



Faculty of Cognitive Sciences and Human Development

**Perceived Social Support and Mental Health Outcomes: A Study on
Indigenous Groups Among Urban and Rural Young Adults in Sarawak**

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**PERCEIVED SOCIAL SUPPORT AND MENTAL HEALTH OUTCOMES: A STUDY
ON INDIGENOUS GROUPS AMONG URBAN AND RURAL YOUNG ADULTS IN
SARAWAK**

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I dedicate this thesis to my Iban grandparents and all my ancestors who came before me—warriors, farmers, educators, mothers, workers, and survivors; stewards of our indigenous communities and lands. While the definition of decolonization varies among individuals, for me today, it is about acknowledging the existence of indigenous knowledge. With great gratitude and respect, this thesis serves as an active acknowledgment of the existence of my people and other indigenous groups, and the rich history that has unfolded on this sacred land. The community emphasis of the Iban people and the values that have been carried on for generations inspired me to research this topic as part of the anticolonial project of indigenous knowledge recovery.

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ABSTRACT

Social support has been studied as a common buffer against negative mental health outcomes. However, there is a lack of understanding of the relationship between indigenous populations in Sarawak. This quantitative study aims to study perceived social support and mental health outcomes among young adults in indigenous populations, with a focus on studying group differences between indigenous groups (Iban, Bidayuh, Melanau and Orang Ulu), and residential types such as urban and rural dynamics. Utilising a cross-sectional survey design, the study yielded 161 respondents aged 20 to 29, predominantly female and single, with a high educational background. Perceived social support was measured using the Multidimensional Scale of Perceived Social Support (MSPSS-12) meanwhile mental health outcomes were measured using the General Health Questionnaire (GHQ-28), where both scales were administered in English. Results indicated a significant negative correlation between perceived social support and mental health outcomes, $r(159) = -.364, p < 0.01$. Meanwhile, no significant differences were found across different indigenous groups or between urban and rural settings. These findings highlight the universality of the relationship between perceived social support and mental health outcomes, which is important in understanding health outcomes in applied settings such as mental health interventions. The study was limited by a small sample size and limited generalizability of the findings. Further research should focus on longitudinal studies, mixed-method approaches, the development and usage of locally validated scales, and community-based participatory research. This research contributes to a growing body of indigenous knowledge in understanding the socio-cultural determinants of mental health in diverse communities.

Keywords: social support, mental health, indigenous, youth, socio-cultural

ABSTRAK

Sokongan sosial telah dikaji sebagai penampan umum terhadap kesihatan mental yang negatif. Walaubagaimanapun, terdapat pemahaman yang kurang tentang hubungan antara tersebut dalam kalangan populasi Orang Asal di Sarawak. Kajian kuantitatif ini bertujuan untuk mengkaji sokongan sosial yang dirasakan dan tahap kesihatan mental dalam kalangan belia dari populasi Orang Asal, dengan tumpuan kepada perbezaan kumpulan antara kumpulan asli (Iban, Bidayuh, Melanau, dan Orang Ulu) dan perbezaan antara penduduk bandar dan luar bandar. Kajian tinjauan keratan rentas, ini melibatkan 161 responden berumur antara 20 hingga 29 tahun, kebanyakannya wanita dan bujang, dan mempunyai tahap pendidikan yang tinggi. Sokongan sosial yang dirasakan diukur menggunakan MSPSS-12 manakala tahap kesihatan mental diukur menggunakan GHQ-28 dengan menggunakan instrumen Bahasa Inggeris. Keputusan penyelidikan menunjukkan korelasi negatif yang signifikan antara sokongan sosial yang dirasakan dan tahap kesihatan mental, $r(159) = -.364, p < 0.01$. Sementara itu, tiada perbezaan yang signifikan ditemui antara kumpulan Orang Asal yang berbeza mahupun antara penduduk bandar dan luar bandar. Penemuan ini menekankan universaliti hubungan antara sokongan sosial yang dirasakan dan tahap kesihatan mental, yang penting dalam memahami pembentukan program kesihatan mental. Kajian ini dihadkan oleh jumlah responden yang rendah, dan kebolehjadian penemuan yang terhad. Para penyelidik yang akan datang harus menumpukan kepada kajian berbentuk longitudinal, pendekatan kaedah campuran, pembangunan dan penggunaan skala yang sesuai di komuniti setempat, serta penyelidikan berasaskan komuniti. Penyelidikan ini menyumbang kepada pengetahuan terhadap pengetahuan tentang Orang Asal terutama dalam sosio-budaya kesihatan kesihatan mental dalam komuniti yang pelbagai.

Kata kunci: sokongan sosial, kesihatan mental, Orang Asal, belia, sosio-budaya

CHAPTER ONE

INTRODUCTION

1.0 Introduction

Mental health and well-being are often discussed within the intersection of different factors that can influence the outcome of an individual's overall psychological state and, thus their health as well. These factors may encompass, but are not limited, to factors such as subjective experiences, biological, psychological, social, cultural, economic, environmental, and spiritual factors. In the Malaysian context, mental health problems are becoming increasingly prevalent, which poses a threat to public health in the country (Institute of Public Health, 2015). Research from previous literature (Milgrom et al., 2019; Brailovskaia et al., 2017) on social support has shown that it safeguards against mental health issues.

This research aims to investigate the relationship between social support and mental health outcomes in the Malaysian state of Sarawak where there are multiple indigenous groups present within its general population. This chapter will introduce the topic by discussing the background and the context of perceived social support and mental health outcomes, followed by the research problems, aims, objectives, and questions, the significance of the research, and finally the limitations of the study.

1.1 Background of Study

According to the World Health Organisation (2022), mental health refers to a condition of mental well-being that allows people to manage the stressors that are present in their respective lives, recognise their capabilities, engage in learning and professional pursuits, and actively participate in contributing to their communities. Although there seems to be an increased awareness of individual mental health, studies have shown mental health issues are becoming more common. For instance, the Institute for Health Metrics and Evaluation (2019) noted

approximately 970 million individuals globally were coping with a mental disorder, which translates to 1 in every 8 people, with mood disorders such as anxiety and depressive disorders reporting the highest prevalence. Meanwhile, the latest epidemiological information disclosed by the Malaysian Institute of Public Health (2019) reported that 2.3% of Malaysian adults, or half a million people within the country, suffer from depression. The same data set indicated that sociodemographic groups such as females, individuals residing in rural areas, and those who were single reported a higher prevalence. For comparison, the reported figures are a threefold increase when compared to numbers reported in a 1996 version of the survey (Institute of Public Health, 2019). More importantly, the financial burden of mental health issues in the workplace was significant, as it was estimated to cost RM14.46 billion to the Malaysian economy in the year 2018 (Chua, 2020). In the past, the Ministry of Health has implemented the Mental Health Act 2001, which functions as a policy direction for providing mental health services within the country (Haque, 2005). Although many efforts have been made to improve services in the country, the Malaysian healthcare system lacks the labour to provide the best care to its consumers, with a ratio of only 1.27 psychiatrists per 100,000 population as proven by Chong Guan et al. (2018). These numbers are significantly below the WHO (World Health Organisation) recommendation which is 10 psychiatrists per 100,000 population.

Located in East Malaysia, or the Borneo part of Malaysia, Sarawak is a heterogeneous state with multiple ethnic groups present within its borders. With a populace totalling 2.5 million, it comprises Bumiputeras (72.21%), followed by Chinese (22.57%), non-citizens (4.83%), and other minority groups (<1%). The Bumiputras are further divided into various ethnic groups, such as Malays, Ibans, Bidayuhs, Melanau, Orang Ulu etc. Sarawak's population is divided almost equally among its population centres, with 59.9% living in urban areas while 40.1% live in rural areas in the state (Economic Planning Unit Sarawak, 2021). Mental health

problems are not foreign to the Borneo state, with a survey conducted by the Institute of Public Health (2015) reporting that the prevalence of adult mental health was at 35.8% (95% CI 30.1-41.9), the fourth highest in the country. Further studies have also raised the fact that mental health for university students and young people in general has shown there is increasing concern (Brown, 2016, p. 66; McGorry, 2021; Sheldon et al., 2021).

It must be noted that due to how diverse the population of Malaysia is, different ethnic groups may approach topics of mental health illnesses differently (Phang et al., 2011). It is common for the public to correlate mental illness with the lack of religious faith, or supernatural beliefs, which prompts unfavourable connotations towards mental health problems (Phang et al., 2011). The word *gila*—crazy or madness in Malay, is often synonymous with psychiatric illness, where the association holds strong negative connotations. One of the earliest studies attempting to understand the conceptualisation of mental illnesses in Sarawak was conducted by Schmidt (1968) where the researcher studied the Murut indigenous group. Schmidt found that the Murut believes that the dysfunction of the mind is due to supernatural forces, where the *Roh*—soul, is in possession of a foreign spirit. The Murut's identified varieties of mental illness—such as the *ruden rupan*, *ruden talai*, *ruden menuai*, and *ruden sinoso* etc, were compared to various forms of schizophrenia due to the similarity in symptoms. Meanwhile, among the Land Dayak or Bidayuh, the general category of insane is called *gira* which is then divided into two groups; (a) *bako*, meaning dull, to categorise catatonic-related symptoms, and (b) *de kuat jaat*, which means fierce, to label manic or paranoid symptoms. A common feature across these groups would be the existence of a native healer, such that in the case of the Murut people, a *Nguror* typically deals with those with manifestations of mental illness (Schmidt, 1968). For comparison, the major ethnic groups also have their respective traditional healers; the Malays would consult *bomoh*, the Chinese have *sinseh*, and the Indians have *vaidya* (Phang et al., 2011). Understanding the disparities and differences in indigenous mental health requires

understanding the unique set of challenges that are faced by indigenous populations. As mentioned by King et al., (2009) indigenous population cultural elements such as historical oppression, trauma, racism, the erosion of language, and ties to native land, the deprivation of the environment, and a sense of spiritual and emotional disconnection have shaped how native populations view their health.

The study of understanding social relationships has long been studied by researchers, who focused on social resources in stressful situations (Cohen & Wills, 1985; House et al., 1988). Furthermore, social support theory was first emphasised to a wider audience from a presidential address that was shared by Cullen (1994) to the Academy of Criminal Justice Sciences. Cullen highlighted that supportive communities and relationships can reduce crime rates. Cullen et al. (1999) described the conceptualisation of social support as an approach to conveying human, cultural, material, and social capital, between individuals or within wider social elements such as communities or states, and their respective constituents. Recent research has revealed that perceived social support presents significantly stronger evidence of correlations as measured against received social support (Eagle et al., 2018).

