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The Relationship Between Mental Health Status and Stigma among UNIMAS
Undergraduate Nursing Students

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DECLARATION

I declare that the work in this thesis was carried out in accordance with the regulations of Universiti Malaysia Sarawak. Except where due acknowledgements have been made, the work is that of the author alone. The thesis has not been accepted to any degree and is not concurrently submitted in candidature of any other degree.



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ABSTRACT

Mental health issues such as anxiety, depression, and stress are increasingly prevalent among university students, particularly within nursing programs due to academic and clinical demands. However, stigma toward mental illness continues to hinder help-seeking behaviours and exacerbate psychological distress. This study aimed to examine the relationship between mental health status and stigma among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). A cross-sectional descriptive quantitative design was employed, involving 163 students selected through simple random sampling. Data were collected using the Depression, Anxiety, and Stress Scale (DASS-21) and the Stigma and Self-Stigma Scale (SASS). Results revealed that while most students exhibited normal levels of depression and stress, a considerable proportion experienced mild to moderate anxiety. Moderate levels of internalized stigma particularly anticipated stigma, avoidant coping, and reluctance to seek help were also evident. Spearman's correlation analysis showed a statistically significant relationship between mental health status and stigma. These findings highlight the importance of integrating stigma-reduction strategies and mental health support within nursing education to promote psychological well-being and professional preparedness among nursing students.

Keywords: Mental health, stigma, nursing students, anxiety, depression, DASS-21, SASS, help-seeking behaviour

***Hubungan Antara Status Kesehatan Mental dan Stigma dalam Kalangan Pelajar
Kejururawatan Prasiswazah UNIMAS***

ABSTRAK

Isu kesihatan mental seperti kebimbangan, kemurungan dan tekanan semakin meningkat dalam kalangan pelajar universiti, khususnya pelajar kejururawatan yang berdepan tekanan akademik dan tanggungjawab klinikal. Namun begitu, stigma terhadap penyakit mental masih menjadi halangan utama kepada tingkah laku mendapatkan bantuan dan memburukkan lagi tekanan psikologi. Kajian ini bertujuan untuk menilai hubungan antara status kesihatan mental dan stigma dalam kalangan pelajar kejururawatan prasiswazah di Universiti Malaysia Sarawak (UNIMAS). Kajian ini menggunakan reka bentuk kuantitatif deskriptif keratan lintang melibatkan 163 pelajar yang dipilih secara persampelan rawak mudah. Data dikumpul menggunakan alat soal selidik yang disahkan iaitu Depression, Anxiety, and Stress Scale (DASS-21) dan Stigma and Self-Stigma Scale (SASS). Dapatan menunjukkan bahawa walaupun kebanyakan pelajar berada dalam julat normal bagi kemurungan dan tekanan, sebilangan besar mengalami tahap kebimbangan yang ringan hingga sederhana. Tahap stigma dalaman yang sederhana turut dikenal pasti, termasuk stigma jangkaan, strategi penyesuaian mengelak, dan keengganan untuk mendapatkan bantuan. Analisis korelasi Spearman's menunjukkan terdapat hubungan yang signifikan secara statistik antara status kesihatan mental dan stigma. Kajian ini menekankan kepentingan pelaksanaan strategi pengurangan stigma dan sokongan kesihatan mental dalam pendidikan kejururawatan bagi meningkatkan kesejahteraan psikologi dan kesiapsiagaan profesional pelajar kejururawatan.

Kata kunci: *Kesehatan mental, stigma, pelajar kejururawatan, kebimbangan, kemurungan, DASS-21, SASS, tingkah laku mendapatkan bantuan*

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LIST OF ABBREVIATION

COVID-19	Coronavirus Disease 2019
DASS-21	Depression Anxiety Stress Scale-21
FMHS	Faculty of Medicine and Health Sciences
GPA	Grade Point Average
PIS	Participant Information Sheet
SASS	Stigma and Self-stigma Scale
SPSS	Statistical Package for the Social Sciences
UNIMAS	Universiti Malaysia Sarawak

CHAPTER ONE

INTRODUCTION

1.0 Introduction

This chapter discusses the context of the study, which is the relationship between mental health status and stigma among Universiti Malaysia Sarawak (UNIMAS) undergraduate nursing students, as well as a potential solution to the study's problems. The background of study is explained in section 1.1, while the problem statement is then explored to determine the research gap in section 1.2. The research questions in section 1.3, research objective in section 1.4, and research hypothesis in section 1.5. The significance of research is then explained in section 1.6. Conceptual and operational definitions of concepts are provided to explain the terms used in this study in section 1.7. The last part of this chapter is the summary in section 1.8.

1.1 Background of Study

Mental health encompasses emotional, psychological, and social well-being. It influences cognition, emotion, and behaviour, and plays a crucial role in stress management, interpersonal relationships, and decision-making (Buzzitta, 2023). Mental health refers to a state of well-being wherein individuals acknowledge their abilities, manage typical daily stressors, participate in purposeful activities, and contribute to their community (World Health Organization, 2022). It encompasses various aspects such as subjective well-being, perceived self-efficacy, autonomy, and the ability to form relationships. Mental health encompasses more than the mere absence of mental illnesses; it represents a spectrum that varies among individuals (McCalla, 2024). Mental disorders are health conditions marked

by notable disruptions in cognition, emotional regulation, or behaviour, resulting in distress or functional impairment (World Health Organization, 2022). These illnesses may present in several forms, including anxiety disorders, mood disorders, and psychotic disorders. The classification of these conditions is essential for understanding mental health status and its implications for individuals and society.

The stigma associated with mental health related to the adverse attitudes and ideas that society maintains towards persons with mental diseases (Subramaniam et al., 2016). This stigma can lead to discrimination, social exclusion, and barriers to accessing care. It typically manifests in two forms: public stigma, which represents societal attitudes towards mental illness, and self-stigma, wherein individuals internalise these negative perceptions, resulting in feelings of shame and diminished self-esteem (Subu et al., 2021). Research indicates that stigma can significantly impact the mental health status of nursing students (Martínez-Martínez et al., 2022). Those who perceive high levels of stigma may be less likely to seek help for their own mental health issues or provide compassionate care to patients with similar challenges (Martínez-Martínez et al., 2022). The stigma associated with mental health can also contribute to a culture of silence within healthcare settings, preventing open discussions about mental well-being among healthcare providers (Knaak et al., 2017).

The Biopsychosocial Model, introduced by George L. Engel in 1977, highlights the interaction of biological, psychological, and social elements in comprehending mental health (Tripathi et al., 2019). This approach is significant since it emphasises the impact of stigma on the psychological well-being of persons with mental illness, as well as their social relationships and overall health outcomes (Potter et al., 2017). The Health Belief Model is an appropriate model established in the 1950s by social psychologists at the U.S. Public Health Service, asserting that an individual's beliefs on health risks and benefits affect their

health behaviours. In the context of mental health, this model can help explain how nursing students' perceptions of stigma may impact on their willingness to seek help for mental health issues or to provide compassionate care to patients with mental illnesses (Gosman, 2021). By understanding these beliefs, educational interventions can be designed to address misconceptions and reduce stigma among nursing students. Research indicates that nurses often hold stigmatizing attitudes towards individuals with mental illnesses, which can hinder effective patient care (Grover et al., 2020). By incorporating the Biopsychosocial Model and the Health Belief Model into conceptual framework, the relationships between mental health status and stigma among UNIMAS undergraduate nursing students can be explored. This approach will provide valuable insights into how stigma affects both individual well-being and professional practice in nursing, ultimately informing strategies for enhancing mental health literacy and support within nursing education.

1.2 Problem Statement

The prevalence of mental health issues among Malaysian adults is concerning, with approximately 4.6% suffering from depression, particularly among individuals aged 16 to 29 years, as reported by the National Health and Morbidity Survey (NHMS) in 2023. This issue is compounded by a pervasive stigma surrounding mental health care, where over 85% of Malaysians fear that seeking help may adversely affect their career prospects, and 52% express concerns about negative reactions from family and friends. Such stigma not only affects the psychological well-being of individuals but also significantly impacts their social interactions and overall health outcomes. Research indicates that stigma can lead to lower self-esteem, increased severity of mental illness symptoms, and even suicidal ideation (Rajagopal et al., 2023).

Among nursing students, this stigma represents a substantial barrier that adversely affects their mental well-being and academic performance. Despite the high prevalence of mental health conditions in this demographic, many students refrain from seeking help due to fears of being labeled or judged by peers and faculty (Martínez-Martínez et al., 2022). This reluctance can exacerbate symptoms of anxiety, depression, and stress, ultimately compromising their ability to succeed in a demanding educational environment (Meng et al., 2022). The problem is particularly acute for nursing students who are already under immense pressure from rigorous academic requirements and clinical responsibilities. Failure to address stigma can lead to prolonged mental health issues, decreased academic performance, and an increased risk of burnout (Clement et al., 2015).

Considering these issues, a considerable gap persists in comprehending how certain remedies might be tailored to address the distinct requirements of nursing students. Additional study is required to investigate effective methods for mitigating stigma in this group and to assess the effects of these methods on mental health outcomes. This problem statement clearly delineates the context and importance of your work, emphasising the necessity for more research in this domain.

1.3 Research Questions

- I. What is the prevalence of mental health status of UNIMAS undergraduate nursing students?
- II. What is the level of stigma towards mental health status among UNIMAS undergraduate nursing students?
- III. Is there any relationship between stigma and mental health status among UNIMAS undergraduate nursing students?

1.4 Research Objectives

1.4.1 General Objective

To determine the relationship between mental health status and stigma among UNIMAS undergraduate nursing students.

1.4.2 Specific Objective

- I. To assess the prevalence of mental health status of UNIMAS undergraduate nursing students.
- II. To assess the level stigma towards mental health status among UNIMAS undergraduate nursing students.
- III. To examine the relationship between stigma and mental health status among UNIMAS undergraduate nursing students.

1.5 Research Hypotheses

1.5.1 Null Hypothesis

There is no significant relationship between mental health status and stigma among UNIMAS undergraduate nursing students.

1.5.2 Alternative Hypothesis

There is a significant relationship between mental health status and stigma among UNIMAS undergraduate nursing students.

1.6 Significance of Study

The significance of this study lay in its potential to address critical gaps in understanding the mental health status and stigma associated with mental health among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). By assessing the mental health status of nursing students, this study aimed to raise awareness about the psychological challenges faced by this population. Given that nursing students often endured significant stress due to academic and clinical demands, it was essential for educators and administrators to recognize the need for supportive measures (Abdelmonaem et al., 2024). Recent studies indicated a significant rise in mental health problems, with reports showing that the prevalence of depression among Malaysian university students escalated from 10% in 2011 to 20% in 2016 (Khairul Azhar et al., 2023).

The study investigated the incidence of stigma associated with mental health concerns among nursing students. Stigma inhibited persons from pursuing assistance, thereby exacerbating their mental health issues. This study guided measures to cultivate a more supportive atmosphere that promoted open talks about mental health by recognising

the degrees of stigma existing (Simonelli-Muñoz et al., 2023). Mitigating stigma was essential, since it had been demonstrated to obstruct help-seeking behaviours and adversely affect overall well-being. This research identified characteristics contributing to stigma, hence guiding interventions to foster positive attitudes and behaviours towards mental health within healthcare teams (Thornicroft et al., 2016). Examining the correlation between stigma and mental health status yielded significant insights into their interplay within the realm of nursing education (Simonelli-Muñoz et al., 2023). Comprehending this link informed the creation of therapies designed to mitigate stigma while concurrently enhancing mental health outcomes.

The results of this study had significant implications for nursing curricula and training programs at UNIMAS. By highlighting the mental health challenges faced by students, educators developed more effective support systems tailored specifically to the needs of nursing students, such as counselling services and peer support programs (Abdelmonaem et al., 2024). This aligned with the broader goal of preparing competent healthcare professionals who were not only skilled in clinical practice but also equipped to manage their own mental well-being (Sonmez et al., 2023). Additionally, the findings served as a foundation for future research in this area, contributing to a growing body of literature on student mental health in nursing education (Sodeify & Tabrizi, 2020). This study inspired further investigations into specific interventions that could enhance student resilience and improve overall mental health outcomes. For instance, an integrative review highlighted the importance of resilience in enabling nursing students to cope with adversities such as academic pressures and clinical responsibilities, suggesting that resilience enhancement programs should be integrated into nursing curricula to support students' mental health (Aryuwat et al., 2022).

1.7 Definition of Terms

1.7.1 Mental Health Status

Conceptual Definition: Mental health status pertains to an individual's emotional, psychological, and social well-being. It comprises the cognitive, emotional, and behavioural aspects of humans in their daily lives. World Health Organisation (WHO) in 2022 defined mental health as a condition of well-being wherein an individual recognises their potential, manages the typical stressors of life, works productively and effectively, and contributes to their community.

Operational Definition: Mental health status will be evaluated via standardised instruments, including the Depression, Anxiety, and Stress Scale (DASS-21). These tools will quantify particular aspects of mental health, encompassing anxiety, depression, and stress levels among UNIMAS undergraduate nursing students (Wittayapun et al., 2023).

1.7.2 Stigma

Conceptual Definition: Stigma refers to the poor attitudes and beliefs that society harbours towards individuals with mental health disorders. It manifests in several forms, including public stigma (societal attitudes), self-stigma (internalised negative beliefs by individuals), and structural stigma (systemic barriers that restrict opportunities for those with mental health challenges) (Vaishnav et al., 2023). Stigma can result in discrimination and social exclusion, profoundly affecting individuals' propensity to seek assistance.

Operational Definition: Stigma will be measured using the Stigma and Self-Stigma Scale (SASS). These scales will evaluate participants' perceptions of stigma related to mental health issues (Docksey et al., 2022).

1.7.3 Undergraduate Nursing Students

Conceptual Definition: Undergraduate nursing students are individuals enrolled in a bachelor's degree program in nursing at a university or college (Law Insider, n.d.). This group is typically engaged in both theoretical coursework and practical clinical training to prepare for careers as registered nurses. They face unique challenges related to academic pressures, clinical responsibilities, and exposure to patient care.

Operational Definition: Undergraduate nursing students will be defined as those currently enrolled in the Bachelor of Nursing program at Universiti Malaysia Sarawak (UNIMAS). The sample will include students from various year levels within the program to ensure a comprehensive understanding of mental health status and stigma across different stages of their education.

