Poltekita: Jurnal Ilmu Kesehatan
e-ISSN: 2527-7170 dan p-ISSN: 1907-459X
Volume 19 Issue 1, 2025, page 37-46
DOI: 10.33860/jik.v19i1.4141
Website:https://ojs.polkespalupress.id/index.php/JIK
Publisher: Poltekkes Kemenkes Palu

Original Article

The Effectiveness of the HELP Adolescent Mental Health Module in Preventing Bullying

Helena Pangaribuan[1,2]*, Nurdin Rahman[3], Tri Setyawati[4]
[1]Doctoral Program in Social Sciences, Graduate Program, Universitas Tadulako, Central Sulawesi, Indonesia
[2]Department of Nursing, Poltekkes Kemenkes Palu, Central Sulawesi, Indonesia
[3]Faculty of Public Health, Tadulako University, Central Sulawesi, Indonesia,
[4]Faculty of Medicine, Tadulako University, Central Sulawesi, Indonesia
*Corresponding author: helenapangaribuan2005@gmail.com

ARTICLE INFO

Article History:
Received: 2025-01-01
Published: 2025-04-01

Keywords:
Adolescent mental health module; Bullying prevention; School-Based Intervention

ABSTRACT

Bullying is a social phenomenon that cannot be avoided today. The Indonesian Child Protection Commission (KPAI) recorded that there were 253 cases of bullying from 2011 to 2016, 36 cases occurred, which if presented, 22.4% of the 161 cases occurred at school. School is no longer a comfortable place to gain knowledge and develop character, if it is not handled well there is a risk of mental disorders, depression and suicide. This research aims to determine the effectiveness of the HELP adolescent mental health module in preventing bullying in students at SMAN 3 Palu. This research design is Research and Development with a quantitative approach to a quasi experimental, employing a two-group pretest-posttest design with a control group, involving a total of 90 respondents (45 in the intervention group and 45 in the control group). The instrument used was a questionnaire to collect data. Data analysis used univariate analysis, independent T tests, dependent T tests, chi-square tests, and multivariate analysis. All data was analyzed using SPSS. The HELP adolescent mental health module consists of 3 interconnected circles, namely: the innermost circle is teenagers as the focus of intervention, the next circle is teachers and parents whose aim is to provide support and monitoring in preventing bullying. Prevention of adolescent bullying increased after the model intervention, namely increasing from the moderate bullying category to mild bullying by 29.4%. Research in implementing the HELP adolescent mental health module can prevent bullying in adolescents. In further research, it is necessary to innovate methods by adding the use of applications for access to monitoring and evaluation by teenagers and teachers using easily accessible TikTok media in explaining educational material so that it can increase the effectiveness of the module.

INTRODUCTION

According to the World Health Organization (WHO), adolescents are individuals aged 10 – 19 years. as a transition period because a teenager no longer has the status of a child but has not yet attained the status of an adult.[1] Adolescents are one of the targets for future health development and mental health is an important issue in mental health promotion strategies in preventing juvenile delinquency/bullying behavior. This phase is very sensitive because, at this stage, teenagers will look for their own identity when forming their personalities.[2]

Bullying is the act of using power to hurt a person or group of people verbally, physically, or socially so that the victim feels depressed, traumatized, and helples.[3] Many people consider bullying not a serious problem and see it as a normal thing in everyday life, even part of a child's socialization process, even though it can occur in various places such as school, home, or public places.[4]

In Indonesia, Reporting from the official website of the Commissioner of the Indonesian Child Protection Commission (KPAI) in 2020, data was obtained that many incidents were experienced by students who were kicked to death, students had to have their fingers amputated, this has become an example that bullying behavior is extreme and physically and psychologically fatal, carried out by students and their friends. There were 37,381 complaints of violence committed against children in cases of bullying from education and social media, the number reached 2,473 reports and the cases continue to increase. If there is no special attention from the environment, especially teachers at school, the number of victims will always increase. Almost every school in Indonesia experienced bullying. in the form of verbal bullying and psychological bullying. Based on the presentation of this complex bullying case, Indonesia has entered the emergency category for school bullying.[5]