Social determinants of health are important in understanding the way people live their lives and how these circumstances may affect their health outcomes (Alegría et al., 2018). One of the major social determinants of health that can impact mental health is social support, which is defined as the information from others that an individual is taken care of, and is part of a supportive network (Cobb, 1976). The broad term can be further broken down into perceived support, which is the subjective perception that other individuals are readily available to help when needed, and received support which is the tangible assistance that is received from the social networks (Uchino et al., 2016). Moreover, due to the complex nature and dynamics of social relationships, social support has critical effects on the role of health (Marmot & Wilkinson, 2005). Research in social support and its association towards mental health have

been studied extensively, and show that social support can act as a buffer against mental illness such as depression, anxiety, stress etc. (Cobb, 1976; Lakey & Orehek, 2011). This is supported by more contemporary studies such as Uchino et al. (2016) where the author highlighted that social support acts as a buffer in preventing stress and diminishes the intensity of strength between life stress and mental health outcomes. In addition, ethnic minorities experience more negative experiences when it comes to social determinants of health (McKnight-Eily, 2021), which further raises the importance of addressing the disparities and promoting equitable health outcomes. Urban and rural dynamics may also play a huge role in determining mental health outcomes due to differences in access to treatment and expectations of life (Zhang et al., 2021; Reilly, 2021; Bonnell et al., 2022)

1.2 Problem Statement

Despite the considerable research that has been carried out in the realm of mental health, there is insufficient exploration within the context of different indigenous groups in Sarawak and the study on the relationship between mental health and how perceived social support can affect its outcomes (Phang et al. 2011; Raaj et al., 2021; Khor & Shariff, 2019). Epidemiological data also shows that there is an increasing concern about levels of mental health outcomes in the country (Institute for Public Health, 2015; Chua, 2020; Raaj et al., 2021). It must be noted that psychological research is notoriously American-oriented and there is a lack of focus on a non-Caucasian population (Arnett, 2008). Thus, the conceptualisation of social support, mental illness, literacy, and mental health may not reflect the cultural and social boundaries of those who are in Sarawak, or Malaysia as a whole. Furthermore, there is a lack of objectivity on the unique challenges that indigenous groups face and the role of social support in lessening disparities in mental health outcomes. Consequently, within the context of clinical and counselling settings, the lack of knowledge of indigenous social support systems can lead to intervention methods which may not be culturally sensitive towards the target

population. The inability to understand perceived social support and mental health outcomes among indigenous groups in Sarawak may lessen the efficiency of intervention methods such as awareness campaigns, support groups, and therapeutic relationships (Smith & Trimble, 2016). The inconsistencies in research regarding the overall connection between perceived social support and mental health outcomes highlight difficulties in establishing a clear cause-and-effect relationship, thus is worth further researching (Alnazly et al., 2021; Gabriellie et al., 2023; Madrid miles et al., 2022)

1.3 Research Objectives

1.3.1 General Objective

This study aims to investigate the relationship between perceived social support and mental health outcomes.

1.3.2 Specific Objectives

1. To measure the levels of perceived social support and mental health outcomes among indigenous young adults.
2. To examine the relationship between perceived social support and mental health outcomes.
3. To compare the differences in the levels of perceived social support and mental health outcomes across different indigenous groups.
4. To compare the differences in the levels of perceived social support and mental health outcomes between urban and rural residential areas.

1.4 Research Questions

1. What are the levels of perceived social support and mental health outcomes among indigenous young adults in Sarawak?
2. What is the relationship between perceived social support and mental health outcomes?

3. Is there a significant difference in the levels of perceived social support and mental health outcomes across different indigenous groups?
4. Is there a significant difference in the levels of perceived social support and mental health outcomes between urban and rural residential areas?

1.5 Research Hypotheses

The following are the hypotheses of the study:

H₁: There is a significant relationship between perceived social support and mental health outcomes among indigenous young adults.

H_{2a}: There are significant differences in perceived social support across indigenous groups.

H_{2b}: There are significant differences in mental health outcomes across indigenous groups.

H_{3a}: There are significant differences in the levels of perceived social support between urban and rural residential areas.

H_{3b}: There are significant differences in the levels of mental health outcomes between urban and rural residential areas.

1.6 Conceptual Framework

Figure 1

Conceptual Framework



Figure 1. illustrates the relationship among the variables, with perceived social support being the independent variable (IV), and mental health outcome being the dependent variable (DV). This conceptual framework depicts the dynamic interaction between the two variables,

highlighting how perceived social support influences mental health outcomes. In this study, perceived social support measures sources of social support from families, friends, and significant others, based on Zimet et al (1988), meanwhile mental health outcome measures somatic symptoms, anxiety/insomnia, social dysfunction, and severe depression, based on Goldberg (1978).

1.7 Significance of Study

This current study will add to the current existing pool of research and knowledge on the relationship between social support and mental health outcomes, within the context of indigenous young adults in Sarawak, in which mental health issues are widespread. The research will help address the current lack of research in this area and provide individuals, policymakers, and organisations with real-world tangible data that can help shape policymaking and guidelines on social support programmes. Next, the study will also increase understanding of the indigenous perspective of the social support dynamics of different ethnic groups, ultimately fostering a more inclusive and nuanced approach to promoting a positive and healthy psychological state. Importantly, it will positively improve overall health outcomes as greater culturally sensitive interventions are planned by mental health professionals as they refer to evidence-based psychotherapy (Smith & Trimble, 2016). Furthermore, a better understanding of the topic will emphasise the importance of social support in the elements of social determinants of health in Sarawak, further improving the gap in health disparities that exist in the state. Lastly, the study will also shed light on the inconsistencies in the relationship between perceived social support and mental health outcomes.

1.8 Definition of Terms

1.8.1 Perceived social support

Conceptual Definition: Perceived social support is defined as the individual's subjective perception of the available provision of information that fosters the belief that one is being supported and engaged within a supportive social network (Uchino et al., 2016).

Operational Definition: Perceived social support is measured using the Multidimensional Scale of Perceived Social Support (MSPSS-12) which has 12 items that identify the perceived level of social support among three social networks; family, friends, and significant others (Zimet et al., 1988).

1.8.2 Mental health outcome

Conceptual Definition: Mental health outcomes are connected to individual scores, or the summed scores of individuals, which measure the extent of an individual's symptoms or disorders related to mental health (Barbalat et al., 2019).

Operational Definition: Mental health outcome is measured using the General Health Questionnaire-28 (GHQ-28). The questionnaire measures psychological well-being with its subscales measuring somatic symptoms, anxiety/insomnia, social dysfunction, and severe depression. The GHQ-28 acts as an early screening for possible cases of psychiatric distress (Goldberg, 1978).

1.8.3 Young adult

Conceptual Definition: Arnett (2000) defined emerging adulthood as a lifespan period where young adults are required to become more independent and explore different life possibilities.

Operational Definition: A young adult in this study is defined as an individual aged between 20 to 29 years old.

1.8.4 Indigenous groups

Conceptual Definition: Indigenous refers to descendants of communities that can trace their ancestry to a specific country or geographical area. These groups maintain some or all their own distinct social, economic, cultural, and political institutions (Morgan et al., 2009).

Operational Definition: Indigenous groups within the parameters of this research will study the Ibans, Bidayuhs, Melanau, and Orang Ulu which are ethnic groups that are indigenous to Sarawak.

1.9 Summary

This present study focuses on exploring the dynamic relationship between perceived social support and mental health outcomes among different indigenous groups of urban and rural young adults in a Sarawak context. The background of the study highlights the significance of social support while considering factors that can affect the variables such as culture, economics, and environmental influences. The present study aims to address the current gaps in research and knowledge by delving into different challenges that are faced by different ethnic groups, particularly the following: Iban, Bidayuh, Melanau, and Orang Ulu. The research objectives include investigating levels of perceived social support and mental health outcomes, examining the relationship between the two variables, and comparing differences across different indigenous ethnic groups, and urban or rural areas. The study's theoretical framework incorporates the Social Support Theory and Social Determinants of Health, emphasising the impact of social connections on the mental well-being of individuals, particularly young adults. The significance of the study allows for the contribution to a nuanced understanding of social support dynamics among diverse ethnic groups, better-informed policymaking, and decision-making, and lastly promoting mental health interventions that are culturally sensitive.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

This literature review chapter depicted the current context of literature, theories, and concepts on perceived social support and mental health, with an emphasis on urban and rural young adults, and indigenous ethnic groups. The review was organised into several sections. Firstly, it discussed the general concept of social support and mental health, with an emphasis on indigenous contexts. Then it focused on mental health in young adults and the urban and rural dynamics. The review also discussed past and current research while referring to theoretical frameworks that are related to social support and mental health outcomes. Lastly, gap identification in the current literature was discussed.

2.1 Social Support

Social support is an essential social determinant of health and has been studied extensively in various contexts. This section outlined the overall impact of social support on health outcomes before focusing on specific sources of social support, such as family, friends and significant others, across different ages, and cultural backgrounds.

Several studies have reported that social support plays a crucial role in assisting people in confronting challenging life situations, such as chronic illnesses such as cancer, or even tragic life events such as bereavement. Farzan et al. (2023) found that social support levels were moderate for burn patients, and there was a significant negative relationship with factors relating to mental health. In the context of cancer survivors, social support persists as an important factor even years after cancer treatment is completed (Deegan et al., 2023). Despite

the growing literature on social support and health outcomes, the association is not often strong with some studies reporting modest or weak associations (Xiong et al., 2022; Miller et al., 2019). The collective studies highlight the importance of social support in various settings, however, there is also debate on the overall effect and association of social support regarding mental health.

With the emphasis on social support, it is vital to identify and distinguish the sources of social support. (Chang et al., 2018) conducted a study investigating assorted sources of social support on depression levels among Chinese adolescents, where the researchers distinguished parents, teachers, and friends as sources of support. Meanwhile, studies such as Shaigerova et al. (2022) and Lee et al. (2020) investigated the association of mental health indicators with different sources of perceived social support, mainly friends, family, and significant others. When the sample of the studies utilises adults, the common sources of perceived social support seem to be among friends, family, and significant others. Whereas young children or adolescents would mostly focus on support from peers, parents, and their teachers. Thus, the source of social support varies significantly depending on the individual's developmental stage.

2.1.1 Indigenous social support

Indigenous social support based on previous findings found that it plays a significant role in the mental health of indigenous people. In a cross-sectional study focusing on indigenous adults in Taiwan, it is reported that perceived social support is adversely linked with symptoms such as depression and anxiety (Lai & Teyra, 2022). Interestingly, Lai & Teyra found that perceived social support became a protective factor for those who had low levels of ethnic identity from manifesting depressive symptoms. Zagefka et al. (2023) conducted a longitudinal study on indigenous people from Chile and highlighted that greater levels of perceived social support

would decrease depressive symptoms. Additionally, social support has also been a crucial factor in determining the health outcomes of Aboriginal and Torres Strait Islanders in Australia (Santiago et al., 2023). However, the same study highlights the need for more culturally valid and sensitive instruments for measuring social support in an indigenous setting. Although not a defined concept, indigenous social support is a pivotal factor that positively influences the mental health of indigenous populations.

