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# Knowledge, Belief and Attitude Towards Depression Among Youths in Kuantan, Pahang, Malaysia

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## ABSTRACT

**Background:** Depression is a common mental health problem among young-adults. This study was carried out to determine the level of knowledge, belief and attitude towards depression among youth in Kuantan, Malaysia and to find out its relationship with demographic characterises.

**Methods:** The design of this research was a questionnaire-based-online cross-sectional study, carried out in Widad University College (WUC) from April to June, 2022. As a part of the requirement of fulfilment of Community Medicine posting, this study was done by a group of year-4 medical students under the guidance of a supervisor from Microbiology Unit and in collaboration with Community Medicine Unit of WUC. Youths of Kuantan city in Malaysia were the study populations from where a sample of 111 participated in this study. A self-administered standardized questionnaire was used to measure the knowledge, belief and attitude towards depression among the respondents.

**Results:** The study revealed that >80% respondents showed a good general knowledge and recognition of symptoms except for sexual dysfunction. More than 90% respondents believed that, the major causes of depression were: death of loved ones, home/family disharmony, relationship

breakups and interpersonal/sad or guilt feeling, and they preferred to seek professional treatment. However, choices for alternative medicine were: ‘religious/spiritual therapy’ (84.7%), ‘people affected can solve it better’ and ‘meditation/yoga/exercise together’ (81.1% each), aromatherapy (79.3%) and others.

**Conclusion:** Overall, a very good knowledge-score on the symptoms of depression was observed. Male, Malay youths and those who lived in urban area has better knowledge. University graduates prioritised education related issues and home/family disharmony as main causes of depression. Religious/spiritual treatment was the first choice of alternative treatment chosen by youth who were single. Small sample size was the limitation of this study; however, the study findings contribute the baseline data of depression among the youth in Kuantan. Further large-scale study is recommended for more information on it.

**Keywords:** Knowledge, Belief, Attitude, Depression, Mental health, Youth.

## 1.0 INTRODUCTION

Depression is a state of low mood and aversion to activity that can affect a persons' thoughts, motivation, behaviour, feelings, and sense of well-being. It is the most common type of mental health disorders among the population that causes disability. It is anticipated to be the leading cause of disease burden globally by 2030 (IPH, 2020). According to the World Health Organization (WHO), the total number of people in all ages living with depression in the world is more than 300 million and almost half of these people are living in the South-East Asia and Western Pacific Region (WHO, 2017). It is estimated that 5% of adults worldwide suffer from this illness. Depressive disorders are identified by the features of sadness, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, feelings of tiredness, and poor concentration or difficulty in thinking. Depression can be of single episode, recurrent, and bipolar disorder where depressive episodes alternate with periods of manic symptoms, such as euphoria, increased activity or energy, irritability, talkativeness etc. Depression can significantly impair an individuals' ability to function at work or school or cope with daily life. At its most severe, depression can lead to suicide (WHO, 2021a). Around 788,000 people died every year due to suicide, although the number attempted is many more. Suicide accounts for 1.5% of all deaths worldwide which is the second leading cause of death in 15-29 years old globally in 2015 (WHO, 2017). Depression affects everyone, regardless of their age, region, or socioeconomic status. In Malaysia, according to the National Health and Morbidity Survey 2019, 2.3 percent of Malaysian adults, that is nearly about half a million of Malaysian adults suffered from depression, with the state of Putrajaya having the highest rate at 5.4 percent. Depression rate differed with gender (male 2.0% vs female 2.6%), area (rural 3.6% vs urban 1.9%), marital status (single 3.2%, married 1.8%, divorcee/widower 2.0%) and household incomes below RM 1000 (4.9%) compared to others (IPH, 2020).

