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Mental Health of Indonesian University Students: UK Comparison, and Relationship Between Mental Health Shame and Self-Compassion

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Abstract

While the Indonesian higher education has been growing rapidly, poor student mental health including a high level of mental health shame, is a cause for concern in Indonesia. This study aimed to evaluate their mental health, shame and self-compassion. 156 participants completed self-report measures regarding mental health problems (depression, anxiety and stress), mental health shame (negative attitudes, and external, internal and reflected shame) and self-compassion. Data were first compared with 145 UK students, then correlation and regression analyses were performed. Indonesian students showed higher levels of mental health problems, family-related mental health shame, and self-compassion than UK students. Each type of mental health problems and mental health shame was positively associated with each other. Self-compassion was negatively associated with mental health problems, but not with mental health shame. Self-compassion was consistently the strongest predictor of mental health problems. Among the mental health shame types, only family external shame predicted the level of depression. Self-compassion training and mental health education for their family are recommended to protect the mental health of university students in Indonesia.

Keywords: mental health, Indonesian students, mental health shame, self-compassion

Rapid Increase of Students in Indonesian Higher Education

Indonesia has made great progress in education and academic development over the past 20 years. As Indonesia's economy has grown exponentially, largely due to greater industrialisation and export, a higher demand for skilled workers, particularly science and technology graduates, fuelled the development of the higher education system (Logli et al., 2016; Rifa'i et al., 2019; Wicaksono & Friawan, 2011). Though the figure is still low compared with Western European countries (e.g., 4% in the United Kingdom; Office for National Statistics, 2021; Clark, 2021), the number of students in Indonesian higher education (HE) has almost doubled (96% increase) in the past five years: 1.47 million students in 2016 (0.56% of the population) to 2.99 million in 2020 (1.1%) (Statista Research Department, 2021). Since 2002, the number of students in Indonesia has grown by 10 million, which is supported by the increased government funding and decentralisation (World Bank, 2020). With greater numbers of individuals attending universities in Indonesia and growing pressure to contribute to the labour market (Lauder & Mayhew, 2020; Mulyaningsih et al., 2021), it is imperative that the infrastructure for mental health support services for students is available.

Various Stressors to Indonesian Students

Student-stress in Indonesia is multifaceted: While many students experience stress from study workload, other common sources of stress include social relationships, limited financial support and living conditions (Kloping et al., 2021). In a study examining 1792 undergraduate medical students across 29 Indonesian universities, 93% reported disengagement, 95% reported exhaustion and 74% reported symptoms of mental health illness (Lili et al., 2021). Furthermore, Indonesian students reported that (1) personal responsibility and engagement with heavy university workload to ensure a future in the fast-growing labour market, (2) individual sacrifice and dedication to academic achievement, and

(3) conforming to social norms and rigid hierarchical expectations were key stressors (Wijaya Mulya et al., 2022).

Similar to the global trend, where 31% of university students are depressed (Ibrahim et al., 2013), the rates of mental health problems in Indonesian students are also high. Astutik et al. (2020) identified 25% and 51% of university students in Indonesia experienced clinically relevant symptoms of depression and anxiety respectively. Greater concerns are highlighted by a multinational study, which reported that students from Indonesia were most likely to report suicidal ideation among 12 Muslim countries (Eskin et al., 2019).

Moreover, Indonesian students may also be affected by environmental stressors unique to Indonesia, contributing to poorer mental health illness than students from other countries. This includes the aftermath of natural disasters, such as the 2004 tsunami which led to higher rates of trauma and posttraumatic stress disorder, military conflict such as the Civil War in Aceh (Pols & Wibisono, 2017) and terrorist incidents, such as the Sibolga explosion in 2019 (Dasopang et al., 2020). As such, several studies have highlighted differences in stress in university students between regions in Indonesia (Hartini et al., 2018; Kloping et al., 2021), suggesting the importance of accounting for regional-specific requirements for mental health support. Greater university-based and government-funded support is required to ensure mental health illness in Indonesian student populations is sufficiently considered.