2.2 Mental health

Mental health is a complex concept that can be influenced by various factors including but not limited to socioeconomic background, cultural factors, and significant life events. More so with an impactful global event such as the COVID-19 pandemic, conversations about mental health have been emphasised.

A study conducted by Crawford et al. (2016) on British patients (n=14,587), implicated that 5% of therapy patients have experienced ‘‘lasting bad effects’’ of therapy. Although there is a plethora of issues such as unhelpful therapist behaviours, the power imbalance in the therapeutic relationship, and many more that may cause the arrival of such a conclusion (Crawford et al., 2016), an important issue to consider is the lack of cultural validity within therapeutic settings. In a paper discussing the intricacies of global mental health, Montenegro and Ortega (2020) emphasised the arguments of the universality vs cultural specificity of psychopathology. Montenegro and Ortega argued that it is important the context of mental health is adapted to its local understandings in terms of culture and social definitions. This stance is particularly important for both mental health service providers as well as users for interventions to work successfully as exploring the nature of mental health interventions within a culturally sensitive context can reduce harm towards its users. This is supported by Curran et al. (2019) where contextual issues such as the lack of awareness towards cultural settings can

misalign client expectations, thus contributing towards a negative therapeutic process. This issue elucidates the imminent need to understand the cultural background of diverse cultural populations to improve mental health interventions and outcomes.

During the COVID-19 pandemic, researchers saw an upward trend in negative mental health outcomes. (Sergeant et al., 2020) synthesised that pandemics can negatively impact mental health outcomes, especially for those who have had pre-existing mental health issues. This fact potentially exacerbated their access to proper healthcare services and support. Numerous studies reported that there was a higher likelihood of mental health issues and psychological distress, particularly disorders such as depression, anxiety, stress-related disorders, and anger, when associated with isolation and quarantine during COVID-19 (Henssler et al., 2020; Xiong et al., 2020). Understanding these predicaments, a post-pandemic world suggests that global mental health is characterised by increased levels of mood disorders such as anxiety, depression, and stress. Galea et al. (2020) indicated the necessity for using remote methods in reaching out and screening for loneliness and related mental health issues, ensuring the provision of social support.

2.2.1 Indigenous mental health

Indigenous mental health is understood differently and holistically by different populations, such as the American Indians in the United States who view mental health problems not from a Eurocentric perspective, but rather anchor the existing problems of community mental health towards the process of colonisation (Gone, 2021). Interestingly, Mehl-Madrona and Mainguy (2022) explored the commonalities among North American traditional cultural healers and users and found that there were positive outcomes in mental health for those who utilised traditional cultural healers. The researchers found that the emphasis on community and building upon communal relationships has helped in social and spiritual connectedness. As

such, it is worth studying and understanding how these settings lead to improved results in mental health as compared to conventional practice. In the past, ethnic groups in Borneo also utilised spiritual leaders to seek mental health support (Schmidt, 1968), though there is not much evidence on the effectiveness of traditional healers. In Malaysia, there exists a significant lack of research on understanding how mental health operates for its indigenous populations. Rather, research focuses only on well-being factors (Saifullah et al., 2021). Hobden et al. (2023) explored the relationship between mental health and substance use co-occurrence among indigenous people in a global context through a scoping review, where most studies (71%) were overwhelmingly from the United States, meanwhile, one study from Malaysia was included. The researchers recommended more research should be conducted within indigenous groups outside of the United States.

In terms of mental health outcomes, an Australian study reported the prevalence of common mental disorders (CMD) among its indigenous population was higher for indigenous populations living in Aboriginal reserves as compared to those living in urban non-traditional areas (Nasir et al., 2018). The same study supported the idea of connection to traditional land as an important protective factor while also advocating for a larger sample size to understand population prevalence.

2.2.2 Mental health for Young Adults

Young adulthood has been characterised as a developmental stage that comes with its own set of challenges. Lenz (2001) considered young adulthood the period where individuals are required to take responsibility when it comes to matters of health and lifestyle choices. The learning experiences of health-seeking behaviours before young adulthood are typically shaped by family, friends, and the school environment. For young adults, this circle of influence may dynamically change as they move away from their homes and settle into settings such as higher

education and the workplace. The transition into adulthood is when mental health issues and substance use disorders tend to manifest, exerting a substantial impact on the productive years of emerging adult life (McGorry, 2021; Kessler et al., 2007). The researcher also mentioned how challenging and vulnerable it is for young people to take care of their mental health due to increasing difficulties in accessing mental health systems due to barriers caused by socioeconomic factors. This is also supported by Mei et al. (2020), where the researchers discussed that young adults are disproportionately affected by mental disorders, where prevalence has not significantly decreased. University students are at an increased risk due to various factors such as rumination on negative thoughts, parental separation, encounters with sexual harassment, genetics, childhood adversity, and financial difficulties (Sheldon et al., 2021). The collective research highlights the dynamic shift of young individuals and their respective spheres of influence. Furthermore, the studies also emphasised the critical need for mental health support that is effective in the context of young people to further safeguard their mental well-being.

2.3 Social Support & Mental Health

The relationship between social support and mental health has been established in mainstream literature, with most research showing that lower levels of social support can act as a protective buffer towards stressful life situations that can negatively impact mental health. This section reviews various studies that highlight the protective role of perceived social support against mental health issues while also analysing contradictory findings.

A systematic review conducted by Bedaso et al. (2021) found that women who lack social support are more prone to risks of mood disorders, and self-inflicted harm during their pregnancy. Similarly, Wang et al. (2018) found that those who are more socially isolated and

have lower perceived social support are linked to unfavourable outcomes in depression. Hu et al. (2022) explored COVID-19-related stress and the mediating effect of social support, whereby it was found that social support functioned as a protective element against negative mental health outcomes. However, a meta-analysis undertaken by Gabarrell-Pascuet et al. (2023) determined that loneliness had a greater interaction with mental disorder symptoms than social support. Meanwhile, a study focusing on Jordanian healthcare workers also reported that there were weak significant correlations found between social support and outcomes such as fear, depression, anxiety, and stress (Alnazly et al., 2021). Overall, while a majority of the studies suggest that social support contributes positively to mental well-being, the association between the two phenomena can vary across different populations and circumstances. While most research indicates a favourable connection between social support and mental health, some contradictions have been highlighted.

Perceived social support is found to have a significant relationship with mental health outcomes. Multiple studies have shown that, when there are increased measures of perceived social support, it is correlated with reports of better mental health. This is supported by a study conducted by Gök & Çiftçi (2023) that studied perceived social support for post-traumatic growth in COVID-19 patients. The study's investigators recommended that social support should be promoted by healthcare workers to reduce the mental health challenges of the patients. Additionally, there have also been studies reporting that lower levels of perceived social support will result in worse mental health outcomes, with links to increased levels of depression and lower life satisfaction (Uchino et al., 2016). To synthesise, these findings highlight that perceived social support is an important factor in mental health outcomes, and social support may play an important role in healthcare interventions.

Postpartum depression and mental health are also moderated by perceived social support, where it is highlighted higher measures of perceived social support act as a buffer towards the negative outcomes of postpartum depression (Jamshaid et al., 2023). Additionally, social support has acted as a protective factor against stressors, where receiving support from immediate social networks has lowered risks of depression, nervousness, loneliness, and sleep troubles (Ji et al., 2023). Ji et al., also stated that the study's cross-sectional design precludes the establishment of a causal relationship, and there was also a lack of incorporation of multiple sociocultural factors.

The connection between perceived social support and mental health outcomes may also differ as it depends on the population that is being studied. For example, a study conducted by Gabrielli et al. (2023) found differences in factor structures for two different populations: foster-care youth, and community youth. Hence, it is important to examine and consider whether different populations perceive social support differently.

2.3.1 Urban vs rural dynamics

Geographical location may significantly affect the dynamics of social support and mental health outcomes. This section synthesizes the differences between urban and rural settings, presenting how these different environments may impact social support networks and mental well-being.

A study among Canadian young adult cancer survivors has shown that rural populations experience higher distress and poorer health outcomes as compared to their urban counterparts, where social support and its effect varies depending on geographical location (Tulk et al., 2023). Interestingly, Gu et al. (2023) found that the dynamics of social support differ as in rural areas, there is an emphasis on family support, meanwhile instrumental support

and social connectivity from friends. Although there are differing focuses on social support, both urban and rural settings in the study are associated with lesser depressive symptoms. On the contrary, Bonnell et al. (2022) conducted a study involving cross-sectional randomised controlled trial (RCT) data which encompassed 2,726 participants with chronic health conditions medically and behaviourally. Bonnell et al. found that rural residents had better mental health outcomes compared to their urban counterparts, and thus concluded that it was not consistent with previous findings. In contrast, rural Ecuador found that there was no correlation between health outcomes and social support (Madrid Miles et al., 2022).

In the context of mental health, research has demonstrated that there are notable discrepancies in mental health between urban and rural dwellers. A Chinese study examining mental health inequalities found that urban residents had improved mental well-being than their rural counterparts (Nie et al., 2023). Not only that, Shora et al. (2023) highlighted and discussed that rural research participants were often underrepresented in mental health research, which may lead to a lack of information when formulating policies or interventions that are inclusive and generalisable. In terms of health barriers, Bergaoui et al. (2022) argued that those in Tunisian rural areas had difficulty accessing proper mental health care due to lower income, delays in seeking treatment, and may suffer from illness longer than those from urban areas. Conversely, the environment in cities can also impact mental health and well-being as it effects physical and psychological processes. Müller et al. (2022) discussed the need for more evidence between mental health outcomes and their correlation towards urban settings as there are a multitude of risk factors that can affect an individual's mental health while living in urban areas. These findings underscore the necessity for tailored mental health interventions and strategies that can improve both urban and rural populations and determine the level of differences between the two residential settings.

2.4 Social Support Theory

Social Support Theory is a psychological framework that focuses on the significance of social connections and their role in the well-being of individuals, with an emphasis on periods where stress or challenges arise (Cullen et al., 1999; Butler, 2017; Diao, 2019). According to Lakey & Cohen (2000), three theoretical perspectives can serve as the foundation for the research niche on social support, mainly: (1) the stress and coping perspective which focuses on social support that protects individuals from the negative effect of stress, (2) the social constructionist perspective which proposes that social support affects health due to self-esteem and self-regulation, and (3) the relationship perspective, where health is effected by relationship processes such as companionship, intimacy, and social conflict.