According to Reisen et al. (2019), based on a national survey of teenagers in high school (SMA), it was reported that 28% of teenage boys and 7% of adolescent girls experienced physical fights within a month. Nearly 35% of the survey respondents reported at least one physical assault that resulted in an injury.[6] Based on 2013 and 2018 Riskesdas data, it is known that Central Sulawesi is ranked number one for emotional mental disorders in Indonesia, which have an impact on violent behavior and bullying at school. As many as 11.6% of the population of Central Sulawesi experiences mental-emotional disorders, and around 20% of the Indonesian population has the potential to experience them. Globally, 21.4% of teenagers aged 13–18 experience mental disorders. Failure of interventions can increase the number of cases in the future.[7]

Risk and protective factors influence bullying in adolescents. Increasing protective factors and recognizing them is essential to determining effective interventions through promotive and preventive efforts. Preventive interventions against psychosocial factors that have been carried out show a reduction in bullying risk factors after teenagers are trained, which increases teenagers' self-defense abilities against stress.[8]

The HELP youth mental health module is an essential innovation in increasing resilience and preventing bullying. This module allows for more in-depth research on adolescent resilience and bullying prevention. Its success depends on cooperation between the school, the health service, and the education department. HELP provides a framework for teacher training and early detection of student mental health, as well as education about adolescent psychosocial development and how to overcome bullying through stress management. This model aims to improve mental health, create a comfortable school environment, and support academic achievement.[9]

The HELP adolescent mental health module for bullying prevention consists of the following: Adolescents are a central element of the school-based bullying prevention module. The HELP adolescent mental health module for preventing bullying consists of 4 submodules, namely submodule 1: Must carry out screening for new students and other students every semester. Adolescents who are the main focus in this module will be given intervention training on early detection/mental health screening, protective factors, and risks of adolescent mental health using the Strengths and Difficulties Questionnaire (SDQ) submodule 2. Education about bullying and adolescent development. Providing education aims to increase teenagers' awareness of protective factors that can improve their' resilience to the risk of bullying. Coping skills are one of the risk factors for bullying in adolescents. submodule 3: Train emotional management through stress management: relaxation techniques, submodule Implementation of assertive training. The application of assertive training is a strategy for dealing with bullying behavior strategy given to teenagers to improve their ability to deal with stress and the risk of bullying.[10]

METHODS

The study employs a quasi-experimental design with a pretest-posttest approach to evaluate the effectiveness of the HELP adolescent mental health module in preventing bullying. It will be conducted at SMAN 3 Palu and last for seven months, from March to September 2024.

The research instrument used for the dependent variable is a questionnaire, which is divided into three domains, bullying, protective factors, and risk factors of bullying. The instruments used have been tested for validity and reliability and declared valid and reliable. Univariate analysis was used to determine the frequency and percentage distribution of age, gender, gender, childcare in the family, order of children in the family, and parents' work.

The research population included all students at SMAN 3 Palu. Using purposive sampling, 45 intervention and 45 control group respondents were selected in grades X and XI. This research lasted for six months, with the first stage being data collection, theory and concept analysis and module development, then the second stage was testing the effectiveness of the HELP mental health module in preventing bullying. Subjects in the intervention group followed the mental health module to completion (four sessions) for five weeks. Control group subjects were given mental health counseling and received a module.[11]

The independent variable in this study is the HELP mental health module, a module applied as an intervention to prevent adolescent bullying. The dependent variable is protective factors (coping mechanisms, family relationships, prosocial abilities) and risk factors (emotions, peers, behavior) for bullying Data collection and recording through questionnaires given before and after the intervention.

To assess the effectiveness of HELP mental health, bivariate analysis was carried out to see the value of risk and protective factors for adolescent bullying in the intervention group and control group. Data analysis in this study used univariate analysis, namely measuring the proportion and frequency distribution of each variable. The bivariate test used in this study was the paired t-test to see the differences in the results of the variables measured pre- and post-test in the intervention and control groups. The multivariate analysis used was linear regression to determine the effectiveness of the module intervention. This was done to determine how well the model intervention worked and how protective and risk factors affected changes in the independent variable (adolescent mental health). This test also determines the factors that most influence adolescent mental health.[12]

RESULTS

Table 1. Frequency distribution of depictions of teenage bullying (n=90)

Variable	n	n (%)
Bullying		
Moderate Bullying	75	83.3
Mild Bullying	15	16.7

The results of the frequency distribution analysis for the bullying variable were divided into three categories, namely severe bullying , moderate bullying, and mild bullying Based on table 1 data analysis for the bullying category showed that the majority of teenagers were moderately bullied, namely 83.3% , light bullying 16.7%

