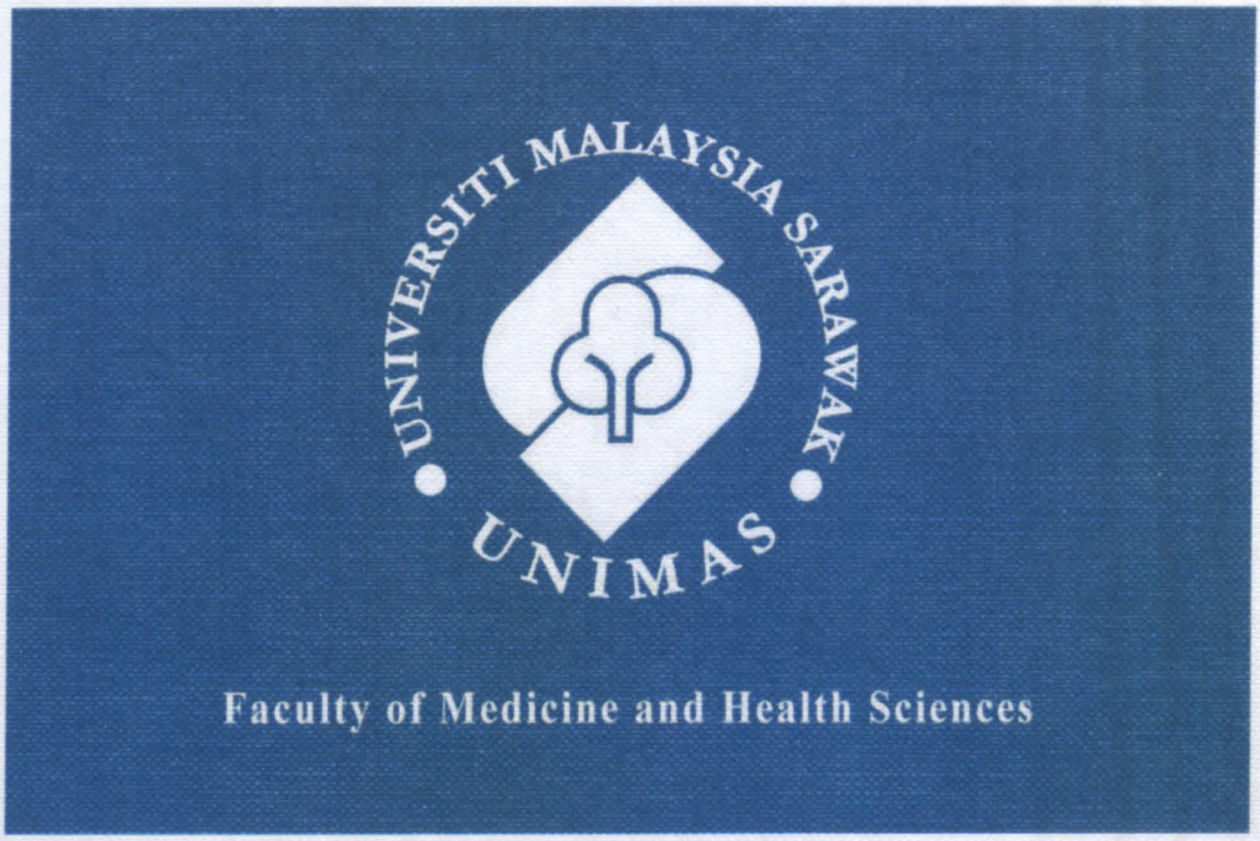


QUALITY OF HELPING INTENTION OF ADOLESCENT TOWARD PEERS WITH DEPRESSIVE SYMPTOMS IN KUCHING DIVISION OF SARAWAK

Muhammad Najib Bin Hasan @ Ahmad

Master of Public Health

2020

QUALITY OF HELPING INTENTION OF ADOLESCENT TOWARD PEERS WITH DEPRESSIVE SYMPTOMS IN KUCHING DIVISION OF SARAWAK

MUHAMMAD NAJIB BIN HASAN @ AHMAD

A thesis submitted in partial fulfillment of the requirement for Master of Public Health

Faculty of Medicine and Health Sciences
UNIVERSITY MALAYSIA SARAWAK
2020

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List of Abbreviation

DALYs	Disability Adjusted Life Years
DSES	Daily Spirituality Experience Scale
DSM-IV	Diagnostic and Statistical Manual of Mental Disorders
MDD	Major Depressive Disorder
MHFA	Mental Health First Aid
MHL	Mental Health Literacy
MREC	Medical Review and Ethics Committee
NMRR	National Medical Research Register
SPSS	Statistical Package for the Social Sciences
UNIMAS	University Malaysia Sarawak
WHO	World Health Organization

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Abstract

Background: Mental health issue primarily related to depression among adolescents, is worrying because it may lead to serious complications such as suicide. When suffering from depression, a friend is one source of help for an adolescent. Therefore, helping response of adolescent who provides first-hand assistance toward the depressed teenager need an evaluation.

Objectives: The study aimed to determine the quality of helping intention of the adolescent in the Kuching Division of Sarawak toward their peers who suffered from depressive symptoms and their association with age, gender, previous history with mental health patient, spiritual level, confidence level, stigma and knowledge of mental health.

Method: During 2020, a total of 589 adolescents age 12 to 19 years old in the Kuching Division of Sarawak participate in a cross-sectional study. A set of questionnaires with a vignette portraying a friend who suffered from depression with suicidal ideation was given to the adolescents to answer. Logistic and linear regression models were used to examine predictors of the helping intention.

Result: The quality of helping responses among adolescents was still inadequate. The most common helping intention among adolescents was that they would listen to their friends' problems, advise them what to do, help them to connect with adults, and not talking about suicide. Those who had low social distance scale scores, rural adolescents and adolescents with previous experience with a patient with mental health problem showed better helping intention.

Conclusions: Adolescents were willing to help their friends with depression. However, the quality of help that they recommended was still inadequate. Factors such as gender, stigma, age of the adolescent, confidence level, and knowledge on mental health first aid should be considered when planning an intervention program.

Keywords: Adolescent, teenager, Mental health first aid, helping intention, helping response, depression, Kuching, Sarawak

Abstrak

Latar Belakang Kajian: Kesihatan mental dalam kalangan remaja terutamanya isu yang berkaitan dengan penyakit kemurungan adalah membimbangkan. Ini kerana ia boleh menyebabkan impak yang serius seperti kes bunuh diri. Rakan merupakan salah satu sumber untuk remaja meminta bantuan apabila berada dalam kemurungan. Oleh itu, adalah penting untuk kita menilai kualiti bantuan dan respon yang diberikan oleh remaja terhadap rakan mereka yang mempunyai masalah kemurungan.

Objektif: Tujuan penyelidikan ini dilakukan adalah untuk mengetahui tahap kualiti respon bantuan terhadap rakan yang mempunyai tanda kemurungan dalam kalangan remaja di bahagian Kuching dan kaitannya dengan umur, jantina, sejarah berhubung dengan mereka yang mempunyai masalah kesihatan mental, kerohanian, tahap keyakinan diri, stigma dan tahap keilmuan berkenaan kesihatan mental.

Kaedah Kajian: Pada tahun 2020 seramai 589 remaja berumur antara 12 hingga 19 tahun telah menyertai kajian yang dilakukan di bahagian Kuching, Sarawak. Setiap daripada mereka telah diberikan satu set borang soal selidik menggunakan kisah yang menggambarkan seorang remaja yang mempunyai masalah kemurungan dan ingin membunuh diri. Faktor kepada keinginan dan respon bantuan kepada rakan yang mempunyai kemurungan telah di analisis menggunakan model *logistic regression* dan *linear regression.*

Keputusan: Tahap kualiti respon terhadap rakan yang inginkan bantuan ketika mempunyai masalah kemurungan adalah kurang memuaskan dalam kalangan remaja. Respon yang paling banyak didapati dalam kalangan remaja adalah mereka akan mendengar permasalahan rakan mereka, memberitahu rakan mereka tentang apa yang perlu mereka lakukan, membantu rakan mereka berhubung dengan orang dewasa, dan tidak bercakap tentang membunuh diri. Remaja yang mempunyai markah rendah dalam *social distance scale*, remaja tinggal di pedalaman, dan

remaja yang pernah mempunyai sejarah bersama orang yang mempunyai masalah kesihatan mental menunjukkan respons bantuan yang lebih baik.

Rumusan: Remaja di bahagian Kuching mempunyai keinginan yang tinggi untuk membantu rakan mereka yang mempunyai kemurungan. Walau bagaimanapun, kualiti respon yang diberikan adalah kurang memuaskan. Faktor seperti jantina, umur, stigma, tahap keyakinan diri, dan tahap ilmu tentang kesihatan mental harus diambil endah ketika merangka program intervensi dalam kalangan remaja.

Kata kunci: remaja, keinginan membantu, bantuan kecemasan kesihatan mental, kemurungan, Kuching, Sarawak

Chapter 1: Introduction

1.1 Background of the study

Mental health problem in the community has become an increasingly important issue in public health nowadays. The most common mental health problem worldwide is depression and anxiety. Depression is a medical illness that commonly and negatively affects how humans feel. One of the consequences due to depression is, it will change the way individuals think and act. It may cause anhedonia which is the feeling of losing interest in something that a person used to enjoy. In the most severe case, depression can lead to emotional and physical problems and decrease the ability of human beings functioning at home or work. Fortunately, depression is a treatable disease if detected early.

The prevalence of depression is increasing over the years. In 1990 depression affected 416 million people, and it grew to 615 million in 2013. In 2018, it affected around 300 million people, regardless of age worldwide (WHO, 2019). It is important to realise that depression among adolescents may lead to severe complications like suicide if not attended to satisfactorily. Around the globe, almost 53,000 deaths due to suicide occurred, and it was among the top three reasons for mortality among late adolescents aged 15 to 19 years old in 2016 (WHO, 2018). Even though deaths due to mental health is increasing, disability among adolescents due to depression is also worrying. Depression is reported to be among the top ten leading causes of disability in teenagers. The World Health Organisation (WHO, 2018) estimated that among five adolescents and children, one would suffer from a mental health problem, most commonly in the form of depression and anxiety.

As we may know, around 1.2 billion of the world's population are adolescents, and that consists of 16 per cent of the world population(UNICEF, 2019). Generally speaking, from the public health perspective, adolescent holds a significant period during the life cycle of an

individual. Every risk factor that happens during their adolescent life will play a significant effect on their mental health in their later life. As has been noted in multiple epidemiological studies, most adult mental health problems originate during their adolescence period. A study by Bardone et al., (1996) suggested that compared to a healthy girl, a girl that was depressed at the age of 15 has 3.5 times higher risk of developing depression when they reached 21 years old of age. In addition to that, another study suggested that any depressive problem during the teenage years will result in an increased risk of a mental health problem such as Major Depression Disorder. (Fergusson and Woodward, 2002, Terhi Aalto-Setälä et al., 2002).

Depression can be described as one of the most burdensome diseases worldwide in this millennial year. When the risk factor of depression or the depression itself occurs during adolescence period, it will affect the mental health of a person during their working life later in adulthood. Hence, this will increase more economic burden to the nation. The loss of Disability Adjusted Life Years (DALYs) due to neuropsychiatry disorders was more than 7%, and about one-third of it was due to depression (Murray et al., 2012). In addition, a study by (Hu, 2004) concluded that economic burden due to depression would be increased if the individual that suffers from the condition left untreated and lead to more severe outcome from the disease. The cost of treatment mainly come from health services and consultation, hospital stay, medication, and counselling (Hu, 2004). The study estimated that the cost of services for treating depression in Australia was 615 million dollars in 1997 to the year 1998. Further, there was an increased cost due to MDD in the United States of America (Greenberg et al., 2015). From 2005 to 2010, the cost increased from 173.2 billion dollars to USD 210.5 billion. In other words, the increment was increased by 21.5% in a span of 5 years—most of this cost being due to the direct medical cost and workplace presenteeism.

From a broader perspective, based on the study in 36 countries, more than 12 billion days of lost productivity that is equivalent to more than 50 million years of work, is expected to be lost due to depression and anxiety disorder. It is estimated to cost around USD 925 billion each year. Assuming the same distribution of costs across lower-income and higher-income countries holds for all other countries, which represent 20% of the world's population, the global cost per year is USD1.15 trillion. For comparison, among people without these disorders, only 4.7 billion extra days are lost, at the cost of 592 billion dollars (Chisholm et al., 2016)

Importance of knowledge about mental disorders

The World Health Organisation has identified mental health literacy as one of the essential components of the social determinants of health. It may be a stronger predictor of an individual's health status than income, employment status, education, and ethnic group (WHO, 2013). A previous study found that there was low mental health literacy among Malaysians compared to some other countries (Furnham, 2014). The cross-cultural study comparing mental health literacy among Malaysian, Hong Kong, and the British population conducted in 2012 showed that Malaysian mental health literacy was lower compared to people in Hong Kong and Britain. The study used a hypothetical scenario to portray a person with a certain mental health issue and let the respondent answered based on the scenario given. Of all the vignettes given in the study, the vignettes showing people with depression symptoms were the most identified by Malaysian participants. Malaysian participants tended more to define the problem as "exogenous" as stemming from personality or situational factors, compared to British and Hong Kong participants(Loo et al., 2012). In the study, around 18% of Malaysians thought that the problem of depression was due to self-esteem issues and personal problems. Knowledge regarding mental health is important for an individual to identify themselves or others to have and depression. Only when they recognise the symptoms and sign of mental illness, stigma

regarding mental illness can be reduced. Thus will improve help-seeking and intention to give help to the population.

Factors associated with the prevalence of depression

Multiple risk factors were identified in various studies. The majority of researchers believed that the causes of depression are multifactorial. For example, a study that was done among 9863 students aged between 11 to 15 years old in the United States of America showed that factors such as the history of being bullied, student involvement in substance abuse, and presence of somatic symptoms tended to develop depression (Saluja et al., 2004). Locally, a cross-sectional study in Selangor by (Latiff L.A et al., 2016), showing that there was an association between adolescents living with a single parent as a risk factor of depression. Evidence from the study suggested that adolescents who lived with a single parent were twice more likely to suffer from depression than the adolescents who lived with both parents. Another study that was done in 2013, also suggested that a single parent was a risk factor for mental health among adolescents. The study also indicated that other factors, such as the use of illicit drugs and alcohol consumption, were risk factors toward depression in the adolescent. (Medina-Mora and Gibbs, 2013).

Social support as a guarding factor for mental health

As for protective factors for depression, the environment plays a vital role in dealing with an adolescent with depression. Among adolescents, the environment that has a significant effect is their family, friends, and school. In one of the most cited research for social support in depression (Bokhorst et al., 2010), adolescents age 9 to 15 years old perceived parents and friends to be equally supportive in dealing with the mental health issue. However, late teenagers aged 16 to 18 years old believed that friends' support was more important than parental support in dealing with depression. Additionally, for students with good classmate support, the

association between depression and suicidal ideation was not established, and even at any level of depression, the suicidal intention of such students was not high. On the other hand, depressive symptoms and suicidal ideation were higher for the adolescents who lived with less peer support (Bokhorst et al., 2010). These finding demonstrated that good friend support acted as a protective factor in mental health.

While this may be true, another study by (Brausch and Decker, 2014) found otherwise. In their research, support from friends had no buffering effect on depression and suicidal ideation. Moreover, it was reported that parents' support had a higher buffering effect on depression and suicidal ideation. Nevertheless, the latest study conduct in 2017 showed that both excellent support from parents and peer at school resulted in low ideation of suicide and had a positive impact among depressed teenagers (Fredrick et al., 2018). Even though there are still inconsistent findings on the issue, we can nevertheless conclude that depressed adolescents require good support either from parents or peer in dealing with the problem.

Health Seeking Behaviour in Adolescence

When having a mental health problem, an adolescent will always try to get help, either from a doctor, counsellor, family member, or friends. How a peer first reacts to a friend with depressive symptoms can affect the friend's recovery later. It is a known fact that people who had depression most likely would not seek professional assistance (Andrews et al., 2001) and that if they wanted help, they would probably go to seek help only if their relatives or friends proposed it (Jorm, 2000). A comprehensive review by (Gulliver et al., 2010) identified barriers that made adolescents reluctant to seek help from professionals. Among the barriers were the adolescents were relying more on themselves when solving problems, confidentiality issue, lack

of social skills to interpret their emotional state, fear of others knowing about their problems, and viewing seeking professional help negatively.