Efforts to conceptualise social support have been conducted by Langford (1997) where the researchers concluded that the main characteristics of social support are appraisal, emotional, instrumental, and informational. Barrera (1986) conceptualised the contrast in definitions for perceived social support and received social support, such definitions are still utilised by more contemporary researchers, such as Vangelisti (2009). Perceived social support has been defined as the individual's interpretation of the available provision of information that fosters the belief that one is being supported and engaged within a supportive social network meanwhile received social support is the actual amount of social support received from social relationships (Uchino et al., 2016).

2.5 Social Determinants of Health

The Social Determinants of Health (SDH) is a framework focusing on understanding the way individuals live and participate in labour to shape their respective health outcomes (Ramirez et al., 2008). Magnan (2017) mentioned that only 10-20% accounts for the health outcomes of the population meanwhile the remaining 80-90% are commonly referred to as the

Social Determinants of Health, which encompasses health-related factors such as behaviour, socioeconomic factors, and environmental factors. According to research, there is a connection between mental health disorders and social determinants of health, as poor mental health well-being can affect individual decision-making negatively (Alegría et al., 2018). The same paper determined that one of the key indicators for SDH is familial relationships. Numerous studies have reported that social support is significantly associated with mental health outcomes (Han & Lee, 2013; Brydsten et al., 2018; Salami et al., 2017; Han et al., 2018).

2.6 Past findings

Studies revolving around perceived social support and mental health outcomes have previously been studied by researchers. For instance, a systematic review conducted by Wang et al. (2018) investigated the association between several mental disorders such as depression, schizophrenia, anxiety, and bipolar between loneliness and perceived social support. The researchers found that there was major evidence that specifically for depression, poorer perceived social support is linked to worse outcomes concerning symptoms, recovery, and functioning. Meanwhile, other disorders showed initial evidence of comparable results. Wang et al. suggested more studies to understand the nature of loneliness, perceived social support and mental health problems, especially in a longitudinal nature with repeated measures.

Samsudin et al. (2024) studied mental health among youth aged 15 to 30, where a data set consisting of 21,126 respondents from all over Malaysia was analysed. Samsudin et al. found that certain demographics were more likelier to experience mental disorder symptoms, mainly referring to depression, stress and anxiety. Specifically, those who are women, and youth at a younger age had a higher likelihood. The researchers also found that social interaction significantly affects the likelihood of experiencing such symptoms and called for effective policymaking to address the issue. Samsudin et al. argued that elements of social

capital such as relations, community, and connection can help maintain good mental health. The absence of such elements can cause loneliness, which has been correlated to certain mental disorders.

In an older study conducted by Tam et al. (2011) examining differences in mental health and perceived social support in terms of gender, the relationship between parents' income, and educational levels; Tam et al. found higher perceived social support levels for females compared to males, meanwhile there was no differences in mental health status between the genders. Better mental health status was associated with higher parental income, though a low association was reported. The study, however, focused only on the Selangor state, where the more urbanised area may have more access to services that can help cope with mental health status, and no indicators of ethnic groups were studied. The researcher also discussed that cultural differences can be a possible moderator between the two variables due to the collectivistic nature of the respondents when compared to non-Malaysian studies.

2.7 Improvements in the Present Study

In terms of current gaps in research, there is limited exploration of cultural validity within therapeutic settings which may further affect therapy outcomes. To the researcher's current knowledge, there is also a scarcity of understanding how the mental health landscape is for indigenous populations in Malaysia, where there exists an absence of comprehensive exploration of mental health issues and factors that can significantly contribute to its outcomes, such as perceived social support. From a more global perspective, there is a major imbalance when it comes to indigenous mental health research, with most studies concentrated within populations from the United States. There is a need to significantly understand the mental health dynamics of diverse populations. Additionally, the literature review highlights the need to include diverse populations and settings in research. Some studies highlighted weak or

modest associations, highlighting the complex relationship between the two variables. The inconsistencies in research regarding the overall connection between perceived social support and mental health highlight difficulties in establishing a clear cause-and-effect relationship, thus is worth further researching. Lastly, urban, and rural settings need to be further studied to understand the nuances of the dynamics of perceived social support and mental health outcomes.

2.8 Summary

Acknowledging these current contexts in literature and gaps, this present study seeks to provide more cultural insights on different indigenous populations, with an emphasis on indigenous mental health among young adults in Sarawak. It will also bridge the global perspective on indigenous mental health by further understanding the unique challenges that indigenous minorities, specifically Iban, Bidayuh, Melanau and Orang Ulu populations, face within their communities. Lastly, this study will also contribute towards understanding the dynamics of urban and rural settings in mental health, as Sarawak's population is divided approximately between the two residential types.

Overall, the literature review has presented key findings on the relationship between social support, especially perceived social support and mental health across different populations and contexts. The discussion brings forward the significance of needing cultural nuances in mental health praxis, especially within settings of indigenous populations. Recent studies also focused on the effects of restrictions and the COVID-19 pandemic, hence a need to understand post-pandemic strategies. The review also acknowledged the unique difficulties experienced by different demographical categories, such as that of young adults and urban vs rural residents. These discussions are important overall to understand the need for social support in mental health services and intervention

CHAPTER THREE

METHODOLOGY

3.0 Introduction

In this chapter, the methodology section served as a blueprint for the implementation and planning of the present research. The research design in terms of its research philosophy, methods, data collection procedures, data analysis procedure, and ethical considerations was discussed to understand the rationale behind the overall research design. This chapter discussed the strategies to address the aforementioned research objectives, questions and hypotheses in regard to the variables, perceived social support and mental health outcomes. Furthermore, a pilot study was conducted and reported to understand the feasibility of the present study.

3.1 Research Design

This research utilised a positivist research philosophy, which is typically the norm for quantitative research. Positivist research holds a deterministic philosophical outlook as studies focus on the causes that can probably determine outcomes. As such, it is reductionist as positivist research intends to break down concepts and theories into compact sets for testing, like the factors that comprise hypotheses and research questions (Creswell & Creswell, 2017). To emphasise, positivism prefers the scientific method approach, where the research starts with a theory, and then proceeds to collect data to validate or challenge the theory at hand and adjust as needed. From here, researchers would then conduct further research or testing to refine understanding, and finally come to a generalised conclusion. This research philosophy is justified for this study as it relies on empirical evidence and observable phenomena. In the context of this study, positivism allowed for the collection of quantitative data, which enabled

statistical techniques to be employed for an enriched objective understanding of the relationship between perceived social support and mental health outcomes across diverse indigenous groups. Congruent with positivism, this study utilises quantitative methods, an approach that requires the researcher to test for objective theories by exploring the connection between various variables that can be assessed, usually through instruments of measurement which will enable the analysis of numerical data through statistical methods (Creswell & Creswell, 2017).

The survey that is carried out is cross-sectional, meaning data will only be collected at one point in time. This method was preferred as it will be able to capture a current and comprehensive view of the variables that are currently being investigated. A cross-sectional method of data collection allows the researcher to explore the topic by identifying associations and patterns between perceived social support and mental health outcomes to provide a foundational understanding. The researcher also acknowledges constraints in resources and time that prohibit a longitudinal method that may not be feasible.

To collect the data, a quantitative survey was distributed to research participants that fit the inclusion criteria. A quantitative survey design typically offers a quantitative depiction of trends, attitudes, or opinions within a specific population, or it examines the associations among different variables within the selected population through the study of a sample. As mentioned by Creswell & Creswell (2017), a survey design can help the researcher to address the research questions in these categories: (a) descriptive questions (e.g., What are the levels of perceived social support among indigenous young adults in Sarawak?), (b) questions about the relationship between variables (e.g., What is the relationship between social support and mental health outcomes?). Furthermore, a survey design was chosen as it is the more cost-efficient method that can enable the researcher to explore the perceived social support and

mental health outcomes. Alternatively, an experimental approach was not considered for this study as it would be difficult to test and measure the variables within an experimental setting due to the lack of proper instrumentation and tools. Certainly, it would also be unethical to put participants in different conditions of perceived social support as it would be invasive towards their personal lives.

3.2 Population and Sample

The research site for this study has been identified as Sarawak. The selected population for the study is young adults who currently reside in the state. The sample of this study are Sarawakians who identify and belong to the following indigenous groups: (a) Iban, (b) Bidayuh, (c) Melanau, and (d) Orang Ulu. Furthermore, this study has defined its demographic age population as 20 to 29 years old. However, due to the unavailability of more granular data on the exact number of indigenous groups based on the age group population, this study will utilise approximation to calculate the sample size of the study.

Table 1

Total Population of Indigenous Persons by Ethnic Group

Ethnic Group	Total Population*
Iban	723,400
Bidayuh	197,000
Melanau	133,400
Other Indigenous	141,300
Total	1,195,000

*Note. *Adopted from Sarawak Facts & Figure 2021 (Economic Planning Unit, 2021).*

Table 2

Population by Age Group in 2020

Age Group	Total Population*
20 – 24	277,300
25 - 29	285,900
<i>Total</i>	<i>433,431</i>

*Note. *Adopted from Sarawak Facts & Figure 2021 (Economic Planning Unit, 2021).*

Based on Table 2, 433,431 of the population were between the ages of 20 to 29. The overall population of the state of Sarawak is 2,560,600 (Economic Planning Unit, 2021). These age groups would account for 16.92% of the entire population. Based on Table 1, the total number of indigenous persons is 1,195,100. Assuming that 16.92% of the indigenous population is between the ages of 20 to 29, this approximation would yield 202,210 as the estimated population. Based on Krejcie and Morgan's (1970) calculation for sample size, when the population size (N) is 200,000, the appropriate sample size (S) to generate a 95% confidence interval for the study is a sample size of 384 survey participants.

For this present study, the sampling method selected was purposive sampling, consistent with the objective of the study to compare the levels of perceived social support and mental health outcomes across different indigenous groups. Purposive sampling is a non-random sampling method that involves recognising and choosing cases abundant in information related to the present study (Palinkas et al., 2015). This was conducted by introducing an inclusion criterion whereby only participants from the Iban, Bidayuh, Melanau, and Orang Ulu indigenous groups residing in the state of Sarawak were allowed to participate in the study.

3.3 Instruments

The demographic questions for this study is attached in *Appendix A*. For this study, two instruments were used to represent the two measured variables: namely Multidimensional Scale of Perceived Social Support Scale (MSPSS-12) as shown in *Appendix B*, and General Health Questionnaire-28 (GHQ-28) as shown in *Appendix C*. An online Google Form and physical form which encompasses three sections, Section A: Demographic Information, Section B: MSPSS-12, and Section C: GHQ-28 will be distributed to participants.

