, 154, W1) 4. Psychiatric hospital (S3, 592; S4, 594; S5, 599, W2) 5. Seminar (S2, 621, W3), (S4, 594, W2)
8.	Willingness to seek psychological help	1. Depending on the type and severity of problem: a. Depending on the problem, if it is severe and cannot be resolved alone, go to psychologist (S5, 172, W1), (S4, 686-688, W3), (S4, 643; S3, 629-630, W2) b. Willing to go to a psychologist, have had a psychological test previously (S6, 167-169, W1) 2. Choose to solve the problem yourself: Solve it yourself (S4, 176, W1), (S3, 666-668, W3) 3. Familiarity factor (perceived psychologist is a foreigner): a. Embarrassed to share the problem (S5, 156-158, W1) b. Fear of adding to the burden of others (S5, 160, W1) c. Not comfortable telling stories to strangers (S2, 162, W1; S3, 164, W1), (S2, 607-608; S5, 612-615, W2) 4. Perception of tariffs: a. Have to pay expensively (S1, 177-179, W1), (S1, 618, W2) b. Want it for free (S2, 642, W3) 5. Other psychological help alternatives:

No	Categories	Sub-category
		a. Going to *pesantren* (S3, 666-668, W3) b. Solve problems with family, second alternative psychologist (S5, 690-692; S6, 703-706, W3) 6. Perception of distance: No psychologist nearby (S4, 640, W2)

Discussion

Based on the results above, it can be seen that the understanding of mental health from both the survey and FGD showed that most of the participants tend to mention other terms of mental health such as mental well-being or psychological health without being able to explain their meaning. Furthermore, on the notion of mental health, it can also be seen that the understanding of participants related to mental health is not yet holistic which includes various aspects of human psychology, but most of the answers tend to focus on only one psychological aspect so that six categories emerge to explain what mental health is. These six aspects are as follows: 1) cognitive aspects of mental health are seen as the ability to solve problems and think logically, 2) emotional aspects related to the ability to control emotions and experience various positive emotions, 3) behavioral aspects related to the ability to control behavior when things go wrong. desirable, 4) social aspects related to communication skills and interpersonal relationships, 5) physical aspects focused on physical health, and what may differ from other notions of mental health is the addition of 6) spiritual aspects in which mental health is associated with one's religiosity. The emergence of spiritual aspect might caused by the level of religiosity of the Indonesian people, especially students in the city of Semarang who are the participants in this study who were all Muslim. It is also supported by Hutapea (2014)'s study which showed that Indonesian students' religiosity score were in high category.

Furthermore, on the notion of stress, both survey results and FGD showed that some participants associate the word stress with "crazy" or experiencing mental disorders which were described as someone who does not wear proper clothes, was neglected, and was often on the side of the road. According to the Big Indonesian Dictionary, the word stress itself meant "*a mental and emotional disturbance or disorder caused by external factors; tension*" while the word "crazy" means "*sick memory (not good memory); mental illness (nerves are disturbed or his mind is not normal)*" and can also mean "*unusual: not as it should be*". Based on this, it can be seen that in Indonesian language, stress and crazy actually have two different meanings, where stress is a disorder while crazy is a mental illness or a more severe mental disorder condition. However, many Indonesians use the term stress to refer to people who are crazy or who have mental disorders. This also found by Rachmayani & Kurniawati (2017)'s study where some respondents reported using the word crazy or stress to describe mental illness. Not only that, this also found among Vietnamese society, where according to Chi, Thai, & Nguyen (2018) most of their respondents using the word "stress" to

describe depression and only one third of the respondents mentioned the depression term correctly. On the other hand, most of the participants were able to adequately explain what stress is, which is a condition in which a person experiences excessive pressure either due to internal or external problems. In addition, several participants responded that stress was a person's hampered communication, emotional changes (irritable or sad), and a chaotic state of mind.

In the sense of anxiety, the participants' answer is centered on fear or concern about something that will not necessarily happen or be scary in the future. Some participants also focused on the emotional aspects of anxiety, such as worrisome; cognitive aspects, such as not being able to think clearly; physical aspects such as physical changes due to anxiety, and behavioral aspects such as rushing to make decisions. In general, the participants' answer to the notion of anxiety is sufficient to accommodate the notion of anxiety in accordance with DSM V which states that the main features of anxiety are excessive fear of current conditions and anticipation of the future as well as behavioral disturbances and muscle tension as a result of these conditions (American Psychiatric Association, 2013).