1.8 Summary

Mental health issues, such as anxiety, depression, and stress, are prevalent among university students, including those in nursing programs. However, stigma surrounding mental health remains a significant barrier to seeking help, which can exacerbate these conditions and negatively impact academic performance and well-being. While previous studies have explored the prevalence of mental health stigma among university students, few have specifically targeted nursing students. This gap is significant because nursing students not only face the pressures of academic and clinical responsibilities but also serve as future healthcare providers who will interact with patients experiencing mental health challenges. Understanding how stigma affects their mental health status is essential for developing interventions that address both their personal well-being and their professional preparedness. This study aims to explore the extent of stigma and its correlation with mental health status

among undergraduate nursing students at UNIMAS. This inquiry will be guided by three research aims. This chapter offers contextual information and operational terminology about mental health status and stigma.

CHAPTER TWO

LITERATURE REVIEW

2.0 Introduction

In this chapter, literature review will be presented to establish a general idea of the research topic. Section 2.1 describes the prevalence of mental health status among nursing students. The stigma towards mental health status among nursing students is presented in Section 2.2. Next, the relationship between stigma and mental health status among nursing students is presented in Section 2.3, while conceptual framework is presented in Section 2.4. The reflection of the literature review is presented in Section 2.5. A systematic literature search was conducted across four databases: Google Scholar, PubMed, ResearchGate, and ScienceDirect. The search included articles published between 2015 and 2025. Keywords used were “mental health status,” “anxiety,” “depression,” “stress,” “stigma,” “nursing students,” and “university students,” combined using Boolean operators (AND, OR). The search was limited to English-language articles. After removing duplicates, titles and abstracts were screened for relevance, followed by full-text review to apply inclusion and exclusion criteria. Studies published more than 10 years ago or without publication dates were excluded. The selection process was documented using the PRISMA 2020 flow diagram, ensuring transparency and reproducibility of the review process.

2.1 Mental Health Status Among Nursing Students

The mental health status of nursing students has garnered significant attention in recent years, particularly due to the high-stress environment associated with their training.

Research indicates that nursing students are at a heightened risk for mental health issues such as anxiety, depression, and stress (Gao et al., 2021).

A study conducted by Rogers et al. (2021) highlighted that nearly 50% of nursing students reported experiencing moderate to severe anxiety during their studies. This anxiety can stem from various factors, including academic pressures, clinical responsibilities, and fear of making mistakes in patient care. The research highlighted the necessity of mental health support networks in nursing school to tackle these widespread concerns.

A systematic evaluation by Labrague et al. (2017) revealed that nursing students frequently experience significant stress stemming from their demanding training and clinical exposure. The review identified workload, fear of clinical situations, and lack of support as significant contributors to mental health deterioration among nursing students. These findings suggest that the unique demands placed on nursing students create an environment where mental health issues can thrive.

The COVID-19 epidemic has significantly affected the mental health of nursing students. Cross-sectional research done during the pandemic indicated that 71.5% of nursing students exceeded the threshold for probable mental health issues on the General Health Questionnaire (GHQ-12). This study emphasised that inadequate sleep and nutrition during the pandemic were strongly associated with increased risks of mental health disorders, highlighting the pressing necessity for focused treatments. One study found that individuals reporting disturbed sleep were more likely to experience significant symptoms of depression and anxiety, emphasizing the importance of addressing sleep disturbances as a potential intervention point for improving mental health outcomes (Rajkumar, 2020).

A literature review by Morton (2022) reported that 63% of university students indicated a decline in their mental health since the onset of the pandemic. This decline was

particularly pronounced among nursing students who faced increased academic and clinical pressures during this challenging time. The review called for further research and interventions to combat rising rates of mental health issues in this population. As highlighted in recent studies, nursing students face significant psychological challenges, including increased levels of anxiety, depression, and stress, which can adversely affect their academic performance and overall well-being (Sonmez et al., 2023). The review identified various intervention strategies such as psychotherapy, exercise programs, and mental health training that have shown promise in improving mental health outcomes among nursing students (Li et al., 2018).

2.2 Stigma Towards Mental Health Status Among Nursing Students

Stigma surrounding mental health is an issue that significantly affects individuals' willingness to seek help, particularly among nursing students. Research indicates that stigma can lead to negative attitudes towards those with mental health conditions and deter individuals from disclosing their struggles (Prizeman et al., 2024). A study conducted among internship nursing students revealed that more than three-fifths (approximately 60%) did not exhibit stigma towards seeking professional psychological help (Abdelmonaem et al., 2024).

A study conducted by Huang et al. (2020) revealed a significant degree of stigma around mental illness among nursing students, which adversely affected their propensity to seek assistance for their own mental health concerns. This stigma frequently emerges as apprehension over judgement from peers and professors, resulting in feelings of shame and isolation among individuals with mental health difficulties. A research identified a substantial negative connection ($r = -0.372$, $p < 0.01$) between self-stigma and attitudes

towards seeking professional help, suggesting that increased self-stigma correlates with fewer favourable views towards obtaining support for mental health concerns (Abdelmonaem et al., 2024).

The concept of self-stigma, where individuals internalize negative societal attitudes towards mental illness (Gärtner et al., 2022). This internalization can exacerbate feelings of worthlessness and hopelessness, further complicating an individual's ability to seek help. However, the study also indicated that self-stigma was a significant barrier, with males exhibiting higher levels of self-stigma compared to females (mean = 2.872) (Abdelmonaem et al., 2024). Nursing students may experience heightened self-stigma due to their roles as future healthcare providers, creating an additional layer of complexity regarding their mental health.

A systematic review by Sibanda et al. (2022) highlighted that self-stigma is prevalent among nursing students and is associated with poorer mental health outcomes. The review found that higher levels of self-stigma correlated with increased levels of anxiety and depression, suggesting that stigma not only affects individuals' self-perception but also has direct implications for their overall well-being. In a cross-sectional study involving 1,002 healthcare students (502 medical and 500 nursing), it was reported that approximately 50.8% of students would not disclose their own mental illness to colleagues (Chang et al., 2017). This highlights a significant reluctance to share personal mental health struggles due to stigma.

Furthermore, a qualitative study by Hirani et al. (2022) examined the determinants of stigma among nursing students. Participants indicated that faculty views and institutional culture substantially influenced the stigma associated with mental health disorders in their school setting. The research highlighted the necessity of establishing supportive educational

environments to reduce stigma and encourage help-seeking behaviours. By cultivating a culture of comprehension and support, institutions can enable nursing students to prioritise their mental health and improve their preparedness to care for others in their future professions.

2.3 Relationship Between Mental Health Status and Stigma Among Nursing Students

Research consistently demonstrates that stigma can deter individuals from seeking necessary psychological support. A study by Mason et al. (2019) examined anticipated stigma, specifically the fear of being judged or discriminated against due to mental health issues, and its impact on help-seeking intentions among nursing students. The findings indicated that nursing students often fear negative judgment from peers and faculty when disclosing mental health struggles. The fear of being stigmatized significantly affected students' willingness to seek help. Many participants expressed concerns that revealing their mental health challenges would lead to discrimination or a loss of respect among colleagues and instructors (Mason et al., 2019).

Sibanda et al. (2022) found that nursing students exhibiting elevated self-stigma had heightened anxiety and sadness, resulting in feelings of shame and worthlessness. Nursing students exhibiting elevated self-stigma were more prone to express feelings of anxiety and sadness, signifying a direct effect on their mental health state (Sibanda et al., 2022). This indicates that internalised stigma may intensify preexisting mental health issues, establishing a detrimental cycle in which poor mental health contributes to heightened stigma and vice versa. Heightened anxiety and depression can result in increased self-stigmatization, as individuals may perceive their mental health challenges as indicative of personal failure or

weakness. This loop may impede recovery and dissuade help-seeking behaviours, hence prolonging the mental health difficulties encountered by nursing students (Sibanda et al., 2022).

Cross-sectional research done during the COVID-19 pandemic indicated that male nursing students had elevated levels of PTSD, anxiety, and depression relative to their female peers (Zhang et al., 2022). Research indicates that male nursing students frequently encounter mockery and social exclusion in educational environments, adversely affecting their mental health (Zhang et al., 2022). They may experience exclusion or differential treatment in relation to their female counterparts, resulting in heightened psychological discomfort. The disparities in mental health outcomes between male and female nursing students highlight the influence of gender dynamics on experiences of stigma and mental health. Males may face societal expectations that discourage emotional expression, leading to increased internalization of stress and mental health issues (Zhang et al., 2022). This disparity highlights how gender dynamics may influence both stigma experiences and mental health outcomes within this population.

Finally, Morton (2022) reported that many nursing students rely on friends rather than professionals for support due to stigma surroundings seeking help for mental health concerns. Many students fear judgment or discrimination from peers and faculty, leading them to turn to friends for support instead (Morton, 2022). This reliance on informal support systems can lead to ineffective coping mechanisms and further exacerbate mental health issues. While friends can provide emotional support, they may not have the training or expertise to help nursing students navigate complex mental health challenges. This can result in the adoption of ineffective coping strategies, such as avoidance or denial, which can exacerbate feelings of anxiety and depression over time (Brown et al., 2024). Although peer

support can foster a sense of community, it may also perpetuate negative patterns if friends share similar struggles or lack the knowledge to provide constructive advice. Studies indicate that negative social support characterized by criticism or lack of understanding can significantly worsen mental health outcomes among nursing students (Brown et al., 2024). Accessing professional mental health services is crucial for nursing students, as these services can provide evidence-based interventions tailored to their specific needs. Educational institutions should work to reduce stigma by promoting mental health resources and encouraging open discussions about mental well-being (Waqas et al., 2020).

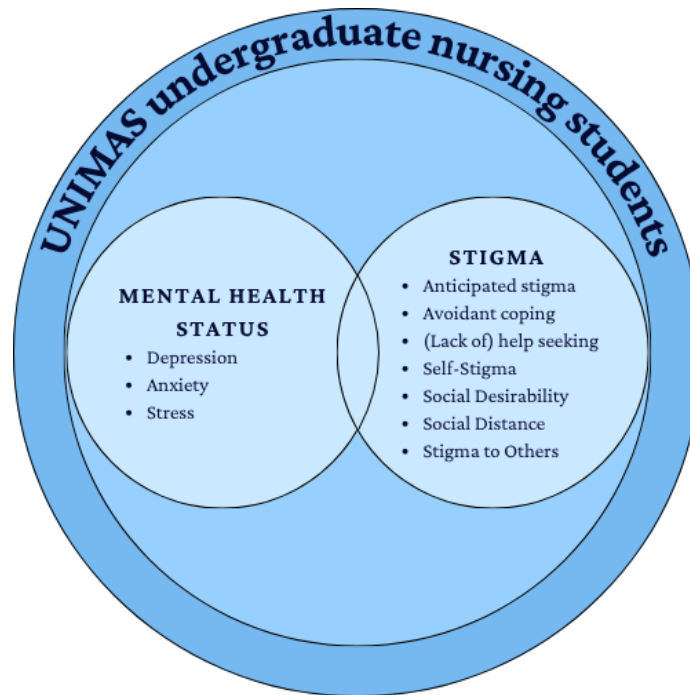
2.4 Conceptual Framework

In a research paper, a conceptual framework is used to describe the main ideas or variables and the connections that need to be examined. According to Biopsychosocial Model proposed by George L. Engel in 1977, emphasizes the interplay of biological, psychological, and social factors in understanding mental health (Tripathi et al., 2019). This model is particularly relevant as it highlights how stigma can affect not only the psychological well-being of individuals with mental illness but also their social interactions and overall health outcomes (Potter et al., 2017). Another pertinent model is the Health Belief Model a social psychological framework developed in the 1950s by social psychologists at the U.S. Public Health Service, which posits that an individual's beliefs about health risks and benefits influence their health behaviors. In the context of mental health, this model can help explain how nursing students' perceptions of stigma may impact on their willingness to seek help for mental health issues or to provide compassionate care to patients with mental illnesses (Gosman, 2021). In this study, socio-demographic variables such as age, gender, academic year, ethnicity and religion are incorporated into the conceptual framework as important factors influencing both stigma and mental health status

among UNIMAS undergraduate nursing students. Guided by the Biopsychosocial and Health Belief Models, these socio-demographic factors provide essential context for understanding individual differences in mental health and stigma experiences. Descriptive statistics were used to summarize these socio-demographic characteristics, providing an overview of the sample profile. Subsequently, bivariate analyses, including chi-square tests and correlation analyses, were conducted to explore the relationships between socio-demographic variables, stigma, and mental health outcomes. This approach allowed for the identification of significant relationship and potential moderating effects of socio-demographic factors within the broader conceptual framework, thereby informing targeted strategies to enhance mental health literacy and reduce stigma in nursing education.

Based on the Biopsychosocial Model and the Health Belief Model into conceptual framework, the relationships between mental health status and stigma among UNIMAS undergraduate nursing students can be explored. This approach will provide valuable insights into how stigma affects both individual well-being and professional practice in nursing, ultimately informing strategies for enhancing mental health literacy and support within nursing education.

Figure 1
Conceptual Framework



2.5 Summary

The literature over the past decade underscores the pressing need to address both mental health status and stigma among nursing students. The interplay between these factors is complex; while many students experience significant mental health challenges, stigma often prevents them from seeking help. Interventions aimed at reducing stigma through education and awareness are essential for improving the mental health outcomes of nursing students. Future research should continue to explore this relationship in diverse cultural contexts to develop tailored strategies that promote positive attitudes toward mental health within nursing education.

CHAPTER THREE

METHODOLOGY

3.0 Introduction

This chapter will describe the research design in section 3.1, research setting in 3.2, population in section 3.3, the sampling method, sampling size and the inclusion and exclusion criteria in section 3.4. Research instruments will be explained in section 3.5, ethical considerations in section 3.6. Pilot study, reliability and validity in section 3.7 and the data collection procedure in section 3.8. Meanwhile, in section 3.9, the data analysis method will be explained. Limitation will be in section 3.10 and lastly, summary in section 3.11.

3.1 Research Design

This research utilised a cross-sectional descriptive quantitative approach to investigate the mental health status and stigma associated with mental health among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). This design **was** suitable for obtaining a snapshot of the current mental health status and stigma within this community at a specific point in time.