3.3.1 Multidimensional Scale of Perceived Social Support (MSPSS-12)

The Multidimensional Scale of Perceived Social Support -12 (MSPSS-12) is a 12-item questionnaire developed by Zimet et. al (1988). The author of the questionnaire developed the questionnaire to consist of three subscales that identify different sources of perceived social support: (a) Family, (b), Friends, and (c) Significant Others. The questionnaire deploys a 7-point Likert scale rating, with scores ranging from (1) *very strongly disagree* to (7) *very strongly agree*. Factor analysis conducted by Zimet et al. identified three 4-item subscales, which are Family (items 3, 4, 8, 11), Friends (items 6, 7, 9, and 12), and Significant Others (items 1, 2, 5, 10). The total score of MSPSS-12 ranges from 12 to 84. Higher scores indicate higher levels of perceived social support. Mean scale scores are used to associate with other measures.

Notably, the questionnaire is easy to understand and can be administered and evaluated quickly. Furthermore, it has been widely used across various populations such as pregnant women (Zimet et al., 1990), urban adolescents (Janie & Zimet, 2000), cancer patients (Calderon et al., 2021; Song et al., 2023), university students (Brugnoli et al., 2022; Talwar & AR, 2013). Thus, the questionnaire has demonstrated its reliability and validity across diverse samples. It has even been translated into multiple languages and versions such as the Chinese

version (MSPSS-C) administered by Kee (2000), a Thai version conducted by Wongpakaran et. al (2011), and a Turkish version validated by Basol (2008). In Malaysia, the questionnaire has been translated into the Malay language (denoted as MSPSS-M) with its psychometric properties being examined by Ng et al. (2010).

3.3.1.1 Psychometric Properties of MSPSS-12

Zimet et al. (1990) studied three different subject groups, where the MSPSS-12 subscales reported good internal reliability. The prepartum group (n=265) reported a total scale coefficient alpha value of .92, the adolescents group (n=74) reported an alpha value of .84, meanwhile paediatric residents (n=55) reported an alpha value of .90. In a more recent study investigated by Talwar and AR (2013), which utilised a nonclinical university sample from a local public university in Sarawak, the Cronbach's alpha value reported by the investigators was a value of .921. The values of Cronbach's alpha reported by the mentioned studies are well above the accepted cut-off score of .7 for acceptable internal reliability (George & Mallery, 2003). Zimet et. al (1988) mentioned that the test-retest reliability for the scale ranged from .72 to .85. Furthermore, most studies reported good construct validity for the scale (Sharif et al., 2021; Clara et al., 2003; Kieu et al., 2023).

3.3.2 General Health Questionnaire (GHQ-28)

The General Health Questionnaire (GHQ) is an instrument constructed by Goldberg (1972) used to detect individuals with a possible diagnosable psychiatric disorder, often used within a primary care setting. The author of the instrument mentioned that the questionnaire is based on recognising two primary issues: (1) the incapacity to perform normal healthy functions, and (2) the manifestation of recent and distressing occurrences (Goldberg & Hillier, 1979). The original GHQ consisted of a 60-item questionnaire. The GHQ-28 consists of 28 items based on four identified subscales focusing on somatic symptoms (items 1-7), anxiety & insomnia (items

8-14), social dysfunction (items 15-21), and lastly severe depression (items 22-28). Goldberg & Hillier also mentioned that there is a strong correlation between the anxiety subscale and the overall score, indicating that a common manifestation of psychiatric disorders is anxiety. However, care should be taken to not interpret the scores of the subscales independently, and users should refrain from using them to diagnose any specific psychological condition or disorder. Rather, the GHQ-28 is employed for screening symptom presence (Salter et al., 2013). The scoring method applied for this study is based on the original scoring system (Goldberg and Hillier, 1979), which utilises a 4-point Likert scale of 0, 1, 2, and 3. The minimum score for the version is 0 while the maximum is 84. Goldberg and Hillier (1979) recommended that participants with a score of 23 and below are considered non-psychiatric, meanwhile, 24 and above are classified as psychiatric.

The GHQ is widely used across the globe, with the questionnaire being available in 38 languages (Jackson, 2006). The 28-item version of the questionnaire has been widely used across diverse pools of populations such as patients with stroke (Hjelle et al., 2019), non-psychiatric community-dwelling adults (Kadioglu et al., 2013), and university students (Kokkinis et al., 2017).

3.3.2.1 Psychometric Properties of GHQ-28

The questionnaire has reported good reliability, with some studies reporting a Cronbach's alpha value ranging from .75 to .9 (Malakouti et al., 2006; Jackson, 2006). Furthermore, several studies have also reported excellent test-retest reliability (Robinson & Price, 1982; Taghavi, 2002). A meta-analysis that studied the four-factor structure subscale reported that the four subscales of the GHQ-28 are strongly supported and suggested (Shafer, 2022).

3.4 Pilot Study

A pilot study (n=35) was carried out to evaluate the feasibility of the study and to inquire if any improvements could be made to the research design before the actual study. By conducting a pilot study, the reliability of the instruments that are to be used for the present study's population can be determined. A reliability analysis was conducted using SPSS. Jhangiani et al. (2019) defined reliability as the consistency of the measures which encompasses three different types, mainly: test-retest reliability, internal consistency, and inter-rater reliability. For this present study, only internal consistency will be calculated. Internal consistency refers to the uniformity of the responses towards the instruments where all items in the measures are intended to measure the same construct, which will result in correlations between individuals' scores (Jhangiani et al., 2019). Table 3 below shows a general rule of thumb on the reported values of Cronbach's alpha and their levels of internal reliability.

Table 3

Cronbach's Alpha Criteria

Cronbach's alpha coefficient range	Internal Reliability
$\alpha \geq 0.9$	Excellent
$0.9 > \alpha \geq 0.8$	Good
$0.8 > \alpha \geq 0.7$	Acceptable
$0.7 > \alpha \geq 0.6$	Questionable
$0.6 > \alpha \geq 0.5$	Poor
$0.5 > \alpha$	Unacceptable

3.4.1 Reliability of MSPSS-12

Table 4

Reliability Statistics for MSPSS-12

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.894	.897	12

In determining the internal consistency of the Multidimensional Scale of Perceived Social Support (MSPSS-12), used to measure perceived social support, Cronbach's alpha obtained was $\alpha = .894$, which is regarded as very good reliability. This suggests that the items in the questionnaire are measuring the same construct reliably. This level of reliability is well above the accepted cut-off score that is considered good reliability, which is .7 and above.

3.4.2 Reliability of GHQ-28

Table 5

Reliability Statistics for GHQ-28

Cronbach's Alpha	Cronbach's Alpha Based on Standardized Items	N of Items
.912	.910	28

In determining the internal consistency of the General Health Questionnaire (GHQ-28), used to measure mental health outcomes, the Cronbach's alpha obtained was $\alpha = .912$, which is regarded as excellent reliability. This suggests that the items in the questionnaire are measuring the same construct reliably. This level of reliability is well above the accepted cut-off score that is considered good reliability, which is .7 and above.

3.5 Data Analysis Procedures

Qualitative data gathered through the survey are analysed using both descriptive and inferential statistics using Statistical Package for the Social Sciences (SPSS) Version 29. This current study utilises a conventional confidence interval of 95%. Hence, if the reported p-value is less than .05, then the null hypothesis H_0 , will be rejected.

3.5.1 Descriptive Data Analysis

In descriptive data analysis, descriptive statistics will be used to summarise and present key data such as the demographic information that is collected. These data include age, gender, residential type, marital/dating status, education level and ethnicity. Data such as age will utilise the calculation of mean, median, and standard deviation to describe the central tendency as well as the dispersion of data. Meanwhile, gender, residential type, marital/dating status, education level, and ethnicity will utilise the calculation of frequency and percentage of participants. Visualisation of data will be represented by charts to further illustrate distribution.

3.5.2 Inferential Data Analysis

For inferential data analysis, the statistical tests used are determined by the nature of the hypotheses and research questions. The table below indicates the type of statistical test used based on the stated hypotheses. For this study, the researcher has also chosen to conduct the study by using a correlational method to analyse the relationship between perceived social support and mental health outcomes. Within this framework, the study seeks to understand how the independent variable, perceived social support, can influence the dependent variable, mental health outcomes.

H_1 : There is a significant relationship between perceived social support and mental health outcomes among indigenous young adults.

For H₁, a Pearson correlation analysis will be used to assess the strength and direction of the relationship if a normal distribution is reported using the Shapiro-Wilk test. For the same hypothesis, a regression analysis will be used to explore the predictive nature of the two variables, perceived social support and mental health outcome.

H₂: There are no significant differences in perceived social support and mental health outcomes across indigenous ethnic groups.

For H₂, analysis of variance (ANOVA) will be used to compare means between the indigenous ethnic groups. If there is a significant difference, a post-hoc test such as Tukey's HSD will be used to identify which groups have significant differences.

H₃: There are significant differences in the levels of social support and mental health outcomes between urban and rural residential areas.

For H₃, an independent samples t-test is used to compare the means between the means of social support and mental health outcomes between the urban and rural groups.

Table 6

Summary Table of Research Question, Hypotheses and Statistics Technique Used

Research Question	Research Hypotheses	Statistical Technique
1. What are the levels of perceived social support and mental health outcomes among indigenous		Descriptive statistics

young adults in Sarawak?		
2. What is the relationship between social support and mental health outcomes?	H ₁ : There is a significant relationship between perceived social support and mental health outcomes among indigenous young adults.	Pearson's product-moment correlation
3. Is there a significant difference in the levels of social support and mental health outcomes across different indigenous groups?	H _{2a} : There are significant differences in perceived social support across indigenous groups. H _{2b} : There are significant differences in mental health outcomes across indigenous groups.	Analysis of variance (ANOVA)
4. Is there a significant difference in the levels of social support and mental health outcomes between urban and rural residential areas?	H _{3a} : There are no significant differences in the levels of social support between urban and rural residential areas. H _{3b} : There are significant differences in the levels of mental health outcomes	Independent samples t-test

between urban and rural
residential areas.

3.6 Ethical Consideration

This present study upholds ethical standards that are rigorous to guarantee that the well-being and rights of the participants are safeguarded. Before participating in the study, they are provided with a research information sheet that emphasises the current study's purpose and background, inclusion criteria, procedures, confidentiality, risks and discomforts, benefits, voluntary participation, and contact details of the researcher for further inquiries, as shown in *Appendix A*. Anonymity is preserved throughout the study as participants' information is recoded into identification numbers. Participants are also allowed to withdraw at any given time in the study.

The survey contains non-sensitive questions, and the collected data is only accessible to the research team. A debriefing is provided to participants at the end of the research that includes mental health resources such as mental health hotlines and a grounding technique information poster. This current study is committed to research honesty and integrity, as well as the respect for the dignity of the research participants by ensuring ethical and responsible knowledge pursuit.

3.7 Data Cleaning

Data cleaning was conducted using IBM SPSS Statistics Version 29. A total of 2 outliers were identified and detailed. To ensure assumptions were met for data analysis, normality and histograms were examined for each variable. The skewness for the General Health Questionnaire (GHQ-28) was -0.104 meanwhile the kurtosis was -0.687, meanwhile the

Multidimensional Perceived Social Support (MSPSS-12), where all values are acceptable levels of skewness and kurtosis. Q-Q plot was visualised to the normality of data for both variables, where both reported approximately normally distributed data.