Globally, depression is a common mental health problem and a leading cause of disability among adolescents. It is estimated that 1 in 7 (14%) of 10–19-year-olds experience mental health disorder, accounting for 13% of the global burden of disease in this age group (WHO, 2021b). A recent study showed that the COVID-19 crisis causes a significant impact on the mental health of young people between the ages of 15-24 years where around 30-80% reported symptoms of depression or anxiety than adults in Belgium, France and the United States in March 2021 (OECD, 2021). In Malaysia, several studies have examined adolescent depression and associated risk factors (Kaur et al., 2019; Ishak et al., 2020 and Latiffah et al., 2016). Kaur et al, (2019) revealed that 17.7% of adolescents have depressive symptoms and

the risk factors includes feeling lonely, Indian ethnics, using drugs, and being bullied. Ishak et al, (2020) found school students suffer from moderate (11.8%) to severe (2.4%) and very high level of depression (0.8%). Another study in South Malaysia showed prevalence of the symptoms of moderate, severe, and extremely severe depression was 21.5%, 18.1%, and 3.0%, respectively among secondary school children (Latiffah et al., 2016). Recent cross-sectional study conducted among secondary school children from five random schools in an urban city of Kuala Lumpur showed that 21.5% of the participating students were found to have depression (n = 99). Younger age and Chinese ethnics had significant association with adolescent depression (p=0.032 and 0.017), respectively (Ibrahim et al., 2022). Another study evaluating the knowledge and perception of depression among 500 University students (mean age 22 years) in Penang reported that Chinese females had a comparatively better knowledge (***p***=0.058) of the symptoms of depression in comparison with Malays and Indians. Female students were more inclined towards the use of alternative and traditional medicines. the majority preferred to consultation with a psychiatrist in regard to seeking professional help (Khan et al., 2010).

In Pahang state of Malaysia, prevalence of depression among the elderly (more than 60 years) was 19.3% as reported in year 2019 (Azman, 2019). In spite of having several studies conducted in Malaysia, data for depression among Youths in Kuantan, Pahang is still lacking. As such, the objectives of this study were to determine the knowledge, belief and attitude of Youths regarding depression and its relationship with various demographic variables.

## 2.0 MATERIALS AND METHODS

### *Study Design, Study Period, Study Population, and Sample Size*

This was a cross-sectional questionnaire-based descriptive study, carried out online by the 4th year medical students of Widad University College (WUC) at Kuantan, during their community medicine posting. The study period was from April to June 2022 and it was done as a part of the requirement of fulfilment of their Community Medicine posting under the guidance of a supervisor from Microbiology Unit, in collaboration with Community Medicine Unit at WUC. Kuantan is the capital state of Malaysia with a population of approximately 500,000 (Kuantan population 2020). Although the minimum sample size needed for this study was 73 calculated using the standard formula from Srivastav and Vaidya (2022), the actual sample was 111.

### *Inclusion and Exclusion Criteria*

Inclusion criteria of the participants were a) Malaysian citizens who were 15-25 years of age; b) live in Kuantan; c) able to read and write Bahasa Melayu or English. Exclusion criteria were a) non-Malaysian citizens b) who were younger than 15 years and older than 25 years of age c) unable to read and write Bahasa Malaya or English d) incomplete responses.

### *Study Instrument*

The self-administered survey instrument/questionnaire used in this study was adopted from a pretested and validated questionnaire by (Khan et al., 2010) to determine the level of knowledge, belief and attitude regarding depression among youths. The questionnaire comprised of 40 statements. All statements were rated with the options of Yes/No or Agree/Disagree against each except two open-typed questions under the section-2.