3.2 Research Setting

This research was conducted in the Faculty of Medicine and Health Sciences (FMHS) at Universiti Malaysia Sarawak (UNIMAS). The target group of this study comprised undergraduate nursing students at UNIMAS, spanning from Year 1 to Year 4. Studies demonstrated that undergraduate nursing students were more susceptible to mental

health challenges such as anxiety, depression, and stress. One study revealed that a substantial proportion of nursing students reported encountering these problems, which may have been intensified by the rigorous demands of their academic and clinical training (Martínez-Martínez et al., 2022). By including all undergraduate nursing students, the study was able to comprehensively assess the extent of these mental health issues across different cohorts and educational backgrounds.

3.3 Population

The target population for this study comprised undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS), ranging from Year 1 to Year 4. This population was essential for determining the extent of mental illness stigma among nursing students and its influence on their attitudes towards mental health. Based on available data, the total number of undergraduate nursing students at UNIMAS was estimated to be approximately 237 students.

3.4 Sampling

3.4.1 Sampling Method

A simple random sampling method was employed as a statistical strategy to select participants from the larger population, ensuring that each member had an equal probability of being chosen. This approach was utilised to select participants from the entire population of 237 nursing students. The process involved defining the population, which consisted of all undergraduate nursing students currently enrolled at UNIMAS, and compiling a complete list to serve as the sampling frame. Participants were then randomly selected using methods such as a random number generator (e.g., RANDOM.ORG) or

statistical software, guaranteeing that every individual had an equal chance of inclusion. This randomness helped to eliminate selection bias and ensured that the sample was representative of the overall population. Typically, the sampling was conducted without replacement, meaning once an individual was selected, they could not be chosen again. Following selection, participants were contacted, informed about the study's purpose and procedures, and their informed consent was obtained prior to data collection. The use of simple random sampling enhanced the validity and generalisability of the study findings by providing an unbiased and fair selection process, thereby contributing to the robustness and credibility of research outcomes related to mental health awareness and stigma reduction within nursing education.

3.4.2 Sampling Size

The Taro Yamane (1967) formula is a commonly employed technique for calculating a suitable sample size in research projects. This method is especially beneficial when the overall population size is known, and the researcher aims to guarantee that the sample is representative while adhering to a given margin of error.

The Taro Yamane formula is expressed as follows:

$$n = \frac{N}{1 + N \cdot e^2}$$

Where:

- n = sample size
- N = total population size
- e = margin of error (commonly set at 0.05 for a 95% confidence level)

Substituting the values:

$$n = \frac{234}{1 + (234 \cdot 0.05^2)} \approx 147.6$$

$$n = 148$$

Target sample size:

$$n = 148 + 10\% \approx 162.8$$

$$n = 163$$

This calculated sample size ensures that the study will have enough power to detect significant relationships between mental health status and stigma while minimizing sampling error. Utilizing the Taro Yamane formula allows researchers to achieve a balance between practicality and statistical rigor, ensuring that the findings will be robust and applicable to the broader population of nursing students at UNIMAS.

The Taro Yamane formula ensures that researchers can calculate a sample size that balances precision and practicality, making it an essential tool for quantitative research. By using this method, researchers can confidently select a sample that minimizes bias and enhances the reliability of their findings.

It is essential to account for potential non-response when determining the sample size. Given that the total population of nursing students is 237, and considering a non-response rate of 10%, adjustments will be made to ensure that the final sample size is adequate for achieving reliable results. The target sample size is approximately 163 undergraduate nursing students.

3.4.3 Inclusion and exclusion criteria

Specific inclusion and exclusion criteria were set to guarantee a targeted and pertinent sample for this study, which examined the association between stigma and mental health status among Universiti Malaysia Sarawak (UNIMAS) undergraduate nursing students. The inclusion criteria outlined the attributes that participants had to exhibit to qualify for the study. This meticulous selection facilitated the formation of a sample that precisely represented the target population, thereby augmenting the validity of the study outcomes. Conversely, exclusion criteria identified characteristics that disqualified potential participants. By implementing these criteria, the researchers minimised biases and ensured that the sample was representative of the specific demographic under investigation. This approach not only increased the reliability and reproducibility of the results but also safeguarded against ethical concerns related to participant vulnerability and informed consent, ultimately contributing to a more robust understanding of how stigma affected mental health among nursing students at UNIMAS.

The study encompassed undergraduate nursing students from Year 1 to Year 4 of the Bachelor of Nursing programme at UNIMAS. This range ensured a varied representation of students at all educational stages, facilitating a thorough comprehension of mental health and stigma throughout the curriculum. Participants were required to be at least 18 years old to provide informed consent and to possess the ability to comprehend and communicate in English, as the surveys were conducted in that language.

Students who were post-registration or enrolled in nursing programmes other than the Bachelor of Nursing at UNIMAS were excluded from the research. Furthermore, participants who had engaged in a pilot project related to this research were excluded to

prevent any bias stemming from prior exposure to similar topics or themes. This ensured that the data gathered accurately represented the experiences of current undergraduate nursing students, free from the influence of previous research or interventions.

Three students were excluded from the total population because they were post-registration students, resulting in a final population of 234 undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). This adjustment ensured that the study focused exclusively on pre-registration nursing students enrolled in the Bachelor of Nursing programme, thereby maintaining the relevance and accuracy of the sample for examining mental health stigma within this specific group.

3.5 Research Instrument

The Depression, Anxiety, and Stress Scale (DASS-21), the Stigma and Self-Stigma Scale (SASS), and a demographic data questionnaire were the three main research tools used in this study investigating the relationship between stigma and mental health status among Universiti Malaysia Sarawak (UNIMAS) undergraduate nursing students. For a comprehensive overview of the instruments used, including specific questions and response formats, the full questionnaire was provided in Appendix D.

The demographic data questionnaire collected essential information about participants, including age, gender, year of study, race and religion. This data helped to contextualize the findings and identify any potential correlations between demographic characteristics and mental health status or stigma levels.

DASS-21 developed by Lovibond and Lovibond (1995) is a widely recognized self-report instrument designed to measure the levels of depression, anxiety, and stress experienced by individuals (Moya et al., 2022). Comprising 21 items rated on a 4-point

Likert scale, it allows for a nuanced assessment of mental health status. DASS-21 has demonstrated strong psychometric properties, making it an effective tool for capturing the psychological challenges faced by nursing students in their demanding academic environment (Moya et al., 2022).

Additionally, the Stigma and Self-Stigma Scale by Docksey et al (2022) was employed to assess participants' perceptions of stigma related to mental health issues. This scale evaluated both public stigma (the attitudes held by society) and self-stigma (the internalized negative beliefs individuals may hold about themselves due to their mental health challenges) (Docksey et al., 2022). By utilising these validated instruments, this study aimed to provide a comprehensive understanding of how stigma and mental health status interact among nursing students. The combination of demographic data, DASS-21 results, and SASS will facilitate a robust analysis that can inform future interventions aimed at improving mental health awareness and reducing stigma within nursing education (Foster et al., 2019).

Facilitating a more nuanced understanding of how diverse factors impacted mental health outcomes by integrating demographic information, one may identify trends and connections across different groups. The DASS-21 is a validated self-report tool that assesses depression, anxiety, and stress, offering essential insights into the psychological difficulties encountered by nursing students in a rigorous academic setting. This comprehensive method, along with SASS measures, allowed researchers to investigate the relationship between mental health state and stigma, therefore identifying areas necessitating focused treatments.

3.6 Ethical consideration

Various ethical issues were emphasised to maintain the integrity of the research and safeguard participants. In performing this study on the correlation between mental health state and stigma among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS), acquiring informed permission is a crucial ethical obligation. Participants were provided with comprehensive information on the study's goal, the procedures involved, any hazards, and their opportunity to withdraw at any time without repercussion. This procedure ensured that participants may render an informed decision on their participation. This transparency is crucial for cultivating trust and ensuring that participants feel at ease and confident in their involvement.

Confidentiality and privacy were strictly maintained throughout the research process. Personal identifiers were eliminated from the obtained data, and all information will be securely stored to prevent unauthorised access. Participants were assured that their responses will remain anonymous and used solely for research purposes. Additionally, the principle of nonmaleficence, or "do no harm," guided the study. Given that discussions around mental health can evoke sensitive emotions, measures were taken to create a safe environment for participants, including providing resources for mental health support should any participant feel distressed during or after completing the questionnaires. Furthermore, mental health resources will be made available for those who may feel distressed during or after their participation. This proactive strategy not only mitigates potential emotional difficulties but also signifies a dedication to participant welfare.

Data security mechanisms were established to safeguard the integrity of the obtained data; electronic data were stored on password-protected devices, and physical papers were secured in locked cabinets accessible only authorised research team members only.

Upholding participants' autonomy is essential; they possess the freedom to decline participation or exit from the research at any point without incurring any penalty. This aligns with ethical standards that prioritize individual choice and self-determination. Cultural sensitivity was also emphasised throughout the research process, ensuring that research instruments are culturally appropriate and relevant to all participants to minimize potential biases or misunderstandings. By acknowledging cultural settings and subtleties, researchers reduced the risk of biases or misconceptions that may occur during data collecting, thereby enhancing the validity of the results and fostering an inclusive environment where all participants felt respected and valued.

Prior to data collection for the study examining the correlation between mental health status and stigma among UNIMAS undergraduate nursing students, ethical approval was obtained from the UNIMAS Research Ethics Committee. This step was essential to ensure compliance with recognised ethical standards for research involving human participants. The process involved submitting a detailed application, including the research design, participant information sheets, and informed consent forms, which outlined the study's objectives, methodologies, and potential risks. By securing this ethical clearance, the researchers affirmed their commitment to maintaining high ethical standards, thereby protecting participants and strengthening the legitimacy and reliability of the study outcomes. Addressing these ethical considerations was vital in exploring sensitive issues related to mental health and stigma among nursing students at UNIMAS, fostering a respectful and responsible research environment that prioritised participant welfare while contributing valuable insights to the field.

3.7 Pilot study

A pilot study was undertaken as an initial measure to evaluate the feasibility and efficacy of the research instruments and methodologies (Brice, 2024). A pilot study, also known as a feasibility study, functioned as a preliminary trial of primary research, enabling researchers to detect probable problems and implement essential modifications prior to the comprehensive inquiry (In, 2017). This limited study engaged a specific cohort of nursing students who will fill out the demographic data questionnaire, the Depression, Anxiety, and Stress Scale (DASS-21), and the Stigma and Self-Stigma Scale.

The main aims of the pilot project were to examine the clarity and suitability of the survey instruments, evaluate participant comprehension of the questions, and collect feedback on the entire data collection process (Brice, 2024). By engaging participants who closely resemble the target population, researchers can identify ambiguities or difficulties in questionnaires that may affect data quality (Srinivasan & Lohith, 2017). Additionally, the pilot study will help determine logistical aspects such as recruitment strategies, time required for completion, and any ethical considerations that arose during data collection. Participant feedback from the pilot project yielded significant insights to improve the design of the main study (In, 2017). This phase enabled researchers to detect and rectify any problems with survey instruments, like vague phrasing, imprecise instructions, or irrelevant questions, which may otherwise jeopardise data quality in the comprehensive study. For example, if participants report confusion regarding specific items on the DASS-21 or stigma scales, adjustments can be made to improve clarity and ensure accurate responses. Furthermore, this preliminary phase allowed researchers to refine their approach to participant engagement and support, ultimately leading to a more robust research design.

Implementing a pilot study was crucial for mitigating risks linked to larger studies,

as it enabled researchers to identify and address potential challenges beforehand. Pilot studies evaluated logistical components, including recruitment strategies and the duration needed for participant completion. By optimising these factors early, researchers improved the feasibility of the primary study and facilitate a more seamless execution. This anticipatory strategy not only bolstered the validity and reliability of the results but also strengthened the overall research design. As noted in various studies, pilot studies played a critical role in improving research quality by identifying potential pitfalls and providing insights that lead to better planning and execution of the main research (Brice, 2024). Overall, the pilot study served as a critical foundation for successfully investigating mental health status and stigma among nursing students at UNIMAS.

3.7.1 Validity and Reliability

Reliability is an essential factor that guarantees the consistency and dependability of study findings. Reliability is the extent to which research tools yield steady and consistent outcomes throughout time (Chiang et al., 2015). In this scenario, internal consistency reliability is selected. Internal coherence Reliability denotes the degree to which items in a survey or test consistently assess the same construct (Chiang et al., 2015). Cronbach's alpha can be utilised for assessment, yielding a coefficient between 0 and 1, with elevated values signifying enhanced dependability. A Cronbach's alpha of 0.70 or above is deemed satisfactory, although values over 0.90 indicate excellent internal consistency (Pua et al., 2019). This measure is crucial in your study as it ensures that all items in your instruments, such as the DASS-21 and stigma scales, are aligned and effectively capturing the constructs of mental health status and stigma among nursing students. This study seeks to bolster the credibility of its findings by utilising this dependability, guaranteeing that any found

correlation between mental health status and stigma among nursing students is not attributable to measurement error but accurately represents genuine trends within this demographic. Establishing robust dependability is crucial for fostering trust in study findings and creating a solid basis for future interventions designed to enhance mental health awareness and mitigate stigma in nursing education.

Table 1

Cronbach's Alpha for DASS-21 and SASS from Pilot Study

Questionnaire	Number of Item	Cronbach's alpha
Depression, Anxiety, Stress Scale (DASS-21)	21	.872
Stigma and Self-Stigma Scale (SASS)	42	.826

Validity is the extent to which a study's findings accurately represent the phenomena under investigation, encompassing various critical categories, including internal and external validity (Chiang et al., 2015). Face Validity evaluates whether a measurement accurately reflects its intended purpose, relying on subjective assessment (Chiang et al., 2015). While it does not provide empirical evidence of validity, having strong face validity is important for ensuring that participants perceive the instruments as relevant and appropriate for the constructs being studied. Engaging experts or stakeholders in reviewing the items can help affirm that the questions are relevant and understandable to the target population. This step can enhance participant engagement and cooperation during data collection.

Assessing face validity was crucial at an early stage in the research process, especially when developing new measures or applying existing tests to new conditions or populations. This early evaluation allowed researchers to identify and address any problems before a more extensive study was conducted, ensuring the research tools would

provide the necessary answers. Feedback on face validity could be collected through structured forms to gather specific information on relevance and clarity, qualitative insights from open-ended questions and quantitative analysis of numerical ratings. This iterative process, involving the analysis of feedback and subsequent adjustments to the assessment, helped improve perceived relevance and effectiveness.