Strong Stigma Associated With Mental Health Problems

Stigma about mental health illness in Indonesia is pervasive and persistent (Puspitasari et al., 2020; Subu, 2015). The consequences of mental health stigma include discrimination and negative stereotyping of individuals with mental health illness in daily life by the general public (Corrigan et al., 2004; Sickel et al., 2019). Stigma results in reduced opportunities in work, relationships and living independently (Arboleda-Flórez, 2008). Furthermore, pervasive stigma is associated with lower treatment-seeking in individuals with

mental health illness (Sickel et al., 2019). At a higher level, stigma also leads to structural discrimination where opportunities are restricted unintentionally or intentionally at an institutional level (Rüsch et al., 2005). Structural discrimination includes discriminative legislations, or poor allocation of economic funds to mental health services compared with other sectors (Corrigan & Watson, 2003; Rüsch et al., 2005).

In an effort to reduce stigma in the general population and focus resources on improvements in mental health, the Government of Indonesian implemented the Mental Health Act in 2014. This led to integration of mental health services into community outreach programmes, reaching 30 million households across the country. Additionally, this prompted greater access to mental health medication, greater mental health training for staff, and community-based awareness activities which aimed to reduce mental health stigma (Kozik, 2019). However, mental health remains a highly political issue in Indonesia (Bikker et al., 2021): Inadequate financial investment of only 6% of the national health budget is attributed to mental health expenditure (World Health Organization [WHO], 2017). Furthermore, there is a shortage of mental health practitioners: the ratio for psychiatrists in Indonesia is 1 to every 300,000 individuals in the general population (WHO, 2017).

Continued mental health stigma, shortage of trained mental healthcare professionals, and limited access to mental health services has led to continued practice of *pasung* (physical restraint and confinement of individuals with mental health illness), particularly in rural areas of Indonesia (Laila et al., 2019; Minas & Diatri, 2008). *Pasung*, which is now illegal in Indonesia, is still practiced by family members to reduce harm to the individual with mental health illness: this often takes place when treatment is not available to them (Yunita et al., 2020). The continued practice of pasung is an indicator that government-funded long-term psychiatric care is still needed in the general population (Laila et al., 2019; Nurjannah et al., 2015).

Mental health stigma and the lack of access to psychological services found in the general population, is also reflected in the higher education student population. For example, a recent study indicated that more than half of university students in Indonesia had negative perceptions of mental health illness (Puspitasari et al., 2020). To address this, interventions to help students disclose their mental illness may be effective in reducing stigma. Better knowledge about mental health is associated with lower stigma towards individuals with mental health illness (Hartini et al., 2018). Building upon evidence that students would welcome the opportunity to discuss and self-disclose their mental health with peers (Corrigan et al., 2014), a recent US college study found enduring mental health stigma reduction in students following peer-led intervention (Hundert et al., 2022). University counselling services are limited, unevenly distributed across universities, and often dependent on the presence of mental health practitioners at the university (Rahmadiana et al., 2021). Reducing stigma and increasing access to psychological services or peer-led support at Indonesian universities is needed.

Mental Health Shame

Stigma leads to a sense of shame (Corrigan et al., 2014). Stigma is an undesirable social mark, which is experienced as a negative emotion of shame, failing to meet some standards that one holds (Tangney, 1990). Shame-focused attitudes directed toward mental health problems (hereafter referred to as ‘mental health shame’) are associated with poor mental health. This is consistent across student populations, including business, healthcare, and humanities, where students with higher mental health shame suffered more mental health problems (DeVylder et al., 2022; Kotera et al., 2019a, 2019c; Kotera, Ting & Neary, 2021). Mental health shame is diverse and includes, but is not limited to, an individual perceiving that because of *their* mental health: others would view them (external shame) or their family members (reflected shame) negatively; and/or they view themselves negatively (internal

shame) (Gilbert et al., 2007). Interestingly, research has indicated that cultural differences may exist in the type of mental health shame that individuals exhibit, with Asian populations reporting stronger external mental health shame than non-Asian populations (Gilbert et al., 2007; Kotera, Sheffield et al., 2021). Further, Asian populations have been found to experience more shame when disclosing mental health problems (Haroz et al., 2017).