Figure 2

Normal Q-Q Plot for Mental Health Outcomes

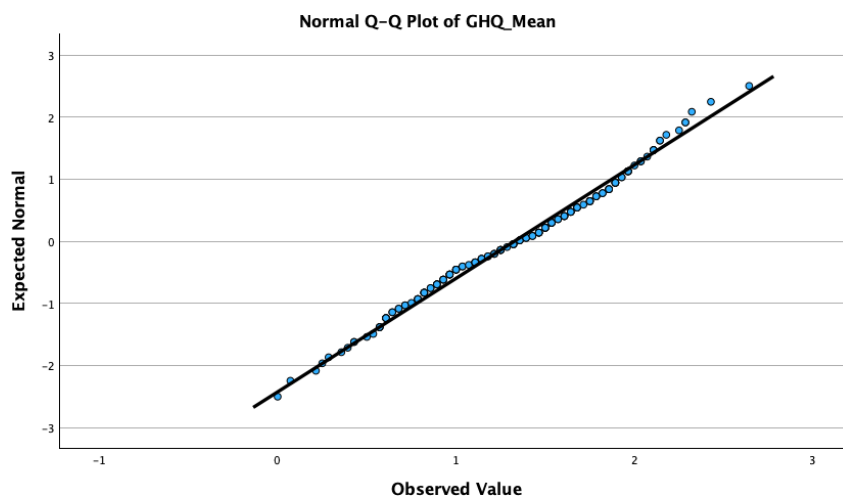
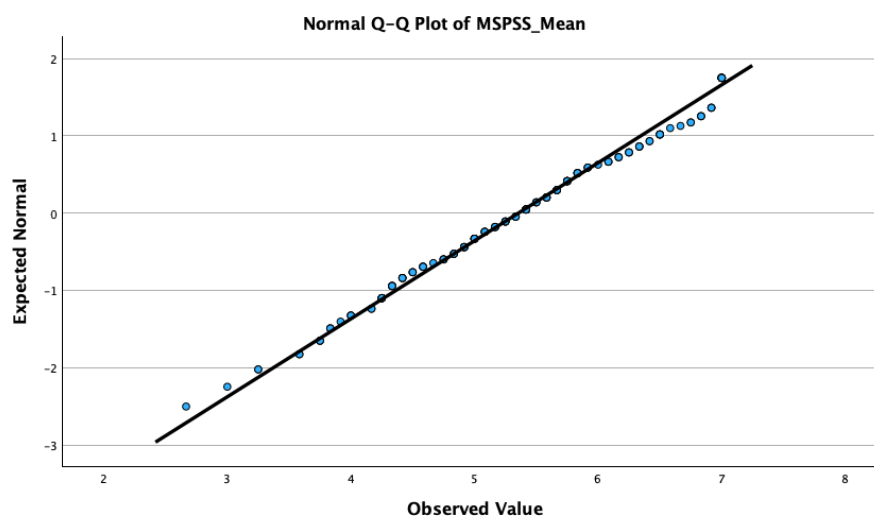


Figure 3

Normal Q-Q Plot for Perceived Social Support



3.8 Summary

To conclude, this current study uses a positivist research philosophy where it utilises quantitative methods to collect and analyse data. The researcher uses purposive sampling to ensure that the cases collected are from the mentioned indigenous groups. Next, a survey method is utilised to collect data as it is cost-efficient and saves time. The data collected will be analysed using SPSS Version 29. A pilot study (n=35) was conducted to measure the reliability of the instruments on the targeted population where Cronbach's alpha value showed excellent internal reliability for all measures.

CHAPTER FOUR

FINDINGS AND DISCUSSION

4.0 Introduction

The main research objective of this study was to enquire about the relationship between perceived social support and mental health outcomes in Sarawakian indigenous populations. This objective is met by findings presented in this chapter, where results from the sample were analysed through statistical methods. The demographic data was presented to evaluate the representativeness and generalisability of the sample data. Inferential data was also presented to further understand the relationship between the variables.

4.1 Demographic Data

Table 7

Demographic Profile of Sample Size

Demographic		Frequency (%)	Mean (SD)
<i>Gender</i>	Male	44 (27.33)	
	Female	117 (72.67)	
<i>Age</i>			22.45 (1.89)
<i>Relationship Status</i>	Single	114 (70.81)	
	Dating	43 (26.71)	
	Married	4 (2.48)	
<i>Education Level</i>	Bachelors	131 (81.37)	
	Foundation/STPM/Diploma	21 (13.04)	
	Masters	7 (4.35)	

	Not applicable	1 (0.62)
	PhD	1 (0.62)
<i>Indigenous Group</i>	Iban	63 (39.13)
	Bidayuh	33 (20.50)
	Melanau	34 (21.12)
	Orang Ulu	31 (19.25)
<i>Residential Type</i>	Urban	122 (75.78)
	Rural	39 (24.22)

Table 7 shows the proportion of participants for categories such as gender, relationship status, educational level, ethnicity, and residential type. A total of 161 respondents participated in the study consisting of Sarawakians aged 20 to 29. The research sample may only reflect the sampling strategy and may not be representative of the overall population of the study. There were more female participants than males, and most of the respondents reported being single. 160 of the participants have some form of educational background, with most currently studying for a bachelor's degree with only 1 respondent reporting not applicable. This means the study cannot be generalised to a population that may not have similar educational backgrounds. The ethnicity of the sample was mostly Iban (39.13%), followed by Melanau (21.12%), Bidayuh (20.50%), and Orang Ulu (19.25%) while it was mostly even among the rest of the ethnic groups. The sample size was skewed towards urban residents (75.78%) as compared to rural residents (24.22%).

4.1.2 Levels of Perceived Social Support & Mental Health Outcomes

Table 8

Descriptive Statistics for Perceived Social Support & Mental Health Outcomes

	Mean	Std. Deviation	N	Min	Max
Perceived social support	5.3551	.99095	161	2.67	7.00
Mental health outcomes	1.3268	.54703	161	0	2.64

The first and second research objective intends to measure the levels of perceived social support among indigenous young adults and to measure the levels of mental health outcomes among indigenous young adults respectively. Descriptive statistics for the measures of perceived social support and mental health outcomes are shown in Table 8. On measures of perceived social support, the participants reported a mean of 5.36 (SD = 0.55, range 0-2.64) which is considered high, meanwhile measures for mental health outcomes, the participants reported an average mean of 1.33 (SD = .55, range 2.67-7.00), which is considered moderate.

4.2 Inferential Statistics

4.2.1 Relationship between perceived social support and mental health outcomes

H₁: There is a significant relationship between perceived social support and mental health outcomes among indigenous young adults.

Table 9

Pearson Product-Moment Correlation Coefficient

		Mental health outcomes	Perceived social support
Mental health outcomes	Pearson Correlation	1	-.364**
	Sig. (2-tailed)		<.001

	N	161	161
Perceived	Pearson Correlation	-.364**	1
social support	Sig. (2-tailed)	<.001	
	N	161	161

**. Correlation is significant at the 0.01 level (2-tailed).

The third research objective was to examine the relationship between perceived social support and mental health outcomes among indigenous young adults. It was hypothesised that perceived social support would have a significant relationship with mental health outcomes. A Pearson product-moment correlation coefficient was computed to examine the relationship between the independent variable, perceived social support and the dependent variable, mental health outcomes. The results indicate that there was a **significant moderate negative** correlation between perceived social support and mental health outcomes, $r(159) = -.364$, $p < .001$. Hence, there is enough evidence to reject the null hypothesis. This indicates that higher levels of perceived social support are associated with lower levels of mental health outcomes.

4.2.2 Group Differences in Perceived Social Support & Mental Health Outcomes

Table 10

Tests of Homogeneity of Variances

		Levene Statistic	df1	df2	Sig.
Mental health outcomes	Based on Mean	.142	3	157	.935
	Based on Median	.106	3	157	.956
	Based on Median and with adjusted df	.106	3	151.828	.956
	Based on trimmed mean	.135	3	157	.939
	Based on Mean	.596	3	157	.618

Perceived social support	Based on Median	.599	3	157	.616
	Based on Median and with adjusted df	.599	3	156.866	.616
	Based on trimmed mean	.601	3	157	.616

Table 11

Descriptive Statistics Across Indigenous Groups

Indigenous					
	group	N	Mean	Std. Deviation	Std. Error
Mental health outcomes	Iban	63	1.2472	.54119	.06818
	Bidayuh	33	1.4708	.59148	.10296
	Melanau	34	1.3866	.52874	.09068
	Orang Ulu	31	1.2696	.51614	.09270
	Total	161	1.3268	.54703	.04311
Perceived social support	Iban	63	5.3413	.98165	.12368
	Bidayuh	33	5.1869	.91050	.15850
	Melanau	34	5.4412	1.08353	.18582
	Orang Ulu	31	5.4677	1.00845	.18112
	Total	161	5.3551	.99095	.07810

Table 12

ANOVA Table

		Sum of Squares	df	Mean Square	F	Sig.
Mental health outcomes	Between Groups	1.306	3	.435	1.468	.225
	Within Groups	46.572	157	.297		
	Total	47.878	160			

Perceived social support	Between Groups	1.591	3	.530	.535	.659
	Within Groups	155.527	157	.991		
	Total	157.118	160			

H_{2a}: There are significant differences in perceived social support across indigenous groups.

The fourth research objective was to compare the differences in the levels of perceived social support and mental health outcomes across different indigenous groups. It was hypothesised that there are significant differences in perceived social support between the Iban, Bidayuh, Melanau, dan Orang Asli indigenous groups. Descriptive statistics for the four indigenous groups are presented, Iban (M = 5.34, SD= .98), Bidayuh (M=5.19, SD= .91), Melanau (M= 5.44, SD= 1.08) and Orang Ulu (M=5.47, SD=1.00).

A one-way analysis of variance was conducted between the 4 demographic groups and perceived social support. From Table 10, which shows the Test of Homogeneity of Variances, $p\text{-value} = .618 > 0.05$, therefore variances are homogenous. From Table 12, which shows the ANOVA Table, $F(3,157) = .535, p = .659 > 0.05$. Hence, fails to reject the null hypothesis. **Therefore, there are no significant differences in perceived social support across indigenous groups.**

H_{2b}: There are significant differences in mental health outcomes across indigenous groups.

The fourth research objective was to compare the differences in the levels of perceived social support and mental health outcomes across different indigenous groups. It was hypothesised that there are significant differences in mental health outcomes between the Iban, Bidayuh, Melanau, and Orang Asli indigenous groups. Descriptive statistics for the four indigenous

groups are presented, Iban (M = 1.25, SD= .55), Bidayuh (M=1.47, SD= .59), Melanau (M= 1.39, SD= .53) and Orang Ulu (M=1.27, SD=.52).