By combining internal consistency reliability with face validity in study, you can strengthen the credibility of your findings. Internal consistency ensures that your instruments yield reliable data, while face validity helps confirm that participants view the measures as relevant and applicable to their experiences. These aspects contributed to a more comprehensive understanding of mental health and stigma in nursing education at Universiti Malaysia Sarawak (UNIMAS).

3.8 Data collection

This study's data collection technique on the correlation between mental health state and stigma among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS) adhered to a systematic and ethical methodology. The target population comprised undergraduate nursing students at UNIMAS, with participants chosen by a simple random sampling procedure that guarantees equal selection probability for all individuals in the target population. Data were gathered by a demographic questionnaire and two validated instruments: the Depression, Anxiety, and Stress Scale (DASS-21) to assess mental health state, and the Stigma and Self-Stigma Scale (SASS) to evaluate several dimensions of stigmatic attitudes concerning mental health issues. The tools consisted of self-administered questionnaires delivered to participants during in-person sessions.

Before data collection, ethical permission was secured from UNIMAS's Research

Ethics Committee to guarantee compliance with ethical standards. Informed consent was provided on the first page of the questionnaire, effectively conveying critical information to participants, clearly outlining the study's aim, methods, potential risks, and their right to withdraw at any time. Participants were selected by instruments such as random number generators, guaranteeing an absolutely impartial selection procedure. This technique was beneficial since it yielded a representative sample of the population, essential for precisely analysing the correlation between mental health state and stigma. A pilot study was conducted to improve the dependability of the data obtained before the major data gathering phase. This pilot project included a cohort of 24 nursing students who completed questionnaires to ascertain any possible challenges related to clarity or understanding. The feedback from this pilot group guided essential modifications to the instruments or methods prior to the primary data collection.

Data collection took place over a specified period, namely on 14th April 2025 until 25th April 2025 which is the first six weeks of semester 2, session 2024/2025 which participants were recruited through announcements in classes. Participants were given 20-30 minutes to answer the questionnaire. Informed consent was obtained from each participant prior to their involvement in the study. To ensure confidentiality, all responses were anonymized, and data were stored securely.

3.9 Data Analysis

This study's data analysis employed several statistical approaches to ensure a thorough comprehension of the gathered data. The study's data analysis will employ quantitative approaches, utilising SPSS version 27.0 to examine data derived from demographic information, the Depression, Anxiety, and Stress Scale (DASS-21), and the

Stigma and Self-Stigma Scale (SASS). Descriptive statistics were applied to summarise participants' demographic characteristics, including calculations of means, medians, standard deviations, frequencies, and percentages for variables such as age, gender, and year of study, alongside their scores on the DASS-21 and SASS scales. This provided a summary of the sample and highlighted any trends or patterns in mental health status and stigma levels. Understanding the average results on the DASS-21 facilitated the assessment of the general mental health of nursing students.

Inferential statistics were conducted to explore relationships between variables. Correlation analyses examined the strength and direction of associations between mental health status (as measured by DASS-21 scores) and stigma levels (as measured by scores on the Stigma and Self-Stigma Scale). This investigation ascertained if elevated stigma levels correlate with worse mental health outcomes in nursing students. Inferential statistics were utilised to derive inferences and formulate predictions for the larger population based on the sample data. This will encompass correlation analyses to investigate the associations between mental health status (as represented by DASS-21 scores) and stigma levels (as indicated by scores from the Stigma and Self-Stigma Scale). A normalcy test is a crucial component of the data analysis procedure.

Normality tests formed a crucial part of the data analysis procedure. Tests such as the Kolmogorov-Smirnov and Shapiro-Wilk were employed to determine whether the data followed a normal distribution, a fundamental assumption for many parametric statistical tests including Chi-square. A p-value below 0.05 typically indicated a significant deviation from normality, leading to the rejection of the null hypothesis. Inferential tests such as Chi-square was applied to compare mean scores among various demographic groups (e.g., first-year versus fourth-year students) to identify significant differences in mental health status

or stigma levels based on year of study or other demographic variables. These analyses clarified whether higher stigma was associated with poorer mental health outcomes.

Spearman's rank correlation test was utilised to examine the association between mental health status and stigma among undergraduate nursing students at UNIMAS. This statistical method was particularly suited for evaluating the strength and direction of the monotonic relationship between two continuous or ordinal variables, such as scores from the DASS-21 and SASS, especially when the data did not meet the assumptions of normality required for Pearson's correlation. Prior to conducting the Spearman correlation, the data were assessed for normality and linearity. As the normality assumption was violated, Spearman's rank correlation was considered the appropriate analytical method. The findings from the Spearman correlation analysis determined whether significant correlations existed between mental health status and stigma levels among nursing students.

3.10 Summary

The study will utilize both descriptive and inferential statistics to analyse the data. Descriptive statistics will summarize participant characteristics and overall scores on the DASS-21 and SASS scales, while inferential statistics, including Pearson correlation analysis, will examine the relationships between mental health status and stigma levels. Additionally, potential differences in these variables based on demographic factors such as year of study or gender will be explored.

CHAPTER 4

RESULTS / FINDINGS

4.0 Introduction

This chapter describes the number of respondents in section 4.1, descriptive statistics in 4.2, inferential statistics in section 4.3 and summary in section 4.4. This chapter presents the analysis and interpretation of data collected from undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). Using the Statistical Package for the Social Sciences (SPSS) version 27.0, both descriptive and inferential statistical methods were employed to examine the mental health status and stigma levels among the participants.

4.1 Number of Respondents

The population of the research are the nursing undergraduate students of Universiti Malaysia Sarawak (UNIMAS). The total population of nursing undergraduates' students in UNIMAS is estimated to be around 237. According to Taro Yamane (1967), the minimum required sample for this study that aligned with the estimated total number of undergraduate nursing students is 237 students in order to obtain more accurate data regarding the population. The questionnaire was distributed to UNIMAS undergraduate students from 24 April to 2 May. As a result, a total of 163 questionnaire sets were further analyzed.

4.2 Descriptive Statistics

4.2.1 Demographic Background of the Respondents

The demographic background of respondents was analysed using descriptive statistics based on seven factors: age, gender, year of study, ethnicity, and religion. Descriptive statistics refer to data that is summarized using a statistical approach to describe the features of the sample's scores. Frequency count and distribution, graphical presentation of data, and statistical summary are all important groups to consider while analysing descriptive statistics. The frequency count and distribution of data, as well as the summary of statistics, were used as the method as descriptive statistical analysis in this study. The background of respondents was obtained from Section A of the questionnaires.

Table 2

Socio-demographic data of UNIMAS undergraduate nursing students

		Frequency (n)	Percentage (%)
Gender	Male	30	18.4
	Female	133	81.6
Age	20	31	19.0
	21	35	21.5
	22	38	23.3
	23	44	27.0
	24	13	8.0
	25	2	1.2
Year of Study	1 st Year	36	22.1
	2 nd Year	41	25.2
	3 rd Year	41	25.2
	4 th Year	45	27.6
Ethnicity	Bidayuh	11	6.7
	Chinese	8	4.9
	Dusun	13	8.0
	Indian	1	0.6
	Iban	31	19.0
	Malay	68	41.7
	Others	31	19.0

Religion	Buddhism	1	.6
	Christianity	69	42.3
	Hinduism	1	.6
	Islam	92	56.4

A total of 163 undergraduate nursing students participated in this study. The majority of the participants were female (n = 133, 81.6%), while 30 participants were male (18.4%).

In terms of age distribution, the highest proportion of students were 23 years old (n = 44, 27.0%), followed by 22 years old (n = 38, 23.3%), 21 years old (n = 35, 21.5%), and 20 years old (n = 31, 19.0%). A smaller number of participants were aged 24 (n = 13, 8.0%) and 25 (n = 2, 1.2%).

Regarding the year of study, 45 students (27.6%) were in their fourth year. Both third-year and second-year students accounted for 25.2% (n = 41) each, and first-year students comprised 22.1% (n = 36) of the sample.

Ethnic background varied among respondents. The majority identified as Malay (n = 68, 41.7%), followed by Iban (n = 31, 19.0%) and those categorized as “Others” (n = 31, 19.0%). Smaller representations included Dusun (n = 13, 8.0%), Bidayuh (n = 11, 6.7%), Chinese (n = 8, 4.9%), and Indian (n = 1, 0.6%).

As for religious affiliation, more than half of the participants identified as Muslim (n = 92, 56.4%). Christianity was the second most reported religion (n = 69, 42.3%), while Buddhism and Hinduism were each represented by one participant (0.6%, respectively).

4.2.2 Prevalence of mental health status among UNIMAS undergraduate nursing students (n=163)

Table 3

DASS-21 score by each category (Depression, Anxiety, Stress) of Respondents

Category (score)	Frequency (n)	Percentage (%)
Depression		
Normal (0-9)	138	84.7
Mild (10-13)	16	9.8
Moderate (14-20)	7	4.3
Severe (21-27)	2	1.2
Extremely Severe (28+)	0	.0
Anxiety		
Normal (0-7)	22	13.5
Mild (8-9)	98	60.1
Moderate (10-14)	35	21.5
Severe (15-19)	7	4.3
Extremely Severe (20+)	1	.6
Stress		
Normal (0-14)	157	96.3
Mild (15-18)	4	2.5
Moderate (19-25)	2	1.2
Severe (26-33)	0	.0
Extremely Severe (34+)	0	.0

The mental health status of undergraduate nursing students was assessed using the Depression, Anxiety, and Stress Scales (DASS-21). The findings revealed that most students were within the normal range for depression and stress, while anxiety levels showed a higher degree of mild to moderate symptoms.

For depression, the majority of respondents 138 (84.7%) reported normal levels. Mild depression was observed in 16 students (9.8%), followed by moderate depression in 7 students (4.3%), and severe depression in 2 students (1.2%). None of the participants reported extremely severe depression.

In terms of anxiety, only 22 students (13.5%) had normal levels. The majority

exhibited mild anxiety symptoms, 98 students (60.1%), while 35 students (21.5%) had moderate anxiety. Severe and extremely severe anxiety were reported by 7 (4.3%) and 1 (0.6%) student(s), respectively.

Regarding stress, almost all participants, 157 students (96.3%) fell within the normal range. Meanwhile, 4 students (2.5%) reported mild stress and moderate stress reported by 2 students (1.2%), with no cases of severe or extremely severe stress observed in the study. These results indicate that while depression and stress levels among nursing students were generally low, a considerable proportion of the students experienced mild to moderate levels of anxiety.

Table 4
Item Results of Mental Health Status

ITEMS	0 n (%)	1 n (%)	2 n (%)	3 n (%)	M	SD
Depression						
Q3. I couldn't seem to experience any positive feeling at all.	87 (53.4)	55 (33.7)	18 (11.0)	3 (1.8)	.61	.756
Q5. I found it difficult to work up the initiative to do things.	39 (23.9)	80 (49.1)	34 (20.9)	10 (6.1)	1.09	.830
Q10. I felt that I had nothing to look forward to.	85 (52.1)	54 (33.1)	20 (12.3)	4 (2.5)	.65	.790
Q13. I felt down-hearted and blue.	60 (36.8)	76 (46.6)	20 (12.3)	7 (4.3)	.84	.801
Q16. I was unable to become enthusiastic about anything.	79 (48.5)	64 (39.3)	16 (9.8)	4 (2.5)	.66	.755
Q17. I felt I wasn't worth much as a person.	98 (60.1)	39 (23.9)	22 (13.5)	4 (2.5)	.58	.815
Q21. I felt that life was meaningless.	109 (66.9)	34 (20.9)	16 (9.8)	4 (2.5)	.48	.773
Anxiety						
Q2. I was aware of the dryness in my mouth.	49 (30.1)	40 (24.5)	51 (31.3)	23 (14.1)	1.29	1.048
Q4. I experienced breathing difficulties (eg: excessively rapid breathing, breathlessness in the absence of physical	90 (55.2)	51 (31.3)	18 (11.0)	4 (2.5)	.61	.781

exertion).							
Q7. I experienced trembling (eg: in the hands).	61 (37.4)	67 (41.1)	31 (19.0)	4 (2.5)	.87	.805	
Q9. I was worried about situations in which I might panic and make a fool of myself.	25 (15.3)	72 (44.2)	44 (27.0)	22 (13.5)	1.39	.905	
Q15. I felt I was close to panic.	77 (47.2)	58 (35.6)	22 (13.5)	6 (3.7)	.74	.830	
Q19. I was aware of the action of my heart in the absence of physical exertion (eg: sense of heart rate increase, heart missing a beat).	54 (33.1)	63 (38.7)	34 (20.9)	12 (7.4)	1.02	.916	
Q20. I felt scared without any good reason.	75 (46.0)	59 (36.2)	22 (13.5)	7 (4.3)	.76	.845	
Stress							
Q1. I found it hard to wind down.	25 (15.3)	106 (65.0)	26 (16.0)	6 (3.7)	1.08	.676	
Q6. I tended to over-react to situations.	36 (22.1)	74 (45.4)	42 (25.8)	11 (6.7)	1.17	.851	
Q8. I felt that I was using a lot of nervous energy.	37 (22.7)	82 (50.3)	32 (19.6)	12 (7.4)	1.12	.842	
Q11. I found myself getting agitated.	50 (30.7)	80 (49.1)	25 (15.3)	8 (4.9)	.94	.811	
Q12. I found it difficult to relax.	62 (38.0)	72 (44.2)	22 (13.5)	7 (4.3)	.84	.816	
Q14. I was intolerant of anything that kept me from getting on with what I was doing.	58 (35.6)	84 (51.5)	16 (9.8)	5 (3.1)	.80	.736	
Q18. I felt that I was rather touchy.	65 (39.9)	67 (41.1)	23 (14.1)	8 (4.9)	.84	.846	

Indicators: 0- Did not apply to me at all, 1- Applied to me to some degree, or some of the time, 2- Applied to me to a considerable degree or a good part of time, 3- Applied to me very much or most of the time, M-Mean, SD- Standard Deviation

The depression subscale items indicated generally low to moderate symptom severity among the participants. For example, the item “I couldn’t seem to experience any positive feeling at all” (Q3) had a mean score of 0.61 (SD = 0.76), with 53.4% of respondents

indicating it did not apply to them at all. Similarly, “I felt that life was meaningless” (Q21) had a lower mean of 0.48 (SD = 0.77), with 66.9% reporting no experience of this feeling. Items related to diminished initiative and feeling downhearted (Q5 and Q13) showed slightly higher means of 1.09 (SD = 0.83) and 0.84 (SD = 0.80), respectively, indicating some participants experienced these symptoms to a mild or moderate degree.