There were seven demographic variables under section-1 which were age, gender, marital status, ethnicity, living area, education level, and household income. In section-2, there were total eight questions regarding general knowledge on 'heard about depression', 'depression affects people of a particular of age', 'do you consider depression as a health problem', 'people with depression are dangerous to themselves and others' 'depression can lead to suicide' and 'have you ever suffered from depression' with two open ended questions regarding source of information and knowledge on medical term of depression. In section-3, there were eight questions regarding knowledge on recognition of symptoms of depression which were: sadness/bad moods, lack of appetite/overeating, lack of interest in routine activities, suicidal or self-harming, fatigue and body aches, sleep disorder, lack of energy, sexual dysfunction. The level of knowledge on recognition of symptoms of depression was scored by giving every correct answer 1 point. The knowledge level of recognition of symptoms were rated as zero (very poor), 1-2 (poor), 3-4 (moderate), 5-6 (good) and 7-8 (very good) based on the number of correct answers. Section-4 consists of nine questions for perception/belief about the causes of depression which were: 'failure in achievements', 'interpersonal/sad or guilt feelings', 'examinations', 'projects', 'chemical imbalance in brain', 'death of loved ones', 'home/family disharmony', 'relationship breakups', and 'automatically'. Section-5 has eight questions for attitudes towards treatment. The first question was on respondents' 'willingness to seek medical treatment from either a general practitioner or psychiatrist' and the rest on attitude to alternative medicine which were 'Spa treatment/massage', 'Religious/Spiritual therapy',

'Aromatherapy', 'Person affected can solve it better', 'Love is the best solution'; 'Meditation/Yoga/Exercise', and 'Traditional medicine'.

***Methods of Data Collection***

The questionnaire with QR code was posted online as Google forms link distribution through WhatsApp, Facebook, Telegram and Instagram to ensure that each respondent answer the questionnaire only once. Participants were assured about the confidentiality and privacy of their responses as no data such as addresses and even names of participants were required in this study.

***Methods of Data Analysis***

Data were collected, entered and analysed by the Statistical Package for Social Sciences (SPSS 25.0). Descriptive statistics were used to analyse the socio-demographic characteristics, participants' knowledge, belief and attitude on depression and presented as frequency and percentage distribution. For comparison of knowledge level differences between the two groups (gender, area of living) and more than three groups (ethnicity), T-test and ANOVA were done respectively. The Chi square test was used to examine the relationship between socio-demographics of the participants with belief and attitude for depression. The ***p*** value of less than 0.05 was considered significant.

## 3.0 RESULTS

A total of 113 responses were received from youths lived in different areas in Kuantan via social media platforms. However, two responses were excluded from the study due to incomplete data. Therefore, 111 responses were included for final analysis. Baseline demographic data of participants were shown in Table-1. Out of total 111 participants, more than half of participants were male (56.8%), and in the age group of 18-22 years (53.2%). Among total participants, 75 (67.6%) were Malays, followed by Chinese 18, (16.2%), Indians 14, (12.6%) and others 4, (3.6%). Most of the youths were of single marital status (88.3%), have received University education (64.0%), and lived in urban area of Kuantan (53.2%).

**Table 1: Socio Demographic Data of the Participants (n=111)**

| Demographic Variables | | Number (Percentage) |
|---|---|---|
| Age in year | 15-17 | 14 (12.6) |
| | 18-22 | 59 (53.2) |
| | 23-25 | 38 (34.2) |
| Gender | Male | 63 (56.8) |
| | Female | 48 (43.2) |
| Marital status | Single | 98 (88.3) |
| | Married | 13 (11.7) |
| Ethnicity | Malay | 75 (67.6) |
| | Chinese | 18 (16.2) |
| | Indian | 14 (12.6) |
| | Others | 4 (3.6) |
| Living Area | Urban | 59 (53.2) |
| | Rural | 52 (46.8) |
| Education level | University student | 71 (64.0) |
| | High school student | 17 (15.3) |
| | Employed | 14 (12.6) |
| | Unemployed | 9 (8.1) |
| Household income (MYR) | 0-1499 | 37 (33.3) |
| | 1500-4999 | 35 (31.5) |
| | 5000-9,999 | 24 (21.6) |
| | >10,000 | 15 (13.5) |