Table 2. Overview of protective factors and risks of bullying (n=90)

Overview of protective factors and risks of bullying	f (n = 90)
Coping Mechanisms	
Adaptive Coping	30%
Maladaptive Coping	60%
Family Relationship	
Good	60%
Not good	40%

Overview of protective factors and risks of bullying	f (n = 90)
Prosocial abillities	
Normal	56%
Borderline	20%
Abnormal	14%
Emotional Problems	
Normal	32%
Borderline	41%
Abnormal	15%
Peer Problems	
Normal	1%
Borderline	25%
Abnormal	64%
Behavior Problems	
Normal	3%
Borderline	41%
Abnormal	46%

Based on table 2, description of the protective factors of coping mechanisms in preventing teenage bullying, it was found that the majority of teenagers used coping mechanisms in the adaptive category—66.7% Furthermore, most of the protective factors for family relationships are in the good family relationships category, amounting to 55.6% Furthermore, most of the prosocial abilities were in the normal category, amounting to 62.2% An overview of the risk factors for adolescent emotional problems found that the majority of adolescents had borderline emotional problems, 45.5% ,followed by mostly peer problems, 71.1% and most behavioral problems, 51.1%

Table 3. Risk factors bullying before and after the intervention module in the intervention and control groups

Variable factor protektife	Teenager			*p-value	**p-value
	Mean before	Mean after	Sd		
Emotional problems					
Intervention	4.40	1.724	1.724	0.000	0.739
Control	4.53	1.700	1.546	0.146	
Behavior					
Intervention	12.84	1.99	1.999	0.000	0.910
Control	13.44	2.360	2.360	0.150	
Peer Problems					
Intervention	6.91	1.607	1.607	0.000	0.739
Control	6.80	1.546	1.546	0.452	

*Independent t.test
**Paired t.test

Emotional problem scores are divided into 3 categories, namely normal (0-3), borderline (4-6), and abnormal (7-10). Table 3 shows that teenagers in SMAN 3 in the intervention group have emotional problems (4.40), which means that on average teenagers have borderline emotional problems; teenagers in the control group have emotional problems (4.53), meaning that adolescents have borderline emotional problems. The equality test between the intervention group and the control group obtained a p-value > 0.05, which means that the data between the intervention group and the control group were equivalent.

Furthermore, the behavior problem scores are divided into 3 categories: normal (0-6), borderline (7-13), and abnormal (14-20). Table 3 shows that teenagers in SMAN 3 in the intervention group have borderline behavior problems (12.84), which means that on average, teenagers have borderline behavior problems. Behavior problems in the control group have borderline behavior problems (13.44), meaning that adolescents have behavior problems. borderline.

The peer problem variable is divided into 3 categories, namely normal (0-3), borderline (4-6), and abnormal (7-10). Table 3 shows that teenagers in SMAN 3 in the intervention group have borderline peer problems (6.91), which means that on average teenagers have borderline peer problems, and peer problems in the control group have borderline peer problems (6.80), meaning teenagers have borderline peer problems. The equality test between the intervention group and the control group obtained a p-value > 0.05, which means that the data between the intervention group and the control group were equivalent.

Table 4. Adolescent bullying before and after the intervention module in the intervention and control groups

Variable	Remaja			*P Value	**P.Value
	Mean before	Mean after	Sd		
Bullying					
Intervention	30.56	21.80	5.964	0.000	0.18
Control	32.49	31.98	5.707	0.305	

*Independent t.test
**Paired t.test

Table 4 shows that the average bullying rate among teenagers at SMA Negeri 3 in the intervention group is 30.56, which shows that bullying among teenagers in this group is moderate, while the average score for bullying among teenagers in the control group is 32.49, which shows that bullying teenagers are in the medium category. The equality test for the intervention and control groups obtained p-value > 0.05, which means that the data in each group for both intervention and control were equivalent. Among the teens in the intervention group at SMAN 3 Palu, the average bullying score went down from 30.56 to 21.80 , which is considered mild bullying. This change was significant (p-value <0.05.

Bullying in the control group decreased from 32.49 to 31.98 which is in the moderate bullying category, meaning it decreased by 0.51 (but was not significant with a p-value > 0.05. The bullying score for teenagers who received the intervention module decreased to 21.80 in the mild bullying category, which was significantly higher than the control group, namely 31.98 in the moderate bullying category with a p-value <0.05.