Anxiety symptoms were somewhat more pronounced. The item “I was worried about situations in which I might panic and make a fool of myself” (Q9) had the highest mean score of 1.39 (SD = 0.91), with 44.2% of students reporting this applied to them to some degree or more. Other items such as “I was aware of dryness in my mouth” (Q2) and “I experienced trembling (e.g., in the hands)” (Q7) had mean scores of 1.29 (SD = 1.05) and 0.87 (SD = 0.81), respectively, indicating mild to moderate anxiety symptoms related to physiological arousal.

Stress-related items also showed mild to moderate symptom levels. The item “I found it hard to wind down” (Q1) had a mean of 1.08 (SD = 0.68), with 65% of respondents indicating this symptom applied to them at least some of the time. Similarly, “I tended to over-react to situations” (Q6) and “I felt that I was using a lot of nervous energy” (Q8) had mean scores of 1.17 (SD = 0.85) and 1.12 (SD = 0.84), respectively, suggesting that many students experienced difficulties managing stress.

The data suggest that UNIMAS undergraduate nursing students experience mild to moderate levels of depression, anxiety, and stress symptoms. Anxiety symptoms, particularly those related to panic and physiological responses, were the most commonly reported. These findings underscore the need for mental health support and stress management interventions tailored to nursing students.

4.2.3 Prevalence of depression, anxiety and stress among UNIMAS undergraduate nursing students (N=163)

Table 5

SASS score by each category (Anticipated stigma, Avoidant coping, Lack of help-seeking, Self-stigma, Social Desirability, Social Distance, Stigma to others) of Respondents

Category (score)	Frequency (n)	Percentage (%)
Anticipated Stigma		
Minimal (0-6)	8	4.9
Low (7-12)	28	17.2
Moderate (13-18)	86	52.8
High (19-24)	41	25.2
Avoidant Coping		
Minimal (0-6)	3	1.8
Low (7-12)	40	24.5
Moderate (13-18)	103	63.2
High (19-24)	17	10.4
(Lack of) Help Seeking		
Minimal (0-6)	0	.0
Low (7-12)	45	27.6
Moderate (13-18)	109	66.9
High (19-24)	9	5.5
Self-Stigma		
Minimal (0-6)	8	4.9
Low (7-12)	48	29.4
Moderate (13-18)	82	50.3
High (19-24)	25	15.3
Social Desirability		
Minimal (0-6)	0	.0
Low (7-12)	34	20.9
Moderate (13-18)	122	74.8
High (19-24)	7	4.3
Social Distance		
Minimal (0-6)	1	.6
Low (7-12)	35	21.5
Moderate (13-18)	111	68.1
High (19-24)	16	9.8

Stigma to Others		
Minimal (0-6)	56	34.4
Low (7-12)	88	54.0
Moderate (13-18)	17	10.4
High (19-24)	2	1.2

The findings revealed varying levels of stigma across different dimensions related to mental health. In terms of anticipated stigma, the majority of students, 86 (52.8%) reported moderate levels followed by 41 (25.2%) high levels, and 28 (17.2%) low level. Only 8 (4.9%) of participants reported minimal anticipated stigma.

For avoidant coping, 103 (63.2%) reported moderate levels, with 40 (24.5%) at low levels and 17 (10.4%) at high levels. A minimal level of avoidant coping was reported by only 3 (1.8%).

In the domain of (lack of) help seeking, the majority of participants, 109 (66.9%) also reported a moderate level, with 45 (27.6%) reporting low level, and 9 (5.5%) at a high level. No participants scored in the minimal range.

Regarding self-stigma, half of the participants, 82 (50.3%) scored at a moderate level, 48 (29.4%) scored low, and 25 (15.3%) scored high. Minimal levels were reported by 8 (4.9%).

For social desirability, 122 (74.8%) of the respondents reported moderate levels, 34 (20.9%) reported low levels, and 7 (4.3%) reported high levels. No participants scored in the minimal range.

In the category of social distance, 111 (68.1%) were within the moderate range, while 35 (21.5%) scored low, and 16 (9.8%) scored high. Minimal scores were reported by only 1 (0.6%).

Interestingly, in the category of stigma to others, more than half of the students, 88

(54.0%) reported low levels, 56 (34.4%) reported minimal levels, while only 17 (10.4%) reported moderate and 2 (1.2%) reported high levels of stigma towards others.

These results indicate that while many students exhibit moderate levels of internalized stigma and coping challenges, fewer hold stigmatizing attitudes toward others with mental health conditions.

Table 6*Item Results of Personal Stigma of Mental Illness*

ITEMS	0	1	2	3	4	<i>M</i>	SD
	N (%)	N (%)	N (%)	N (%)	N (%)		
Anticipated stigma							
Q2. If I had a mental disorder, I would worry other people would think that I am weak.	4 (2.5)	19 (11.7)	23 (14.1)	80 (49.1)	37 (22.7)	2.78	1.006
Q11. If I had a mental disorder, I would worry other people would avoid talking to me.	4 (2.5)	14 (8.6)	37 (22.7)	75 (46.0)	33 (20.2)	2.73	.963
Q18. If I had a mental disorder, I would worry other people would think I was exaggerating my difficulties.	4 (2.5)	16 (9.8)	39 (23.9)	68 (41.7)	36 (22.1)	2.71	.998
Q29. If I had a mental disorder, I would worry that other people might think that I was “not really ill”.	11 (6.7)	21 (12.9)	45 (27.6)	65 (39.9)	21 (12.9)	2.39	1.080
Q32. If I had a mental disorder, I would worry other people would think of me as a failure.	13 (8.0)	21 (12.9)	39 (23.9)	66 (40.5)	24 (14.7)	2.41	1.132
Q37. If I had a mental disorder, I would worry other people would feel sorry for me or patronise me.	6 (3.7)	16 (9.8)	36 (22.1)	84 (51.5)	21 (12.9)	2.60	.959
Avoidant coping							
Q6. Drinking alcohol never helps when you are stressed.	10 (6.1)	14 (8.6)	24 (14.7)	38 (23.3)	77 (47.2)	2.97	1.234
Q7. It’s often best to ignore problems and hope they go away.	20 (12.3)	44 (27.0)	41 (25.2)	42 (25.8)	16 (9.8)	1.94	1.190
Q10. Taking illegal drugs can never help when you are stressed by something.	17 (10.4)	12 (7.4)	7 (4.3)	45 (27.6)	82 (50.3)	3.00	1.338
Q14. I do my best not to think about my problems.	7 (4.3)	21 (12.9)	38 (23.3)	72 (44.2)	25 (15.3)	2.53	1.038
Q27. The best way to cope with problems is not to think about them.	21 (12.9)	40 (24.5)	50 (30.7)	36 (22.1)	16 (9.8)	1.91	1.173
Q39. Mental health problems are best tackled head on.	9 (5.5)	22 (13.5)	80 (49.1)	43 (26.4)	9 (5.5)	2.13	.910

(Lack of) Help-seeking							
Q3. If I had a mental disorder, I would be happy to seek help from a mental health professional	5 (3.1)	17 (10.4)	33 (20.2)	67 (41.1)	41 (25.2)	2.75	1.044
Q5. If I had a mental disorder, I would NOT feel comfortable telling my manager.	2 (1.2)	30 (18.4)	40 (24.5)	66 (40.5)	25 (15.3)	2.50	1.002
Q8. I would NOT tell anyone if I had a mental disorder in case they judge me.	9 (5.5)	25 (15.3)	61 (37.4)	44 (27.0)	24 (14.7)	2.30	1.072
Q12. I would NOT feel comfortable discussing my mental health problems with a colleague.	6 (3.7)	24 (14.7)	35 (21.5)	70 (42.9)	28 (17.2)	2.55	1.055
Q24. I am confident that I could ask for help if I had a mental health problem	8 (4.9)	19 (11.7)	50 (30.7)	64 (39.3)	22 (13.5)	2.45	1.025
Q42. It's best not to tell anyone about your mental health problems	20 (12.3)	45 (27.6)	51 (31.3)	27 (16.6)	20 (12.3)	1.89	1.192
Self-stigma							
Q9. If I had a mental disorder, I would feel ashamed.	13 (8.0)	28 (17.2)	62 (38.0)	45 (27.6)	15 (9.2)	2.13	1.061
Q15. If I had a mental disorder and I could not solve my own problems, I would feel bad about myself.	6 (3.7)	14 (8.6)	46 (28.2)	76 (46.6)	21 (12.9)	2.56	.950
Q17. If I had a mental disorder, I would feel weak.	10 (6.1)	29 (17.8)	61 (37.4)	48 (29.4)	15 (9.2)	2.18	1.030
Q19. If I had a mental disorder, I would feel like no one would want to get close to me.	6 (3.7)	30 (18.4)	38 (23.3)	68 (41.7)	21 (12.9)	2.42	1.047
Q22. I would feel a burden to my colleagues if I had a mental disorder.	7 (4.3)	21 (12.9)	33 (20.2)	82 (50.3)	20 (12.3)	2.53	1.008
Q40. I would feel a failure if I became mentally unwell.	9 (5.5)	25 (15.3)	52 (31.9)	58 (35.6)	19 (11.7)	2.33	1.048
Social Desirability							
Q4. I always eat a healthy diet.	2 (1.2)	15 (9.2)	63 (38.7)	62 (38.0)	21 (12.9)	2.52	.877
Q13.If I found a £10 note I would try to find its owner.	6 (3.7)	13 (8.0)	38 (23.3)	64 (39.3)	42 (25.8)	2.75	1.043
Q23. I always tell the truth.	5 (3.1)	23 (14.1)	73 (44.8)	49 (30.1)	13 (8.0)	2.26	.907

Q30. I have never dropped litter.	16 (9.8)	45 (27.6)	56 (34.4)	38 (23.3)	8 (4.9)	1.86	1.042
Q35. I sometimes lie to people.	3 (1.8)	13 (8.0)	48 (29.4)	83 (50.9)	16 (9.8)	2.59	.844
Q36. I always obey rules even if no one is looking	6 (3.7)	13 (8.0)	53 (32.5)	74 (45.4)	17 (10.4)	2.51	.919
Social Distance							
Q1. I'm good at talking to people with mental health problems	1 (0.6)	17 (10.4)	79 (48.5)	52 (31.9)	14 (8.6)	2.37	.810
Q20. I am comfortable when around people with a mental disorder.	0	17 (10.4)	70 (42.9)	62 (38.0)	14 (8.6)	2.45	.795
Q28. I would feel comfortable discussing a colleague's mental health problem with them.	10 (6.1)	31 (19.0)	57 (35.0)	59 (36.2)	6 (3.7)	2.12	.967
Q33. If I were an employer, I would feel comfortable employing someone with a mental disorder	5 (3.1)	24 (14.7)	75 (46.0)	52 (31.9)	7 (4.3)	2.20	.852
Q34. If I had a mental health disorder and needed help, I would feel comfortable going to a therapist.	7 (4.3)	10 (6.1)	36 (22.1)	82 (50.3)	28 (17.2)	2.70	.970
Q41. Having a mental disorder is nothing to be ashamed of.	2 (1.6)	6 (3.7)	41 (25.3)	81 (49.7)	33 (20.2)	2.84	.831
Stigma to other							
Q16. People with mental disorders are NOT really ill and should just get on with things.	34 (20.9)	54 (33.1)	40 (24.5)	26 (16.0)	9 (5.5)	1.52	1.151
Q21. Employees suffering from mental disorders are less reliable than other employees.	11 (6.7)	53 (32.5)	57 (35.0)	35 (21.5)	7 (4.3)	1.84	.981
Q25. People with mental disorders are weak.	41 (25.2)	64 (39.3)	47 (28.8)	7 (4.3)	4 (2.5)	1.20	.948
Q26. People with mental disorders should just "snap out of it."	45 (27.6)	63 (38.7)	43 (26.4)	8 (4.9)	4 (2.5)	1.16	.968
Q31. People with mental disorders cannot live good, rewarding lives.	51 (31.3)	77 (47.2)	24 (14.7)	10 (6.1)	1 (0.6)	.98	.875
Q38. People with mental disorders are NOT really ill.	42 (25.8)	53 (32.5)	35 (21.5)	27 (16.6)	6 (3.7)	1.40	1.147

Indicators: 0- Strongly disagree, 1- Disagree, 2- , Neither agree or disagree, 3- Agree, 4- , Strongly agree, *M* -Mean, *SD*- Standard Deviation

Participants responded to items measuring various dimensions of personal stigma related to mental illness, using a 5-point Likert scale. The response options were: 0 = Strongly disagree, 1 = Disagree, 2 = Neither agree nor disagree, 3 = Agree, and 4 = Strongly agree. The mean (*M*) and standard deviation (*SD*) for each item are presented, along with the frequency distribution for each response option.

Respondents generally expressed moderate to high levels of anticipated stigma, indicating concerns about how others might perceive them if they had a mental disorder. For instance, the item "If I had a mental disorder, I would worry other people would think that I am weak" (Q2) yielded a mean of 2.78 (*SD* = 1.01). A substantial proportion (71.8%) of participants agreed or strongly agreed with this statement. Similarly, participants expressed worry that others would avoid talking to them (Q11; *M* = 2.73, *SD* = 0.96) or think they were exaggerating their difficulties (Q18; *M* = 2.71, *SD* = 1.00). Concern about being perceived as a failure (Q32; *M* = 2.41, *SD* = 1.13) and others feeling sorry for or patronizing them (Q37; *M* = 2.60, *SD* = 0.96) also garnered notable agreement, suggesting a prevalent fear of negative judgment and social rejection related to mental illness.

Responses to items assessing avoidant coping strategies were varied. Participants largely rejected substance use as a coping mechanism; the items "Drinking alcohol never helps when you are stressed" (Q6; *M* = 2.97, *SD* = 1.23) and "Taking illegal drugs can never help when you are stressed by something" (Q10; *M* = 3.00, *SD* = 1.34) had the highest mean scores, indicating agreement with these statements. However, items reflecting cognitive avoidance, such as "It's often best to ignore problems and hope they go away" (Q7; *M* = 1.94, *SD* = 1.19) and "The best way to cope with problems is not to think about them" (Q27; *M* = 1.91, *SD* = 1.17), showed lower mean scores, suggesting that while some

endorsement of cognitive avoidance exists, it is less pronounced than the rejection of substance use. Conversely, there was relatively neutral agreement with "Mental health problems are best tackled head on" (Q39; $M = 2.13$, $SD = 0.91$), with a large proportion (49.1%) providing a neutral response.