Table-2 showed the participants' general knowledge and knowledge on recognition of symptoms of depression. More than 80% of the respondents answered questions on general knowledge correctly. Highest number of participants 108 (97.3%) agreed that depression can lead to suicide. Total 58 (52.3%) respondents reported having had personal experience of depression. Regarding the recognition of symptoms of depression, participants had a good knowledge in recognizing the symptoms. The highest score is on recognizing the symptoms of 'Sadness/bad moods' and 'suicidal or self-harming' while the lowest score in on 'sexual dysfunction'. In response to the first open ended question asking about sources from where they heard about depression, social media (39.6%) ranked as the first followed by school (35.1%), friends (17.1%) and articles (8.1%). Regarding the second question about the type of depression, two-third of the respondents were able to answer with correct medical terminology (66.7%) while the remaining (33.3%) answered with incorrect or unsuitable term.

**Table-2: Participants' Knowledge on Depression (n=111)**

| Knowledge on Depression | | Yes (n /%) | No (n /%) |
|---|---|---|---|
| General knowledge | Have you heard about depression | 103 (92.8) | 8 (7.2) |
| | Depression affects people of a particular of age | 8 (7.2) | 103 (92.8) |
| | Do you consider depression as a health problem | 97 (87.4) | 14 (12.6) |
| | People with depression are dangerous to themselves and others | 91 (82.0) | 20 (18.0) |
| | Depression can lead to suicide | 108 (97.3) | 3 (2.7) |
| | Have you ever suffered from depression | 58 (52.3) | 53 (47.7) |
| Recognition of symptoms of depression | Sadness/bad moods | 103 (92.8) | 8 (7.2) |
| | Lack of appetite/overeating | 99 (89.2) | 12 (10.8) |
| | Lack of interest in routine activities | 100 (90.0) | 11 (9.9) |
| | Suicidal or self-harming | 103 (92.8) | 8 (7.2) |
| | Fatigue and body aches | 94 (84.7) | 17 (15.3) |
| | Sleep disorder | 99 (89.2) | 12 (10.8) |
| | Lack of energy | 96 (86.5) | 15 (13.5) |
| | Sexual dysfunction | 85 (76.6) | 26 (23.4) |
| Source of information (open question) | Social media | 44 (39.6) | |
| | School | 39 (35.1) | |
| | Friends and family | 19 (17.1) | |
| | Articles/ leaflets | 9 (8.1) | |
| Medical terminology of depression (open question) | Correct answer | 74 (66.7) | |
| | Incorrect or unsuitable term | 37 (33.3) | |

Table-3 revealed the participants belief about causes of depression and attitude towards the mode of treatment and use of alternative medicine for treating depression among respondents. More than 90% participants believed that familial reason such as death of loved ones (93.7%), home/family disharmony (91.9%), relationship breakups (90.1%) and personal reasons such as interpersonal/sad or guilt feelings (92.8%) were major causes of depression. There are reasons which are related with study such as examination (89.2%), projects (80.2%), failure in achievements (89.2%) and other reason such as chemical imbalance in brain (84.7%). Regarding attitude towards treatment, more than 90% of respondents (n=102) preferred to seek professional help from psychiatrists and general practitioners. However, there are also preference for the alternative medicine. 'Religious/spiritual therapy' ranked the highest (n=94, 84.7%), followed by 'people affected can solve it better' and 'meditation/yoga/exercise together' (90, 81.1% each), aromatherapy (88, 79.3%) and others.