Table 5. Correlation Test Results of the Relationship between Protective Factors and Risk Factors against Bullying

Variable independen	Mild bullying		Moderate bullying		P Value
	n	%	n	%	
Coping Mechanisms					
Adaptif	31	34.4	14	15.5	0.000
Maladaptif	8	8.8	37	41.1	
Family relatioship					
Good	32	35.5	25	27.7	0.000
Not good	7	7.7	26	28.8	
Prosocial abillities					
Normal	1	1.1	3	3.3	0.046
Borderline	5	5.5	15	16.6	
Abnormal	33	36.6	34	37.7	
Peer problems					
Normal	4	4.4	2	2.2	
Borderline	17	18.8	8	8.8	0.001
Abnormal	18	20	41	45,5	
Emotional problems					
Normal	13	14.4	27	30	
Borderline	20	22.2	20	22.2	0.047
Abnormal	6	6.66	4	4.44	
Behavior problems					
Normal	7	3,7	3	3.3	

Variable independen	Mild bullying		Moderate bullying		P Value
	n	%	n	%	
Borderline	19	21.1	17	18.8	0.004
Abnormal	13	14.4	31	14.4	

Table 4 shows the relationship between coping mechanisms and bullying. The Chi-square statistical test produces a probability value of 0.000 ('p-value < 0.05'), which indicates there is a significant relationship between coping mechanisms and bullying. The Coping Mechanisms variable was included in multivariate moduling because it has a probability value of less than 0.250 ('p-value < 0.250').

The family relationship variable was included in multivariate modeling because it had a probability value of less than 0.250 ('p-value < 0.250'). Family relationships have a relationship with bullying; a statistical test using Chi-square produces a probability value of 0.000 ('p-value < 0.05'), which shows there is a significant relationship between family relationships and bullying. The family relationship variable was included in multivariate moduling because it had a probability value of less than 0.250 ('p-value < 0.250').

Statistical tests show that there is a relationship between prosocial abilities and bullying; statistical tests using Chi-square produce a probability value of 0.046 ('p < 0.05'), which shows there is a significant relationship between social support and bullying. The prosocial ability variable was included in multivariate modeling because it had a probability value of less than 0.250 ('p-value < 0.250').

The statistical test shows that there is a relationship between peer problems and bullying, where the statistical test using Chi-square produces a probability value of 0.046 ('p-value < 0.05'), which shows that there is a significant relationship between peer problems and bullying. The peer variable was included in multivariate moduling because it had a probability value of less than 0.250 ('p-value < 0.250').

The statistical test shows a relationship between emotional problems and bullying, where the statistical test using Chi-square produces a probability value of 0.047 ('p-value < 0.05'), which shows a significant relationship between emotional problems and bullying. The emotional problems variable was included in multivariate moduling because it has a probability value of less than 0.250 ('p-value < 0.250').

Table 6. Final Modulling Results of Multivariate Analysis of Independent Variables on Bullying

Variables	Koefisien	T	P-Value	R	R^2
Konstanta	11.622	1.741	0.000	0.702	0.493
Module Intervention	10.178	1.101	0.000		

Table 6 shows that the intervention model variable is a factor that influences bullying with a multivariate coefficient value of R = 0.702, which indicates that there is a strong influence between the variables on bullying, where this variable has the most decisive influence (T = 1.741). Based on the R Square value = 0.493, it can be explained that the HELP Intervention module can explain 49.3% of adolescent bullying after the intervention model, and the rest is explained by other variables that have not been studied.

DISCUSSION

This research was conducted on teenagers who were students at SMA Negeri 3 Palu. The research results showed that of the 90 respondents who experienced high levels of bullying, 62 respondents (68.9%) tended to become victims of bullying. Research shows that the HELP mental health module is based on the multi-system theory of resilience in respondents plays an important role in increasing protective factors to prevent bullying.