To answer the notion of depression, the stood out responses from most of the participants was depression perceived as an advanced condition that is more severe than stress or anxiety that occurs due to accumulated stress conditions. It indicated that the participants did not understand the symptoms of depression well. Furthermore, some participants saw depression from the emotional aspect, which was the emergence of feelings of worthlessness, hopelessness, and loss of interest; from the social aspect such as the inhibition of social relationships such as confining oneself; the cognitive aspect such as not being able to think logically to find solutions, and the behavioral aspect which were destructive behavior and commit suicide. These results indicated that from an emotional, social, and cognitive perspective, in general, the depression perceived by the participant is relatively the same as the symptoms of depression that can be found in the guidance of depression diagnosis, except for the perception of depression as a continuation of anxiety. The study by Brintnell, Sommer, Kuncoro, Setiawan, & Bailey (2013) regarding the expression of depression in severely depressed patients in Java, also showed that there were six themes that emerged: 1) barriers in interpersonal relationships, 2) feelings of hopelessness, 3) physical complaints, 4) difficulty in thinking, 5) extreme sadness, and 6) loss of energy which was in accordance with the findings in this study except for the aspect of physical complaints.

On the aspect of attitudes towards psychological help, it can be seen that based on the survey results, most of the participants' responses when experiencing psychological problems were to seek help from health professionals such as psychologists and psychiatrists, followed by close people, parents, religious figures, and counselors. Knowledge related to seeking professional psychological help was also discovered by Rachmayani & Kurniawati (2017) which shows that 60% of the respondents said that people with mental disorders needed psychological and medical treatment and 32% needed rehabilitation and mental hospitals. Furthermore, in this study, most of the survey participants

also knew where to find a psychologist, although, for questions about psychological services nearby, most of the participants said they did not have any or did not know where to see a psychologist. This is also strengthened by the results of the FGD which showed that almost all participants did not know where to see a psychologist, some said they could meet a psychologist in a mental hospital or seminar. From this, it can be concluded that although they know that the treatment for mental disorders is through psychological and medical professionals, most of the participants in both the survey and FGD did not know where to get these psychological services.

When experiencing psychological problems, the highest option of help-seeking chosen by participants was sharing stories with the closest people (family and friends), the second is trying alone or autonomously to solve problems, for example by being alone, introspection, and self-affirmation. It followed by catharsis, doing activities, being passive, and finally seeking religious help such as worshiping, praying, meeting religious figures (ustadz). The general results of the study in people with collectivism culture and strong identification of religiosity show that they prefer to seek help from family or friends and religious figures. Religiosity contributes the most to the preference for seeking religious help (Crosby & Bossley, 2012). It also found by Am dkk., (2007) which shows that Chinese ethnic students in Australia indicate that they prefer to seek psychological help from non-professionals such as acupuncture, religious figures, healers, and so on. Furthermore, students in Vietnam also have a similar tendency where they prefer to seek help from family and friends, while health professionals were considered helpful but not as much as these informal sources. This due to tight social support and ties between family and friends that health professionals were considered less needed (Chi et al., 2018). Nonetheless seek help from informal sources was not necessarily negative behavior because it is the initial stage of the search process in the professional psychological help (Rickwood et al., 2007).

In addition to seeking help on informal sources as described above, the responses that stood out from the participants was autonomy or attempt to resolve their own problems. This may occur because the participants in this study were students who were in the early adult developmental stage, where at this stage the individual believed that they should be independent and free as to avoid relying on professional help. This belief corresponded to the process of individuation and the development of adult independence which was an important developmental task (Arnett, 2000). In the other hand, this can be become an important barrier in adolescents and early adults in seeking professional psychological help (Wilson et al., 2011).