**Table 3: Participants' Belief on Causes of Depression and Attitude towards the Mode of Treatment (n= 111)**

| Belief and Attitudes | **Causes** | **Yes (n / %)** | **No (n / %)** |
|---|---|---|---|
| Belief about cause of depression | Death of loved ones | 104 (93.7) | 7 (6.3) |
| | Interpersonal/sad or guilt feelings | 103 (92.8) | 8 (7.2) |
| | Home/family disharmony | 102 (91.9) | 9 (8.1) |
| | Relationship breakups | 100 (90.1) | 11 (9.9) |
| | Failure in achievements | 99 (89.2) | 12 (10.8) |
| | Examinations | 99 (89.2) | 12 (10.8) |
| | Chemical imbalance in brain | 94 (84.7) | 17 (15.3) |
| | Projects | 89 (80.2) | 22 (19.8) |
| | Automatically | 72 (64.9) | 39 (35.1) |
| Attitude towards treatment | Professional help from psychiatrists and general practitioners | 102 (91.9) | 9 (8.1) |
| | Religious/Spiritual therapy | 94 (84.7) | 17 (15.3) |
| | Person affected can solve it better | 90 (81.1) | 21 (18.9) |
| | Medication/Yoga/Exercise | 90 (81.1) | 21 (18.9) |
| | Aromatherapy | 88 (79.3) | 23 (20.7) |
| | Traditional medicine | 79 (71.2) | 32 (28.8) |
| | Spa treatment/massage | 77 (69.4) | 34 (30.6) |
| | Love is the best solution | 66 (59.5) | 45 (40.5) |

Table-4: Regarding the relationship of socio- demographic variables with the knowledge score on recognition of symptoms, gender, ethnicity and living area showed significant difference while other socio demographic variables of age, marital status, educational level and household income did not show any significant difference. Only significant results were shown here in the table. More than 80% (n=90) of youth showed very good level of knowledge score of 7-8 regarding the recognition of symptoms of depression and significant differences found on three variables namely, male gender compared to female (***p***=0.003), Malays compared to all other ethnic groups (***p***=0.005) and people living in urban area compared to rural area (***p***=0.045).

**Table 4: Distribution of Relationship of Knowledge level on Recognition of Symptoms with Gender, Ethnicity and Living Area**

| **Knowledge level** | | **Very poor** | **Poor** | **Moderate** | **Good** | **Very good** | ***p* value** |
|---|---|---|---|---|---|---|---|
| Score | | 0 | 1-2 | 3-4 | 5-6 | 7-8 | |
| Gender | Male | 1 (0.9%) | 3 (2.7%) | 3 (2.7%) | 7 (6.3%) | 49 (44.1%) | 0.033* |
| | Female | 2 (1.8%) | 0 | 1 (0.9%) | 4 (3.6%) | 41 (36.9%) | |
| Ethnicity | Malay | 2 (1.8%) | 2 (1.8%) | 1 (0.9%) | 5 (4.5%) | 65 (58.5%) | 0.005* |
| | Chinese | 1 (0.9%) | 0 | 0 | 2 (1.8%) | 15 (13.5%) | |
| | Indians | 0 | 0 | 3 (2.7%) | 3 (2.7%) | 8 (7.2%) | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | Others | 0 | 1 (0.9%) | 0 | 1 (0.9%) | 2 (1.8%) | |
| Living area | Urban | 1 (0.9%) | 1 (0.9%) | 0 | 5 (4.5%) | 52 (46.8%) | 0.045* |
| | Rural | 2 (1.8%) | 2 (1.8%) | 4 (3.6%) | 6 (5.4%) | 38 (34.2%) | |

* Significant

Table-5: Regarding the relationship of socio-demographics with the cause of depression, the significant result was found in the relationship of educational level of the participants with causes of depression. University students perceived higher relationship with education related issues (failure of achievement: ***p***=0.014, projects: ***p***=0.001), and home/family disharmony (***p***= 0.019) as the cause of depression compared to other educational status of the participants.