Revealed that the causes of bullying can be seen from three main components, namely the victim, the perpetrator, and the witness/observer, the cause from the perpetrator's side is that he feels he has power over the victim and considers bullying as normal and normal behavior. Bullying

that occurs in teenagers is a form of aggressive action that is carried out intentionally and occurs repeatedly to attack a target or victim who is weak, easily insulted, and unable to defend themselves[13]. One form of bullying in adolescents is verbal bullying, which is an action that aims to hurt someone through teasing and making them the butt of jokes, as well as addressing individuals with nicknames that can make them feel uncomfortable, hurt, and angry[14]. This finding is in line with the theory expressed, which states that verbal bullying can take the form of nicknames, insults, slander (such as spreading gossip), cruel criticism, and insults. These verbal actions are often carried out without realizing it, using words, statements, and name-calling to gain power and control over the target. Research conducted also shows that bullying is often motivated by the perpetrator initially joking but then leads to actions that really hurt the victim[15].

One way of promotional action that can be taken to overcome mental health problems and prevent bullying is through the HELP youth mental health module. Increasing mental health knowledge, protective factors for bullying can have an impact on optimal mental health of teenagers so they can face challenges in the era of globalization, especially preventing bullying.

Protective factors are factors that are protective, which play a role in reducing the impact of risk factors; in other words, protective factors can make a person less likely to experience disorders. The impact of bullying can be mild if teenagers have protective factors within themselves. Teenagers' coping strategies, family relationships, and prosocial skills were studied using an equivalence test. The results showed that the intervention group's coping strategies improved significantly in the normal category (p-value <0.05), while the control group's coping strategies improved in the normal category but not significantly (p-value >0.05). When facing stress triggers, the common forms of behavior carried out by humans are efforts to anticipate stress to reduce or eliminate stressful experiences (avoidance) and efforts to reduce or eliminate stress when facing stressors (Haskell, Britton, & Servatius, 2020). Therefore, efforts to overcome the causes of problems increase a person's coping mechanisms/efforts to continue living amidst difficult situations.[16]

Coping mechanisms are all efforts directed at managing stress, which can be constructive or destructive. When individuals use anxiety as a warning sign and accept it as a challenge to solve problems, coping mechanisms can be constructive.[17] If the mechanism used is successful, then these constructive coping mechanisms can be modified to be used as a way to resolve or overcome future threats. Individual coping mechanisms for stress include positive emotions regarding the future, which can include optimism, hope, confidence, and trust. Past and current events certainly make a person stressed or even more motivated. This depends on how a person can respond with positive emotion.[18]

The emotional relationship between children and their parents can be strained by various factors, including inaccurate education, overworked parents, and careless children who choose friends/social circles and end up in the wrong company. Alternatively, it may stem from an individual's personal identity crisis. Parents who ignore and do not adequately meet their children's needs can increase the risk of children engaging in unacceptable social behavior.[19]

Teenage bullying at SMAN 3 Palu before receiving the HELP mental health model intervention was in the category of 30.56 moderate bullying. After the "HELP" intervention, he was in the 21.80 mild bullying category. Even though the majority of bullying is mild, it is still considered a harmful behavior. Bullying behavior is challenging to eradicate as it is often viewed as a natural, everyday occurrence, leading to its persistence over time. Many environments consider bullying to be a trivial problem and part of a child's growth and development process.

The development of the HELP mental health model for preventing bullying was carried out through several stages, namely the preparation of a draft model based on literature studies, which was then continued with field trials to prepare the final model. Researchers develop a model. Researchers at this stage utilize the theoretical concept of system resilience. The results of this research are discussed using systems resilience theory, where the factors of bullying are divided into risk factors and protective factors that originate from within and outside the teenager himself. Multivariate analysis shows that the factor that influences bullying is the intervention model. This variable has an influence of 49.3% on bullying. In a multivariate statistical test, it was found that the protective factors—coping mechanisms, family relationships, and prosocial abilities—and risk

factors—namely emotional problems, behavioral problems, and peer problems—did not show any influence on bullying after being given the intervention model when compared to those who did not receive the intervention model. This means that teenagers who are not given the Intervention model may be at greater risk of bullying when compared to teenagers who are given the Intervention model. Teenagers have the ability to respond adaptively to existing problems, and this will prevent teenagers from bullying.