Unsurprisingly, mental health shame has been found to act as a barrier to help-seeking in Indonesian students and adults, and their family members (Subu et al., 2021). While mental health problems may be self-limiting, delaying care can lead to poor clinical outcomes (Clement et al., 2015; Dell'Osso et al., 2013) and therefore understanding and reducing mental health shame is vital. To date, the prevalence of mental health shame and its relationship to mental health in Indonesian students has not been examined. Understanding these relationships is important for developing and to tailor new approaches to treating their mental health.

Self-Compassion

Self-compassion reduces shame and mental health problems (Gilbert & Procter, 2006). Self-compassion involves: treating oneself, particularly during adversity, with kindness and understanding rather than excessive criticism; viewing one's experiences not as isolated from, but as part of the human condition; and acknowledging one's negative emotions and thoughts without over-identifying with them (Neff, 2003a, 2003b). These attitudes have been consistently linked to mental wellbeing (MacBeth & Gumley, 2012; Zessin et al., 2015) and can help individuals cope with the negative impact of loneliness, shame and self-criticism (Akin, 2010; Johnson & O'Brien, 2013; Neff, 2003a). Recent research found that in university students, self-compassion is associated with better mental health and wellbeing in both Western (Fong & Loi, 2016; Gunnell et al., 2017; Kotera et al., 2019a, 2019c), and Eastern cultures, including in Indonesia (Rahmandani et al., 2021; Kyeong, 2013). Self-compassion has also

been found to mediate the impact of negative mental health attitudes (including mental health shame) on mental health problems, with higher self-compassion reducing the impact of negative mental health attitudes on mental health in both Japanese and Malaysian populations (Kotera et al., 2019b; Kotera, Ting & Neary, 2021) with evidence suggesting this may be due to self-compassion reducing mental health stigma (Heath et al., 2018). Importantly, self-compassion can be cultivated through both face-to-face and online interventions (Kotera & Van Gordon, 2021; Raab et al., 2015; Yogeswaran & El Morr, 2021) and can promote resilience against psychopathology (Trompetter et al., 2017). Further understanding of the role of self-compassion in mental health among students in Indonesia is important.

Comparing With UK University Students

Indonesia and the UK display cultural differences. Indonesia exhibits collectivistic values, whereby individuals integrate into societal groups which are loyal to and care for all ingroup members. In comparison the UK is more individualistic, with care tending to be focused on oneself and immediate kin (Hofstede et al., 2010). Interestingly, while collectivism is more prevalent among Asian countries in general, Indonesia displayed the highest levels of collectivism among all the East/ South-eastern Asian countries researched (Hofstede et al., 2010). Indonesia and the UK further differ in relation to what is known as power distance. In Indonesia, less powerful society members are more willing to accept and conform to inequality in power distribution (high power distance). In the UK however, power inequality is less accepted, and equality of power is sought after (Hofstede et al., 2010). Indonesia is a multi-ethnic country, and recent research found that high collectivism and high power distance is found among not only the predominant Javanese ethnicity, but also among other ethnic groups (Suharnomo & Syahruramdhan, 2018). High collectivism and high power distance was identified as an explanatory factor for mental health problems in a Malaysia-UK study (Kotera, Ting & Neary, 2021), however this has not evaluated in Indonesia.

Aims

The present study aimed to evaluate the mental health of Indonesian students, appraising each type of mental health shame and self-compassion. First, the levels of mental health problems, mental health and self-compassion were assessed by comparing with UK students (Aim 1). Second, correlations among those variables were evaluated (Aim 2). Lastly, predictors of mental health problems were identified (Aim 3).