A one-way analysis of variance was conducted between the 4 demographic groups and mental health outcomes. From Table 10, which shows the Test of Homogeneity of Variances, $p\text{-value} = .935 > 0.05$, therefore variances are homogenous. From Table 12, which shows the ANOVA Table, $F(3,157) = 1.47, p = .225 > 0.05$. Hence, fails to reject the null hypothesis. **Therefore, there are no significant differences in mental health outcomes across indigenous groups.**

4.2.3 Urban and Rural Differences in Perceived Social Support & Mental Health Outcomes

Table 13

Descriptives for Urban vs Rural in Mental Health Outcomes & Perceived Social Support

Residential		N	Mean	Std.	Std. Error Mean
Type				Deviation	
Mental health outcome	Urban	122	1.3563	.54583	.04942
	Rural	39	1.2344	.54748	.08767
Perceived social support	Urban	122	5.3340	.99687	.09025
	Rural	39	5.4209	.98210	.15726

Table 14

Independent Samples Test (Perceived Social Support)

	Perceived social support	
	Equal variances assumed	Equal variances not assumed
F	0.023	

Levene's Test for Equality of Variances	Sig.	.881	
t-test for Equality of Means	t	-.476	-.479
	df	159	64.941
	Sig. (2-tailed)	.227	.230
	Mean Difference	-.08692	-.08692
	Std. Error Difference	.18273	.18132

H_{3a}: There are significant differences in the levels of perceived social support between urban and rural residential areas.

The fifth research objective was to compare the differences in the levels of perceived social support and mental health outcomes between urban and rural residential areas. It was hypothesised that there are significant differences in perceived social support between urban and rural residents.

An independent samples t-test was conducted to compare perceived social support between urban and rural residents. Urban residents ($M = 5.33$, $SD = 1.00$) had a lower mean score than rural residents ($M = 5.42$, $SD = .98$), $t(159) = -.476$, $p = .635$. These results indicate that there is **no significant difference** in perceived social support between urban and rural residents.

Table 15

Independent Samples Test (Mental Health Outcomes)

	Mental health outcomes	
	Equal variances assumed	Equal variances not assumed
F	0.006	

Levene's Test for Equality of Variances	Sig.	.941	
t-test for Equality of Means	t	1.213	1.211
	df	159	63.958
	Sig. (2-tailed)	.635	.633
	Mean Difference	.12183	.12183
	Std. Error Difference	.10048	.100064

H_{3b}: There are significant differences in the levels of mental health outcomes between urban and rural residential areas.

It was hypothesised that there are significant differences in mental health outcomes between urban and rural residents. An independent samples t-test was conducted to compare mental health outcomes between urban and rural residents. Urban residents (M = 1.36, SD = 0.55) had a higher mean score than rural residents (M = 1.23, SD = .55), $t(159) = 1.213, p = .635$. These results indicate that there is **no significant difference** in mental health outcomes between urban and rural residents.

Table 16

Summary of Inferential Findings

Research Question	Research Hypotheses	Findings
1. What is the relationship between social support and	H ₁ : There is a significant relationship between perceived social support and mental health outcomes	Accepted. $r(159) = -.364, p < .001$

mental health outcomes?	among indigenous young adults.	
2. Is there a significant difference in the levels of social support and mental health outcomes across different indigenous groups?	H _{2a} : There are significant differences in perceived social support across indigenous groups. H _{2b} : There are significant differences in mental health outcomes across indigenous groups.	Rejected. $F(3,157) = .535, p = .659 > 0.05$ Rejected $F(3,157) = 1.47, p = .225 > 0.05$
3. Is there a significant difference in the levels of social support and mental health outcomes between urban and rural residential areas?	H _{3a} : There are significant differences in the levels of social support between urban and rural residential areas. H _{3b} : There are significant differences in the levels of mental health outcomes between urban and rural residential areas.	Rejected. $t(159) = -.476, p = .227.$ Rejected. $t(159) = 1.213, p = .635$

4.3 Discussion

4.3.1 Levels of Perceived Social Support & Mental Health Outcomes

In this study, the researcher examined levels of perceived social support and mental health outcomes among indigenous young adults using the Multidimensional Scale of Perceived Social Support (MSPSS-12) and the General Health Questionnaire (GHQ-28).

The findings revealed from each measure revealed high levels of perceived social support. This finding is consistent with those of other studies such as Talwar & AR (2013) that studied perceived social support among university students in Sarawak, where the total scale reported high levels of perceived social support ($M = 5.33$, $SD = 1.12$). It can be deduced that strong social support networks are common in indigenous communities in Sarawak, though care must be taken in interpreting these results since most of the respondents come from a higher education background, thus it cannot be extrapolated to all indigenous populations, especially those that do not have a similar educational background. Education can be a strong factor that supports social mobility, hence better socioeconomic environments that would have different social networks. Further research should question the role of different educational backgrounds in moderating the levels of perceived social support.

In contrast, the findings showcased that there are moderate levels of mental health outcomes, indicating the possibility of distress and symptoms present in some parts of the sample. The score suggests that while many participants of the sample are coping well with their mental health, a significant portion of them are still experiencing distress. Especially with a young sample, the participants may have experienced significant transitions and/or life events that are distressing. It is encouraging to compare these results with those found by Samsudin et al. (2024) where it is reported that younger individuals in Malaysia displayed a higher prevalence of mental disorder symptoms. Implications for this finding are important for mental

health interventions that are aimed at indigenous young adults, especially since social interaction and community-based approaches involving family and peer support address individual and systemic factors that can impact mental health outcomes. Nonetheless, the cross-sectional nature of the research design may restrict the ability to infer causality which is further exacerbated by the lack of diverse representativeness of the sample, which is skewed towards female, single, and educated backgrounds.

The study presents high levels of perceived social support and a moderate level of mental health outcomes among indigenous young adults in Sarawak, highlighting the importance of social support networks in mental health interventions.

4.3.2 Relationship Between Perceived Social Support and Mental Health Outcomes

Studies have consistently shown that social support can act as a buffer against stressful life situations. The current study examined the relationship between perceived social support and mental health outcomes within a young indigenous population.

Interestingly, there was a negative moderate correlation between the two variables, further validating the universality of the phenomenon. This finding supports previous research into perceived social support and mental health outcomes (Gök & Çiftçi, 2023; Jamshaid et al., 2023; Ji et al., 2023; Uchino et al., 2016). However, the results were also in contrast to studies such as Alnazly et al., (2021) instead reported weak associations between social support and outcomes in mental health concerns, where the researchers found that social support may be beneficial but not as pronounced as other factors such as accessibility to mental health services and socioeconomic background. The difference in findings may be explained by different sample characteristics, in which Alnazly et al., focused on an older population as compared to the current study which had a younger population. Additionally, there may have been

methodological variations since the study utilised different measures used to assess social support and mental health. The dimensions that were measured may have been altogether different.

Given the moderate strength of association, it is important to note that while perceived social support is a significant factor, it is not the sole determinant of mental health outcomes. As previously discussed, social determinants of health encompass various factors that contribute to the overall health outcome of an individual. Other factors such as socioeconomic status, access to healthcare services, and familiarity with cultural identity may influence the relationship. Furthermore, a longitudinal design may help better understand inferring causal relationships for the two variables in the Sarawakian indigenous population.

4.3.3 Differences in Perceived Social Support & Mental Health Outcomes between Indigenous Groups

The current study found no significant differences between the indigenous groups when it comes to perceived social support and mental health outcomes respectively. The findings demonstrate that the lack of differences in perceived social support and mental health outcomes between groups may suggest similar cultural and social frameworks across the four indigenous groups. This may be caused by the small sample size from each group which was not statistically powerful enough. Additionally, it is worth exploring what specific factors contribute to perceived social support and mean health within each group which was not measured in this current study. Although directly comparable studies within this context are scarce, comparisons can be made based on research on social support and mental health in broader indigenous populations. For instance, Lai & Teyra (2022) and Zagefka et al. (2023) highlighted the protective nature of social support on mental health among indigenous communities in Taiwan and Chile respectively. Methodological improvements can be made to

the study by employing qualitative approaches that can provide deeper insight into the lived experiences of indigenous individuals, which allows for more cultural nuance in understanding the mechanisms of perceived social support and mental health outcomes in these indigenous communities.

4.3.4 Perceived Social Support & Mental Health Outcomes: Urban vs Rural Dynamics

The current study also explored differences between urban and rural populations in terms of perceived social support and mental health outcomes. Contrary to previous studies, the results indicated no significant differences between both population centres regarding these variables.

While general literature has conflicting consensus on the issue, more research needs to be conducted to understand the variability of factors that differentiate urban and rural settings. For instance, Tulk et al. (2023) reported rural populations experienced higher distress and poor health outcomes compared to their urban counterparts, and Gu et al. (2023) found that rural areas emphasise a lot on family support meanwhile urban settings rely more on instrumental support and social connectivity from friends.

The current study's findings may suggest environmental and contextual factors that affected the overall results. Possibly, there can be other variables that contributed to similar levels of perceived social support and mental health outcomes. However, there was a major imbalance in the number of respondents coming from rural areas, with only roughly 25% of the respondents being rural residents. Hence, more data points are needed before generalisation and conclusions can be conducted on the overall urban-rural dynamics.

4.4 Summary

This current study investigated the relationship between perceived social support and mental health outcomes among Sarawakian indigenous young adults, with a total of 161 respondents.

Findings revealed that there were high levels of perceived social support and moderate levels of mental health outcomes among the participants. This finding highlights the role of social support in acting as a buffer in navigating mental health challenges. A significant moderate negative correlation was found between the two variables, perceived social support and mental health outcome, indicating that higher perceived social support is associated with lower levels of mental health outcome. No significant differences were found in perceived social support and mental health outcomes across indigenous groups or between urban and rural residents. In summary, the research emphasized the crucial role of social support in promoting mental health among Sarawakian indigenous populations while also criticizing the generalisability of the results due to the lack of a diverse respondent pool, further mentioning caution in interpreting results.

CHAPTER FIVE

LIMITATION, IMPLICATION, RECOMMENDATION AND CONCLUSION

5.0 Introduction

This chapter provides an overview of the limitations and implications of the current study based on the findings and discussions conducted in the previous chapter. Additionally, these findings and discussions, recommendations for improvements were provided for possible consideration and implementation for future research. Finally, a conclusion highlighting a summary of key insights towards the overall study was provided.

5.1 Limitations of Study

This current study aimed to investigate the relationship between perceived social support and mental health outcomes. While valuable insights and findings have been provided, the current study had several limitations that must be acknowledged.