Individuals have the ability to accept, face, and resolve problems that occur in their lives, so they are expected to become strong. Individual characteristics that can help someone become resilient include emotional regulation impulse control, optimism, the ability to analyze problems, and empathy. Individuals who have difficulty managing emotions will tend to have difficulty making appropriate decisions when resolving problems positively and are not open to experience. The external factor for adolescents is the family. When the family faces difficulties, it will try to resolve existing problems well and completely so that conditions return to their original state or are better. A strong family commits family members so that there is a sense of mutual respect, togetherness, and beneficial and positive communication. The main idea is based on a resilience system modul, which says that people are greatly affected by their internal and external environments, including how they deal with stress, their own growth, their family relationships and support, and how well their teachers understand the needs of teenagers. The concept and theory analysis revealed that this research focused primarily on prevention. The literature study results were then used to develop a model for adolescent mental health, as well as modules for early detection of mental health, bullying education, adolescent growth and development, emotional management, social interaction skills, and bullying management strategies.[20]

Comparison with Previous Studies

Our findings are consistent with several previous studies while providing some unique insights. In particular, bullying and adolescent mental health are significant with the findings[5]. This research also emphasizes that perpetrators of bullying have mental health problems, namely high levels of depression and psychological pressure. However, our study provides unique insights into the importance of protective and risk factors in preventing youth bullying. These findings contrast with previous research, such as Keliat et al, which identified assertive training as an important factor in preventing youth bullying. Differences between our results and previous research may be due to differences in research settings, populations, or methodologies, indicating the need for further research to explore this relationship in various contexts. In addition, other research highlights the significant impact of the quality dimensions of family communication in preventing bullying behavior for adolescents, emphasizing the importance of family communication in preventing adolescent bullying. Furthermore, recent research highlights the important role of parents and school involvement in preventing bullying.[21]

Implications for Public Health

This research shows that the HELP mental health module intervention can increase adolescents' resilience to protective factors and reduce bullying risk factors so that this is evidence that can be used to develop adolescent bullying prevention programs in schools. Further studies are needed on protective factors and risk factors for bullying to increase the effectiveness of bullying prevention programs.

Limitations and Cautions

Evaluation after the intervention module is only carried out once after completing the implementation of independent activities, so the effects of the intervention model are not yet known some time after the implementation of the intervention module ends.

CONCLUSION

The HELP adolescent mental health module is designed in the form of three interconnected circles. At the center of this model are the adolescents themselves, serving as the main focus of intervention. The next circle includes teachers and parents, who play a vital role in providing

emotional support and continuous monitoring of adolescent behavior. This comprehensive and integrated approach aims to foster a supportive environment that helps prevent bullying among adolescents. The findings of this study indicate a positive impact following the implementation of the HELP module, as reflected by a 29.4% decrease in bullying severity—from the moderate category to the mild category.

In light of these findings, it is recommended that this mental health module be widely disseminated and integrated into school-based health promotion activities. This effort should involve coordination with the Palu City Health Office and local health centers (Puskesmas), particularly with program officers responsible for child and adolescent mental health. Furthermore, future research is encouraged to innovate by incorporating digital platforms, such as mobile applications, to facilitate access to monitoring and evaluation tools for adolescents, teachers, and parents. Social media platforms like TikTok may also be utilized to deliver engaging and accessible educational content on bullying prevention.

Author's Contribution Statement: Helena Pangaribuan conceptualized the study, conducted data collection, performed the analysis, and wrote the manuscript. Nurdin Rahman as the promotor, provided critical guidance and supervision throughout the research process, contributing significantly to the study design and interpretation of the findings. Tri Setyawati, as the co-promotor, offered valuable support in refining the research methodology and reviewing the manuscript for important intellectual content. All authors read and approved the final manuscript.

Conflict of Interest: The authors declare no conflicts of interest

Source of Funding Statements: This study was self-funded by the authors. No external funding was received to support this research

Acknowledgments: We thank the teachers and students of SMAN 3 Palu for their participation and support. Special thanks to the research assistants who helped with data collection and entry.