In another study done among students in the United Kingdom, one of the barriers to help-seeking is a lack of trust toward their doctor or general practitioner. In this case, only 10% of respondents were willing to go to a doctor for their depression problems, while 60% of them preferred their friends as a source of help rather than health professionals (Leavey et al., 2011). Similar results were found in a subsequent cross-sectional qualitative study in the United Kingdom, which focussed on the adolescents' refusal to seek the help of health professional. It was found out that one of the primary reasons was the teenagers' belief that the doctors will disclose their personal information to their parent(Corry and Leavey, 2017).

This is where adolescents as peer play a role. In situations where adolescents preferred their friends as a source of help, it is essential that adolescents are prepared and equipped to give an adequate response and assistance when helping other adolescents who were experiencing mental health crises or problems. They should also be able to encourage other adolescents with depression problems to seek proper advice where necessary. 'MHFA skills' is a term used to describe this ability, and MHFA skills are a significant component of mental health literacy (Jorm, 2012).

As far as we know, there have been very few studies on MHFA knowledge in the Malaysian population. The latest study regarding mental health in Malaysia assessed knowledge and opinions about psychiatric disorders and their management (Ibrahim et al., 2019). However, the population's helping response and intention toward mental health were rarely studied directly. Thus, we are unaware of how the public will react towards people who showed depressive symptoms. It is useful to know whether our population is willing to help and whether their help will be helpful or harmful to the person concerned.

In this study, we will examine several factors affecting how adolescents react towards their friends with depression. These factors include socio-demographic characteristics, daily spirituality level of the adolescent, previous experience with mental health patients, mental health literacy level, stigma, and personal confidence of the adolescent. The study will provide baseline information on adolescents' helping intention toward other adolescents with mental health issues in Sarawak.

1.2 Problem Statement and Significance of the Study

The purpose of the study was to determine the quality of helping intention among adolescents aged 12 to 19 years old towards their peers who suffered from depressive symptoms and their associated factors in the Kuching Division. The results from the study would provide information on whether the adolescents are well equipped and prepared in managing their peers' mental health problem. This study would also provide information regarding the predictors of the quality mental health first aid. Among the predictors examined were stigma, knowledge on mental health, spirituality factor, personal confidence level factor, and socio-demography characteristic and their association with the adequacy of helping intention among adolescents when in contact with their peers who have depressive symptoms. The information would be useful to public health authorities when developing policies or future intervention programmes to address mental health problems among adolescents.

1.3 Research Questions

This study addressed the following research questions:

1. What are the socio-demographic characteristics of the adolescents who have a high quality of helping intention toward a friend with depressive symptoms?
2. What are the steps of action that adolescents intended to give toward their peers who suffered from depressive symptoms?

3. Is the help that the adolescents intend to give to their friends with depression symptoms adequate?
4. Is there any association between the quality of their intended action and their mental health literacy level, their spirituality level, mental health personal stigma, and their previous experience dealing with a person having mental health problems?

1.4 Research Objective

General objective

The general objective of this study is to determine the quality of helping intention of adolescents aged 12 to 19 years old in the Kuching Division of Sarawak toward peers who suffered from depressive symptoms and their associated factors.

Specific objectives

The specific objectives of this study are to determine the:

1. Socio-demographic profile of the adolescents who were recruited into the study.
2. Level of personal stigma, mental health literacy, spirituality level, personal confidence level and the quality of helping intention toward peer's depressive symptoms among adolescents.
3. Type of helping action toward peers with depressive symptoms among adolescent who had prior experience with a person suffered from mental health problems.
4. Relationship between the quality of helping intention with socio-demographic factors, mental health literacy level, personal stigma level, personal confidence level and spirituality level among adolescents.

1.5 Research Hypotheses

The research hypotheses were as follows:

1- Knowledge of mental health has a role in the quality of helping intention towards peers with a depressive symptom.

2- Mental health stigma has a role in the quality of helping intention towards a peer's depressive symptom.

3- Spirituality level has a role in the quality of adolescent quality of helping intention towards peer's depressive symptoms.

4- Personal confidence level has a role in the quality of helping intention towards peer's depressive symptoms.

5- Previous experience with mental health patients has a role in the quality of helping intention towards peer's depressive symptoms.

6- The overall quality of helping intention among adolescents is low compared to other countries.

1.6 Conceptual Framework

A conceptual framework was constructed base on an extensive search of literature related to the helping intention toward depressive symptoms among peers. Several factors were reported to be associated with the quality of helping intention toward depressive symptoms among peers, namely socio-demographic factors such as age and gender, knowledge on mental health, stigma, personal confidence level, and previous experience dealing with mental health patients.

However, there is no study to date that has examined the association of spirituality level and the helping intention of adolescents toward their peers with depressive symptoms. The

question of whether the level of spirituality among adolescents plays a role in their willingness to provide helping intention toward their depressed peers. It is useful to know this because Sarawak is a multicultural state with various religious and spiritual beliefs. Therefore, spirituality has always been an integral part of the Sarawak culture and an important factor that need to be explored. The conceptual framework constructed for this study is shown in Figure 1.6.1 below.

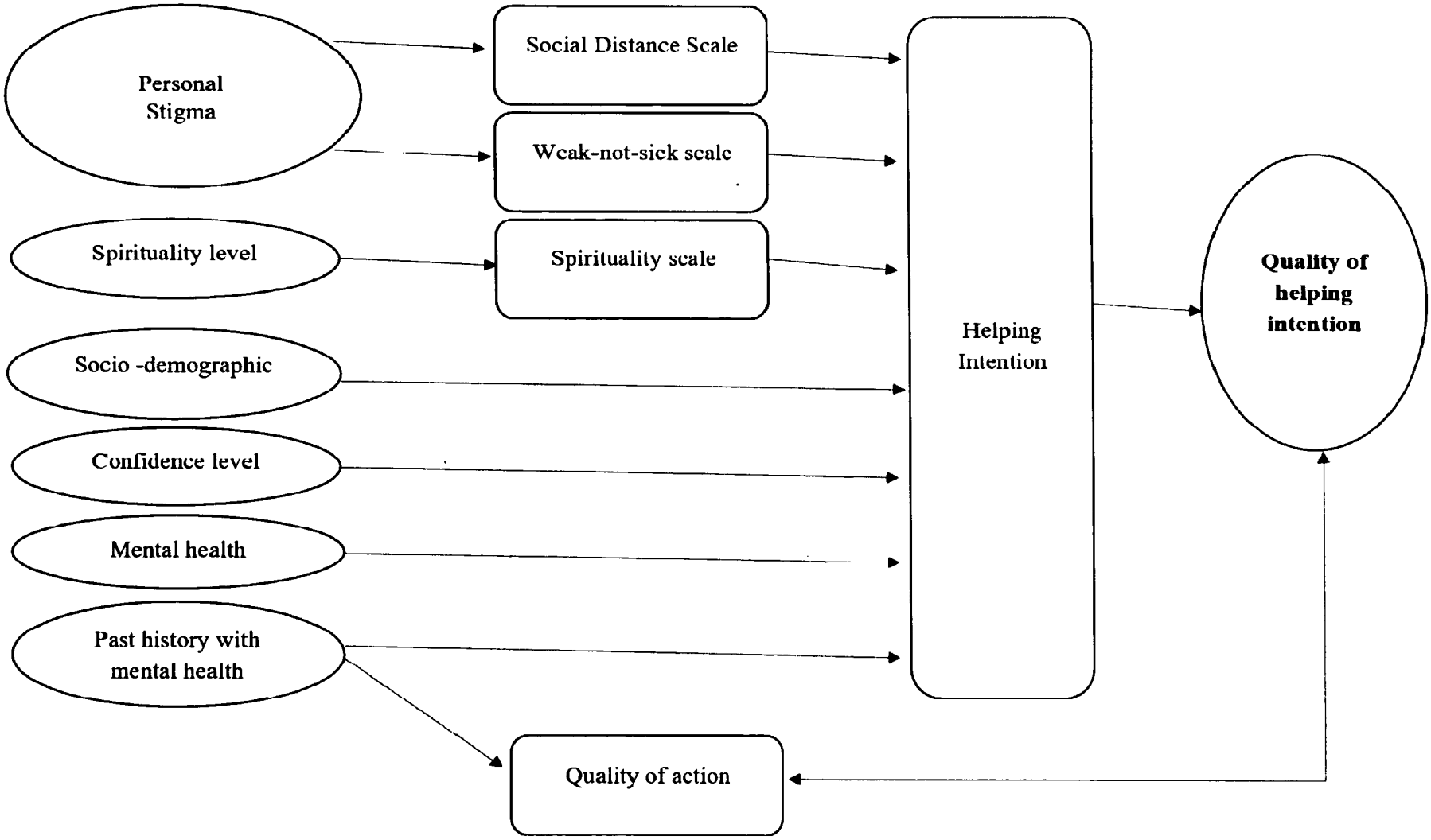


Figure 1.6.1: Conceptual framework of the study

Chapter 2: Literature Review

2.0 Introduction

In this chapter, the literature on helping intention and the quality of helping intention will be reviewed. The literature search was done through several credible web sites and databases such as PubMed, Google Scholar, World Health Organisation, and other websites that focussed on multiple aspects of mental problems, more specifically on mental health, helping intention in mental health and mental health first aid (MHFA). Around 230,000 articles were found in Google Scholar websites, and 119 articles related to mental health and helping intention were found in PubMed. Sixty-two articles were excluded for multiple reasons such as old articles with the availability of latest articles discussing the topic, unavailable in the English version, or were not related to mental health helping intention. From the remaining 57 articles, only 22 was selected to be review. The remaining 35 articles were excluded as they were not related to the depression issue of mental health. Some of the articles discussed other problems in mental health, and some of the articles were not related to the adolescent population.

The review was divided into issues regarding mental health, especially depression, mental health literacy (MHL), factors associated to health-seeking behaviour, social support in mental health, MHFA, quality of MHFA in a different country, and predictors of quality of helping intention toward a person with mental health. The review included all the available previous studies that were conducted in other parts of the world, and especially in Malaysia.

2.1 Adolescence definition

The WHO defines adolescents as individuals who are in the 10 to 19 years-old age group. It may be different from the definition of youth who are individuals in the age group of 15 to 24 years old and "young people" who are in the age group of 10 to 24 years old (WHO, 2020). Adolescence can be further classified into early and late adolescence. Early adolescence

comprises individuals who are within the age group of 10 to 14 years old. Late adolescence comprises individuals in the age group 15 to 19 years old. The adolescence stage of life is where the physical, mental, and social development of human beings have a growth spurt, and that may affect their development during adulthood (UNICEF, 2020).

2.2 Adolescent role in giving help

From the adolescents' perspective, they are very optimistic about their ability to give help. From a report in 2011, the majority of adolescents mentioned that they understood well how to help friends who were going through tough times (Chambers et al., 2017). Another study (Jorm et al., 2007) indicated that adolescents were more confident than a young adult in providing help to their peers and that girls were more confident than boys. In the Malaysian context, the Programme for International Student Assessment (PISA) 2018 data (Chin, 2019), revealed that 41% of Malaysian adolescents had a growth mindset, and 80% said they could usually find solutions when dealing with problems. The report also mentioned that 87% of Malaysian adolescents agreed that helping students who were having problems was a good thing.

2.3 Theory and model of helping intention

The bystander effect or theory was prompted by the murder of Kitty Genovese about which it was wrongly reported that 38 bystanders watched passively. That story made Darley and Latane start to investigate the bystander theory. The theory suggests that an individual's intervention on the particular crisis is more likely to happen when in the person is alone with the victim, but less likely if there are others present because the responsibility has fallen to others (Darley and Latane, 1968). A five-step model of the Bystander Intervention Process has become the foundation for the bystander education program (Latané and Darley, 1970). The

first step is to notice the events and the second step is the identification of the event as high risk and requires intervention(Latané and Darley, 1970). A common barrier preventing action was a failure to notice the event and recognising that it was an emergency. The third step is to decide either to take responsibility to intervene or not. The relationship with the victim and feeling a diffusion of responsibility are among the barriers(Burn, 2009). The fourth step is deciding how to help, and the lack of skill is the apparent barrier at this step (Burn, 2009; Latane & Darley, 1970). And the final step is for the bystander to act based on his/her skills and knowledge.

The other barriers in this theory are the fear of embarrassment, awkwardness to do the intervention, and concern about social perspective. In this theory, it was found that bystanders opted not to respond when surrounded by a lot of people. This shows the concept of diffusion of responsibility among the bystanders (Burn, 2009; Latane & Darley, 1970). Bystander behaviour will modify what has been the norm in the community so that everyone is acting with the same knowledge and skills. Most of the studies that investigated the predictors of bystanders taking action were focusing more on cases of sexual assault and violence. For example, in the bystander literature based on sexual assault, the results show that lack of awareness regarding the assault and stigma, belief about their survival were reasons why no intervention had been intended by the bystanders(Franiuk et al., 2008). Stigma and lack of awareness also occur in issues regarding mental health. This might be the reason why there was inadequate intervention toward a peer who was having a mental health problem. A systematic review of the awareness level of mental health (Singh et al., 2019) suggested that mental health literacy was still low among youths, especially among older youths. The issue of mental health stigma will be discussed later in this chapter.

The bystander theory suggested that the diffusion of responsibility occur among the bystanders. For this reason, most of the studies relating to this theory were addressing obvious

situations such as violence and bullying. On the other hand, most cases of mental health problems are secluded and secretive by nature. The only way for bystanders to detect mental health problems in people that they meet is by increasing their awareness of the signs and symptoms of mental health problems. This knowledge and awareness will help bystanders to identify and intervene in a situation of someone having mental health problems, systematically according to the mental health first aid guidelines. (Hadlaczky et al., 2014)

By the same token, a model (Rossetto et al., 2018) relating to the intention of giving help toward a person with mental health showed that factors such as the trigger for concern on situation and helper consideration to become involved led to a spectrum of help in a mental health situation. What is needed to trigger the concern of a person toward another person having a crisis and in need is to be aware of the other person's situation. Some other factors that determine whether the helper would consider being involved include the relationship between helper and recipient, the helper ability, characteristic of the helper, his or her experiences, characteristics of the recipient who receive the help, and the severity of the problem (Rossetto et al., 2018)

2.4 Mental health literacy (MHL)

Mental health literacy refers to the ability of individuals to gain access, to understand and use the information on mental health, in ways that promote and maintain good health for themselves, their families, and their communities(Kanj and Mitic, 2014). Four factors are associated with mental health literacy, namely: i) awareness on knowing how to maintain good psychological health, ii) understanding psychological disease or problem and their curative measure, iii) reducing stigma concerning psychiatric problems, and iv) enhancing someone's efficacy for help-seeking. Based on those factors, we would need persons with mental health

problems to know how, when, and where they can get appropriate mental health care and become more competent until they can take care of themselves (Kutcher et al., 2016).

As mentioned earlier, one of the barriers to providing help is the lack of knowledge regarding the emergency or crisis situation. This barrier may lead to the failure of the intervention of the problem (Latané and Darley, 1970). The importance of mental health literacy (MHL) is underlined by the results of the following studies. A study involving 797 Filipino college students aged 15 to 21 years old showed that 55.2% of them had proper knowledge of detecting mental health problems base on the given vignette. Furthermore, 95.7% of the students expressed the need to seek help from different sources with the highest being advice from non-professional sources such as family (58.5%) and friends (48.8%) if one day they were to suffer from a mental health crisis (Ines, 2019). Another MHL study involving 1815 young adolescents aged 12 to 14 years old in Selangor secondary schools, it was found that the adolescent had an extremely low ability to label depression correctly. In that study, only 3.5% of the participants correctly identified the depression problem. In contrast, a study among adolescents in China found that they had much higher levels (16.4%) of the adequacy of MHL (Lam, 2014). However, there was no data on the quality of any helping intention or mental health first aid action provided in the study.

2.5 Recommendation of helping a person with mental health

One of the most renowned guidelines for recommended helping action towards a person with mental issues was mental health first aid (MHFA). MHFA is defined as "the help given to a person having a mental health problem or who was currently in a mental health crisis." The first aid should be given to the person until the person gets the received treatment from

professionals or until they are out from the crises (Jorm and Ross, 2018). This definition is used in multiple studies on MHFA.

An MHFA training programme's primary focus is to guide laypeople on giving appropriate, and high-quality help that can be given as a non-professional before the person who was in mental distress received professional help (Jorm et al., 2019a). The research by Aakre et al. (2016) focused on the effectiveness of this programme. They found that there was a positive correlation between mental health first aid training and positive, helpful intention among youths. The programme appeared to have an impact on young persons' confidence to help, awareness of mental health, and their mental health helping-strategies.