Materials and Methods

Sample Selection

In order to participate, students had to be at least 18 years old, and studying at an Indonesian university: students on a study break were excluded. Of 162 full-time students in caring subjects approached, 156 (128 females, 25 males, 3 unanswered; Age 19.07 ± 0.98, range = 18–22 years) completed self-reported scales regarding mental health problems, mental health shame, and self-compassion. Our sample demonstrated similar age to, but more females than the general Indonesian student population (Age: 20 years old, 49% female: Indonesian Higher Education Data Base, 2020). Tutors who were not co-authors of this study sent out the study materials including the consent form, and students who had agreed to take part responded to the scales online. To protect students, the information about the student wellbeing was informed to them before and after the study. All study materials were prepared in English. No compensation was awarded for participation.

Data obtained from Indonesian students were compared with 145 UK students who were also studying in caring subjects, and recruited with the same participation criteria (130 females and 15 males; 133 undergraduates and 12 postgraduates; Age 26.80 ± 8.64, range = 17–52 years old; Kotera, Green & Sheffield, 2021).

Materials

Mental health problems, namely depression, anxiety and stress, were assessed using the Depression Anxiety and Stress Scale (DASS21), a shortened form of DASS42 (Lovibond & Lovibond, 1995). DASS21 comprised 21 items that were responded to on a four-point Likert scale (0 = 'Did not apply to me at all' to 3 = 'Applied to me very much or most of the time'). The 21 items are divided into three subscales (seven items each); depression (e.g. 'I felt that I had nothing to look forward to'), anxiety (e.g. 'I felt I was close to panic') and stress (e.g. 'I felt that I was rather touchy'). These subscales had high internal consistency in our sample (α = .77–.88).

Attitudes Towards Mental Health Problems Scale (ATMHPS; Gilbert et al. 2007) was used to measure mental health shame. ATMHPS consisted of 35 items on four-point Likert scale (0 = 'Do not agree at all' to 3 = 'Completely agree') considering seven subscales: (1) community attitudes and (2) family attitudes assess how their community and family perceive mental health problems (e.g. 'My community/family sees mental health problems as a personal weakness'); (3) community external shame and (4) family external shame regards their view on how their community and family would see them if they had a mental health problem (e.g. 'I think my community/family would see me as inferior'); (5) internal shame relates to how they view themselves if they had a mental health problem (e.g. 'I would see myself as inadequate'); (6) family-reflected shame shows their worries about their family's reputation if they had a mental health problem (e.g. 'My family would be blamed for my problems'); and (7) self-reflected shame refers to their worries about their own reputation if a close relative had a mental health problem (e.g. 'I would worry that others would not wish to be associated with me'). All of the subscales had good Cronbach's alphas in our sample, indicating high internal consistency (α = .84–.94).

Lastly, the Self-Compassion Scale-Short Form (SCS-SF; Raes et al., 2011), a shortened version of the Self-Compassion Scale (Neff, 2003a) was used for self-compassion.

SCS-SF is a 12-item scale responded on a five-point Likert (1 = 'Almost never' to 5 = 'Almost always'; e.g. 'When something painful happens I try to take a balanced view of the situation.'). Six items (1, 4, 8, 9, 11, and 12) were negatively worded, therefore the scores are reversed. SCS-SF had high internal consistency in our sample ($\alpha = .72$).

Procedure

First, collected data were screened for outliers and the assumptions for parametric tests. Second, in order to examine the mental health of Indonesian students (Aim 1), t-tests were performed to compare the levels of mental health with 145 UK students in caring subjects. Third, to elucidate the relationships among mental health problems, mental health shame, and self-compassion (Aim 2), correlation analyses were conducted. Finally, regression analyses were used to identify significant predictors of mental health problems (Aim 3). IBM SPSS version 27 was used for these analyses.

Results

No outliers were identified, and the assumption of normality was maintained. Table 1 summarised the means and standard deviations of each variable.

Levels of Mental Health (Aim 1)

The scores of Indonesian students were compared with UK students. Because the assumption of homogeneity of variances was violated for depression, anxiety, stress, community external shame, internal shame, and self-compassion (Levene's test for equality of variances, $p < .05$), Welch t-tests were performed.