Firstly, the study was only able to yield a total of 161 respondents. Based on Krejcie & Morgan (1970), the ideal sample size would have been 384 for the appropriate population of study. This discrepancy raises concerns about the statistical power of the analysis conducted and the generalisability of the findings. Due to the lack of respondents, it may not capture the full range of the interaction between the two variables in the broader population. This can lead to biased estimates and downplay the robustness of the conclusions that have been drawn.

Secondly, due to the cross-sectional design of the study, the data collected only represents the exposure and outcome at that specific time. By limiting data collection to a single point in time, the ability to infer causality between perceived social support and mental health outcomes is restricted. While the association between the two variables can be identified, it is

difficult to establish the causative interaction between the two relationships since both treatment and exposure are measured simultaneously. Longitudinal studies would be able to overcome this issue as changes over time are measured.

Additionally, the demographic profile presented does not reflect the diversity of the general population, where the respondents were skewed towards female, single, educated, and urban, identifying individuals. The lack of a broader respondent pool limits the generalisability of the findings, making it challenging to apply the results and implications to populations with different socioeconomic, cultural and geographic backgrounds. Furthermore, the introduction of the inclusion criteria of the four indigenous groups (Iban, Bidayuh, Melanau, and Orang Ulu) means that the results are only applicable to these groups. Likewise, the overrepresentation of urban respondents means that it was difficult to establish a comparison between the two groups, potentially overlooking important interactions and variations in between-group comparisons towards perceived social support and mental health outcomes.

5.2 Implications

The current study has contributed to several particular contributions to the body of knowledge on perceived social support and mental health outcomes, especially within a Sarawakian indigenous context where research in these areas is relatively scarce and related literature is quite limited. Firstly, the findings generally support the universality of the relationship between social support that can act as a buffer against negative mental health outcomes. Despite limited generalisability, the relationship that was produced was consistent with mainstream literature. Secondly, policymakers and mental health practitioners can consider a universal approach to promoting social support in mental health intervention. Moreover, the study's findings suggest that perceived social support is consistent across different indigenous groups. Therefore, similarities in social support structures and dynamics need to be considered across these groups

when developing and implementing interventions. This practice will facilitate the development of culturally sensitive programs that can further assist indigenous groups in handling stressful life events that can negatively affect their mental health. In summary, the universal relationship between perceived social support and mental health outcomes highlights the need for broad, culturally sensitive interventions that can positively impact indigenous communities.

5.3 Recommendations

To improve further research direction and practice, several recommendations can be implemented by researchers. Firstly, to better understand the causal relationship between the two variables, perceived social support and mental health outcome, future research should consider adopting a longitudinal mixed-methods design. A longitudinal study will help understand the dynamics between the two variables over time and can provide insight into the long-term effects of social support towards negative mental health outcomes, meanwhile, a mixed-method research design will allow for more subjective themes to be generated. Next, researchers should also utilise locally translated and validated scales when administering the tests towards diverse populations. Using culturally sensitive measurements will allow for better reliability and validity of the data collected. Next, researchers should also engage indigenous community members as active partners in research. This is to ensure the design, data collection, and interpretation of findings are not the researcher's preconceived bias and assumptions, but rather quality representation of the community and indigenous population that is being studied. Lastly, future research should also compare within-group variability to gain a deeper understanding of the factors that can influence the relationship between perceived social support and mental health outcomes. From here, nuanced factors such as age, gender, and cultural contexts can be further studied to understand its moderating effects towards the relationship of the two variables.

5.4 Conclusion

This thesis has explored the relationship between perceived social support and mental health outcomes, within a Sarawakian indigenous context; studying between-group differences of the Iban, Bidayuh, Melanau, and Orang Ulu populations, and residential settings. The findings indicated that while perceived social support plays an important role in mental health across the different indigenous groups, there were no significant differences in outcomes. Similarly, different residential settings show similar levels of perceived social support and mental health outcomes; indicating that there might not be a huge difference between the two population centres. However, results must be interpreted with caution due to the small pool of respondents. These findings highlight the importance of culturally sensitive interventions for indigenous communities that acknowledge the diversity of socio-cultural dynamics. Methodologically, the thesis can provide a preliminary framework of research towards mental health research into indigenous populations in Sarawak, with recommendations towards improving methodology by utilising mixed methods and longitudinal designs. Moving forward, indigenous communities must be at the forefront of health-related research to close the gap in health inequity.

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APPENDIX A

Participant Information Sheet

Participant Information Sheet

Please read this participant information sheet carefully before participating in this study.

PURPOSE AND BACKGROUND

Researcher: Samuel Nullai Anak Sawa (78510), 3rd year Psychology undergraduate

Institution: Faculty of Cognitive Science & Human Development (FCSHD), Universiti Malaysia Sarawak (UNIMAS)

Supervisor: Dr Voon Siok Ping

Research title: "Perceived social support and mental health outcome: a cross-cultural comparison between different indigenous minority groups among urban and rural young adults in Sarawak."

INCLUSION CRITERIA

To take part in this study, you must be:

- A Malaysian citizen currently residing in Sarawak.
- Aged between 20 to 29 years old
- Identify and belong to any of the following indigenous ethnic groups: **(a) Iban, (b) Bidayuh, (c) Melanau, and (d) Orang Ulu.**
- Able to understand English
- Able to provide consent and willing to take part in this study

PROCEDURES

There are three parts to this Google Form. **Section A** requires you to fill in your demographic information. **Section B** requires completion of the 12-item self-reported **Multidimensional Scale of Perceived Social Support (MSPSS-12)**. Lastly, **Section C** requires completion of the 28-item self-reported **General Health Questionnaire (GHQ-28)**. This would take approximately 5-10 minutes for you to complete the entire survey.

CONFIDENTIALITY

All collected data will only be used for academic purposes. The collected data will be ensured anonymity and kept confidential, with each respondent labelled with a unique code that does not reveal private information. This information will only be accessible to the researcher and the supervisor.

RISKS AND DISCOMFORTS

As a participant, you will not experience any risk or discomfort. Do note that the questionnaires are self-reporting in nature, thus the measures are dependent on your answers. A psychological debriefing will be provided at the end of the study.

BENEFITS

As a participant, you will not receive any compensation or direct benefits for participating in this data collection.

VOLUNTARY PARTICIPATION

By participating in this study, you acknowledge that it is voluntary. You can also choose not to participate and may withdraw from this study at any time. There is no penalty for those who withdraw or do not participate in this survey.

QUESTIONS

If you have any questions or doubts about this study, please contact the researcher at 78510@siswa.unimas.my

1. I have read and understood the informed consent form and agreed to participate in this study voluntarily
 - Yes

Section A: Demographic Profile

2. Age: ____
3. What is your gender?
 - Male
 - Female
4. Where do you currently reside?
 - Urban
 - Rural
5. What is your marital/relationship status?

- Single
 - Dating
 - Married
 - Divorce
 - Widowed
6. What is your current education level?
- Foundation/STPM/Diploma
 - Bachelors
 - Masters
 - PhD
 - Not applicable
7. Which ethnicity do you identify and belong as?
- Iban
 - Bidayuh
 - Melanau
 - Orang Ulu

Section B: Multidimensional Scale of Perceived Social Support MSPSS-12

We are interested in how you feel about the following statements. Read each statement carefully. Indicate how you feel about each statement.

		Very Strongly Disagree	Strongly Disagree	Mildly Disagree	Neutral	Mildly Agree	Strongly Agree	Very Strongly Agree
1.	There is a special person who is around when I am in need.	1	2	3	4	5	6	7
2.	There is a special person with whom I can share joys and sorrows.	1	2	3	4	5	6	7
3.	My family really tries to help me.	1	2	3	4	5	6	7
4.	I get the emotional help & support I need from my family.	1	2	3	4	5	6	7
5.	I have a special person who is a real source of comfort to me.	1	2	3	4	5	6	7
6.	My friends really try to help me.	1	2	3	4	5	6	7
7.	I can count on my friends when things go wrong.	1	2	3	4	5	6	7
8.	I can talk about my problems with my family.	1	2	3	4	5	6	7
9.	I have friends with whom I can share my joys and sorrows.	1	2	3	4	5	6	7
10.	There is a special person in my life who cares about my feelings.	1	2	3	4	5	6	7
11.	My family is willing to help me make decisions.	1	2	3	4	5	6	7
12.	I can talk about my problems with my friends.	1	2	3	4	5	6	7

Section C: General Health Questionnaire (GHQ-28) by Goldberg & Hillier
(1979)

Please read this carefully: We would like to know if you had any medical complaints and how your health has been in general over the past few weeks. Please answer ALL the questions by simply choosing the answer which you think most nearly applies to you.

Remember, we want to know about present and recent complaints, not those that you had in the past. This GHQ-28 utilises a 4-scale Likert rating. Each question has a different description of choices.

HAVE YOU RECENTLY	
1.	Been feeling perfectly well and in good health?
2.	Been feeling in need of a good tonic?
3.	Been feeling run down and out of sorts?
4.	Felt that you are ill?
5.	Been getting any pains in your head?
6.	Been getting a feeling of tightness or pressure in your head?
7.	Been having hot or cold spells?
8.	Lost much sleep over worry?
9.	Had difficulty in staying asleep once you are off?
10.	Felt constantly under strain?
11.	Been getting edgy and bad-tempered?
12.	Been getting scared or panicky for no good
13.	Found everything getting on top of you?
14.	Been feeling nervous and strung-up all the time?
15.	Been managing to keep yourself busy and occupied?
16.	Been taking longer over the things you do?
17.	Felt on the whole you were doing things well?
18.	Been satisfied with the way you've carried out your task?
19.	Felt that you are playing a useful part in things?
20.	Felt capable of making decisions about things?
21.	Been able to enjoy your normal day-to-day activities?
22.	Been thinking of yourself as a worthless person?
23.	Felt that life is entirely hopeless?
24.	Felt that life isn't worth living?

Acknowledgements and debriefing

Please press submit after reading the following debrief

Thank you so much for participating in this study. Your contributions will shed light on the objective experiences of indigenous groups in Sarawak regarding social support and mental health. If you experience any distress or require further mental health resources, do look into the following:

MENTARI: <https://mentari.moh.gov.my/contact-us-2/contact-us-sarawak/>

HOSPITAL SENTOSA, 7TH MILE: 082-612321

DEPT OF PSYCHIATRIC & MENTAL HEALTH, SGH: 082-241753

KLINIK KESIHATAN PETRAJAYA: 082-440661

BODHI COUNSELING: 082-256428/29

S'WAK WOMEN FOR WOMEN SOCIETY CRISIS PHONE LINE: 082-422660

GRACE CENTRE KUCHING: 082-256411

BEFRIENDERS KUCHING: 082-242800

UNIT KAUNSELING KELUARGA: 082-411036

MENTAL HEALTH ASSOCIATION KUCHING: 082-231459