Participants demonstrated a moderate willingness to seek professional help for mental health but also expressed some reluctance regarding disclosure to certain individuals. Over two-thirds of respondents (66.3%) agreed or strongly agreed that they "would be happy to seek help from a mental health professional" (Q3; $M = 2.75$, $SD = 1.04$). However, there was a notable degree of discomfort in discussing mental health problems with managers (Q5; $M = 2.50$, $SD = 1.00$) and colleagues (Q12; $M = 2.55$, $SD = 1.06$). The item "I would NOT tell anyone if I had a mental disorder in case they judge me" (Q8; $M = 2.30$, $SD = 1.07$) and "It's best not to tell anyone about your mental health problems" (Q42; $M = 1.89$, $SD = 1.19$) also garnered moderate agreement, indicating a perceived risk of judgment influencing disclosure.

Items measuring self-stigma revealed moderate endorsement of negative self-perceptions related to mental illness. Approximately one-third (36.8%) of respondents agreed or strongly agreed that they would "feel ashamed" if they had a mental disorder (Q9; $M = 2.13$, $SD = 1.06$), and 46.6% reported they would "feel bad about myself" if they could not solve their own problems (Q15; $M = 2.56$, $SD = 0.95$). Concerns about feeling weak (Q17; $M = 2.18$, $SD = 1.03$), being a burden to colleagues (Q22; $M = 2.53$, $SD = 1.01$), and feeling like a failure (Q40; $M = 2.33$, $SD = 1.05$) also showed moderate mean scores, indicating a potential for internalized negative beliefs.

Responses to social desirability items generally indicated a tendency for participants to present themselves in a favourable light. High mean scores were observed for items

reflecting socially approved behaviours, such as always eating a healthy diet (Q4; $M = 2.52$, $SD = 0.88$) and trying to find the owner of lost money (Q13; $M = 2.75$, $SD = 1.04$). The item "I sometimes lie to people" (Q35) had a mean of 2.59 ($SD = 0.84$), suggesting a tendency to agree with this statement, potentially reflecting an honest, rather than overly socially desirable, self-assessment for this specific item.

Participants generally reported moderate levels of comfort in interactions related to mental health. The item "Having a mental disorder is nothing to be ashamed of" (Q41) received strong agreement ($M = 2.84$, $SD = 0.83$), reflecting a positive overarching attitude. However, direct interactions showed mixed results; for example, "I'm good at talking to people with mental health problems" (Q1; $M = 2.37$, $SD = 0.81$) and "I am comfortable when around people with a mental disorder" (Q20; $M = 2.45$, $SD = 0.80$) both showed substantial proportions of neutral responses. Comfort discussing a colleague's mental health problem (Q28; $M = 2.12$, $SD = 0.97$) and employing someone with a mental disorder (Q33; $M = 2.20$, $SD = 0.85$) received slightly lower means, indicating some remaining social distance in professional or formal contexts.

Overall, participants demonstrated low levels of explicit stigmatizing beliefs toward individuals with mental disorders. Mean scores for items suggesting negative stereotypes were consistently low. For instance, "People with mental disorders are NOT really ill and should just get on with things" (Q16; $M = 1.52$, $SD = 1.15$) and "People with mental disorders are weak" (Q25; $M = 1.20$, $SD = 0.95$) received low agreement, indicating a general rejection of such views. The lowest mean was for "People with mental disorders cannot live good, rewarding lives" (Q31; $M = 0.98$, $SD = 0.88$), with 78.5% disagreeing or strongly disagreeing. This suggests that participants largely do not endorse overtly discriminatory or dismissive attitudes toward others with mental illness.

4.3 Inferential Statistics

4.3.1 Prevalence of mental health status among UNIMAS undergraduate nursing students

Table 7
Chi-square test for Socio-demographic Data and Mental Health Status

Category		Depression	Anxiety	Stress
Age	Chi-square value	16.106	30.290	9.374
	df	15	20	10
	<i>p</i> -value	.375	.065	.497
Gender	Chi-square value	1.025	.616	1.405
	df	3	4	2
	<i>p</i> -value	.795	.961	.495
Year of Study	Chi-square value	21.954	17.495	6.052
	df	9	12	6
	<i>p</i> -value	.009	.132	.417
Ethnicity	Chi-square value	7.427	17.336	11.575
	df	15	20	10
	<i>p</i> -value	.945	.631	.315
Religion	Chi-square value	5.264	7.718	3.309
	df	9	12	6
	<i>p</i> -value	.811	.807	.769

Chi-square tests were conducted to examine the association between socio-demographic variables (Age, Gender, Year of Study, Ethnicity, Religion) and the categorical levels of Depression, Anxiety, and Stress. The results are summarized in Table 6.

No statistically significant associations were found between depression levels and Age ($\chi^2 = 16.106$, $df = 15$, $p = .375$), Gender ($\chi^2 = 1.025$, $df = 3$, $p = .795$), Ethnicity (χ^2

= 7.427, df = 15, p = .945), or Religion ($\chi^2 = 5.264$, df = 9, p = .811). However, a statistically significant association was observed between Year of Study and depression ($\chi^2 = 21.954$, df = 9, p = .009). This indicates that the prevalence of depression significantly differs across different academic years.

For anxiety, no statistically significant associations were found with Age ($\chi^2 = 30.290$, df = 20, p = .065), Gender ($\chi^2 = .616$, df = 4, p = .961), Year of Study ($\chi^2 = 17.495$, df = 12, p = .132), Ethnicity ($\chi^2 = 17.336$, df = 20, p = .631), or Religion ($\chi^2 = 7.718$, df = 12, p = .807). While the p-value for age (p=.065) was close to statistical significance, it did not reach the conventional threshold of $p < .05$.

Similar to anxiety, no statistically significant associations were found between stress levels and Age ($\chi^2 = 9.374$, df = 10, p = .497), Gender ($\chi^2 = 1.405$, df = 2, p = .495), Year of Study ($\chi^2 = 6.052$, df = 6, p = .417), Ethnicity ($\chi^2 = 11.575$, df = 10, p = .315), or Religion ($\chi^2 = 3.309$, df = 6, p = .769).

4.3.2 Level of stigma towards mental health among UNIMAS undergraduate nursing students

Table 8

Chi-square test for Socio-demographic Data and Stigma

Category		Anticipated stigma	Avoidant coping	(Lack of) Help-seeking	Self-stigma	Social desirability	Social distance	Stigma to others
Age	Chi-square value	11.556	44.465	8.748	9.167	7.405	10.394	27.486
	df	15	15	10	15	10	15	15
	<i>p</i> -value	.712	<.001	.556	.869	.687	.794	.025
Gender	Chi-square value	7.341	5.671	.784	4.789	3.108	4.875	1.588
	df	3	3	2	3	2	3	3
	<i>p</i> -value	.062	.129	.676	.188	.211	.181	.662
Year of Study	Chi-square value	7.714	9.860	4.966	8.348	7.084	8.602	25.742
	df	9	9	6	9	6	9	9
	<i>p</i> -value	.563	.362	.548	.500	.313	.475	.002
Ethnicity	Chi-square value	15.592	20.158	6.199	9.131	6.265	11.044	7.123
	df	15	15	10	15	10	15	15
	<i>p</i> -value	.410	.166	.798	.871	.793	.749	.954
Religion	Chi-square value	4.669	7.436	2.183	2.359	1.597	7.473	1.923
	df	9	9	6	9	6	9	9
	<i>p</i> -value	.862	.592	.902	.984	.953	.558	.993

Chi-square analyses were conducted to examine the associations between socio-demographic characteristics (age, gender, year of study, ethnicity, and religion) and various stigma-related constructs among UNIMAS undergraduate nursing students, including anticipated stigma, avoidant coping, (lack of) help-seeking, self-stigma, social desirability, social distance, and stigma toward others.

The results revealed that age was significantly associated with avoidant coping, $\chi^2(15) = 44.47$, $p < .001$, indicating that the use of avoidant coping strategies in response to mental health issues varied across different age groups. Additionally, age was also significantly associated with stigma toward others, $\chi^2(15) = 27.49$, $p = .025$, suggesting that attitudes toward individuals with mental illness differed among students of different ages. No significant associations were found between age and anticipated stigma, (lack of) help-seeking, self-stigma, social desirability, or social distance ($p > .05$).

Year of study was also found to be significantly related to stigma toward others, $\chi^2(9) = 25.74$, $p = .002$, indicating that students at different academic levels held varying degrees of stigmatizing attitudes toward people with mental illness. However, year of study was not significantly associated with anticipated stigma, avoidant coping, (lack of) help-seeking, self-stigma, social desirability, or social distance ($p > .05$).

No statistically significant associations were observed between gender, ethnicity, or religion and any of the stigma dimensions measured, including anticipated stigma, avoidant coping, (lack of) help-seeking, self-stigma, social desirability, social distance, or stigma toward others ($p > .05$).

4.3.3 Relationship between mental health status and stigma among UNIMAS undergraduate nursing students

Table 9

The relationship between mental health status and stigma among UNIMAS undergraduate nursing students

			Depression	Anxiety	Stress
Spearman's rho	Anticipated Stigma	Correlation Coefficient	.193	.385	.181
		Sig. (2-tailed)	.014	<.001	.021
		N	163	163	163
	Avoidant Coping	Correlation Coefficient	.231	.230	.161
		Sig. (2-tailed)	.003	.003	.040
		N	163	163	163
	(Lack of) Help Seeking	Correlation Coefficient	.114	.244	-.039
		Sig. (2-tailed)	.147	.002	.617
		N	163	163	163
	Self-Stigma	Correlation Coefficient	.221	.311	.031
		Sig. (2-tailed)	.005	<.001	.694
		N	163	163	163
	Social Desirability	Correlation Coefficient	-.092	-.092	-.070
		Sig. (2-tailed)	.241	.242	.378
		N	163	163	163
	Social Distance	Correlation Coefficient	-.067	-.137	-.079
		Sig. (2-tailed)	.396	.081	.315
		N	163	163	163
	Stigma to Others	Correlation Coefficient	-.004	.065	-.081
		Sig. (2-tailed)	.958	.412	.303
		N	163	163	163

A Spearman's rank-order correlation was conducted to examine the relationship between various forms of stigma and mental health status, specifically depression, anxiety, and stress, among undergraduate nursing students (N = 163). The analysis revealed several

statistically significant associations.

There was a significant positive correlation between anticipated stigma and all three mental health outcomes: depression ($\rho = .193, p = .014$), anxiety ($\rho = .385, p < .001$), and stress ($\rho = .181, p = .021$), indicating that higher anticipated stigma was associated with greater levels of depression, anxiety, and stress.

Avoidant coping was also positively correlated with depression ($\rho = .231, p = .003$), anxiety ($\rho = .230, p = .003$), and stress ($\rho = .161, p = .040$), suggesting that students who avoided addressing mental health issues tended to report worse psychological outcomes.

A significant positive correlation was found between (lack of) help-seeking and anxiety ($\rho = .244, p = .002$), but not with depression ($p = .147$) or stress ($p = .617$). This indicates that reluctance to seek help may be particularly associated with elevated anxiety levels among students.

Self-stigma was significantly associated with both depression ($\rho = .221, p = .005$) and anxiety ($\rho = .311, p < .001$), but not with stress ($p = .694$). These results imply that internalized stigma contributes to emotional distress, particularly depressive and anxious symptoms.

In contrast, no significant correlations were found between social desirability, social distance, or stigma to others and any of the three mental health indicators ($p > .05$). This suggests that external or socially oriented stigma attitudes may not directly relate to the students' own mental health conditions.

4.4 Summary

This chapter analyzed data from 163 UNIMAS undergraduate nursing students using SPSS. The majority were female, aged 20–23, mostly in their third or fourth year, with Malay and Iban as the predominant ethnic groups.

Mental health assessment via DASS-21 showed most students had normal depression and stress levels, but anxiety was more prevalent, with many experiencing mild to moderate symptoms. Stigma measures revealed moderate levels of anticipated stigma, avoidant coping, lack of help-seeking, and self-stigma, while stigma toward others was generally low.

Chi-square tests indicated a significant association between year of study and depression, and between age and avoidant coping and stigma toward others. No significant links were found for gender, ethnicity, or religion. Spearman's correlations showed anticipated stigma, avoidant coping, and self-stigma positively correlated with depression and anxiety, while lack of help-seeking related only to anxiety.

These findings suggest internalized stigma significantly impacts nursing students' mental health, underscoring the need for targeted stigma reduction and mental health support within nursing education.

CHAPTER 5

DISCUSSION

5.0 Introduction

This chapter presents a comprehensive discussion of the findings obtained from the study on the relationship between mental health status and stigma among UNIMAS undergraduate nursing students. The discussion aims to thoroughly interpret and analyze the results in relation to the research questions, background, and problem statement outlined in earlier chapters. It connects the findings to the theoretical framework and previous empirical studies reviewed in the literature, highlighting consistencies, discrepancies, and novel insights.

5.1 Mental health status among UNIMAS undergraduate nursing students

This study involved 163 undergraduate nursing students, with a predominance of female participants (81.6%), which aligns with existing literature indicating that nursing remains a female-dominated profession (Smith & Jones, 2020). The gender distribution reflects broader trends in nursing education, where females typically outnumber males by a significant margin (Brown et al., 2019).

The age distribution showed that most students were between 20 and 23 years old, with the largest group being 23 years old (27.0%). This age range is consistent with the typical undergraduate nursing student population, who often enter nursing programs immediately after secondary education or after a brief gap (Lee & Kim, 2021). The

smaller proportion of older students (aged 24 and 25) may indicate either delayed entry into nursing education or part-time study patterns.

Regarding academic progression, the highest number of participants were in their fourth year (27.6%), followed closely by third- and second-year students (25.2% each), and first-year students (22.1%). This relatively balanced distribution across years of study suggests a stable cohort retention and provides a comprehensive perspective of nursing students at various stages of their education (Garcia & Patel, 2022).

Ethnic diversity was notable, with the majority identifying as Malay (41.7%), followed by Iban and other ethnic groups. This diversity reflects the multicultural context of the region and highlights the importance of culturally competent nursing education (Rahman et al., 2023). The representation of multiple ethnic groups within the sample can enrich the learning environment and promote inclusivity in healthcare training.