Table 1

Descriptive Statistics for Indonesian Students, and Welch t-tests Compared With UK Students

	Indonesian students (n = 156)	UK students (n = 145)	Effect size

Scales	Variables (range)	M	SD	α	M	SD	*D*
Depression Anxiety and Stress Scale 21	Depression (0-42)***	15.08	8.07	.80	11.56	10.36	.38
	Anxiety (0-42)***	17.71	8.14	.77	11.22	9.44	.74
	Stress (0-42)***	18.65	7.71	.76	17.14	10.58	.16
Attitudes Towards Mental Health Problems Scale	Community Attitudes (0-12)**	4.21	2.53	.70	3.63	3.07	.21
	Family Attitudes (0-12)***	3.97	2.64	.77	1.99	2.92	.71
	Community External Shame (0-15)	4.64	3.40	.88	5.22	4.54	.15
	Family External Shame (0-15)*	3.96	3.56	.90	2.19	3.61	.49
	Internal Shame (0-15)***	4.99	3.69	.88	7.51	5.03	.57
	Family-Reflected Shame (0-21)	7.64	5.01	.87	6.10	5.30	.30
	Self-Reflected Shame (0-15)**	6.22	4.20	.92	2.91	4.17	.79
Self-Compassion Scale-Short Form	Self-Compassion (1-5)***	3.32	.50	.67	2.84	.79	.73

***p <.001, **p <.01, *p <.05

Of eleven variables measured, significant differences were found in nine: only community external shame (p = .47) and family-reflected shame (p = .29) did not show significant difference. Indonesian students scored higher than UK students in all mental health problems: Depression MD (Mean Difference) = 9.30, 95% CI [7.75, 10.85], t(266.58) = 11.80, p < .001; Anxiety MD = 12.09, 95% CI [10.59, 13.59], t(252.09) = 15.90, p < .001; Stress MD = 10.09, 95% CI [8.58, 11.60], t(275.62) = 13.32, p < .001. Indonesian students showed higher levels of community and family attitudes, family external shame, and self-reflected shame, and a lower level of internal shame than UK students: Community Attitudes MD = 1.61, 95% CI [0.66, 2.55], t(62.20) = 3.41, p = .0011; Family Attitudes MD = 2.41, 95% CI [1.54, 3.82], t(69.78) = 5.51, p < .001; Family External Shame MD = 1.47, 95% CI [0.31, 2.63], t(70.71) = 2.52, p = .014; Self-Reflected Shame MD = 2.60, 95% CI [1.00, 4.20], t(61.09) = 3.24, p = .002; Internal Shame MD = -3.59, 95% CI [2.01, 5.16], t(56.47) = -4.56, p < .001. Lastly,

Indonesian students demonstrated a higher level of self-compassion than UK students: MD = .46, 95% CI [.32, .59], $t(262.73) = 6.65$, $p < .001$. The effect size was particularly large in self-reflected shame ($d = .79$), anxiety ($d = .74$), self-compassion ($d = .73$), and family attitudes ($d = .71$).

Relationships Between Mental Health Problems, Mental Health Shame, and Self-Compassion (Aim 2)

Pearson's correlation was used to evaluate the relationships between mental health problems, mental health shame, and self-compassion (Table 2). Point-biserial correlation coefficient was used for gender (0 = males, 1 = females).

Table 2

Correlations Between Mental Health Problems, Mental Health Shame, and Self-Compassion in Indonesian Students