**Table 5: Relationship between Educational level of Participants and Causes of Depression**

| Causes | High school (n=17) | University (n-71) | Employed (n=14) | Unemployed (n=9) | Chi square | *p* value |
|---|---|---|---|---|---|---|
| Failure in achievements | 15 (13.5) | 63 (56.8) | 14 (12.6) | 7 (6.3) | 2.944 | 0.014* |
| Interpersonal/sad or guilt feelings | 15 (13.5) | 69 (62.2) | 13 (11.7) | 6 (5.4) | 11.760 | 0.178 |
| Examinations | 16 (14.4) | 63 (56.8) | 13 (11.7) | 7 (6.3) | 1.854 | 0.090 |
| Projects | 11 (9.9) | 60 (54.1) | 13 (11.7) | 5 (4.5) | 8.248 | 0.001* |
| Chemical imbalance in brain | 13 (11.7) | 64 (57.7) | 12 (10.8) | 5 (4.5) | 8.413 | 0.121 |
| Death of loved ones | 16 (14.4) | 68 (61.3) | 13 (11.7) | 7 (6.3) | 4.401 | 0.148 |
| Lack of energy | 15 (13.5) | 67 (60.4) | 13 (11.7) | 7 (6.3) | 3.312 | 0.077 |
| Home/family disharmony | 13 (11.7) | 67 (60.4) | 13 (11.7) | 7 (6.3) | 6.634 | 0.019* |
| Relationship breakups | 13 (11.7) | 45 (40.5) | 9 (8.1) | 5 (4.5) | 1.418 | 0.092 |

* Significant

Table- 6: Relationship of socio-demographics with the attitude towards use of alternative medicine for treating depression showed significant result with the marital status. Those who were single were found significantly higher to use the religious/spiritual therapy (***p***=0.001), aromatherapy (***p***=0.021), love (***p***=0.042) and traditional medicine (***p***=0.046) than the married youths.

**Table 6: Relationship of marital status with attitude towards use of alternative medicine for treating depression**

| Alternative medicine to treat depression | Single (n=98) | Married (n=13) | Chi square | *p* value |
|---|---|---|---|---|
| Spa treatment/massage | 69 (62.2%) | 8 (7.2%) | 0.425 | 0.062 |
| Religious/Spiritual therapy | 83 (74.8%) | 11 (9.9%) | 0.000 | 0.001* |
| Aromatherapy | 78 (70.3%) | 10 (9.0%) | 0.050 | 0.021* |
| Person affected can solve it better | 78 (70.3%) | 13 (11.7%) | 3.236 | 0.171 |
| Love is the best solution | 59 (53.2%) | 7 (6.3%) | 0.192 | 0.042* |
| Meditation/Yoga/Exercise | 81 (73.0%) | 9 (8.1%) | 1.348 | 0.110 |
| Traditional medicine | 69 (62.2%) | 10 (9.0%) | 0.237 | 0.046* |

* Significant

## 4.0 DISCUSSION

This present study determines the knowledge, belief and attitude of youths in Kuantan, Pahang, Malaysia about depression and also its relationship with demographic factors such as gender, age group, marital status, ethnicity, education level and household income among respondents lived in different areas (urban and rural) in Kuantan. To our knowledge, this is the first study in Kuantan exploring knowledge, belief and attitude of youth about depression. Overall, most of our respondents showed higher level of general knowledge and knowledge on the recognition of symptoms. The knowledge score regarding recognition of symptoms of depression was found very good (score 7-8) in more than 80% participants. Significant difference was found of the knowledge scores on recognition of symptoms scores in male participants compared to females (***p***=0.003), Malay participants compared to all other ethnic group (***p***=0.005) and participants living in urban area compared to those living in rural area of Kuantan (***p***=0.045).