An extensive literature from the past three decades showed that knowledge about MHFA had been deficient and inadequate among youths. A survey by (Kelly et al., 2006) among Australian adolescents in 2006 is illustrative of the issue. In that study, a vignette portraying a person who had depression was given to the students. They were given a few questions to answer regarding their response toward the person in the vignette. The response from this study was very positive, where around half of the participants gave positive support toward the person in the vignette. However, only a minority of the respondent opted to consult or get help from an adult such as a teacher, parent, or counsellor as a helping intention, which was an essential step in MHFA. The researchers concluded that MHFA skill among teenager was still poor then (Kelly et al., 2006). A year later, an Australian national survey was conducted among their youths aged between 12 to 25, employing a similar method of using a vignette that portrays multiple mental health-related situations, including depression and schizophrenia. These findings were still consistent with the previous literature where consultation with an adult as a helping intention response was still minimal among youths. The other two questions that

received low scores were to listen to the person's problem and to ask about the risk of any harmful intention, such as asking about suicidal ideation (Jorm et al., 2007).

2.6 Knowledge about first aid response for depression

In order to develop a consensus guideline on the quality of first aid response for mental health problems, a series of Delphi studies had been conducted among invited experts. For example, a study in Australia (Langlands et al., 2008) involving 167 mental health patients. caretakers, and physicians who were from English-speaking countries recommended 64 items for mental health first aid. Another Delphi study that was conducted to develop a consensus regarding multiple mental health first aid resulted in i) first aid for panic attacks (Kelly et al., 2009), ii) first aid and guideline of support for someone in the traumatic event (Kelly et al., 2010) and, iii) first aid and guideline of support for a suicidal event (Colucci et al., 2010). Most importantly, all those studies had helped in the development of an MHFA programme, which was later used as a guideline to measure the quality of first aid response(Kelly et al., 2011). It was also used to enhance the knowledge of the public so that they know how to respond when someone that they know was facing mental health problems.

In addition to that, research has been made to develop a scoring system using these guidelines. It enables the researcher to measure the quality of MHFA response among the participants. Thanks to all those research, the method to measure the quality of MHFA has been widely used by researchers in multiple countries other than Australia to determine the level of quality of MHFA(Kelly et al., 2011). Among Australian teenagers, a median score of 2.69 out of total score 10, was found in a study done in 2014 (Rossetto et al., 2014). This scoring system also was used by(Davies et al., 2016) to quantify the quality of the intended response in helping their friend who was depressed among British university students. Based on the findings, the overall quality of the helping intention was found to be poor, as indicated by a mean MHFA

score of 2.89. In Sri Lanka, the mean MHFA score was 2.13, which was also classified as poor (Amarasuriya et al., 2017). It has to be noted that in all of this three studies mentioned, the mean total scores were obtained prior to any intervention.

There are five action steps for mental health first aid based on the guidelines on helping recommendations toward a person with mental health problems. This guideline is specifically meant for adolescents to support their friends who were in a mental health crisis. The action plan was based on the Delphi expert consensus study of youth mental health professionals and consumer advocates. The action plan included: i) Look for a warning sign, ii) Ask how they are, iii) Listen to their problem, iv) Help them connect to adults, and v) Your friendship is important (Ross et al., 2012).

When the findings from multiple studies using the same method of total helping intention calculation are examine, the outcome has been consistent (Kelly et al., 2011). Listening to others' problems had been regarded by the majority of participants across multiple studies as helpful when they were addressing depression (Lam, 2014, Mason et al., 2015, Amarasuriya et al., 2017). The most worrying finding in this review was that many teenagers believed that they did not consider any adult involvement as helpful when they gave their recommendations of help toward a person with mental health issues. This may lead to a delay in seeking professional help and early intervention on the problem. However, a study in Portugal found that the youths there did suggest a high intention of recommending the person to seek professional help. Around 77.2% of young Portuguese did recommend professional help as one of the helping intentions(Loureiro et al., 2013).

Some of the other helpful recommendations that were noted to be ignored by the respondents when dealing with the person who suffered from a mental health crisis were the assessment of their friend's risk of being harmed or, which the questionnaire asked as "how

they are." Rossetto et al. (2014) found that 97% of their respondents did not consider the answer. A similar result was found in Sri Lanka, where 99.8% of the respondents did not consider it as an option (Amarasuriya et al., 2017) and also by Yap and Jorm (2012) and Davies et al. (2016).On the other hand, recommendations such as ignoring the person with mental illness were generally not endorsed as helpful by the vast majority of participants. It was reported in multiple studies (Essau et al., 2013, Lam, 2014, Loureiro et al., 2013) that the knowledge gap about mental first aid initiatives among young people crossed the sociocultural border.

2.7 Gender role and mental health first aid

Much of the helping response on mental health in the literature focused on interpersonal factors. Several of these factors were related to socio-demography, like age and gender. Reports from multiple studies showed that when dealing with a person who has a mental health problem, the gender of the recipient of the help influenced the helping intention and action quality. In particular, males with mental health problems might receive inadequate first aid from young people who were close to them. On the other hand, the gender of the person who gave help also played a major role in the quality of helping response. For example, the same research provided evidence of males reporting being less likely to facilitate their friends toward receiving professional help-seeking. However, when a female was in that situation, they were more likely to encourage that person to receive expert advice (Yap et al., 2011a). An extensive survey of around 1218 British participants in 2012, where the participants received a situation where a male or female character in a vignette experiencing depression found that males were less likely to offer help to the male character in the vignette (Swami, 2012). In comparison, female participants were more likely to give help. Another study in Nottingham also found a similar finding where female participants were more likely to suggest providing support and

information as one of the mental health first aid responses. As a helper, a male was reported as having a lower score on giving help compared to a female (Davies et al., 2016). This finding was supported by a more significant study in Australia involving 3002 participants that showed males had a lower quality of MHFA reaction toward a person portrayed having a depression situation (Jorm et al., 2019b). Females were found to hold more significant concerns over a depressed peer and a good ability to identify individual symptoms of depression. Their expectations also stated that depression required a more extended period of recovery than normal teenage problems(Aluh et al., 2018). However, in a study in 2017 conducted in Sri Lanka involving adolescents with a different cultural background from previous studies found that there was no gender difference toward giving a response to MHFA(Amarasuriya et al., 2017).

2.8 Age as a predictor for helping in MHFA

A study examining multiple predictors for multiple mental health problems among adults, found one significant result. When the respondents aged were under 30 years old, they were less likely to have a high score for intention and action toward giving a helpful recommendation per MHFA guidelines compared to adults. This finding suggested that younger people were less likely to perform helpful responses toward people with mental health issues compared to older individuals (Rossetto et al., 2014). Older people were more likely to suggest professional help and arrange an appointment with a doctor for the person who suffered from a mental health crisis. For an adolescent, it was found to be helpful in the intervention of depression with suicidal ideation(Yap et al., 2011b). In contrast, another cross-sectional study measuring intention to help among university students showed that those who were in senior years were more reluctant to give support compared to the students who were in junior years (Amarasuriya et al., 2017).

2.9 Stigma as a predictor for helping in MHFA

Stigma has always been an issue in mental health. For someone who has a mental health issue and wants to seek treatment, stigma has been a small to moderate detrimental impact on individual help-seeking behaviour. This finding was based on a systematic review done by (Clement et al., 2015). The same review found that stigma was ranked number four out of ten reasons affecting help-seeking behaviour. A study in Malaysia came up with similar findings that self-stigma was a significant predictor of attitudes toward help-seeking, but not perceived public stigma. However, perceived public stigma was still able to negatively predict the attitudes toward mental health help-seeking even though it was not a significant predictor.

Studies of mental health helping intention and recommendations usually tried to examine the effects perceived stigma on the possible helper on the helper's helping intention and recommendations toward their friend's mental health problem. Most of such studies used two stigma-related measures, namely: the Depression Stigma Scale (DSS) (Griffiths et al., 2004) and the social distance scale (Link et al., 1999). The DSS consists of personal stigma toward a person with depression. Personal stigma assessed the respondent's personal attitude toward the person. It was further subdivided into two categories, namely: the "weak-not-sick" and the "dangerous and unpredictable." A high weak-not-sick score means that the person with depression was viewed as being a weak rather than a sick person. A high 'dangerous and unpredictable' score means that the depressed person is assumed to be hazardous to the respondent. Another scale that was utilised was the social distance scale. It examined the desire to distance themselves from persons who had mental health issues. It measures the intended avoidance behaviour of the respondent toward the person with a mental health problem (Yap et al., 2014).

The use of hypothetical scenarios in a questionnaire is common when analysing the association between stigma among adolescents and the quality of the intended first aid response given by them. For example, in the study by (Mason et al., 2015), people who viewed the depressed person in the scenario as having sickness rather than weakness would have a higher quality of helpful response. Low "weak-not-sick," stigma scores can also be used to predict whether someone would recommend adult help for a depressive friend. For the depression with suicidal thoughts vignette, lower social distance scale scores on the scenario was a significant positive predictor for recommending adult help. Low social distance scales scores were a significant positive predictor for providing friendship to their friend in a needy situation. These findings provide us with information that lower stigma scores among adolescents may help in providing good quality of mental health first aid response in the community (Rossetto et al., 2014). Similar results were found in a study among older-age respondents. University undergraduates who perceived depression problems as a weakness rather than sickness were less likely to recommend that the person seek help, and would only give support instead (Amarasuriya et al., 2017). Spiker and Hammer (2019) noted that higher perceived stigma among friends led to a decrease in intention to intervene. Similar findings were reported in multiple other studies (Davies et al., 2016, Jorm et al., 2005, Yap and Jorm, 2011).

2.10 Personal confidence in giving help toward a person with mental health

The personal confidence level is an important factor that is associated with high quality of helping intention. It had been found to predict intention for high-quality MHFA response in the depression (Rossetto et al., 2014), while Spiker and Hammer, (2019) and Bond et al., (2015), found that confidence among bystanders had a significant impact on the quality of first aid response. However, the personal confidence factor had been rarely studied in previous research, and it thus it would be included as one of the predictors in my study.

2.11 Spirituality level, mental health, and intention to help

In general, spiritual faith helps people to find reasons in life or events that would help them persevere when facing daily problems and stresses. Spiritual faith represents a convergence of three main areas in human psychology. It provides a framework for understanding life events, handling these life events like coping strategies, or giving help, and become more complex as it becomes internalised throughout the lifespan. It changes and shapes how individuals interpret current events and respond to those events (Kyle, 2013). A study among 1500 adolescents age 13 to 18 years old in Malaysia suggested that spirituality played an important role in moderating the depression and intention to suicide. This spirituality can lead to a positive coping style against stressful life events (Talib et al., 2017). There is increasing evidence from past studies that spirituality was associated with reduced suicidal behaviour in different populations, such as Indian Americans (Garroutte et al., 2003). The same results were found in a study on Muslim immigrant youths in New Zealand, where a high spirituality among youths affected depression positively(Stuart and Ward, 2018). Moreover, one systematic review of multiple research papers on spirituality showed that 80 % of individuals studied who considered themselves more spiritual reported a lower prevalence of suicidal behaviour (Koenig et al., 2012). On helping intention, a study that was done on adolescents in West Virginia showed that people with high spirituality levels tended to have more helping intention than those with lower spirituality levels(Markstrom et al., 2010). However, not much was mentioned about spirituality as a predictor factor for a good quality of MHFA. To measure spirituality levels among adolescents, Underwood (2011) created a Daily Spirituality Scale, containing a 16-item self-reported questionnaire. It has been used in multiple studies concerning health, such as burn out addiction and physical health.

2.12 Past and present research

Based on the findings from this literature review, see that in the past, the trend of research regarding mental health was concentrating on finding factors causing depression (Saluja et al., 2004, Scott et al., 2014). Then the research area moved toward mental health literacy in the community (Lam, 2014, Aluh et al., 2018, Jorm, 2000, Ines, 2019). And, currently, researchers in developed countries are moving toward research that is related to intervention such as mental health first aid and factors leading to a good quality of helping intention. Thus, it is justifiable to carry out a study to collect baseline data and information on the quality of helping intention among adolescents before we plan to introduce a mental health assistance programme in Sarawak (Umpang, 2019).

Chapter 3: Methodology

3.1 Study Design

The study design was a cross-sectional study. It focussed on adolescents who were currently studying in public secondary schools located in the Kuching Division of Sarawak. We collected data on the factors that could be associated with the quality of helping intention toward peers with depressive symptoms. Those factors included socio-demographic characteristics, depression literacy scale score, mental health stigma scale, personal confidence level, and the spirituality level of the adolescent.

3.2 Study Area

The study was conducted in Kuching Division, which is one of the 12 administrative divisions of Sarawak. With an area of 124,450 km^2, Sarawak is the largest of 13 states in Malaysia. It is located in East Malaysia, with a population of approximately 2.5 million people. The borders of Sarawak consist of Sabah in the northeast, Brunei in the north (in between Miri and Limbang), and Kalimantan Indonesia in the south. Kuching is the capital city of Sarawak. The other administrative divisions of Sarawak are Samarahan, Sri Aman, Betong, Sarikei, Sibu, Kapit, Bintulu, Mukah, Miri and Limbang (Department of Statistics, 2010).

Kuching division (consisting of the Kuching district, Bau district, and Lundu District) in the southern part of Sarawak, was chosen to be the study area because it has the capital city and it is the most populous part of the state with a population of 705,546. That accounted for 26.9% of the total Sarawak population. There were 35 public secondary schools in the Kuching Division with an estimated total of 79,542 student enrollment in 2019.

3.3 Study Duration

The study was conducted from January 2020 to June 2020, a total of six-month duration. It was divided into 4 phases. The first phase consisted of proposal preparation, and approval

from the ethics committee. The second phase consisted of a pre-test and data collection. This phase lasted from January 2020 until June 2020. The third phase, which lasted from May 2020 until July 2020, consisted of data entry and data analysis. Finally, the fourth phase consisted of report writing and presentation, from July 2020 until September 2020.

3.4 Study Population

The study population were adolescents aged between 12 to 19 years old who were studying in public secondary schools located in Kuching Division. In 2019, around 79,542 of them were enrolled in 35 public secondary schools in Kuching Division. The list of secondary schools in Kuching Division was obtained from the Sarawak State Education Office. After obtaining approval from the Ministry of Education, the list of the student was obtained from the school administration.

3.4.1 Inclusion Criteria

1. Students aged 12 to 19 years old.
2. Any student who was currently studying in public secondary schools.
3. A student who had been studying in the selected school for more than three months.
4. The respondent who could read and understand Malay or English.

3.4.2 Exclusion criteria

1. A student who had a psychiatric illness or was known to have follow-up with a psychiatrist.
2. Non-Malaysian citizens.

3.5 Variables

1. The independent variables in this study consisted of six variables. The variables were the socio-demographic characteristics (gender, ethnicity, age, and religion), spirituality

level, mental health literacy, stigma scale score, personal confidence level, and past history of the adolescent dealing with friends or family with a mental health problem.

2. The dependent variable in the study was the quality of the helping intention score. It was a total score of helping recommendation that the adolescent recommended when they were in a situation where their friends who had depression with suicidal ideation approached them for help.

3.6 Sample size

We used PS Software (Dupont and Plummer, 1998) to calculate the sample size for the study. Based on a previous study by Mason et al. (2015) we used the mean (SD) total score for the quality of first aid action of 1.06 (score ranged from 0-10), an alpha value of 0.05, and a power of 0.8, the sample size suggested by PS Software was 486. After including 10% of potential dropouts and a design effect of 1.5, a total sample of 778 students were recruited for the study. The value of 1.5 was taken as cluster sampling was used in the study.

3.7 Sampling frame

Population : Students who age between 12 to19 years old in the Kuching Division

Sample Size : 778 respondents

Sampling method : Multistage Cluster sampling done in 2 stages ;

Stage 1

The sample was divided into rural and urban regions. This stratification was based on the classification of rural and urban schools by the Sarawak State Education Department. Twelve secondary schools were classified as being rural in Kuching Division under the Kuching Education Office, the Bau Education Office, the Lundu Education Office, and 23 secondary schools were classified as urban in the division. Based on the findings of the pilot study, one class might consist of 35 to 40 students, so a total of 22 classes from 11 secondary schools were

chosen as clusters. Four rural secondary schools were selected. The schools that were randomly selected to represent the rural area in Kuching were SMK Lundu, SMK Sematan, SMK Bako, and SMK Lake. Meanwhile, for urban secondary schools, the schools that were randomly chosen were SMK Semerah Padi, SMK Petrajaya, SMK Demak Baru, SMK St Thomas, SMK Green Road, SMK Seri Setia, and Kolej Datu Patinggi Abang Haji Abdillah.

Stage 2

In every school, two classes were randomly picked from all the classes available. Then every student in the chosen classes was selected as the sample in the study.