	1	2	3	4	5	6	7	8	9	10	11	12	13
1 Gender (0=M, 1=F)	-												
2 Age	-.12	-											
3 Depression	.09	-.10	-										
4 Anxiety	.03	-.16*	.65**	-									
5 Stress	.08	-.07	.69**	.76**	-								
6 Community Attitudes	-.02	-.04	.22**	.29**	.25**	-							
7 Family Attitudes	-.04	-.02	.24**	.31**	.24**	.67**	-						
8 Community External Shame	-.07	-.04	.40**	.32**	.31**	.47**	.58**	-					
9 Family External Shame	-.02	-.12	.40**	.34**	.25**	.38**	.58**	.74**	-				
10 Internal Shame	-.06	-.13	.34**	.34**	.28**	.42**	.57**	.74**	.68**	-			
11 Family-Reflected Shame	-.07	.06	.31**	.37**	.30**	.22**	.43**	.56**	.57**	.64**	-		
12 Self-Reflected Shame	-.06	-.001	.24**	.32**	.26**	.23**	.29**	.39**	.45**	.52**	.63**	-	
13 Self-Compassion	.02	.09	-.30**	-.27**	-.26**	-.12	-.01	-.17*	-.11	-.14	-.15	-.13	-

**p <.01, *p <.05

Each subscale of mental health problems, namely depression, anxiety and stress, was strongly and positively interrelated with each other (r = .65-.76). Likewise, each subscale of mental health shame was also positively interrelated with each other (r = .22-.74). All mental health subscales and mental health shame subscales were positively associated with each other. Self-compassion was negatively associated with depression, anxiety, stress and community external shame. Gender and age were not related with mental health variables apart from the negative correlation between age and anxiety.

Predictors of Mental Health Problems (Aim 3)

Multiple regression analyses were conducted to identify significant predictors of each mental health problem (Table 3). Multicollinearity was not a concern (Variance inflation factor < 10).

Table 3

Multiple Regressions: Mental Health Shame and Self-Compassion for Mental Health Problems in Indonesian Students

	Depression					Anxiety					Stress				
	B	SE_B	β	95% CI [Low, Up]		B	SE_B	β	95% CI [Low, Up]		B	SE_B	β	95% CI [Low, Up]	
Community Attitudes	.13	.32	.04	-.51	.77	.42	.33	.13	-.23	1.07	.32	.32	.11	-.32	.96
Family Attitudes	-.13	.35	-.04	-.82	.57	.23	.36	.07	-.48	.93	.14	.35	.05	-.55	.84
Community External Shame	.34	.30	.14	-.25	.94	-.09	.30	-.04	-.69	.51	.30	.30	.13	-.29	.89
Family External Shame	.55	.27	.24*	.02	1.07	.22	.27	.10	-.32	.75	-.06	.27	-.03	-.59	.46
Internal Shame	.01	.27	.01	-.52	.55	.02	.27	.01	-.52	.56	-.07	.27	-.03	-.60	.46
	.08	.18	.05	-.27	.43	.29	.18	.18	-.07	.65	.20	.18	.13	-.15	.55

Family-Reflected Shame															
Self-Reflected Shame	.04	.19	.02	-.33	.40	.19	.19	.10	-.19	.56	.18	.18	.10	-.19	.54
Self-Compassion	-3.76	1.21	-.23**	-6.15	-1.37	-3.50	1.22	-.21**	-5.91	-1.08	-3.14	1.20	-.20**	-5.52	-.76
Adj. R^2			.20					.20					.13		

**p <.01, *p <.05. B = unstandardised regression coefficient, SE_B = standard error of the coefficient, β = standardised regression coefficient.

Self-compassion was the strongest or only predictor of each mental health problem ($p < .01$). For depression, family external shame was also a significant predictor ($p < .05$). Mental health shame and self-compassion predicted 20% of variance in depression and anxiety respectively (medium-large effect size; Cohen, 1988), and 13% in stress (medium effect size; Cohen, 1988).

Discussion

This study aimed to understand the mental health problem, mental health shame, and self-compassion of Indonesian university students by comparing with UK students (Aim 1), evaluating the relationships of these constructs (Aim 2), and identifying the predictors of each mental health problem (Aim 3). Compared with UK students, Indonesian students showed higher levels of all mental health problems namely depression, anxiety and stress. Among mental health shame, their community and family attitudes, family external shame, and self-reflected shame were higher than UK students, while their internal shame was lower than UK students. The level of self-compassion was higher in Indonesian students than UK students. Each type of mental health problems and mental health shame was positively associated with each other in Indonesian students. Self-compassion was negatively associated with all mental

health problems, but not with mental health shame. Among all variables, self-compassion was consistently the strongest predictor for all mental health problems. Among all types of mental health shame, only family external shame predicted the level of depression.