There are various studies that reported different knowledge level of participants. One previous study in Bangladesh showed low depression literacy where 50% of 404 University students answered correctly on nine of 22 items regarding psychotic symptoms, impact and management (Mamun et al., 2020). Likewise, in an Indonesian study, about 50.35% (n=215) of university students had good level knowledge towards mental health disorders (Puspitasari et al., 2020). One possible explanation for the variable findings is that different study population, and use of different survey questions. Higher score rating in this present study might be due to the fact that more than half of our participants (52.3%) had personal experience of depression. Those with personal experience of depression was found to have significantly better knowledge (Khan et al., 2010; Khan et al., 2009). The knowledge level difference on recognizing symptoms was noted in this present study in terms of gender, ethnicity and living

area. Male (***p***=0.033), Malay (***p***=0.005) respondents had the better knowledge score on symptoms of depression compared to female and all other ethnicity respectively. This finding differed from the findings reported by Khan et al., (2009) where Chinese and female respondents were found to have better knowledge of symptoms of depression compared to all other ethnicity and male respondents respectively. Other studies also suggest that females are more prone to depression (Blanco et al., 2010; Sahril et al., 2019). This present study also showed respondents who lived in urban area of Kuantan had better level of knowledge (***p***=0.045). This finding can be explained by the fact that rural populations had fewer personal resources, with a higher proportion of residents without completing high school, lived in or near poverty, and were unemployed compared to urban population (Probst et al., 2006). Other socio-demographic factors did not show any significant difference in terms of knowledge domain. In this present study, a small number of participants (7%-23%) failed to recognize the symptoms and sexual dysfunction was not recognized as many as 26 (24.3%) participants. More awareness program is required in this regard to educate people regarding the knowledge of depression that will ultimately help to seek treatment and reduce the stigma and prejudices related to mental disorder.

Regarding the source of information, our findings indicated that respondents received their information about depression mainly from social media, followed by from school and from family, friends and articles. These findings were comparable with findings from a study by Puspitasari (2020) where majority of Indonesian University students obtain mental health information from social media (93%), formal education (46%) and family, friends (60%). Regarding the response about the medical terminology of depression, two-thirds of the respondents answered with correct medical terminology (66.7%). This higher percentage may have been due to half of our respondents (n=58) were having had personal experience of depression so that they were familiar with medical terminology related to depression.

This study finding on the beliefs about causes of depression showed that majority believed that familial reason such as death of loved ones, home/family disharmony, relationship breakups and personal reasons such as interpersonal/sad or guilt feelings were major causes of depression. The other common reasons noted were related with study or education such as examination, projects, failure in achievements as well as chemical imbalance in brain. Relationship of belief with socio-demography showed that educational level of the participants is significantly associated of with causes of depression in the item of failure in

achievement (***p***=0.014), projects (***p***=0.001), and relationship breakups (***p***=0.019). Similar findings were reported by Khan et al., (2010). It is reported that students who are worried about their academic activities were 1.8 times more likely to exhibit mild to severe anxiety symptoms than students with no such worries (Islam et al., 2020). This could explain the significant association of the educational level with the causes of depression. Another important finding in this present study is that 65% of the participants believe that depression comes automatically without any reason. It is reported that people can have depression for no known reason (Bruce, 2021).

World Health Organization (WHO) reports, depression can result from a complex interaction of social, psychological, and biological factors. Adverse life events such as unemployment, bereavement, traumatic events or physical illness such as cardio vascular disease is related to depression (WHO, 2021a). Study reports showed that family history of depression, childhood abuse and neglect, and female sexuality, recent life stressors, physical illness, poor interpersonal relationships with friends and families, low self-esteem, loneliness are important aetiological factors for depression (Wang et al., 2021). Research showed that beliefs about the causation of depression in western countries mainly focuses on the biological and social risk factors while in non-western countries, the focus is mainly on the supernatural and religious factors (Teferra & Shibre, 2012). In Asian culture, supernatural agents such as witchcraft and possession by evil spirits are believed as a major reason for mental disorder (Khan et al., 2011; Kurihara, 2006). In a systematic review on beliefs and perception about mental health issues, investigators stated that the cultural context is important when studying beliefs regarding mental health; they found out spiritual and supernatural causes are the second most frequent perceived cause of mental health problems in their systematic review (Choudhry et al., 2016). The understanding of mental health and the interpretation vary from culture to culture. Previous findings have provided evidence of supernatural beliefs among Malaysians in relation to psychological problems (Khan et al., 2011 and Razali et al., 1996). Awareness among the population can help to change the populations' view about the mental illness and to implement proper treatment and prevention.