3.8 Data collection procedure

Prior to data collection, permission to conduct the study in the public schools was obtained from the Ministry of Education Malaysia. After receiving written permission from the Ministry of Education, permission to conduct the study from Sarawak Education Department was obtained. A preliminary visit was made to all the selected schools. An introductory meeting with the school principal and school representative was conducted prior to every data collection in the facilities. After obtaining permission, the consent and assent forms were given to the classroom teacher. The teacher distributed the forms to students and collected back the consent forms before data collections. Data collection was done through the self-administered questionnaire and was completed in around 30 minutes.

3.9 Data Collection Instruments

The instrument used to collect data for this study was a paper-based questionnaire that was available in an English or a Malay version. The respondents were free to choose either one of the two versions. The questionnaire was divided into six parts that can be referred to in Appendix B (English version) and Appendix D (Malay version). The questionnaire was divided into six parts, as follows:

Part A: Socio-demographic characteristics:

The questions asked in this part were the general characteristics of the respondents, namely: the age of the respondents, gender, ethnicity, religion, family members, and experience or exposure to any family or friend that has mental health problems.

Part B: Daily Spiritual Experience Scale

This part was a 16-item self-report measure of spiritual experience adopted from (Underwood and Teresi, 2002). This questionnaire was specifically constructed to measure ordinary or daily spiritual experiences and how they were a normal part of the individual's life. However, it did not measure the mystical experiences of the respondent. In this context, examples of mystical experiences were hearing voices or seeing a mythical object. The questionnaire had been widely used to measure spiritual scale for adolescents. A 6-point Likert scale was used to measure the first 15 items of the questionnaire. For items 1 to 15, the answer option was; 1= never or almost never, 2= once in a while, 3= some days, 4= most days, 5= every day, and 6= many times a day. For item 16, a 4-point scale was used in the measurement. The answer option was As close as possible, very close, somewhat close, and not close at all. The first 15 items were usually scored together as a full-scale score, and the score was kept continuous. Item 16 was scored separately. The higher the score means, the higher the level of spirituality.

Part C: Depression literacy questionnaire:

This questionnaire was specifically constructed to assess mental health literacy specific to depression. It could be used to measure literacy among teenagers. A total of 22 questions needed to be answered in this part. Three options were given to the respondents, and they needed to choose one answer from "false," "true," or "I don't know." Each correct response received one point. Higher scores indicated higher mental health literacy on depression. Two additional questions were added and coded separately. The first additional question was,

"Counselling is one of treatment for depression," for which the answer would be "true." The other additional question was, "Cognitive Behavioural Therapy is one of treatment for depression," for which the answer was "true."

Part D: Depression with suicidal intention scenario and helping intention

This part of the questionnaire used case vignette to assess the recognition of depression problems among peers. The application of mental health knowledge and belief to the problem were examined through a vignette which described adolescents who exhibited symptoms of depression with suicidal thought adapted from research done in 2015 (Mason et al., 2015). The names in the vignette were changed from those in used in the original to Adam or Sarah to suit the local culture. The vignette was written to satisfy DSM-IV criteria and was validated by a survey of mental health professionals asking them what was wrong with the person portrayed(Mason et al., 2015). The depression vignette was modified in the current study to suit the local culture. The vignette used in the questionnaire is shown below:

Adam's/Sarah's Story

Adam/Sarah is a 16-year-old who has been unusually sad and miserable for the last few weeks. He/She is tired all the time and has trouble sleeping at night. Adam/Sarah doesn't feel like eating and has lost weight. He/She can't keep his/her mind on his/her studies, and his/her marks have dropped. He/She puts off making any decisions, and even day-to-day tasks seem too much for him/her. His/her parents and friends are very concerned about him/her. Adam/ Sarah says he/she will never be happy again and believes his/her family would be better off without him/her. Adam/Sarah says he/she feels so desperate, and he/she has been thinking of ways to end his/her life.

The participants were asked to identify the problem described in the vignette. To enable us to assess the ability of the respondents to recognise correctly the depression problem from the vignette, the following question was asked: "In your opinion, what is going on with Adam or Sarah?". The response format was in close-ended answer. The possible choice of answers was "I do not know," "there is nothing wrong with her," "she has a problem," "depression," "stress," "eating disorder," "cancer," "Schizophrenia," and others. The following questions asked the respondents on their opinion if they were friends with Adam or Sarah, would they help him or her. The question was hypothetical to portray the person in the vignette as their peers, and the respondents' answers were recorded as a Likert scale of "Very agree," "Agree," "Neutral," "Disagree," and "Very Disagree." In this part of the questionnaire, the respondents were also asked regarding their confidence level of helping the hypothetical person in the vignette. This question was also scored using a Likert Scale of 5 to 1, with 5 being "Very confident," and 1 "Not confident at all."

To assess which help the respondents intended to offer when their friend who was portrayed in the vignette as a person with depressive symptoms, the following actions were presented: Tell what he/she needs to do to fix his/her problems, Invite *Adam/Sarah* to hang out and do something fun with me, Ignore him/her because he/she is being attention seeking, Let him/her know I won't want to be friends with him/her any more if he/she like this all the time, Avoid talking about suicide because it might put the idea in his/her head, Tell *Adam/Sarah* I have noticed that something seems wrong, and I want to make sure he/she is okay, Suggest him/her to tell a health professional about his problems, for example, a counsellor, doctor or psychologist, Suggest *Adam/Sarah* to tell an adult other than a health professional about his/her issues, for instance, a parent or teacher, Ask *Adam/Sarah* if he/she is thinking of suicide,

Encourage *Adam/Sarah* to take responsibility and deal with his/her problems on his own, and Listen to Adam/Sarah talk about his/her problems.

Six of the actions presented were helpful intentions, and the other six were harmful intentions toward a person with a mental health crisis. The score of the helpful intention was based on the five steps of the teen Mental Health First Aid action plan. The five steps were;

1. Look for the warning sign.
2. Ask how they are.
3. Listen up.
4. Help them connect with an adult.
5. Your friendship is important.

This action plan was based on the key messages developed using the Delphi expert consensus study of youth mental health professionals and consumer advocates(Reavley et al., 2012). The six helpful responses in the given answer corresponded with the teen mental health first aid action and every answer chosen by the respondent was given a score of 2. Any unhelpful answer chosen by the respondent was given a score of 0. However, if any of the respondents answered either one of the "help them to connect with the adult", they would only receive a score of 2, and the maximum score would then be ten instead of 12.

For the adequacy of helpful intention, for the participant to be determined as having adequate mental health first aid response, they should answer three required first aid responses of 'ask about suicide,' 'tell the person you noticed something is wrong and want to make sure he is okay' and 'suggest the person tell an adult'(Hart et al., 2020). Other than the helping intention, this part of the questionnaire also included the respondents' answer for the person who the respondent considered to be the best to help the person in the vignette. The choice of

the answer varied from a counsellor, doctor, psychologist, best friend, family member, parent, teacher, and religious leaders such as priests and *ustaz*.

Part E: The Depression Stigma Scale

The questionnaire was constructed to examine the association between personal stigma and depression. The youth version of the stigma scale was used in the study to specifically measure stigma among adolescents. Using the same vignette in Part D of the questionnaire, the personal attitude toward the person in the vignette was assessed (Yap et al.,2014). The answer would show how strongly the adolescent personally agreed with the statements mentioned about depression. A 5-point Likert scale was used. The scale ranged from 1= "strongly disagree" to 5=" strongly agree". There were two subcategories under the personal stigma scale, the first being "Weak-not-sick," for which a high score indicated the person portrayed in the vignette as showing personal weakness instead of being sick. The second subcategory was "dangerous/unpredictable," for which a high score indicated that the respondent believed that the person in the vignette was dangerous to them. Responses were then used to calculate scores on two stigma scales. For the "Weak-not-sick," stigma scale, the score was obtained from the answers to statements 1,2,3 and 5, and the " dangerous/unpredictable" stigma scale, the score was obtained from the answers to statements 4, 5, and 6 (Mason et al., 2015). The score reflecting each factor was calculated from each of the two scales, with a high reflecting a stigmatising attitude, and a lower score reflecting low stigmatising attitude toward the person with depression.

Another scale used to measure stigma in this part of the questionnaire was the social distance scale. It was used to measure the level of social rejection and acceptance held by

participants toward the people in the vignette and was specifically used to measure it among young people. The measure consisted of 5 items that asked whether the participant would be happy to (1) Develop a close friendship with Sarah or Adam, (2) Go out with Sarah or Adam on the weekend, (3) go to Sarah or Adam`s house ; (4) invite Sarah or Adam around your house; and (5) work on a project with Sarah or Adam. Each question was rated on a 4-point Likert scale, which 1= "yes, definitely" to 4= " definitely not." (Yap et al. 2014). The higher the score on this scale will indicate the respondent is having social rejection toward the person portrayed in the vignette.

Part F -Helping action scale

The study also contained a series of questions about mental first aid actions performed by the participants which were adapted from previous research (Mason et al., 2015, Hart et al., 2020). In this part, the respondents were asked regarding their experience with a friend who had a mental health crisis in the past 12 months. The person who answered "yes" would need to answer the questions that followed, where they were asked regarding the number of depressed friends that they had contact with and what action that they had taken to help the person. The action plan that they had taken were given in a closed-ended answer. Six of the actions presented were helpful intentions, and the other six were unhelpful intentions toward a person with a mental health crisis. The score of the helpful intention was based on the five steps of the teen Mental Health First Aid action plan, as discusses in part D, page 31.

3.10 Data Management and Quality Control

3.10.1 Pilot Test

A pilot test of the questionnaire was done at a school in Samarahan district, which was a non-sample area. Muara Tuang Secondary School was chosen as the pilot study venue. The objective of this pilot test was to assess the quality of the questions in terms of logically

sequenced, understandability, and the average duration of time to answer the questionnaire. The questionnaire used in the pilot test was the Malay language version, which was the formal language used in schools. The English version of the questionnaire was translated into the Malay language by a linguistic expert followed by back-translation into English. A class was chosen in the school to be part of the pilot study. A total of 40 questionnaires was distributed in a class of 40 students. Only 30 respondents consented to participate in the pilot study. For the socio-demographic characteristics of the pilot study, their ages were between 16 to 17 years old, with 12 males, and 18 females. As for religion, 13 were Muslims, and 17 were Christians.

The reliability test of the questionnaire was done in two parts. The part with the Likert scale questionnaire was done using Cronbach alpha, and then knowledge was examined by the test-retest Pearson correlation test. The pilot study was conducted in January 2020, 2 weeks apart from the first and second data collection. Following the pilot test, the internal consistency was calculated. As for the result of the pre-test, Cronbach's alpha for part B was 0.93, Cronbach's alpha for part D was 0.665, and Cronbach's alpha for part E was 0.644. On the other hand, the Test-retest Pearson Correlation for Part C is 0.769, the Test-retest Pearson Correlation for Question number 3 Part D of the questionnaire is 0.657, and the Test-retest Pearson correlation for Part E is 0.737. A reliability coefficient more 0.6 and above were considered as reliable instruments for survey research.

3.10.2 Supervision and quality checking

Explanation regarding the questionnaire and the study was given to all respondents prior to answering so that they had a better understanding of it. An additional explanation was given to the parents and teachers for the purpose of obtaining consent. Completion of all the parts in the questionnaire was ensured during the data collection, and any uncompleted questionnaire

or any mistake happening during the answering were corrected immediately. The researcher cross-checked the completed data.

3.11 Operational Definition

1) Adolescence: in this study, adolescence referred to all teenagers age between 11 to 19 years old.
2) Helping intention referred to the intended helping action of an adolescent towards their friends who suffered from depression. In this study, it was portrayed through the vignette given in the questionnaire.
3) Mental Health Literacy referred to an understanding of how to obtain and maintain positive mental health by understanding mental health problems and their treatments.
4) Spirituality was defined as seeking a meaningful connection with something bigger than yourself, which can result in positive emotions, such as contentment, gratitude, and helping intention.

3.12 Statistical Analysis

All data were entered into Microsoft Excel and exported to the statistical software, SPSS, for analysis. The data were examined as part of quality control and cleaned. The distributions and frequencies were examined. Outliers were identified from the distribution and based on the acceptable value of the variables. The analyses were done according to the terms, working definition, and tables prepared for the research. To examine the overall quality of helping intention responses, the scores for each intended action plan step were summed to give a total score for each response. The quality of first aid intentions was examined with per cent frequencies. Following these steps, the predictors of the three main outcomes were examined. For the total score of helping intention, the first step, univariate linear regression, was done on

every independent variable with the dependent variable. Only independent variables that achieved a p-value of less than 0.200 were inserted into the model of multiple linear regression. Multiple linear regression was used to measure the predictor for a total score of quality helping intention. Other than that, all the action steps of helping intention, which included six helpful and six harmful intentions, were also analysed. All the independent variables were initially analysed using univariate logistic regression, with each helping intention becoming the dependent variable. Same as previously, only independent variables that achieved a p-value of less than 0.200 were inserted into the model of multiple logistic regression. Among the predictors were gender, mental health literacy, spirituality level, ability to recognize the problem in the vignettes, stigma scale scores, which were divided into three categories, namely: social distance, weak-not-sick, and dangerous/unpredictable stigma scale score. Multivariate analysis was used for the multivariable data. All the findings can be found in chapter 4.

3.13 Ethical considerations

All data obtained from this survey were kept and handled in a confidential manner in accordance with applicable laws and regulations. When publishing or presenting the survey results, respondents' identity would not be revealed. All consent was obtained from their parents prior to the study except for the respondents who were more than 18 years old. The study was registered in the National Medical Research Register (NMRR). Ethical clearance from the Ethics Committee of UNIMAS was obtained prior to the pilot test. Approval from the Ministry of Education was obtained parallel to the Ethics Committee approval. Once permission was obtained, the consent form and patient information sheet were given to schools' principals. This step was necessary due to the vast majority of the respondents' age being below 18 years old, which was the age for consent in Malaysia. All respondents were briefed on the details of the study, such as the objective, how the study would be conducted, its benefits to the respondents,

and its benefit to other people. In addition, it was also mentioned to the respondents that the information obtained was absolutely confidential, and they had the right to withdraw at any time during the study with no effect on them in any way.

Chapter 4 Results

4.1 Introduction

In this chapter, we will present a description of the quantitative data that was obtained from the questionnaire. After that, we will analyse the findings and correlate them with the research objectives. The results will be presented according to the research objectives. The first part will be the descriptive analysis, and the last part of the chapter will be the results of the regression analyses of the dependent variable with the independent variables specified in the objectives.

The research was carried out in public secondary schools in the Kuching Division of Sarawak. A total of 589 respondents had completely filled in the questionnaire, which consisted of 6 parts entirely. The response rate for the research was 75.7%. Around 189 questionnaires were discarded due to multiple reasons such as the refusal of answering the questionnaire, unable to obtain consent, or items in the questionnaire were not answered. The sample consisted of 589 respondents were taken from among Form 1 to Form 6 students from public secondary schools in the Kuching Division area, aged between 13 to 19 years old.

4.2 Socio-demography

Knowing the distribution of respondents, according to socio-demography, is one of the objectives in this study. The age of the respondents was ranged from 13 to 19 years old, with a mean age of 15.37, SD=1.27. Most of the respondents were 16 years old, making up 52% of the total respondents, followed by 13 years old, who made up 30.2% of the respondents. Only 3% of respondents were 17 years-old (0.8%), and 19 years-old (2.2%). Among the 589 adolescents who participated in the study, 63.3% were female, and 36.7% were male. With regard to geographical classification, 53.7% of respondents were from the urban area of Kuching, and 46.3% were from the rural area. Malay ethnic group formed the largest group (52.0%) of the

respondents, followed by Bidayuh (19.5%), Chinese (11.9%), Iban (11.0%) and others (5.6%). On the religion of the respondents, 59.1% were Muslim, 33.6% were Christian, 7.0% were Buddhist, and 0.3% had no religion. The socio-demographic characteristics of the study participants, as well as the characteristics of the 189 whose questionnaires were not included in the analysis, are summarized in table 4.2.1.