Comparison Between Indonesian and UK Students

Our comparative evaluation of mental health between Indonesian students and UK students revealed that Indonesian students suffered from the mental health problems and shame more seriously than UK students, who also scored high in those constructs (Kotera, Green & Sheffield 2021). Because poor mental health is linked with diverse negative consequences in Indonesia including discrimination and negative stereotyping (Corrigan et al., 2004; Sickel et al., 2019), fewer work opportunities and poorer social relationships (Arboleda-Flórez, 2008), fewer institutional opportunities (Rüsch et al., 2005), and less chances to receive economic funds (Corrigan & Watson, 2003), improving mental health has great importance for Indonesian students to achieve academic, social and economic success. As noted in the introduction, mental health problems are still highly stigmatised in Indonesia: students often hesitate to disclose their mental health problems (Sickel et al., 2019). Moreover, there are not enough mental health professionals in Indonesia. Therefore, a lot of students, especially those who live in rural areas, do not have access to professional support even when they actually seek them (Tristiana et al., 2017). As delayed detection leads to poorer treatment outcome (Brown, 2018), more governmental initiatives are needed to increase the understanding of mental health problems as well as access to mental health supports in Indonesia. For instance, in the UK, various initiatives were introduced to encourage people to talk about mental health issues (e.g. ‘Mental Health Crisis Care Concordat’; Welsh Government, 2016). The number of students who have sought out mental health support in the UK increased by more than 50% between 2012 and 2017 (Spitzer-Wong, 2018). Such attempts are needed in Indonesia.

With regards to mental health shame, Indonesian students scored higher in most of the subscales than UK students. The Indonesian cultural nature of stigmatic attitudes toward mental health problems can help explain the high mental health shame of Indonesian students (Hartini et al., 2018). The only subscale that UK students scored higher on was internal shame. These differences may lie in the cultural difference of collectivism/individualism. Collectivism prefers tightly connected society, where people expect their group members to take care of them in return for loyalty, whereas individualism perceives a society loosely connected, where individuals only take care of themselves and their immediate families (Hofstede et al. 2010). Collectivistic Indonesian students are more concerned with how other people would see them if they had a mental health problem, while individualistic UK students are more concerned of how they would see themselves (Kotera, Green & Sheffield 2021). These tendencies correspond with previous findings with Malaysian students (Kotera, Ting & Neary, 2021).

Finally, self-compassion was higher in Indonesian students than UK students. There are no previous studies which directly compared self-compassion of these two countries; however, although Indonesia was not included, the UK was one of the lowest countries in terms of self-compassion in a previous cross-cultural study (Tóth-Király & Neff, 2021). In addition, the cultural dimensions of Long-Term Orientation and Uncertainty Avoidance were positively, and Indulgence was negatively associated with self-compassion (Montero-Marin et al., 2018). Indonesian culture exhibits more Long-Term Orientation and Uncertainty Avoidance, and less Indulgence than UK. Our finding of the higher self-compassion level in Indonesian students than UK students is consistent with these associations suggested in the study.

Correlations of Mental Health Problems, Mental Health Shame, and Self-Compassion

All types of mental health problems and mental health shame were positively interrelated with each other in Indonesian students. This means that the students who suffered from a mental health problem tended to have a high level of mental health shame. This correlation may be again related to the stigmatisation of mental health problems. As our data suggests, the levels of mental health shame were relatively high in Indonesian students. Having mental health problems is regarded as a taboo in Indonesia culture, and Pasung is still practiced especially in rural areas (Hartini et al., 2018). The stigmatised image of mental illness damages the mental health of patients further (Rüsch et al., 2005), as it causes patients to feel powerlessness and damage their self-efficacy (Subu et al., 2021). Negative attitudes toward mental illness cause delayed detections of mental health problems as well, leading to poorer treatment outcome (Seidman et al., 2022). On the other hand, students with good mental health tended to have positive attitudes (less shame) about mental health problems. The ongoing Mental Health Act was evaluated by Indonesian psychiatrists as a step in the right direction to improve mental health services and to raise awareness of mental illness (Bikker et al., 2021). Such nation-level initiatives need to be further introduced to inform students more about mental health, which in turn can reduce mental health shame.