Regarding the attitude towards treatment, more than 90% of respondents (n=102) preferred to seek professional help from psychiatrists and general practitioners. This is good sign that most of our participants preferred to take professional help to treat the depression. Regarding attitude towards alternative treatment for depression, it is interesting to note that religious/spiritual therapy was the most recommended one. These findings were consistent with

study done by Khan et al., where the majority of students also claimed benefits from religious /spiritual therapy (Khan et al., 2010). Other studies also showed that the majority were willing to seek help religious and traditional healers (Khan et al., 2011 and Razali et al., 1996). Based on this present study finding, there is a risk of getting alternative medicine for depression, which may affect the ability of Malaysian youths to seek the evidence based mental healthcare. Culture and tradition including strong religious belief could contribute negative attitude. Ibrahim et al., (2019) reported that the practice of making a spiritual diagnosis and treatment in East Malaysia could delay medical help-seeking in mental health disorder. Preferred modes of treatments comprising of both scientific and unscientific methods may be varied from person to person and from one group to another (Ibrahim et al., 2019). On further analysis of our present data to find out the relationship of attitude with socio-demographic variables, significant result is found with marital status where 'single' respondents believed that religious/spiritual therapy can significantly cure depression than the married respondents ($p= 0.001$).

It is reported that people showed reluctant attitude to seek help for mental disorder which is the first step for the mental health care, so that subsequent steps of proper diagnosis and intervention and management of can be proceeded by professionals (Ibrahim et al., 2019). Globally almost 70% of people do not receive treatment due to various barriers such as financial burden, difficulty in accessing the health care provider, or lack of adequate knowledge to identify the features and need of treatment as well as prejudice and perceived stigmatization and discrimination against people having mental disorder. Researchers found out the association between participants' knowledge of depression with attitude towards getting help (Henderson et al., 2013; Ibrahim et al., 2019). Those who have better information about symptoms, causes and treatment of mental illness generally have more favourable and positive attitudes on seeking mental help (Mottus et al., 2014).

It has been reported globally, mental health programs increase the mental health literacy. According to a local study done in Malaysia, it is found that Depression Literacy Program (including lecture, mental awareness activities and a short video) is effective in upgrading the knowledge of depression and eventually lead to increasing mental help attitudes among adolescents from B-40 households (Ibrahim, 2019). Thus, it is recommended to increase the awareness on mental health among the population, so that the early diagnosis and treatment can be implemented.

There are few limitations in this present study. Firstly, cross sectional study design represents the data of one particular time only. Here the participants are not followed up over time. Secondly; we have used non-random sampling method to collect data among youths lived in Kuantan, Pahang state. Therefore, our findings may not be a representation of the rest of the country. Thirdly, majority of participants in the study were Malay youths who received University education and were single, therefore this result cannot be generalized. The limitations highlight the need for further research with larger sample size and equal distribution of educational and marital status. Despite having above limitations, findings of this study contribute the baseline data of depression among the youth in Kuantan, Pahang State.

## 5.0 CONCLUSION

A very good knowledge score level of the symptoms of depression was observed. Male, Malay youths had better knowledge score. University graduates/students prioritised education related issues such as examinations, failure in achievements and projects were main causes of depression. Religious/spiritual treatment was the first choice of alternative treatment chosen by youth who were single. A majority of youth had a positive attitude upon seeking help from Psychiatrists and general practitioners although they were inclined towards the use of alternative medicine. Further research with larger sample size should be conducted to prove our findings. It is recommended to implement depression literacy program to increase awareness of evidence based mental healthcare among Kuantan youths.

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