Further, in the aspect of attitude towards psychological support shown by the participant FGD showed that most were reluctant to meet with a psychologist with because they wanted to solve problems on their own, not comfortable telling strangers, tariffs of psychologist considered expensive, not having a psychologist around, and choosing alternative problem solving such as seeking religious help or being resolved privately with family. Some participants were willing to go to a psychologist if the problems they face are considered severe and cannot be solved alone. In this aspect, the theme

of autonomy re-emerged, in the form of wanting to solve problems on their own and the preference for getting help from informal sources as an obstacle in attitudes towards psychological help. On the other hand, there were also external factors that hinder the search for professional psychological help, such as the limited availability of psychologist nearby and low accessibility of psychological services.

In general, psychotherapy or psychological services were considered to be a product of the west which emphasizes individual growth, so it is often considered incompatible with collectivist eastern culture (Eshun & Gurung, 2009). In some countries such as the Arab emirates, family was considered to be very important in one's life, which made many people tend to ask for informal help from family rather than professionals. Especially, telling other people about personal problems will considered as disgraceful act and will be seen as damaging the family's reputation (Al-Darmaki et al., 2016; Heath et al., 2016). It can also be seen in participants in this study who had collectivist culture that tends to draw on informal support to the family and those closest to them when experiencing a problem. On the other hand, this is also affected by the low mental health literacy of the Indonesian people related to the care of mental health problems, that many prefer to seek informal help.

The implication of this study is the need for psychoeducation of mental health literacy for students because they have limited knowledge of mental health. In addition, there is also a need for psychoeducation regarding available psychological services nearby and how psychologist can help them.

Conclusion

Based on the explanation above, it can be seen that in terms of mental health, the participant includes aspects of religiosity as part of mental health. In terms of stress, there is a tendency to use the word "stress" to refer to people who have severe mental disorders. The definition of anxiety, mostly in accordance with the guidelines for diagnosis. On the other hand, in terms of depression, most of the participants perceive depression as an advanced condition that is more severe than anxiety or stress. On the aspect of seeking psychological help, most of the participants knew that they needed to see a mental health professional when experiencing psychological problems, but most of them did not know where they could get psychological help. Furthermore, the participant's first choice when experiencing problems is relying on informal support from both family and close relatives, trying to solve it on their own (autonomy), and having a tendency to seek religious help.

Recommendation

Further research related to mental health literacy needs to be done by involving more respondents, not only university students but also students in middle and elementary schools. The results of this study indicated that in general mental health literacy in students still needs to be improved that further research can try to provide interventions to increase mental health literacy. In addition, there are many factors that influence students' attitudes towards professional psychological help, such as autonomy, preference for religious and informal assistance where these factors need to be explored further.

References

Al-Darmaki, F. R., Thomas, J., & Yaaqeib, S. (2016). Mental Health Beliefs Amongst Emirati Female College Students. *Community Mental Health Journal*, *52*(2), 233–238. https://doi.org/10.1007/s10597-015-9918-9

Alemu, Y. (2014). Perceived Causes of Mental Health Problems and Help-Seeking Behavior among University Students in Ethiopia. *International Journal for the Advancement of Counselling*, *36*, 219–228. https://doi.org/10.1007/s10447-013-9203-y

Am, I. B. H., Davenport, T. A., Luscombe, G. M., Rong, Y., Hickie, M. L., & Bell, M. I. (2007). The assessment of depression awareness and help-seeking behaviour : experiences with the International Depression Literacy Survey. *BMC*, *12*, 1–12. https://doi.org/10.1186/1471-244X-7-48

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders Fifth Edition: DSM-5* (Fifth Edit). American Psychiatric Association DSM.

Arnett, J. J. (2000). Emerging Adulthood. *American Psychologist*, *55*(5), 469–480. https://doi.org/10.1037//0003-066X.55.5.469

Badan Penelitian dan Pengembangan Kesehatan Kementerian Kesehatan RI. (2018). *Riset Kesehatan Dasar Republik Indonesia 2018*.

Brintnell, E. S., Sommer, R. W., Kuncoro, B., Setiawan, G. P., & Bailey, P. (2013). The expression of depression among Javanese patients with major depressive disorder : A concept mapping study. *Transcultural Psychiatry*, *0*(0), 1–20. https://doi.org/10.1177/1363461513501709

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as Mud': Toward Greater Clarity in Generic Qualitative Research. *International Journal of Qualitative Methods*, *2*(2), 1–13. https://doi.org/10.1177/160940690300200201

Castillo, R. J. (1997). Culture & mental illness: A client-centered approach. In *Culture & mental illness: A client-centered approach.* Thomson Brooks/Cole Publishing Co.