Table 4.2.1: Socio-demographic characteristics of included and discarded respondents

	Included Respondent		**Discarded Respondent**	
	n	**%**	**n**	**%**
Age group				
10-14	201	34.1	65	34.4
15-19	388	65.9	124	65.6
Locality				
Urban area	316	53.7	144	76.2
Rural area	273	46.3	45	23.8
Gender				
Male	216	36.7	83	43.9
Female	373	63.3	106	56.1
Ethnicity				
Malay	306	52.0	103	54.5
Bidayuh	115	19.5	13	6.9
Chinese	70	11.9	43	22.8
Iban	65	11.0	25	13.2
Indian	0	0.0	2	1.1
Others*	33	5.6	3	1.6
Religion				
Islam	348	59.1	106	56.1
Christianity	198	33.6	64	33.9
Buddhist	41	7.0	15	7.9
Hinduism	0	0	2	1.1
Others**	0	0	2	1.1
No religion	2	0.3	0	0

*others included Melanau, Kadazan, Bajau, Kelabit, and Kedayan ethnic.
**others included Baha`i religion

4.3 Spirituality

Part B of the questionnaire assessed the spirituality level of the adolescents in the study, using the Daily Spirituality Experience Scale which consisted of 16 questions. The spirituality

scale had a mean score of 74.27, SD=13.59, and 95% confidence interval (73.17, 75.37). The score ranged from 23 to 90 points.

4.4 Depression Literacy Scale

Part C of the questionnaire assessed the respondents' knowledge of depression using the Depression Literacy Scale, which contained 22 items with 'true' or 'false' choice of answer. However, in this questionnaire, two questions were added to assess the respondents on two types of treatment for depression and score separately. The choice for answers was "true," "false," and "not sure." We gave 1 point for the right answers and 0 points for the wrong or "not sure" answers.

For the depression literacy (D-lit) 22 item scale, the total mean score was 7.73, SD= 2.85, and 95% CI [7.50, 7.96], which ranged from 0 to 18. Five questions that the vast majority of the adolescents managed to answer correctly were:

1. Loss of confidence and poor self-esteem may be a symptom of depression. (True) 78.90%
2. People with depression may feel guilty when they are not at fault. (True) =74.90%
3. Eating too much or losing interest in food may be a sign of depression. (True) =67.90%
4. People may move more slowly or become agitated as a result of their depression. (True) =67.10%
5. Depression does not affect your memory and concentration. (False) =64.70%

On the other hand, the questions that were least correctly answered were:

1. People with depression should stop taking antidepressants as soon as they feel better (False) =13.20%
2. People with depression often hear voices that are not there. (False) =12.60%
3. Antidepressants are addictive (False) =12.20%

4. Many treatments for depression are more effective than antidepressants. (False) =9.50%
5. Counselling is as effective as cognitive behavioural therapy for depression. (False) =6.50%

Two questions were added to the Depression Literacy Questionnaire to assess the knowledge regarding the treatment of depression among adolescents. For the question "Counselling is one of the treatments for depression," for which the answer is 'true', 512 (86.9%) respondents were able to answer it correctly. For the question "Cognitive and behavioural therapy is one of treatment for depression," for which the answer is 'true', 276 (46.9%) of the respondents managed to answer it correctly. Figure 4.4.1 shows the questions that were asked, and the percentage of the respondents who were able to answer them correctly.

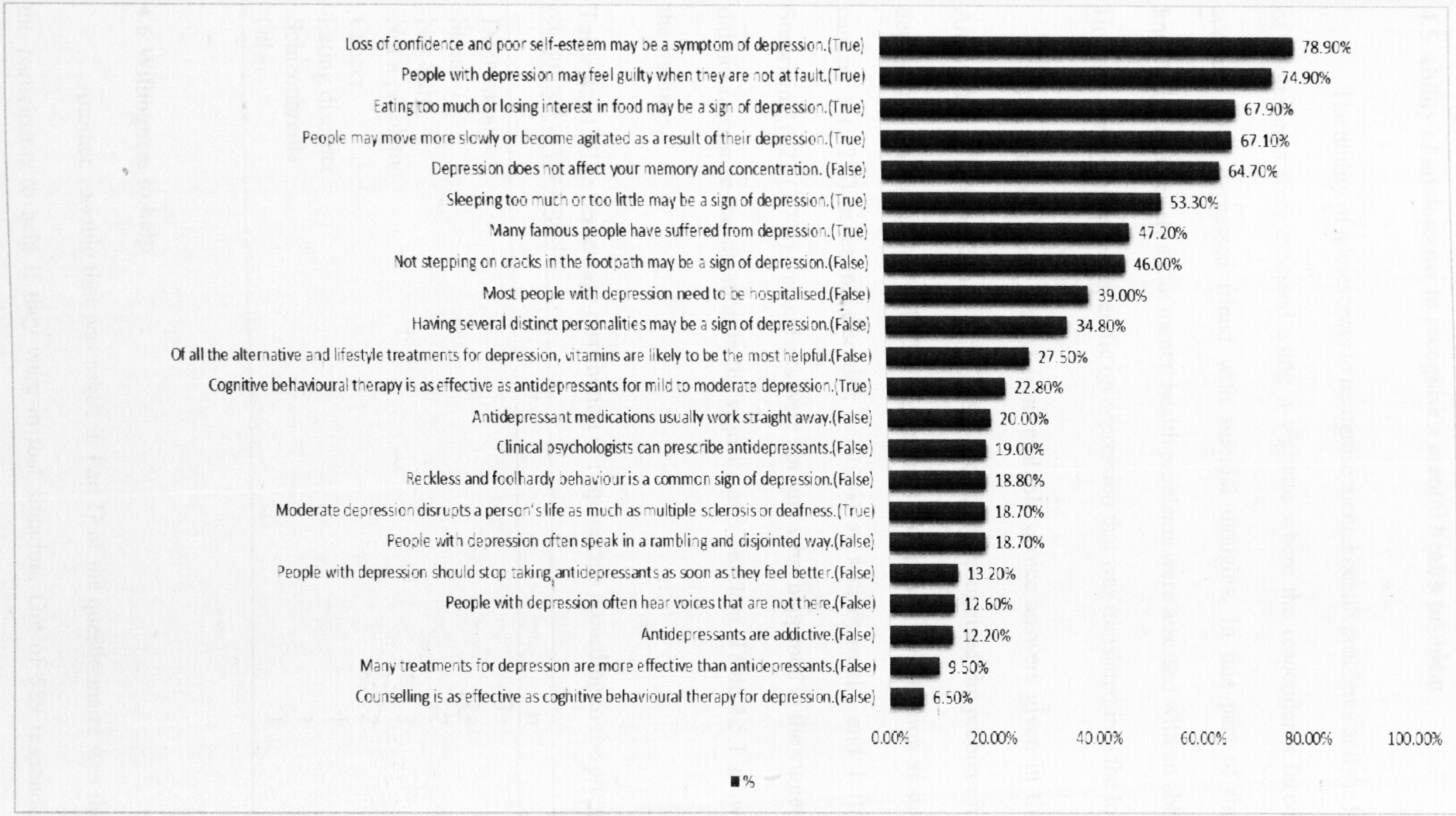


Figure 4.4.1: Percentage of the correct answer for each question in the Depression Literacy Questionnaire.

4.5 Ability of adolescents to recognise a mental health problem

The ability of adolescents to recognise mental health problems and the helping intention of adolescents were assessed using a vignette where the respondents faced a hypothetical scenario of a depressed friend with suicidal thoughts. In this part of the questionnaire, knowledge and beliefs about mental health problems were assessed with an abbreviated Mental Health Literacy Interview specific on depression that was translated into the local language.

The answers were picked from multiple choice answers given in the questionnaire. Among the 589 respondents, 435 (73.9%) correctly recognised the problem in the vignette as depression. The other 124 (21.1%) respondents recognised the situation as stress, 2 (0.3%) as cancer, 1 (0.2%) as eating disorder, 1 (0.2%) as schizophrenia, and 1 (0.2%) as others. Surprisingly, 22 (3.7%) respondents were not sure what happened in the vignette, and 3 (0.5%) did not recognize the situation in the vignette as a problem. Table 4.5.1 shows a summary of the findings.

Table 4.5.1: The percentage distribution of respondents according to the problem they recognised in the vignette

	n	%
Depression	435	73.9
Stress	124	21.1
Not Sure	22	3.7
Not a problem	3	0.5
Cancer	2	0.3
Eating disorder	1	0.2
Schizophrenia	1	0.2
Other	1	0.2

4.6 Willingness to help

Another variable that was asked in Part D of the questionnaire was the willingness of the participants to help if they were in that situation. Out of 589 respondents, 259 (44%)

answered that they were "very agree" to help, and 268 (45.5%) were "agree" to help if they were in that situation. Thus 89.5% of the respondents either 'agreed' or 'very agreed' to help when their friends were in depression. About ten per cent (9.5% or 56 of 589) of the participants were "neutral," neither agreeing nor disagreed to help if they were in a situation like that. Less than 1 per cent (0.8% or 5 of 589) participants did not agree to help, and 1 (0.2%) respondent chose "very not agree" to help (Table 4.6.1).

Table 4.6.1: Percentage distribution of respondents by their willingness to help

	n	%
Very Agree	259	44.0
Agree	268	45.5
Neutral	56	9.5
Not Agree	5	0.8
Very not agree	1	0.2

4.7 Confidence level to help

In part D of the questionnaire, the respondents were asked regarding their confidence to help if they were in such a situation. The answer was on a scale of 1 to 5 where 1 was "not confident at all," 2 was "a little bit confident," 3 was "moderately confident," 4 was "quite a bit confident," and 5 was "extremely confident" to help the person in the vignette. About one-quarter 152 (25.8% of 152 of 589) respondents were very confident, 234 (39.7%) respondents were confident, and 149 (25.4%) were moderately confident when helping the person who portrayed in the vignette. Forty-two respondents (7.1%) had little confidence, and 12 (2.0%) had no confidence in helping,

Each category of confidence was converted into a score where "extremely confident" scored 5, "quite a bit confident" scored 4, "moderately confident" scored 3, "a little bit confident" scored 2, and "not confident at all" scored 1. For the whole sample, the mean score of the confidence level was 3.8. The findings are summarised in table 4.7.1.

Table 2.7.1: Percentage distribution of respondents by their personal confidence level to help

	n	%
Extremely confident	152	25.8
Quite a bit confident	234	39.7
Moderately confident	149	25.4
A little bit confident	42	7.1
Not confident at all	12	2
Total	589	100

4.8 Stigma level of adolescents toward depressed peer

Personal attitudes towards the person in the vignettes were assessed with the youth version of the personal stigma scale. In this scale, we were able to determine the respondents' level of personal stigma, which is the attitude toward the person in the scenario given, and the respondents' perceived stigma, which is their belief about other people's attitudes toward the person in the scenario. This scale was scored on two stigma scales, one of which was the "weak-not-sick" scale which consisted of question numbers 1, 2, 3, and 5. The scale was the "dangerous/unpredictable" which consisted of question numbers 4, 5 and 6 in the questionnaire part E. The score was given as follows: very agree =5, agree=4, neutral = 3, not agree =2, and strongly disagree =1. For the "Weak-not-sick" stigma scale, the mean score was 11.85, SD=2.33, with 95% CI [11.66, 12.04], and a range of possible score of 4 to 20. The "Dangerous/unpredictable" stigma scale mean score was 8.69, SD=2.16, 95% CI [8.51, 8.86] with a range of possible scores of 3 to 15. For the social distance score, the mean was 9.06, SD = 2.56, 95% CI [8.85, 9.27] with a range of possible scores of 5 to 20.

4.9 Intention to help

The questionnaire given was based on the mental health first aid guideline on supporting a friend with depression. It was scored using a close-ended answer. The respondents were presented with 12 answers to choose from. Six of the answers were helpful intention, and the other six were harmful intentions toward a peer with depression symptoms. In order for the

participant to be counted as having an adequate mental health first aid response, they should answer three required first aid responses of 'ask about suicide,' 'tell Adam/Sarah you noticed something is wrong and want to make sure he is okay' and 'suggest Adam/Sarah tell an adult.'

The proportion of students who had adequate first aid responses was just 7.3% (43 out of 589). When we detailed out the helpful intention answered by the respondent, 492 (83.2%) of respondents chose to listen to their peers' problems, 411 (69.7%) suggested to help them connect with a medical professional such as a doctor or counsellor, and 386 (65.4%) suggested them to connect with an adult either parent or teacher. Out of six helpful intention, looking for warning sign which was portrayed in the questionnaire by "asking regarding suicide intention" was the least choice (12.2%) by the respondents or 72 of 589 respondents.

The harmful intention was portrayed by six items in the questionnaire which were "not doing anything," "let them deal the problem himself," "not talking about suicide," " unfriend if still being like that," "ignore him or her" and "order him or her what to do." Out of those six harmful intentions, 444 (75.3%) of the respondent chose to 'order him or her what to do', 373 (63.2%) chose 'not talking about suicide', and 45 people (7.6%) chose "let them deal the problem themselves." Ten (1.7%) of the respondents chose not to do anything if they were in that situation. Table 4.9.1 summarises the findings for helpful intentions and Table 4.9.1 summarised the harmful intentions.

Table 4.9.1: Percentage distribution of respondents by the helpful intentions that they chose*

Helpful Intention	**%**	**n= 589**
Listen up	83.4	492
Help them connect with an adult (doctor/counsellor)	69.7	411
Help them connect with an adult (parent/teacher)	65.4	386
Your friendship is important	61.7	374
Ask how they are	51.2	302
Look for warning signs	12.2	72

*Multiple responses are possible

Table 4.9.2: Percentage distribution of respondents by the harmful intentions that they chose*

Harmful intention	**%**	**n= 589**
Order him/her what to do	75.3	444
Not talking about suicide	63.2	373
Let them deal with the problem himself	7.6	45
Not doing anything	1.7	10
Unfriend if still being like that	1.5	9
Ignore him/her	1.4	8

* Multiple responses are possible

For the overall score of the helping intention, the close-ended helping intention questions were score according to the teen mental health first aid action plan. The answer for help to connect with an adult was scored together for both medical professional and informal help such as parent and teacher. An answer for either one of those two answer choice were given 2 points. The total score for the intention question ranged from 0 to 10, with a mode of 6. The mean total score for intention question was M=5.82, SD 2.40, 95% CI [5.62,6.01]. The score ranged from 0 to 10.

Table 4.9.3 shows the percentage of different people, including a professional and non-professional who could possibly help the respondents' friends who were in a depression, that was endorsed by the respondents to be either harmful, helpful, or neither harmful nor helpful.

The vast majority of the adolescents picked counsellor (91.2%), parents (86.9%), and family members (81.3%) to be helpful to their peers in depression with suicidal ideation. A doctor and teacher were considered to be least helpful by the adolescents in such a situation. Only a minority of the respondent considered the list of individual given as harmful with the highest to be a best friend (4.9%).

Table 4.9.3: Percentage distribution of respondents according to the type of potential of adult help that they endorsed

	Helpful %	Harmful %	Neither %
The person who could possibly help;			
Counsellor	91.2	0.7	8.1
Parent	86.9	2.2	10.9
Family Member	81.3	3.1	15.6
Psychologist	77.9	2.4	19.7
Religious figure	74.4	1.9	23.8
Best Friend	72.2	4.9	22.9
Teacher	72.0	2.0	26.0
Doctor	60.6	1.5	37.9

The respondents were also asked regarding the best individual who they thought could help their friend when they were in a depressed situation. Eight possible answers were given for the respondent to choose from, namely: counsellor, doctor, psychologist, best friend, family member, parent, teacher, and religious people such as *imam*, priest, or *ustaz*. The number and percentage of respondents who chose various 'best individual' were as follows: 159 (27%) chose a counsellor, 133 (22.6%) chose a psychologist, 98 (16.6%) chose parents, 71 (12.1%) chose family members, 58 (9.8%) chose a religious person, and 52 respondents chose best friend as the person who could help. Surprisingly, only 18 (3.1%) respondents chose a doctor, and nobody picked the teacher as a person best to help their friend who was depressed. The findings are summarised in figure 4.9.1.