In terms of religious affiliation, more than half of the participants identified as Muslim (56.4%), with Christianity being the second most common religion (42.3%). The presence of minority religions such as Buddhism and Hinduism, although minimal, further underscores the religious diversity within the student population. Understanding religious backgrounds is crucial for nursing educators to foster respect and sensitivity towards different cultural and spiritual beliefs, which are integral to holistic patient care (Nguyen & Thompson, 2020).

5.2 Stigma among UNIMAS undergraduate nursing students

The findings from the personal stigma of mental illness scale reveal a nuanced picture of attitudes and beliefs among UNIMAS undergraduate nursing students. Moderate to high

levels of anticipated stigma were reported, indicating that many students harbor concerns about how others would perceive them if they experienced a mental disorder. Most notably, worries about being seen as weak, avoided, or not genuinely ill were prevalent. These anticipated stigma concerns align with previous research showing that fear of negative judgment is a significant barrier to mental health disclosure and help-seeking among nursing students (Alhasan et al., 2023). Such fears may contribute to internalized stigma and exacerbate psychological distress, emphasizing the need for stigma reduction interventions that address these perceptions.

Avoidant coping strategies showed mixed endorsement. While students largely rejected substance use as a coping mechanism, some still endorsed cognitive avoidance, such as ignoring problems or not thinking about them. This ambivalence suggests that while students may recognize the ineffectiveness of harmful coping behaviors, psychological avoidance remains a common response to stress and mental health challenges. This is consistent with literature highlighting avoidant coping as a maladaptive strategy linked to poorer mental health outcomes and greater stigma internalization (Corrigan et al., 2014; Zhu et al., 2024). Nursing education programs should therefore incorporate training on adaptive coping skills to replace avoidant tendencies.

Regarding help-seeking attitudes, the results were somewhat encouraging, with a majority expressing willingness to seek professional help if needed. However, discomfort in disclosing mental health problems to managers and colleagues was also evident, reflecting ongoing concerns about workplace stigma and confidentiality (Alhasan et al., 2023). This ambivalence mirrors findings from other studies where nursing students recognize the importance of help-seeking but remain hesitant due to fear of judgment or negative career implications. Creating a supportive educational environment that normalizes mental health

discussions and protects confidentiality is critical to overcoming these barriers.

Self-stigma items revealed moderate feelings of shame, weakness, and fear of being a burden, which are consistent with internalized negative beliefs about mental illness. Such self-stigma can significantly undermine self-esteem and deter individuals from seeking help, thereby worsening mental health outcomes.

Social desirability responses indicated that participants generally endorsed socially approved behaviors, which may reflect a tendency to present themselves favorably. While this is common in self-report measures, it underscores the importance of interpreting stigma-related responses with caution, considering potential response biases.

Social distance findings showed moderate comfort in interacting with people with mental illness, though some reluctance to discuss mental health openly or employ individuals with mental disorders was noted. This suggests residual stigma and highlights the need for experiential learning and contact-based education to reduce social distance and promote empathy (Zhu et al., 2024).

Finally, the low endorsement of stigmatizing beliefs about others with mental illness is encouraging and suggests that overt negative stereotypes are not strongly held among these students. This positive attitude may reflect increased mental health awareness and education but should be reinforced through continued curriculum efforts to sustain and deepen understanding.

In summary, the results indicate that while UNIMAS nursing students generally reject overt stigma toward others, anticipated stigma, self-stigma, and avoidant coping remain challenges that may negatively impact their mental health and help-seeking behaviors. Addressing these internalized stigma components through targeted educational

and supportive interventions is vital to promoting psychological well-being and preparing nursing students to provide compassionate, stigma-free care.

The current study revealed a multifaceted stigma profile among undergraduate nursing students: moderate anticipated stigma (52.8%), avoidant coping (63.2%), and lack of help-seeking (66.9%), alongside notable self-stigma (50.3%). In contrast, public stigma toward others was low. These findings align with previous research showing that nursing students often internalize stigma more severely than they express toward others (Foster et al., 2019; Valentim et al., 2023).

The results demonstrate that among UNIMAS undergraduate nursing students, age and year of study are the primary socio-demographic factors associated with certain stigma dimensions, particularly avoidant coping and stigmatizing attitudes toward others with mental illness. The significant association between age and avoidant coping suggests that younger and older students may differ in their use of coping strategies when facing mental health challenges, which aligns with prior research indicating developmental and experiential factors influence coping styles (Shi et al., 2024).

Similarly, the significant relationship between both age and year of study with stigma toward others highlights that as students progress academically or mature, their attitudes toward people with mental illness may shift. This finding is consistent with evidence that educational exposure, including clinical placements and mental health curricula, can reduce stigmatizing beliefs and promote more positive attitudes (Zhu et al., 2024; Alhasan et al., 2023). The lack of significant associations for gender, ethnicity, and religion suggests that these factors may not strongly influence stigma dimensions within this specific cohort, possibly due to cultural homogeneity or shared educational experiences.

These findings underscore the importance of tailoring anti-stigma interventions to students' academic level and developmental stage. Incorporating targeted mental health education early in the nursing program and reinforcing it throughout the curriculum may foster adaptive coping and reduce stigma, ultimately improving students' mental health and their capacity to provide compassionate care.

5.3 The relationship between mental health status and stigma among UNIMAS undergraduate nursing students

This study explored the relationship between mental health status (depression, anxiety, and stress) and stigma among UNIMAS undergraduate nursing students. The findings revealed significant positive correlations between mental health symptoms and internalized stigma dimensions, namely anticipated stigma, avoidant coping, and self-stigma. Anxiety was also significantly associated with reduced help-seeking behaviour. These results provide important insights into how stigma and psychological distress interact within this population.

The positive correlations between depression, anxiety, and anticipated stigma suggest that nursing students experiencing greater psychological distress tend to expect negative social judgment related to mental illness. This aligns with previous research indicating that anticipated stigma is a major barrier to mental health support among nursing students (Alhasan et al., 2023). Similarly, the association of avoidant coping with all three mental health symptoms highlights the maladaptive strategies students may use to manage stigma-related distress, which can exacerbate their condition.

Self-stigma's significant correlation with depression and anxiety further underscores

its detrimental impact on nursing students' mental health. Internalized stigma has been shown to reduce self-esteem and increase feelings of shame, which in turn discourage help-seeking behaviours (Alhasan et al., 2023; DOAJ, 2024). The finding that anxiety but not depression or stress was significantly related to a lack of help-seeking suggests that anxiety symptoms may particularly inhibit students from accessing psychological support.

Interestingly, social desirability, social distance, and stigma toward others did not show significant relationships with mental health symptoms. This may indicate that internalized stigma (self-stigma and anticipated stigma) has a more direct and profound effect on students' psychological well-being than external stigma or concerns about social approval. This distinction is consistent with the Framework Integrating Normative Influences on Stigma (FINIS), which posits that stigma operates at multiple levels, with personal internalization being a key predictor of mental health outcomes (Zhu et al., 2024).

The implications of these findings are critical for nursing education. Given that stigma can hinder nursing students from seeking help and negatively affect their mental health, psychoeducational interventions targeting self-stigma and anticipated stigma are warranted. Educational programs that combine theoretical knowledge with clinical exposure to mental health care have been shown to reduce stigmatizing attitudes and improve students' acceptance of mental illness (DOAJ, 2024; Zhu et al., 2024). Such interventions can foster healthier coping mechanisms, encourage help-seeking, and ultimately improve both student well-being and the quality of care they provide in their future nursing roles.

Limitations of this study include its cross-sectional design, which limits causal inferences, and reliance on self-reported measures that may be influenced by response biases. Future longitudinal research is recommended to examine how stigma and mental health interact over time and to evaluate the effectiveness of stigma-reduction interventions within

nursing curricula.

In conclusion, this study highlights the pervasive role of internalized stigma in the mental health of UNIMAS undergraduate nursing students. Addressing stigma through targeted educational and supportive strategies is essential to promote psychological well-being and prepare nursing students to provide compassionate care to people with mental illness.

5.4 Implications and recommendations

The findings of this study underscore the significant impact of stigma particularly internalized and anticipated stigma on the mental health status of UNIMAS undergraduate nursing students. The positive associations between stigma dimensions and symptoms of depression, anxiety, and stress suggest that stigma acts as a considerable psychosocial barrier that not only affects students' psychological well-being but may also hinder their willingness to seek help. Given that nursing students are future healthcare providers, their personal experiences and attitudes toward mental illness are critical, as these can influence the quality of care they deliver to people with mental health conditions. The significant relationship between year of study and stigma toward others indicates that students' attitudes evolve throughout their education, highlighting the importance of timely and targeted interventions within the nursing curriculum.

Moreover, the moderate willingness to seek professional help contrasted with discomfort in disclosing mental health issues to peers or supervisors points to an ongoing challenge in creating safe and supportive environments. This suggests that despite some openness to help-seeking, stigma-related fears and concerns about confidentiality remain

barriers. These findings emphasize the need for nursing programs to foster a culture that normalizes mental health discussions and provides accessible, confidential support services.

In light of these implications, it is recommended that nursing education programs integrate comprehensive mental health education throughout the curriculum. Such education should be evidence-based and include not only theoretical knowledge but also contact-based learning opportunities, such as interactions with individuals who have lived experience of mental illness, and simulation exercises. These approaches have been shown to effectively reduce stigma and improve students' confidence in managing mental health issues.

Additionally, regular anti-stigma interventions, including workshops, campaigns, and reflective activities, should be implemented to specifically address internalized and anticipated stigma. Utilizing role-play and personal testimonials can help challenge existing stereotypes and foster empathy among students. Nursing faculties should also prioritize creating supportive environments by establishing confidential counseling services and peer support groups. Training faculty and clinical supervisors to recognize mental health concerns and respond with empathy and nonjudgmental support is essential to encourage help-seeking behaviors.

Given the association between academic progression and stigma, interventions should be tailored to the developmental and educational needs of students at different stages of their training. Reinforcing stigma reduction and mental health promotion throughout the nursing program can help sustain positive attitudinal changes and improve psychological resilience.

Finally, further research is needed to explore longitudinal changes in stigma and mental health status during nursing education and to evaluate the effectiveness of specific

educational and support interventions. Investigating cultural and demographic influences on stigma within diverse student populations will also provide valuable insights for more culturally sensitive approaches.

5.5 Limitation

Several limitations that may impact the findings and their generalizability. As a rookie researcher, one may encounter problems in the study's design and implementation, including potential biases in data collecting and analysis. Lack of expertise can result in challenges in efficiently overseeing the research process, perhaps compromising the overall quality of the data and its interpretations. Additionally, budget constraints may limit the resources available for recruitment and data collection, potentially impacting sample size and diversity. A reduced sample size may diminish the generalisability of the results to the wider population of nursing students. Moreover, time limitations related to completing the study within an academic semester may hinder the thoroughness of data processing and restrict chances for subsequent evaluations. These limitations must be acknowledged when interpreting the data, as they may affect the reliability and application of the conclusions derived from this research. Notwithstanding these issues, this study retains the potential to enhance the comprehension of mental health and stigma inside nursing education.

5.6 Conclusions

This study explored the relationship between mental health status and stigma among undergraduate nursing students at Universiti Malaysia Sarawak (UNIMAS). The findings revealed that while most students reported normal levels of depression and stress, a significant proportion experienced mild to moderate anxiety. Stigma particularly internalized forms such as anticipated stigma, self-stigma, and avoidant coping was found

to be moderately prevalent among the students and significantly correlated with symptoms of psychological distress.

The results underscore the critical influence of internalized stigma on students' mental health and help-seeking behaviours. Notably, anxiety was significantly associated with a reduced willingness to seek professional help, highlighting the urgent need to address stigma in nursing education. In contrast, public stigma and social desirability were less prominent, suggesting that personal beliefs and internal fears play a more substantial role in shaping mental health outcomes than external social norms within this cohort.

Sociodemographic factors such as age and year of study were found to influence certain stigma dimensions, particularly avoidant coping and attitudes toward others with mental illness. These findings suggest that students' perceptions and coping strategies evolve as they progress through their nursing education, further emphasizing the importance of targeted interventions at different stages of academic development.

In conclusion, this study demonstrates a clear and significant link between stigma and mental health among nursing students. Addressing stigma through educational reform, early intervention, and supportive institutional culture is essential to promote psychological well-being, reduce barriers to help-seeking, and prepare nursing students to deliver compassionate and stigma-free mental healthcare in their future professional roles.

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APPENDIX A: COVER LETTER FOR ETHICAL APPROVAL

Nor Amira Binti Mohamad Roslan,
Faculty Medicine and Health Sciences,
Universiti Malaysia Sarawak,
94300 Kota Samarahan,
Sarawak.

The Chairman,
Medical Research Ethics Committee,
Faculty Medicine and Health Sciences,
Universiti Malaysia Sarawak,
94300 Kota Samarahan,
Sarawak.

15th December 2024

Professor/Associate Professor/Dr/Sir/Madam,

REQUEST FOR APPROVAL TO CONDUCT RESEARCH PROJECT

I am a final-year student pursuing a Bachelor of Nursing with Honours at the Faculty of Medicine and Health Sciences, UNIMAS. I enrolled in MDJ 4653 Final Year Project I, in which the course is coordinated by Madam Shalin Lee Wan Fei. Please find my details as follows:

Full name: Nor Amira Binti Mohamad Roslan

Matrix number: 80419

IC No.: 010519-14-0114

I would like to request for the kind approval from the Faculty of Medicine and Health Sciences Medical Research Ethics Committee to conduct the following study:

Research title: The Relationship Between Mental Health Status and Stigma among UNIMAS Undergraduate Nursing Students

Supervisor's name: AP Dr Rekaya Anak Vincent Balang

Email address: vbrekaya@unimas.my

Supervisor's HP number: 019-8892379

Please find the required documents as appended for your kind consideration and approval.

Thank you.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Nor Amira', with a stylized flourish at the end.