Self-compassion was negatively correlated with all types of mental health problems, but with none of mental health shame. This association between mental health problems and self-compassion has been found in previous studies (Kotera et al. 2020; Zessin et al., 2015). Individuals with high self-compassion are able to think that difficulties are part of the human condition and to focus on what is controllable in the situation (Chishima et al., 2018). This way of thinking helps them cope with stress better. Although both mental health problems and self-compassion were higher in Indonesian students than UK students, the strong negative correlation between mental health problems and self-compassion was detected in the current study as well. Self-compassion was deemed important to mental health problems.

Implications of the Current Study

Our regression analysis highlighted the importance of self-compassion to the mental health, consistent with previous studies (Kotera et al., 2020; Zessin et al., 2015; Chishima et al., 2018). Self-compassion was the strongest predictor of mental health problems among all the variables, suggesting that Indonesian universities consider introducing self-compassion training in their curriculum, as enhanced self-compassion can reduce mental health problems and negative mental health attitudes (Gilbert & Procter, 2006; Heath et al., 2018). For example, Haukaas et al. (2018) demonstrated that a three-week intervention consisting of weekly 45-minute group sessions and everyday homework (20-minute guided meditation over two weeks) for promoting self-compassion improved students' self-compassion and mental health. Self-compassion mitigates a sense of loneliness, which is a strong debilitating mental health construct in university students (McIntyre et al., 2018). Because students tend to experience mental health problems during transitional times (Cvetkovski et al., 2017), self-compassion training would be especially helpful to be implemented at these phases such as the beginning and towards the end of their university life. Future research should consider effective ways to implement self-compassion training for Indonesian students to maximise its impact.

Among all types of mental health shame, we found that family external shame was a predictor of depression for Indonesian students. This means that family's negative view of mental health problems can predict a variance in depression. In Indonesia, people with mental health problems are often regarded as crazy and being abandoned by God (Subu et al., 2021; Putri et al., 2021). These individuals with mental health problems are sometimes hidden or ostracised from their family, therefore they are imposed strong pressure of not being mentally ill by their family (Putri et al., 2021). As family support plays a crucial role in mental health treatment, the negative views of family members toward mental health problems can worsen

depression (Subu et al., 2021). Mental health literacy of Indonesian students and their family members must be developed to address the high relevance of family external shame with depression in Indonesian students.

Limitations

Limitations of this study need to be acknowledged. Firstly, opportunity sampling was used at one university, which hindered the generalisability. Secondly, the comparison was done between counselling and education students in Indonesia and counselling and occupational therapy students in the UK: comparing with students in the same subject would illustrate the cultural difference more accurately. Thirdly, self-report measures might have limited the accuracy, especially between samples from different cultures (Kotera et al., 2020). Relatedly, although the scales in this study were well-used in the field, their accuracy is being debated (e.g., SCS-SF; Kotera & Sheffield, 2020). Lastly, the causality of the variables has not been evaluated.

Conclusion

While the number of students in Indonesian higher education expands rapidly, many of them suffer from various stressors. This study evaluated the mental health of university students in Indonesia along with the negative factor of mental health shame and the positive factor of self-compassion. Relative to UK students, Indonesian students had higher levels of mental health problems, family-related mental health shame, and self-compassion. Mental health problems were positively associated with mental health shame and negatively associated with self-compassion. Moreover, self-compassion was the strongest predictor of all mental health problems, and family external shame was another predictor of depression. Self-compassion training for students and providing the right knowledge about mental health for their family are recommended to protect the mental health of university students in

Indonesia. Our findings will help researchers, educators, and students in Indonesia identify effective means to protect the mental health of Indonesian students.

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