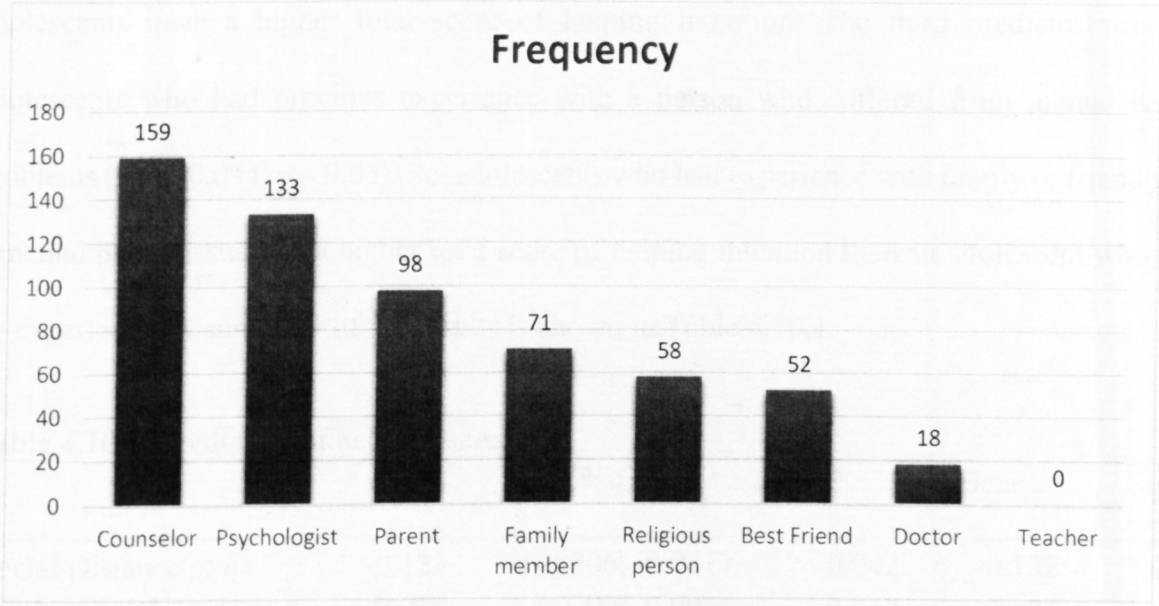


Figure 4.9.1: Percentage distribution of respondents according to their choice of the most helpful individual to a person with depression.

4.10 Predictors of helping intentions

In order to determine the predictors of the quality of helping intentions, data were analysed using the standard multiple linear regression. A preliminary analysis was conducted to ensure no violation of assumptions of normality, linearity, multicollinearity, and homoscedasticity. After entry of the Social Distance Scale (refer to page 46 for the value), the Weak-not-sick Scale (refer to page 46 for the value), the Daily Spirituality scale(refer to page 41 for the value), Personal Confidence level, correct recognition of the problem, socio-demographic factors such as gender, age, school location, religion and experience with a person of mental disorder, the total variance explained by the model as a whole was 8.2%, $F(12,576)=4.411$, $P<0.001$. From the results, the predictors were only able to explain a small percentage of variance in total scores. In the final model, the social distance scale score was inversely related to helping intention. Thus, a lower score was related to a high total score of helping intention (beta=-0.132, $p < 0.005$). The total score of helping intention was also higher in relation to the rural location of the respondent (beta=0.139, $p < 0.005$). Thus, rural

adolescents have a higher total score of helping intention. The third predictor was the adolescents who had previous experience with a person who suffered from mental health problems (beta=0.094, $p < 0.05$). So, adolescents who had experience with family or friend with a mental health issue had a higher total score of helping intention than an adolescent who had no experience. A summary of the results is shown in Table 4.10.1.

Table 4.10.1: Predictors of helping intention

	B	95% CI	SE	Beta	Sig
Social Distance scale	-0.123	(-0.206, -0.041)	0.042	-0.132	0.004
Weak-not-sick scale	-0.076	(-0.158, 0.007)	0.042	-0.074	0.072
Female gender	0.080	(-0.322, 0.481)	0.205	0.016	0.697
Daily Spirituality score	0.008	(-0.007, 0.024)	0.008	0.046	0.297
Confidence level	0.142	(-0.076, 0.361)	0.111	0.057	0.202
Correct recognition of problem	0.230	(-0.203, 0.664)	0.221	0.042	0.297
Age	0.078	(-0.082, 0.239)	0.082	0.041	0.339
Past Experience	0.511	(0.077, 0.946)	0.221	0.094	0.021
Rural location	0.668	(0.271, 1.064)	0.202	0.139	0.001
Islam	-1.868	(-5.242, 1.506)	1.718	-0.383	0.277
Buddhist	-0.987	(-4.352,2.379)	1.714	-0.105	0.565
Christianity	-1.806	(-5.182, 1.569)	1.719	-0.356	0.294
R^2	0.082				

4.11 Predictors for recommending helpful intention

To identify the factors affecting each type of the helping intention that was recommended by the adolescents, multiple binary logistic regression model was fitted to each of the helpful helping recommendations as to the dependent variable. The helpful intention analysed were "Ask how they are," "Listen up," 'Help them connect with an adult (parent or teacher)," "Help them connect with an adult (doctor or counsellor)," "Your friendship is important," and "Look for a warning sign'. The Independent variable was stigma scale which includes social distance scale and weak-not-sick scale (refer to page 46 for the values), personal

confidence level, age of participants, location of the participants, gender, spirituality level, correct recognition of the problem in the vignette, and previous experience with persons who had from mental health problems.

All the variables were entered into the logistic regression model to determine the significant individual contribution. The analysis revealed that social distance scale score (OR = 0.85, 95%CI =0.791, 0.920, p<0.001) and rural adolescent (OR= 1.67, 95% CI = 1.174,2.383, P<0.005) were statistically significant predictors of an adolescent mentioning the importance of their friendship toward the person who suffered from depression with suicidal ideation. For the intention to "ask how they are" toward the person in the vignette, social distance score (OR=0.922, 95% CI = 0.859, 0.989, p< 0.05) was the only statistically predictor.

Another action that was analysed using a binary logistic regression model was the intention of adolescent to help the depressed peers to connect with formal adult help such as doctors and counsellor. We found out that "weak, not sick scale' score (OR= 0.905, 95% CI = 0.828, 0.989) was the only statistically significant predictor for this variable (p<0.05). For every decrease in weak-not-sick stigma scale score, the odds of the respondent having the intention to help their depressed peers to connect with a professional adult such as doctors or counsellors increased by 0.905. On the other hand, for the recommendation of helping their peer to connect with a non-professional adult such as parent or teacher had two statistically significant predictors. The predictors were daily spirituality scale (OR = 1.02, 95% CI =1.007, 1.034 , p < 0.005) and personal confidence level (OR = 1.34, 95% CI = 1.096,1.630, p < 0.005).

The binary logistic regression analysis also revealed that the female gender (OR = 2.508, 95% CI= 0.252, 0.630) was a statistically significant predictor for the intention of listening to their depressed friend problems (p < 0.001). Female adolescents were 2.5 times more likely to listen up to their friends' problems. It was also noted that previous experience

with a person who suffered from mental health problems (OR = 2.03, 95% CI = 1.195, 3.447) appeared to be the main predictor for respondents to report intention of "ask risk of harm" ($p < 0.05$). Adolescents who had experience with someone who had a mental problem were twice more likely to ask regarding suicide intention toward the depressed person than adolescents with no previous experience. The findings are summarised in Table 4.11.1.

Table 4.11.1: Predictors of various helpful intentions based on the results of multiple logistic regression analysis

Predictors	Helpful intentions					
	Friendship is important	Ask how they are	Help to connect with an adult (doctor/counsellor)	Help to connect with an adult (parent/teacher)	Ask risk of harm	Listen up
Low Social Distance scale	*	*				
Low Weak-not - sick scale score			*			
Female Gender						*
Rural Adolescent	*					
Correct recognition of the problem			*			
High Spirituality level				*		
High personal confidence				*		
Experience					*	

*p value < 0.05

4.12 Predictors for the harmful intention

In order to identify the factors influencing the harmful intention toward the depressed peer, multiple binary logistic regression model was fitted to each of the harmful recommendations as the dependent variable. The analysis showed that social distance scale score (OR= 0.915, 95% CI =0.843,0.993) and older-aged adolescents (OR= 1.165, 95% CI= 1.003,1.354) were predictors for "tell them what to do to solve their problem," ($p<0.05$). For "ignore him if he is still like that" variable, the predictor to this intention was social distance scale score (OR= 1.428, 95% CI =1.040, 1.963, $p<0.05$). For every increase of one point in the social distance score stigma scale, the odds of the adolescent choosing this harmful intention increased by a factor of 1.428. Other than that, we also found that the "Dangerous/unpredictable" stigma scale score (OR=1.107, 95% CI =0.881, 1.010) was a predictor for "not ask about suicide" intention ($p<0.05$). For the intention of "not doing anything," the personal confidence level (OR= 0.144, 95% CI= 0.064, 0.324) was the predictor. There was no predictor found for the intention of "let them be responsible" and "unfriend them if they still being like that" variables. A summary of the predictors for harmful intention is shown in Table 4.12.1.

Table 4.12.1: Predictors of various harmful intentions based on the results of multiple logistic regression analysis predicting harmful action of helping intention.

Predictors	Harmful intentions			
	Tell him what to do	Ignore him if he still being like that	Not asking about the risk of harm	Do nothing
Low social distance scale score	*			
High social distance scale score		*		
High dangerous/unpredictable score			*	
High spirituality level	*			
Older age	*			
Low personal confidence				*

**p-value < 0.05*

4.13 Past experience with a mental health problem in the preceding 12 months

Out of 589 respondents, 137 (23.3%) had a real experience with a peer with a mental health problem in the preceding 12 months. Out of the 137 respondents with the experience, 69.3% did offer their help, 9.5% did not offer any help, and 21.2% respondents were not sure whether did they offer any help or not. A summary of the help that was given to peers with mental health problems is shown in Figure 4.13.1.

In order to be deemed to have provided adequate mental health first aid response to the peers, the respondents should answer three required first aid responses of 'ask about suicide,' 'tell their friend that they noticed something is wrong and want to make sure their friend is okay' and 'suggest their friend tell an adult.' Based on the result, only 13.9% adolescents provided adequate mental health first aid, another 35% only offered two out of three helpful

actions, 29.9% only offered one helpful action, and 21.2% provide no helpful action toward their peers.

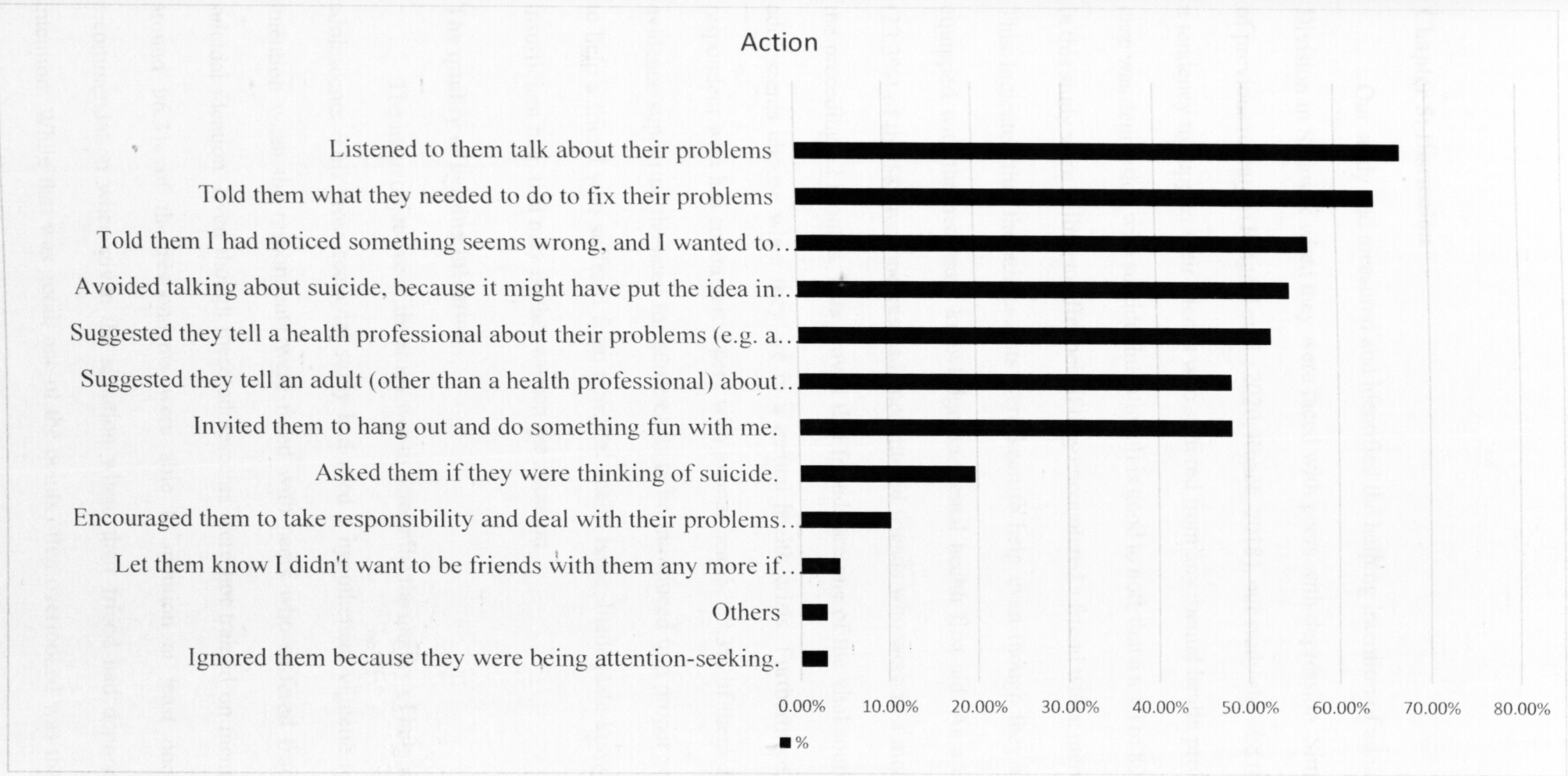


Figure 4.13.1: Actual action of the adolescent who had previous experience in the preceding 12 months

Chapter 5: Discussion

Our study had measured and identified the helping intention of adolescents in Kuching Division in Sarawak when they were faced with peers with depression. Similar to the findings of previous research (Ringdal et al., 2020, Roach, 2018), our study showed that adolescents had a tendency to support their friends who suffered from any mental health problem, which in this case was depression with suicidal intention. It is good to note that a total of 89.5% of adolescents in this study were willing to offer help if they encountered a friend with a mental health problem. This indicated that the adolescents were keen to help even though they might not be well-equipped with the necessary knowledge on mental health first aid. As a matter of fact, 137 (23.3%) of the 589 respondents had encountered friends who were in a mental health crisis in the preceding 12 months. This proved that friends are one of the vital sources of support that adolescents choose when they are in a mental health crisis. Furthermore, from a total 137 respondent who has encountered peer with mental health, 69.3% of them did offer help. This evidence supported the need for adolescents to be introduced to a proper way and knowledge to help a friend who suffered from a mental health issue. Inadequate knowledge may lead to insufficient help that may further worsen the situation.

The quality of helping intention

The main objective of the study was to determine the quality of helping intention among adolescents. This cross-sectional study had used a hypothetical vignette to measure helping intention when the respondents were faced with peers who suffered from depression with suicidal ideation. Even though these adolescents were not trained on mental health first aid, around 96.3% of the respondents were able to mention at least one helpful helping-recommendation when given the situation where their friend had depression with suicidal intention. While that was good, one of the points often overlooked was that the most crucial

part of giving help was the adequacy of the mental first aid that was given. According to a study by (Hart et al., 2020), three criteria must be fulfilled to indicate that the help given was adequate. The criteria are: i) look for warning signs such as suicidal ideation, ii) ask the person how they are, and iii) help them to connect with an adult. Based on these three criteria, it appeared that only 7.3% of the adolescents in our study were able to mention adequate helping intention. Our result was lower compared to those found among Australian adolescents, where 14% of the adolescents were reported to have adequate helping intention. Post-intervention, the percentage of Australian adolescents with adequate helping intention increased to 62% (Hart et al., 2020). This shows that intervention, such as the introduction of an education program on mental health first aid at school, may improve peer support for adolescents who suffered from depression.

The total score of helping intention can be measure using the five steps of teen mental health first aid action plan. The five steps are: look for warning signs, ask how they are, listen up, help them connect with an adult, and your friendship is important. The mean score for adolescents in this study in the Kuching division was 5.82, with SD=2.40. It was higher than the findings among university students in Sri Lanka, M=2.13, S.D.=1.09 (Amarasuriya et al., 2017), British university students, M=2.89, S.D.=1.52 (Davies et al., 2016), and adolescents in Australia, M=2.69, S.D.=1.39 (Mason et al., 2015). However, it is important to realize that in our study, the answer for helping intention used a closed-ended response instead of an open-ended answer that has been used in the previous surveys. That may explain why the total mean score of the helping intention of adolescents in our study varied from those in previous studies.

There was a total of six helpful intentions given in the answer for the adolescent to choose. Our findings showed that the highest percentage of helping intention among the adolescents was to listen up to the person in the vignette regarding their problem. This finding replicates the finding in Sri Lanka (Amarasuriya et al., 2017), which consisted of 52.1% of the

responses but a contrast to finding in Australia (Mason et al., 2015) where the listen up intention was low. As can be seen here, listening up to their peer problem was one of the common helps that the adolescents in the Kuching division offered when dealing with these situations. Moreover, we found in our study that female adolescents were 2.5 times more likely to offer help in the form of listening to their friends' problems compared to male adolescents.