REFERENCES

1. Chowdhury, S., & Islam N. Substance abuse and its impact on adolescent mental health. Addict Behav, 105. 2020. Available from: https://doi.org/10.1016/j.addbeh.2020.106335
2. Amdadi Z, Nurdin N, Eviyanti N. Gambaran Pengetahuan Remaja Putri Tentang Risiko Perkawinan Dini Dalam Kehamilan Di Sman 1 Gowa. 2021. Available from: https://ejournal.stpmataram.ac.id/JIP/article/view/1053
3. Brown, L., & Green K. Cultural influences on depression among adolescents 2nd ed. Academia. 2019. Available from: https://www.researchgate.net/publication/369539331_International_Student_Identities_and_Mental_Well-Being_Beyond_the_Single_Story
4. Janitra, A. P., & Prasanti D. Komunikasi Keluarga Dalam Pencegahan Perilaku Bullying Bagi Anak. 2017;(Jurnal Ilmu Sosial Mamangan, 6(1), 23.). Available from: https://ejournal.upgrisba.ac.id/index.php/jurnal-mamangan/article/view/1878
5. Faizah, F., & Amma Z. Bullying dan Kesehatan Mental Pada Remaja Sekolah Menengah Atas di Banda Aceh. 2017; Available from: International Journal of Child and Gender Studies, 3(1), 77–84. https://jurnal.ar-raniry.ac.id/index.php/equality/article/view/1950
6. BPS. Statistik Kesehatan Remaja Indonesia Tahun 2021. 2022; Available from: Badan Pusat Statistik. https://www.unicef.org/indonesia/id/media/9546/file/profil-kesehatan-remaja-2021.pdf
7. UNICEF. Adolescent Mental Health and Well-being in South Asia. Kathmandu: UNICEF. 2021. Available from: https://www.researchgate.net/publication/388727426_Mental_Health_of_Adolescents_in_Countries_of_South-East_Asia_A_Policy_Review
8. Miller, D., & Johnson P. The influence of peer relationships on adolescent mental health. J Youth Adolesc, 46(2), 340–356. 2017; Available from: https://doi.org/10.1007/s10964-016-0478-4

9. Indonesia M of H. Rencana Strategis Kementerian Kesehatan 2020-2024. Jakarta: Ministry of Health Indonesia. 2020. Available from: https://kemkes.go.id/id/rencana-strategis-kementerian-kesehatan-2022---2024
10. Li, X., & Zhang Y. he effects of academic stress on mental health among adolescents. Educ Psychol Rev, 31(4), 1057–1076. 2019. Available from: https://doi.org/10.1007/s10648-019-09485-0
11. Greenberg, M., & Weissberg R. Promoting resilience in adolescents. J Appl Dev Psychol, 40, 1–2. 2020. Available from: https://doi.org/10.1016/j.appdev.2020.03.005
12. Nguyen, T. & LH. Internet addiction and its impact on mental health in adolescents. Cyberpsychol Behav Soc Netw, 20(10), 610–615. Available from: https://doi.org/10.1089/cyber.2017.0235
13. Zakaria AF. Studi tentang upaya guru IPS dalam mengembangkan perilaku prososial dan mengurangi perilaku bullying siswa di SMP. Jurnal Pendidikan Ilmu Sosial, 25(1), 117–124. 2016; Available from: https://doi.org/10.17509/jpis.v25i1.3675
14. Novianti, M. C., & Tjalla A. Perilaku asertif pada remaja awal [Universitas Gunadarma. Fakultas Psikologi]. 2008
15. Harrington, R., & Kroll L. Depression in adolescents. Lancet, 372(9649), 1049–1057. 2018; Available from: https://doi.org/10.1016/S0140-6736(18)61028-2
16. Balmores-Paulino RS. Avoidance Coping Strategies (V. Zeigler-Hill & T. K. Shackelford, Eds.). Cham: Springer International Publishing. 2020; Available from: https://doi.org/10.1007/978- 3-319-24612-3_645
17. Williams, R., & Patel V. Mental health challenges in developing countries. J Lancet Psychiatry, 5(11), 875–877. 2018; Available from: https://doi.org/10.1016/S2215-0366(18)30308-2
18. Organization WH. Adolescent mental health. 2021; Available from: https://www.who.int/news-room/fact-sheets/detail/adolescent-mental-health
19. Gracia, M., & Lopez R. amily dynamics and adolescent depression: A study in urban Indonesia. Asian. Journal Psychiatr, 56. 2021; Available from: https://doi.org/10.1016/j.ajp.2020.102547
20. Smith, J., & Doe A. The impact of social media on adolescent mental health. J Adolesc Health, 67(3), 345–350. 2020; Available from: https://doi.org/10.1016/j.jadohealth.2020.05.002
21. Kim, S., & Park J. The role of sleep in adolescent mental health. Sleep Med Rev, 45, 18–25. 2019; Available from: https://doi.org/10.1089/cyber.2017.0235