(Nor Amira Binti Mohamad Roslan)

APPENDIX B: PARTICIPANT INFORMATION SHEET (PIS)



PARTICIPANT INFORMATION SHEET

- | | |
|------------------------------|---|
| 1. Title of the study | : The Relationship Between Mental Health Status and Stigma among UNIMAS Undergraduate Nursing Students |
| 2. Main Researcher | : Nor Amira Binti Mohamad Roslan |
| 3. Supervisor | : a) Course coordinator: Shalin Lee Wan Fei
b) Main research supervisor: AP Dr <u>Rekaya Anak Vincent Balang</u> |
| 4. Institution | : Department of Nursing
Faculty of Medicine & Health Sciences
<u>Universiti Malaysia Sarawak</u> |
| 5. Name of sponsor | : No external funding |

PARTICIPANT INFORMATION SHEET AND INFORMED CONSENT FORM
(for adult subjects)

1. Introduction:

It is important that you understand why the research is being done and what it involves. Please take your time to read through and consider this information carefully before you decide if you are willing to participate. Ask the study staff if anything is unclear or if you would like more information. After you are properly satisfied that you understand this study, and that you wish to participate, you must sign this informed consent form.

Your participation in this study is voluntary. You do not have to be in this study if you do not want to. You may also refuse to answer any questions you do not want to answer. If you volunteer to be in this study, you may withdraw from it at any time. If you withdraw, any data collected from you up to your withdrawal will still be used for the study. Your refusal to participate or withdrawal will not affect any medical or health benefits to which you are otherwise entitled.

This study has been approved by the Medical Research and Ethics Committee, Ministry of Health Malaysia.

2. What is the purpose of the study?

The purpose of this study is to determine the relationship between mental health status and stigma among UNIMAS undergraduate nursing students.

This research will be conducted for a duration of 6 months (25/01/2025 till 30/06/2025). The expected number of participants is 163 individuals.

3. What are my responsibilities when taking part in this study?

It is important that you answer all of the questions asked by the study staff honestly and completely which will take about 15 - 20 minutes of your time.

4. What are the potential risks and side effects of being in this study?

Participation to this study is entirely voluntary, your decision to participate will not impact any future treatment you may receive and the risk is minimal. You are free to decline to answer any of the questions that you feel uncomfortable and may withdraw from the study at any time without facing any penalties.

5. What are the benefits of being in this study?

There may or may not be any benefits to you. Information obtained from this study will help provide valuable insights into how the relationship between mental health status and stigma may interact within the context of nursing education. By assessing the mental health status of nursing students, this study aims to raise awareness about the psychological challenges faced by this population. The study will examine the level of stigma surrounding mental health issues among nursing students. Stigma can prevent individuals from seeking help, thereby worsening their mental health conditions.

6. Who is funding the research?

This study does not receive any external funding. You will not be paid for participating in this study.

7. Will my medical information be kept private?

All your information obtained in this study will be kept and handled in a confidential manner, in accordance with applicable laws and/or regulations. When publishing or presenting the study results, your identity will not be revealed without your expressed consent. Individuals involved in this study, qualified monitors and auditors, and governmental or regulatory authorities may inspect the study data, where appropriate and necessary.

8. Who should I call if I have questions?

If you have any questions about the study or if you think you have a study related injury and you want information about this study, please contact the study doctor, AP Dr Rekaya Anak Vincent Balang at telephone number 019-8892379 or e-mail vbrekaya@unimas.my.

If you have any questions about your rights as a participant in this study, please contact: The Secretary, Medical Research & Ethics Committee, Ministry of Health Malaysia, at telephone number 03-3362 8407/8205/8888.

APPENDIX C: INFORMED CONSENT

Title of Study: The Relationship Between Mental Health Status and Stigma among UNIMAS Undergraduate Nursing Students

By signing below I confirm the following:

- I have been given oral and written information for the above study and have read and understood the information given.
- I have had sufficient time to consider participation in the study and have had the opportunity to ask questions and all my questions have been answered satisfactorily.
- I understand that my participation is voluntary and I can at anytime free withdraw from the study without giving a reason and this will in no way affect my future treatment. I am not taking part in any other research study at this time. I understand the risks and benefits, and I freely give my informed consent to participate under the conditions stated. I understand that I must follow the study doctor's (investigator's) instructions related to my participation in the study.
- I understand that study staff, qualified monitors and auditors, the sponsor or its affiliates, and governmental or regulatory authorities, have direct access to my medical record in order to make sure that the study is conducted correctly and the data are recorded correctly. All personal details will be treated as STRICTLY CONFIDENTIAL
- I will receive a copy of this subject information/informed consent form signed and dated to bring home.
- I agree/disagree* for my family doctor to be informed of my participation in this study.
(*delete which is not applicable)

Subject:

Signature:

I/C number:

Name:

Date:

Investigator conducting informed consent:

Signature:

I/C number:

Name:

Date:

Impartial witness:

Signature:

I/C number:

Name:

Date:

APPENDIX D: QUESTIONNAIRE

Section A: Socio-demographic data

Complete the information below accordingly. Please tick (✓) your answers in the boxes provided below or fill in the relevant information in the blanks provided.

1. Age: _____ years
2. Gender
☐ Male ☐ Female
3. Year of Academic Study
☐ Year 1
☐ Year 2
☐ Year 3
☐ Year 4
4. Ethnicity
☐ Bidayuh
☐ Chinese
☐ Dusun
☐ Iban
☐ Indian
☐ Malay
☐ Other: _____
5. Religion
☐ Buddhism
☐ Christianity
☐ Hinduism
☐ Islam
☐ Other: _____

Section B: Mental Health Status

Questionnaire adopted from Depression, Anxiety and Stress Scale (DASS-21) by Lovibond and Lovibond (1995).

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

- 0- Did not apply to me at all
- 1- Applied to me at some degree, or some of the time
- 2- Applied to me to a considerable degree, or a good part of the time
- 3- Applied to me very much, or most of the time

No.	ITEMS	0	1	2	3
1	I found it hard to wind down.	0	1	2	3
2	I was aware of the dryness in my mouth.	0	1	2	3
3	I couldn't seem to experience any positive feeling at all.	0	1	2	3
4	I experienced breathing difficulties (eg: excessively rapid breathing, breathlessness in the absence of physical exertion).	0	1	2	3
5	I found it difficult to work up the initiative to do things.	0	1	2	3
6	I tended to over-react to situations.	0	1	2	3
7	I experienced trembling (eg: in the hands).	0	1	2	3
8	I felt that I was using a lot of nervous energy.	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself.	0	1	2	3
10	I felt that I had nothing to look forward to.	0	1	2	3
11	I found myself getting agitated.	0	1	2	3
12	I found it difficult to relax.	0	1	2	3
13	I felt down-hearted and blue.	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing.	0	1	2	3
15	I felt I was close to panic.	0	1	2	3
16	I was unable to become enthusiastic about anything.	0	1	2	3
17	I felt I wasn't worth much as a person.	0	1	2	3
18	I felt that I was rather touchy.	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg: sense of heart rate increase, heart missing a beat).	0	1	2	3
20	I felt scared without any good reason.	0	1	2	3
21	I felt that life was meaningless.	0	1	2	3

Section C: Stigma

Questionnaire adopted from Stigma and Self-Stigma scales (SASS) by Docksey et al. (2022)

We are going to ask you about your views on mental disorders and people who have mental health problems. It is important that you answer with your own views - not what you think people should say. The questionnaire is “anonymous” meaning that we will not know who has filled out this questionnaire so you can be completely honest about your opinions and about yourself.

For each of the following statements please select which answer you think is best by circling the appropriate number.

The rating scale is as follows:

- 0- Strongly disagree
- 1- Disagree
- 2- Neither agree nor disagree
- 3- Agree
- 4- Strongly agree

No.	ITEMS	0	1	2	3	4
1	I'm good at talking to people with mental health problems	0	1	2	3	4
2	If I had a mental disorder, I would worry other people would think that I am weak	0	1	2	3	4
3	If I had a mental disorder, I would be happy to seek help from a mental health professional	0	1	2	3	4
4	I always eat a healthy diet.	0	1	2	3	4
5	If I had a mental disorder, I would NOT feel comfortable telling my manager.	0	1	2	3	4
6	Drinking alcohol never helps when you are stressed	0	1	2	3	4
7	It's often best to ignore problems and hope they go away	0	1	2	3	4
8	I would NOT tell anyone if I had a mental disorder in case they judge me.	0	1	2	3	4
9	If I had a mental disorder, I would feel ashamed.	0	1	2	3	4
10	Taking illegal drugs can never help when you are stressed by something	0	1	2	3	4
11	If I had a mental disorder, I would worry other people would avoid talking to me.	0	1	2	3	4
12	I would NOT feel comfortable discussing my mental health problems with a colleague.	0	1	2	3	4
13	If I found a £10 note I would try to find its owner.	0	1	2	3	4
14	I do my best not to think about my problems	0	1	2	3	4
15	If I had a mental disorder and I could not solve my own problems, I would feel bad about myself.	0	1	2	3	4
16	People with mental disorders are NOT really ill and should just get on with things.	0	1	2	3	4
17	If I had a mental disorder, I would feel weak.	0	1	2	3	4
18	If I had a mental disorder, I would worry other people would think I was exaggerating my difficulties	0	1	2	3	4
19	If I had a mental disorder, I would feel like no one would want to get close to me.	0	1	2	3	4
20	I am comfortable when around people with a mental disorder.	0	1	2	3	4
21	Employees suffering from mental disorders are less reliable than	0	1	2	3	4

	other employees.					
22	I would feel a burden to my colleagues if I had a mental disorder.	0	1	2	3	4
23	I always tell the truth.	0	1	2	3	4
24	I am confident that I could ask for help if I had a mental health problem	0	1	2	3	4
25	People with mental disorders are weak.	0	1	2	3	4
26	People with mental disorders should just “snap out of it.”	0	1	2	3	4
27	The best way to cope with problems is not to think about them	0	1	2	3	4
28	I would feel comfortable discussing a colleague’s mental health problem with them.	0	1	2	3	4
29	If I had a mental disorder, I would worry that other people might think that I was “not really ill”.	0	1	2	3	4
30	I have never dropped litter	0	1	2	3	4
31	People with mental disorders cannot live good, rewarding lives.	0	1	2	3	4
32	If I had a mental disorder, I would worry other people would think of me as a failure.	0	1	2	3	4
33	If I were an employer, I would feel comfortable employing someone with a mental disorder.	0	1	2	3	4
34	If I had a mental health disorder and needed help, I would feel comfortable going to a therapist.	0	1	2	3	4
35	I sometimes lie to people.	0	1	2	3	4
36	I always obey rules even if no one is looking	0	1	2	3	4
37	If I had a mental disorder, I would worry other people would feel sorry for me or patronise me.	0	1	2	3	4
38	People with mental disorders are NOT really ill.	0	1	2	3	4
39	Mental health problems are best tackled head on	0	1	2	3	4
40	I would feel a failure if I became mentally unwell.	0	1	2	3	4
41	Having a mental disorder is nothing to be ashamed of.	0	1	2	3	4
42	It’s best not to tell anyone about your mental health problems	0	1	2	3	4

APPENDIX E: PERMISSION FROM ORIGINAL AUTHOR

Request for Permission to Adopt Questionnaire for Final Year Project

N

NOR AMIRA BINTI MOHAMAD ROSLAN
To: snowden@cardiff.ac.uk
Thu 21/11/2024 16:37

😊 ↶ ↷ ↲ ↳ ⋮

Dear Robert J. Snowden,

I hope this message finds you well. I am Nor Amira, a final-year Nursing Student at University of Malaysia Sarawak (UNIMAS). I am writing to request permission to use your questionnaire for my Final-Year Project, "The relationship between mental health status and stigma among UNIMAS undergraduate nursing students."

I understand you might be occupied, and I deeply appreciate your time in considering my request. I am seeking your permission to utilize the questionnaire you developed for my research. Your work on "The Stigma and Self-Stigma Scales for attitudes to mental health problems: Psychometric properties and its relationship to mental health problems and absenteeism" perfectly aligned with the objective of my study.

To ensure compliance with ethical guidelines and maintain academic standards, I kindly request the following details:

1. Permission to Adopt Instrument: Format permission to adopt and use the questionnaire, tailored to the context of UNIMAS Nursing Students.
2. Complete Questionnaire Details: If feasible, could you provide the complete questionnaire with distracters/answer options and correct answers? This would ensure the integrity of your original work and aid in accurate data collection.
3. Domains and Sections Within the Questionnaire: A detailed breakdown of the various domains and sections covered in the questionnaire would greatly assist in aligning my study objectives.
4. Instrument/Questionnaire Guide: Any associated guide or manual related to the questionnaire's administration and scoring procedures would be immediately helpful for the success of my research.

I highly value intellectual property rights and assure you that your work will be duly credited in my final report. I am fully committed to complying with any conditions or requirements you may have in granting permission for the adoption of your questionnaire. Thank you very much for considering my request. I eagerly anticipate your positive response. If you require any further information clarification, please feel free to contact me.

Thank you for your time and consideration.

Sincerely,
Nor Amira Binti Mohamad Roslan
80419
UNIMAS Year 4 Nursing Student

RS

Robert Snowden<snowden@cardiff.ac.uk>
To: NOR AMIRA BINTI MOHAMAD ROSLAN

 SASS questionnaire manual.p...
316 KB

 SASS version 2022.docx
30 KB

2 attachments (346 KB) ☁ Save all to OneDrive - UNIMAS ⬇ Download all

Dear Nor,

Please find attached. You have my permission for using the SASS

Good luck with your work.

Bob Snowden

APPENDIX F: GANTT CHART

Activity	Year/Months									
	2024			2025						
	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
Research title determination										
Supervisor meeting										
Literature review										
Oral defense slides submission										
Ethical approval										
First draft submission										
FYP 1: Research submission										
Data collection										
Data analysis										
Report write-up										
Research Poster Presentation										
Final draft submission										
FYP 2: Final project submission										

APPENDIX G: BUDGET

Budget			
Project title	The Relationship Between Mental Health Status and Stigma among UNIMAS Undergraduate Nursing Students		
Duration of the project	October 2024 – July 2025		
Items	Unit price (RM)	Quantity	Amount (RM)
Material and supplies			
Printing questionnaire form	0.38/set	24 set	9.15
Photostatting questionnaire forms	0.29/set	163 set	43.90
Binding	2.50/ring	1 pcs	2.50
Plastic binding cover	1.50/sheet	2 pcs	3.00
Report			
Printing poster presentation	40/poster	1 poster	40.00
Printing FYP 2	0.10/page	110 page	17.00
Others			
SPSS software	5	1	5
Internet data	50	1	50
Total amount			RM170.55

APPENDIX H: TURNITIN SIMILARITY INDEX REPORT

80419

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