One of the highlighted issues found in previous studies was the low number of respondents who recommended their friends to seek adult help (Amarasuriya et al., 2017, Mason et al., 2015). It is crucial for adolescents who has depression and suicidal ideation to get help from adults in order to reduce further complications. By doing that, adults, especially counsellors and doctors, may assess and give proper treatment and intervention to prevent suicide. In contrast, our study in Kuching did show a high percentage of the adolescents who suggested to the person in the vignette to seek help from an adult. A total of 82% of the adolescents in our study did suggest that the depressed person obtain help from an adult either from a professional adult, particularly doctor and counsellor, or informal help from parents and teachers. If we compare the findings, the intention to suggest help from a professional adult was higher than for informal help. Our result is similar to those in Sri Lanka (Amarasuriya et al., 2017), where the respondents had more intention of recommending their friends to obtain help from a professional adult rather than a parent or teacher. This highlighted positive practices among the vast majority of the adolescents in Kuching division.

One of the inadequacies of helping intention by adolescents in our study was the intention to look for warning signs toward friends with depression. From six helpful intentions given in the questionnaire, only 12.2% of respondents had the intention to ask about suicide even though the scenario clearly showed that the person had the intention to commit suicide. Our findings were similar to those among Australian adolescents (Mason et al., 2015), where

only 2.8% had the intention to look for a warning sign, and in Sri Lanka, where only 0.1% had the intention to assess the risk of harm (Amarasuriya et al., 2017).

In our study, it was found out that previous experience with mental health in the family or amongs friends was one of the predictors for the adolescents to ask regarding the warning signs. Adolescents with previous experience were twice more likely to assess the risk of harm compared with an adolescent who did not have any prior experience. This finding is very important due to the low percentage of the respondents who asked regarding suicidal ideation toward the person in the vignette. The awareness that they obtained through experiencing close contact with people who had mental health problems may influence their way of thinking.

On the other hand, out of a total of 589 respondents, 63.2% suggested that not talking about suicide to the person in this scenario might be helpful. Furthermore, our study did reveal that adolescents with a high score on the "dangerous and unpredictable" stigma scale were more likely not to be asking about suicide. Not assessing the risk of harm even though the person has shown a red flag sign is dangerous and may be harmful to the depressed adolescent. This misconception should be taken into consideration when we plan our intervention among adolescents on how they can support their friends. Other than stigma, factors such as gender, knowledge on depression, spirituality, age, and sociodemographic played no role as the predictor for this action. It would be interesting to find out if cultural factors also played a role in asking about suicide because, as we know in some countries, the stigma of suicide is still high due to their cultural belief.

Other harmful intentions, such as ignoring the depressed friend and not doing anything when their friend was having depressive symptoms with suicidal ideation, was still very low. For "ignoring the friend if he is still like that" was 1.4% (n=8), and for adolescents who were

not doing anything was 1.7% (n=10). For the adolescents who preferred not doing anything, it was found that most of them had low personal confidence level, and their mean score of confidence was 2.38. For comparison, the average confidence level of the whole sample was 3.8 out of maximum score 5. Out of ten adolescents who chose to not do anything if in the situation given, 3 had no confidence at all, and 4 had moderate confidence to help. With this in mind, we can conclude that adolescents who had a low confidence level were more likely not to offer any help. From this, we can assume that any intervention for better support among adolescents should focus on increasing their confidence level (among others) in helping others.

Another significant finding in the study was when the respondent asked about their intention toward their depressed friend, a large percentage of the adolescent were prone to instruct their peers on what to do when in this situation. Based on our findings, it is sufficient to point out that low social distance scale score and older age adolescent are factors that were associated with the adolescents choosing this helping recommendation as helpful. However, without proper training or knowledge, advising mental health patients on what to do to solve their problem might be harmful. It would be interesting to find out if the upbringing culture where the parents instruct their child what to do had any influence on the adolescents' choice of helping intention.

Another noteworthy finding was the respondents' choice of the person that may be most helpful in the situation of depression with suicidal ideation. The finding suggested that counsellors, psychologists, and parents were the top 3 choices of adolescents to find help when in this situation. However, the doctor and teacher were the least common choice of adolescents when depressed. It had been mentioned in previous literature that adolescents did not prefer to seek help from doctors when dealing with mental health. There was due to the wrong perception among the adolescents that doctors would expose their personal information to their

parents(Corry and Leavey, 2017). That might have been the primary reason why the doctor was the least popular choice of help support among adolescents in a number of literatures (Leavey et al., 2011, Yoshioka et al., 2015). On the other hand, it was surprising that none of the respondents chose the teacher as the best person to help in this situation. The teacher was supposedly the closest adult to the student, after their parents. Similar results were found in Japan, where most of the adolescents in the study perceived an intervention by a teacher may be harmful to the student with depression. This finding may indicate that there is a barrier between student and their teacher on gaining any help related to mental health.

Predictor for a total score of helping intention

All the six helpful intentions and harmful intentions answer chosen by the respondents were coded and analysed to come with a total score of helping intention. Our study found a higher mean score of helping intention compared to the previous studies. As can be seen in the results, the socio-demographic characteristics were one of the predictors for adolescents to have higher helpful intentions. Our study showed that adolescents who lived in a rural area had a higher total score for helping intention compared to adolescents in the urban area. Additionally, rural adolescents was also a predictor for "friendship is important" action. In our study, this action was portrayed as bringing their friend out to cheer them up. This indicates that when dealing with friends with depression, rural adolescents, compared with urban adolescents, are more likely to focus more on their friendship by cheering up their friends as a way to support them deal with depression. It is interesting to note how urbanization affected helping intention among adolescents. As far as we know, there was no previous study that mentioned the urban and rural area as a factor which determines the helping intention among adolescents.

As Sarawak is a multiracial state, ethnicity might play a role in affecting the dependent variable. However, there was no significant finding related to certain ethnicities among

adolescents who participated in our study, in relation to the helping intention. On the other hand, other sociodemographic characteristics such as gender, age, and religion of the respondents did not affect the total score of helping intention significantly. Findings from previous studies (Mason et al., 2015) did show any evidence of female gender as a predictor for overall first aid quality intention. Although the previous finding indicated that the female gender was found to have a better overall helping intention, our study found that there was no difference between male and female gender towards the total quality of helping intention. Our result is similar to those by Amarasuriya et al. (2017) that showed no gender difference in the overall quality of helping intention. If an intervention was to be conducted, there should be an equal opportunity for both male and female adolescents to be involved. On the positive side, the female gender did have an association with certain helping intentions, such as listen up to their friend problem. Our study showed that female adolescents were twice more likely to listen to their friends than males. It showed how most of the female adolescents tend to help their friend when in this situation.

Another predictor that we would like to discuss is the stigma scale score. In our study, it was divided into the "weak-not-sick" scale score, the "dangerous/unpredictable" stigma score, and the social distance score. Out of these three scales, only a low social distance scale emerged to be a predictor for the total score of helpful intention among adolescents. This means that adolescents who had been in frequent social contact with the person who had a mental problem had higher helpful intention. In a previous study by Amarasuriya et al. (2017), similar results were found with an additional weak-not-sick stigma scale as a predictor for total helpful intention. On the other hand, Mason et al. (2015) also showed that low 'weak, not sick' stigma scale score was a predictor for a higher score of total helpful intention, but social distance score did not emerge as one of the predictors.

Stigma toward mental health was one of the factors for the adolescent in Kuching division to adopt certain action plan when dealing with a person with depression. For example, adolescents who had a low social distance scale score were more likely to adopt helpful intention of showing the importance of their friendship by cheering them or invite them to some activities as a way of support. This group of adolescents were also more likely to ask how their friends were doing when finding them having problems. Another stigma scale that had a significant association with the helpful intention quality was 'weak-not-sick' scale. Low "Weak-not-sick" stigma scale was a predictor toward recommending professional help from doctors or counsellors. A low score on the "Weak-not-sick" scale means the adolescent perceives their friend as sick instead of being a weak person. In this case, as they realised their friend was sick, they opted for the intention to recommend help toward medical professional. As we know, mental health stigma had been mentioned as one of the barriers for individuals who had a mental illness to seek help (Clement et al., 2015). The results of previous studies have shown that individuals with low stigma had a better quality of help-giving toward the person with a mental health problem (Mason et al., 2015, Amarasuriya et al., 2017). Our study has also found mental health stigma to be a barrier for an adolescent to give a quality helping recommendation. This highlights the importance of reducing stigma regarding mental health in our society. To provide a better mental health environment for our adolescent, we should introduce a programme that aims to reduce the stigma on mental illness. Mental health-related education syllabus, awareness campaigns, and mental health first aid programmes are some of the initiatives that may be able to reduce this stigma in our society.

Further analysis found that other factors that had been included in the study were not predictors of the total score of helping intention. Nevertheless, those factors had an association with some of the actions recommended. For example, an adolescent with a high confidence

level tended to give more helpful intentions when facing a situation of a peer with depression. Such adolescents were more likely to listen to their depressed peers or to help them connect with adults such as parents or teachers. This finding supports the results in previous studies where a high confidence level had a role in giving quality mental health first aid (Rossetto et al., 2014). In addition to that, high spirituality level among adolescents was also found to be a predictor for recommending help from adults such as parents and teachers. However, there is no clear explanation of how high spirituality levels affecting the action.

Past experience with a person of mental health problems was also a predictor found in our study. This was not mentioned in the previous research. Adolescents who had past contact with a person with mental health, either their family members or friends, were more likely to have an intention to ask for a warning sign. In this case, they will ask whether the person had any suicidal intentions. This finding is very important due to the percentage of respondents who asked regarding suicidal ideation toward the person in the vignette. The awareness and knowledge that they acquired while experiencing close contact who have mental health problems may influence their way of thinking. This outcome has supported the finding in previous literature that mentioned that young Malaysians who had no prior experience with mental health patients, has limited knowledge on the issue (Clio Berry et al., 2019).

The knowledge of mental health was also analysed in our study. The connection between knowledge and helping intention was not well established in our study. We found that a high literacy score was not a predictor for a high total score of helping intention nor for any of the intended actions of help. However, the ability of an adolescent to correctly recognize problems in the vignette given was a predictor of one of the intended helping actions. Correct recognition of the problem was a predictor for the adolescent to help them connect with a medical professional adult such as a doctor or counsellor. This correlated with the finding by Mason et

al. (2015). Overall, the vast majority of the adolescent in our study managed to recognize the problems happening to the person in the vignette. Around 73.9% of the respondents in our study were able to recognize depression as the problem suffered by the person in the given scenario. It was higher than a previous finding, where only 14.3% correctly identified the problem (Yoshioka et al., 2015). When adolescents knew and were able to identify the problem as one of the mental health diseases, that may influence them to prefer to connect the friend to medical professional rather than informal help such as parent or teacher. This highlights the importance of the emphasis on recognising the signs and symptoms of common mental health illness during mental health awareness program. In addition to that, we should implant awareness among the adolescents to ask for warning signs if the symptoms of suicidal ideation are shown by their friends. Improvement on these knowledge should improve the overall quality of help that are given toward people who suffered from depression.

Our study also examined the actual actions of the adolescents when facing their friend who has depression. Previous literature supports the argument where young people helping intention predict the actual actions that they provide toward people with a mental health problem (Yap and Jorm, 2012). The overall finding of the helping action provided by the adolescent in our study showed almost identical findings with the helping intention. Out of 589 adolescents who participate in the study, only 137 had experience with a peer with mental health problems in the preceding 12 months. Nearly seventy per cent (69.3 %) of the 137 did offer some kind of help, 21.2% were not sure if they offer any help, and unfortunately, around 9.5% of did not offer any help to their friend. Based on the finding, to help their friend in depression, their main response was listening to their friend's problem, tell them what to do, ask how they are, avoid talking about suicide and suggest help from an adult. Corresponding with the intended answer, asking for risk of harm such as suicidal ideation was among the least action provided by the

adolescent. The overall helping action was not sufficient. It was noted only 13.9% of the adolescents manage to provide adequate help if we classify it according to criteria of adequate mental health first aid according to a study by Hart et al. (2020). This finding showed, even though our adolescents were willing to help their friends, the help that they give was insufficient. It is essential for us to realise that the problem occurs due to inadequate knowledge about what to do in such a situation.

Strength and limitation

One of the biggest strengths of our study is that it was the first type of study discussing mental health first aid among adolescents in Sarawak. Previous research was more focused on mental health literacy and factors that may cause mental health issues. Furthermore, the use of the age-specific scoring system to evaluate the quality of mental health helping intention among adolescents gave an accurate measurement of the quality of helping intention. The scoring for depression literacy and spirituality level were also used in the previous study, specifically for adolescents.

Our study has a number of limitations that may be addressed for future research. The first limitation was that the study was held in a school setting and required the respondents to be able to read properly. We might have missed respondents who were illiterate. An alternative interview type of questionnaire for this kind of participant may improve future research. In addition to that, another limitation was that the permission for data collection as only given for non-exam year students. It means that students who were going to sit for the examination in the year 2020, such as PMR for Form 3 and SPM for Form 5, were not allowed to participate. Thus there was minimal representative of data from their age group. This group of an adolescent may be experiencing more stress than other age group adolescent, and it is important if future

research may include this group in their study. The third limitation of the study is that the Chinese-medium schools were excluded from the sample. Only public secondary schools were included in the study. Thus, we have to be very cautious in extrapolating results of the study to the rest of Sarawak. The low percentage of Chinese respondents might have made ethnicity and religion not significant in the study.

The last limitation of our study was the use of a close-ended question rather than the open-ended question that had been used by other authors previously. Given that response might have been limited to the list of possible answers given in the questionnaire, some other types of helping intention among adolescents might have been missed. A close-ended questionnaire with additional interview sessions may improve the current findings. It is also disappointing to find that, even though the model had included multiple variables that theoretically might be the predictors toward helping intention, it was only able to explain a small amount of variance in the model. This may indicate the involvement of other factors that were yet to be investigated which presents an opportunity for future research.

Recommendation

Based on our study findings, age, gender, previous experience with a person having mental problem, stigma, spirituality level, and personal confidence has a role when an adolescent considering to help a friend with depression issue. All these factors should be considered when we are planning an intervention to enhance the helping quality among adolescents. For example, an intervention should focus more on younger adolescents, males, and urban adolescents. Our study found that adolescents with those characteristics had lower helping intention than the others. Focus group discussion among them may improve the overall support of mental health among adolescents in the Kuching Division.

According to our findings, there was no doubt that the adolescents were willing to help their friends who suffered from depression. The only thing lacking was the adequacy of the response and ability to recommend an appropriate, helpful recommendation toward others. For this reason, an educational school programme, for example, teen MHFA, where the programme teaches young adolescents on knowledge and skills to help a person with a mental health problem, can be introduced. The programme was found to increase the ability of a teenager to recognize the mental health problem and increase their support toward a peer with mental illness significantly (Hart et al., 2020). However, in order to implement such a programme, it will need support from all the stakeholders, particularly the policymaker, Ministry of Education, Ministry of Health, and the parents.

Other than that, improving the stigma on mental health, especially on depression, also may improve the overall quality of the support, as has been mentioned in this study and other several studies (Amarasuriya et al., 2017, Mason et al., 2015). One of the ways to reduce stigma is to implement an anti-mental-health stigma campaign in the workplace or school setting. There has been a positive finding of such campaigns on the knowledge and support toward a person with mental health issues (Hanisch et al., 2016). Other than stigma, one more factor that influences the adolescent is the confidence level. The school administrator or the relevant ministries should focus on syllabus and school activities that can enhance adolescent self-confidence. Other than that, camps or programmes to increase self-confidence among adolescents should be encouraged at the school level.

All things considered, adolescents need a systematic intervention programme that focuses on specific factors, as mentioned before, to create a supportive environment for mental health. The effect of such intervention on adolescent mental health support can be one of the future research that we can consider. Another noteworthy finding was when the student asked

regarding who they think best that can help their friend when in a depressed situation, none of the students chooses their teacher, and a small minority choose the doctors. This is interesting to explore because the teacher is the closest adult that the teenagers face daily, and doctors are the person that may best help when they are in depression. Any barrier or negative perception toward them should be identified early to improve the situation.