Chi, Q., Thai, N., & Nguyen, T. H. (2018). Mental health literacy : knowledge of depression among undergraduate students in Hanoi , Vietnam. *International Journal of Mental Health Systems*, *12*(19), 1–8. https://doi.org/10.1186/s13033-018-0195-1

Crosby, J. W., & Bossley, N. (2012). The religiosity gap: preferences for seeking help from religious advisors. *Mental Health, Religion & Culture*, *15*(2), 141–159. https://doi.org/10.1080/13674676.2011.561485

Derajat, M., Psikologi, M., Kekhususan, B., Klinis, P., & Afifah, K. A. (2016). *Literasi Kesehatan Mental Pada Tenaga*.

Eshun, S., & Gurung, R. A. R. (Eds.). (2009). *Culture and Mental Health: Sociocultural, Influences, Theory, and Practice*. Blackwell Publishing.

Falasifah, M., & Syafitri, D. U. (2021). *Hubungan antara literasi kesehatan mental dan stigma publik dengan sikap terhadap pencarian bantuan profesional psikologis pada mahasantri Pesanmasa Unissula*. Universitas

Islam Sultan Agung.

Heath, P. J., Vogel, D. L., & Al-darmaki, F. R. (2016). Help-seeking attitudes of united arab emirates students : examining loss of face , stigma, and self-disclosure. *The Counseling Psychologist*, *44*(3), 331–352. https://doi.org/10.1177/0011000015621149

Hutapea, B. (2014). Stres Kehidupan , Religiusitas , dan Penyesuaian Diri Warga Indonesia sebagai Stres Kehidupan , Religiusitas , dan Penyesuaian Diri Warga Indonesia sebagai Mahasiswa Internasional. *Makara Hubs-Asia*, *18*(1), 25–40. https://doi.org/10.7454/mssh.v18i1.3459

Idham, A., Rahayu, P., & As-Sahih, A. (2019). Trend Literasi Kesehatan Mental Trend of Mental Health Literacy. *Analitika: Jurnal Magister Psikologi UMA*, *11*(1), 12–20.

Jorm, A. F. (2012). Mental health literacy: Empowering the community to take action for better mental health. *American Psychologist*, *67*(3), 231–243. https://doi.org/10.1037/a0025957

Kelly, C. M., Jorm, A. F., & Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *The Medical Journal of Australia*, *187*(7 Suppl), 1–5. https://doi.org/kel10278_fm [pii]

Novianty, A. (2017). Literasi Kesehatan Mental : Pengetahuan dan Persepsi Publik mengenai Gangguan Mental Literacy of Mental Health : Knowledge and Public Perception of Mental Disorders. *Analitika*, *9*(2), 68–75.

Rachmayani, D., & Kurniawati, Y. (2017). Studi Awal: Gambaran Literasi Kesehatan Mental Pada Remaja Pengguna Teknologi. In A. Haq, P. Raihana, A. Kirana, & S. Sulandari (Eds.), *Penguatan Individu di Era Revolusi Informasi* (pp. 91–100). Fakultas Psikologi Universitas Muhammadiyah Surakarta.

Rickwood, D. J., Deane, F. P., & Wilson, C. J. (2007). When and how do young people seek professional help for mental health problems? *Getting There: Proto Pyschiatri*, *187*(7), 35–39.

Sam, D. L., & Moreira, V. (2012). Revisiting the Mutual Embeddedness of Culture and Mental Illness. *Online Readings in Psychology and Culture*, *10*(2), 1–20. https://doi.org/10.9707/2307-0919.1078

Wilson, C. J., Rickwood, D. J., Bushnell, J. A., Caputi, P., & Thomas, S. J. (2011). The effects of need for autonomy and preference for seeking help from informal sources on emerging adults' intentions to access mental health services for common mental disorders and suicidal thoughts. *Advances in Mental Health*, *10*(1), 29–38. https://doi.org/10.5172/jamh.2011.10.1.29

Wong, L. P. (2008). Focus group discussion : a tool for health and medical research. *Singapore Medical Journal*, *49*(3), 256–261.