Chapter 6: Conclusion

Based on the ratio of participants by rural/urban, gender, and ethnicities, the study was fairly representative of the distribution of teenagers in the Kuching Division. The findings from the study contribute to the outcome of previous research on factors that has an association with helping intention toward peers with depression. It also provides some perspective on new factors such as spiritual level association with helping intention. Overall, our findings showed that in an attempt to assist their friends who had mental health problems, adolescents would listen to their friends' problems, instruct them what to do, help them to connect with adults, and not talking about suicide. It was good to know that most of the adolescents preferred to encourage their friends who were depressed to seek adult help. Even though quite a number of respondents did not want to talk about suicide to their friends who were having mental health problems, at least by encouraging adult help, especially professional adults, the adults might detect the risk of harm that may happen to the ill person. The overall finding, however, showed that adolescents in the Kuching division still did not consider all the recommended actions that were listed in mental health first aid guidelines. Even though the mean total score of helpful intention was higher than in other countries, however, the quality of helpful intention was still low.

Furthermore, the adequacy of mental health helping intention among adolescents was also poor. Those who had low social distance stigma scores, rural adolescents, and older adolescents showed better helping intention. Other factors such as gender, personal confidence level, daily spiritual level, correct recognition of the problem, and experience with mental health friend or family had an association with some of their helping intention. When we are considering planning any intervention program, all the factors mentioned should be considered.

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Appendices

APPENDIX A:

Information sheet and consent (English Version)

UNIVERSITI MALAYSIA SARAWAK

FACTOR AFFECTING HELPING INTENTION TOWARD PEER DEPRESSIVE SYMPTOMS AMONG ADOLESCENT IN KUCHING DIVISION

PARTICIPANT INFORMATION SHEET AND INFORMED CONSENT FORM

1. **Title of study**: Factor Affecting Helping Intention Toward Peer Depressive Symptoms Among Adolescent in Kuching Division

2. **Name of investigator (s):** Muhammad Najib Bin Hasan @ Ahmad

3. **Name of supervisor :** Associate Profesor Dr Helmy Hazmi

4. **Institution** : Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak

5. **Name of sponsor :** Self sponsored

6. **Introduction** :

It is important that you understand why the research is being done and what it will involve. Please take your time to read through and consider this information carefully before you decide if you are willing to participate. Ask the study researcher 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 may withdraw from the study 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 or your learning in this university to which you are otherwise entitled. This study has been approved by the Faculty of Medicine and Health Sciences, UNIMAS.

7. What is the purpose of the study?

The purpose of the study is to determine the adequacy of quality helping intention and response among adolescent age 12 to 18 years old towards their peers who has depressive symptoms and their associated factor in Kuching Division.

This research will be conducted for a duration of 6 months (31/01/2020 till 30/06/2020). The expected number of participants will be 778.

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

It is important that you answer all of the questions asked by the study researcher honestly and completely, which will take about ten to fifteen minutes. The study team will also ask your personal information like socio-demographic characteristics. For studies involving a questionnaire/survey, that is, you will be given a survey form to be answered. This form contains Six (6) sections which will inquire your socio-demographic, mental health literacy, mental health first aid response, spirituality level, and confidence level.

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

Participation in this study will not affect your learning in this school, and there will be no physical and mental risk. You are free to decline to answer any of the questions that you feel uncomfortable with.

10. 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 to improve the mental health literacy program among students and improve on mental health first aid response among adolescent.

11. Who is funding the research?

This study is self-sponsored. You will not be paid for participating in this study.

12. Will my 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. Individuals involved in this study, qualified monitors and auditors, and governmental or regulatory authorities may inspect the study data, where appropriate and necessary.

13. Who should I call if I have questions?

If you have any questions about the study, you want further information about this study, please contact Dr Muhammad Najib Bin Hasan at telephone number 60148978539.

INFORMED CONSENT FORM

Title of study: Factor Affecting Helping Intention Toward Peer Depressive Symptoms Among Adolescent in Kuching Division

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 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 freely withdraw my participation from the study without giving a reason and this will in no way affect my learning in this university. 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 investigator's instructions related to my participation in the study.
- While information gained in this study, it may be used in a conference presentation, and may also be published in a journal article, I will not be identified. Information concerning me will remain strictly confidential.
- I understand that study investigators, qualified monitors and auditors, the sponsor or its affiliates, and governmental or regulatory authorities, have direct access to my 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)*

Guardian:

Signature :

I/C number :

Date :

Nam) :

Relationship :

Student Name

Signature :

I/C number:

Date :

Name :

Relationship:

Investigator conducting informed consent :

Signature :

I/C number:

Name :

Date :

Impartial witness :

Signature :

I/C number :

Name :

Date :

APPENDIX B:

Questionnaire (English Version)

Code No:

RESEARCH TITLE:

FACTOR AFFECTING HELPING INTENTION TOWARD PEER DEPRESSIVE SYMPTOMS AMONG ADOLESCENT IN KUCHING DIVISION

Dr Muhammad Najib Bin Hasan @ Ahmad

19030161

Master of Public Health Course

Supervisor

Assoc Prof Dr Helmy Hazmi

Faculty of Medicine and Health Sciences

Universiti Malaysia Sarawak

2019/2020

Part A :Socio-Demographics

I would like to ask a few questions on your personal characteristics. If you have any problem in understanding the questions, please raise your hand. Please, be truthful of your responses and answer your response appropriately in code number.

	Questions	***Response***	
1.	How old are you?	.....years	
2.	Which year of study are you in?	Form.....	
3.	What is your gender?	Male=1 Female=2	
4.	Which ethnic (race) group do you belong to?	Malay=1 Iban=2 Chinese=3 Bidayuh=4 Indian=5 Others..... (specify)=6	
6.	What is your religion?	Islam=1 Christianity=2 Hinduism=3 Buddhism=4 Free thinkers=5 Others..... (specify)=6	
7.	How many members are in your family?	.....	
8.	Have you ever encounter a family member or a friend with a mental health issue?	Yes =1 No =2	

Part B

Instruction : Below is questions related to your spirituality where you might or might not experience it. Please consider the frequency of your experience related to the questions and please ignore either you should or should not have these experiences. There are a few statements that are using the word "GOD" in the question. If you feel uncomfortable with the word, you are free to change the word to another word that related to divine or holy.

	Many Times a Day	Everyday	Most Days	Some Days	Once in a While	Never or Almost Never
1.I feel God's presence						
2.I experience a connection all life						
3. During worship, or at other times when connecting with God, I feel joy, which lifts me out of my daily concerns						
4.I find strength in my religion or spirituality						
5. I find comfort in my religion or spirituality						
6.I feel deep inner peace or harmony						
7.I ask for God's help in the midst of daily activities						
8.I feel guided by God in the midst of daily activities.						
9. I feel God's love for me directly						
10.I fell God's love for me through others						
11. I am spiritually touched by the beauty of creation						
12.I feel thankful for my blessings						

13.I feel a selfless caring for others							
14.I accept others even when they do things that I think are wrong							
15.I desire to be closer to God or in union with HIM							

		Not Close at All	I Somewhat Close	Very Close	As Close as Possible
16.	In general, how close to you feel to God?				

Part C :

Please answer (/) the question below accordingly

	True	False	Don't Know
1. People with depression often speak in a rambling and disjointed way.			
2. People with depression may feel guilty when they are not at fault.			
3. Reckless and foolhardy behaviour is a common sign of depression.			
4. Loss of confidence and poor self-esteem may be a symptom of depression.			
5. Not stepping on cracks in the footpath may be a sign of depression.			
6. People with depression often hear voices that are not there.			
7. Sleeping too much or too little may be a sign of depression.			
8. Eating too much or losing interest in food may be a sign of depression.			
9. Depression does not affect your memory and concentration.			
10. Having several distinct personalities may be a sign of depression.			
11. People may move more slowly or become agitated as a result of their depression.			
12. Clinical psychologists can prescribe antidepressants.			
13. Moderate depression disrupts a person's life as much as multiple sclerosis or deafness.			
14. Most people with depression need to be hospitalised.			
15. Many famous people have suffered from depression.			
16. Many treatments for depression are more effective than antidepressants.			
17. Counselling is a type of treatment for depression			
18. Cognitive behavioural therapy is a type of treatment for depression			
19. Counselling is as effective as cognitive behavioural therapy for depression.			
20. Cognitive behavioural therapy is as effective as antidepressants for mild to moderate depression.			
21. Of all the alternative and lifestyle treatments for depression, vitamins are likely to be the most helpful.			
22. People with depression should stop taking antidepressants as soon as they feel better.			
23. Antidepressants are addictive.			
24. Antidepressant medications usually work straight away.			

Part E

Please read Adam/Sarah's story carefully, as the following questions relate to it.

Adam's/ Sarah Story

Adam/Sarah is a 16 years old who has been unusually sad and miserable for the last few weeks. He/she is tired all the time and has trouble sleeping at night. Adam/Sarah doesn't feel like eating and has lost weight. He/She can't keep his/her mind on his/her studies and his/her marks have dropped. He/She puts off making any decisions and even day-to-day tasks seem too much for him/her. His /Her parents and friends are very concerned about him/her. Daniel/Sarah says he/she will never be happy again and believes his/her family would be better off without him.

1.What, if anything, do you think is wrong with Adam/Sarah?

Please choose one only

ð cancer ð Schizophrenia ð Depression

ð eating disorder ð stress ð Nothing wrong

ð I do not know ð Other _____

2.If Adam/Sarah was a friend, I would help him/her.

- o Strongly Agree
- o Agree
- o Neither Agree or Disagree
- o Disagree
- o Strongly disagree

3. If I was Adam`s / Sarah's Friend, I would ;

Please (/) you can choose more than one

- o Tell what he/she needs to do to fix his/her problems.
- o Invite Adam/Sarah to hang out and do something fun with me
- o Ignore him/her because he/she is being attention-seeking.
- o Let him/her know I won't want to be friends with (him/her) any more if he/she like this all the time.
- o Avoid talking about suicide because it might put the idea in (his/her) head.
- o Tell Adam/Sarah I have noticed something seems wrong and I want to make sure he/she is okay.
- o Suggest (him/her) tell a health professional about his problems (e.g. a counsellor, GP Doctor or psychologist).

- Suggest Adam/ Sarah to tell an adult (other than a health professional) about his/her problems (e.g. a parent or teacher).
- Ask Adam/ Sarah if he/she is thinking of suicide.
- Encourage Adam/ Sarah to take responsibility and deal with his/her problems on his own
- Listen to Adam/ Sarah talk about his/her problems.
- Not do anything.
- Other ; Please Specify

4. If Adam/Sarah was a friend, how confident would you feel in helping him/her

- Not Confident at all
- A little bit Confident
- Moderately confident
- Quite a bit confident
- Extremely confident

5. Which of the following people do you think would be helpful, harmful, or neither helpful nor harmful,for Adam/Sarah 's problem?

Please (/) your answer

	Helpful	Neither	Harmful
Counsellor			
General practitioner (GP) or family doctor			
Psychologist			
Close friend			
Family member			
Parent			
Teacher			
priest , imam, religious teacher			

6. In the list provided in the question above, which one person do you think is the most helpful for Adam/Sarah 's problem?

- Close friend
- Counsellor
- Family member
- General practitioner Doctor(GP) or family doctor
- Minister or priest
- Parent
- Psychologist
- Teacher
- None of the above

7. If I had a problem right now like Adam/Sarah's, I would...

Please note: you can select more than one option.

- Try to deal with it on my own.
- Talk to a friend about it.
- Talk to a health professional about it (e.g. a counsellor, GP or psychologist).
- Talk to an adult (other than a health professional) about it (e.g. a parent or teacher).

- ○ Improve my diet.
- ○ Try to get more sleep.
- ○ Spend more time with friends.
- ○ Try to do more exercise.
- ○ Look for information about my problem on the internet.
- ○ Do nothing.
- ○ Other (please specify):_____

Part E

1.Please indicate how strongly you personally agree or disagree with each statement

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly disagree
1.People with a problem like Adam/Sarah could snap out of it if they wanted.					
2.A problem like Adam/Sarah 's is a sign of personal weakness					
3. Adam/Sarah 's problem is not a real medical illness.					
4.People with a problem like Adam/Sarah 's are dangerous.					
5.It is best to avoid people with a problem like Adam/Sarah 's so that you don't develop this problem.					
6.People with a problem like Adam/Sarah's are unpredictable.					
7.If I had a problem like Adam/Sarah 's, I would not tell anyone					

2. The following questions ask how you would feel about spending time with Adam/Sarah.

Would you be happy to:

	Yes definitely	Yes probably	Probably not	Definitely Not
Go out with Adam/Sarah on the weekend?				
Work on a project with Adam/Sarah?				
Invite Adam/Sarah around to your house?				
Go to Adam/Sarah's house?				
Develop a close friendship with Adam/Sarah?				

Part F :This part contains your experience dealing with someone who has a mental health problem.

DEFINITIONS

A mental health problem is when there is a major change in a person's normal way of thinking, feeling or behaving, which interferes with the person's ability to get on with life, and does not go away quickly or lasts longer than normal emotions or reactions would be expected to. A mental health problem might involve a diagnosed mental illness, a worsening of mental health, an undiagnosed problem, or a drug or alcohol problem.

A mental health crisis is when a person is at increased risk of harm to themselves or to others. Crisis situations include having thoughts of suicide, engaging in self-injury, being very intoxicated with alcohol or other drugs, or experiencing bullying or abuse.

1. In the last 12 months have you had contact with anyone about your age (i.e. between 14-18 years old) who you thought might have a mental health problem or has experienced a mental health crisis?

Please do not report any adults you have had contact with. For this question, we are just interested in

people around your age who you may have helped.

- ○ Yes
- ○ No
- ○ Not sure
- ○ I don't want to answer this question.

If you answer yes for question 1, please proceed with question 2 to 6.
If your answer is "no", "not sure", and " I don't want to answer the question", the survey ends here.

2. Please tell us *how many people about your age* you had contact with who you thought might have a mental health problem or experienced a mental health crisis:

- ○ 1
- ○ 2
- ○ 3
- ○ More than 3 (please specify)

If you have had contact with more than one person about your age who you thought might have a mental health problem or experienced a mental health crisis, please answer the following questions ***about the person who you know best.*** If you only had contact with one person, please answer the following questions about that person.

3. Did you offer the person any help?

- ○ Yes
- ○ No
- ○ Not sure

This page contains questions about what you did to help the person.

4. What did you do to help the person?

Please note: you can select more than one option.

- o Told them what they needed to do to fix their problems.
- o Invited them to hang out and do something fun with me.
- o Ignored them because they were being attention-seeking.
- o Let them know I didn't want to be friends with them any more if they're like this all the time.
- o Avoided talking about suicide, because it might have put the idea in their head.
- o Told them I had noticed something seems wrong, and I wanted to make sure they were okay.
- o Suggested they tell a health professional about their problems (e.g. a counsellor, GP, or psychologist).
- o Suggested they tell an adult (other than a health professional) about their problems (e.g. a parent or teacher).
- o Asked them if they were thinking of suicide.
- o Encouraged them to take responsibility and deal with their problems on their own.
- o Listened to them talk about their problems.
- o I didn't do anything.
- o Other (please specify):_____

5. Do you think it is your responsibility to help him/her?

- o Yes
- o No
- o I don't know

6. If your answer is NO, who you think should be responsible?

_____

APPENDIX C:

Information Sheet and Consent Form

(Malay Version)

FAKTOR MEMPENGARUHI KEINGINAN UNTUK MEMBANTU RAKAN YANG MEMPUNYAI TANDA-TANDA KEMURUNGAN DI KALANGAN REMAJA DI BAHAGIAN KUCHING

(RISALAH MAKLUMAT PESERTA DAN BORANG PERSETUJUAN atau KEIZINAN PESERTA)

1. **Tajuk kajian** : Faktor Mempengaruhi Keinginan Untuk Membantu Rakan Yang Mempunyai Tanda-tanda Kemurungan di Kalangan Remaja Di Bahagian Kuching
2. **Nama penyelidik :** Muhammad Najib Bin Hasan @ Ahmad
3. **Nama penyelia** : Assoc. Profesor Dr Helmy Hazmi
4. **Institusi** : Fakuliti Perubatan Dan Sains Kesihatan, Universiti Malaysia Sarawak
5. **Nama penaja** :Penajaan sendiri

6. Pengenalan:

Borang ini menjelaskan hal-hal berkenaan penyelidikan tersebut dengan lebih mendalam dan terperinci. Amat penting anda memahami mengapa penyelidikan ini dilakukan dan apa yang dilakukan dalam penyelidikan ini. Sila ambil masa yang secukupnya untuk membaca dan mempertimbangkan dengan teliti penerangan yang diberikan sebelum anda bersetuju untuk menyertai penyelidikan ini. Jika ada sebarang kemusykilan ataupun maklumat lanjut yang anda ingin tahu, anda boleh bertanya mana-mana kakitangan yang terlibat dalam penyelidikan ini. Setelah anda berpuas hati bahawa anda memahami penyelidikan ini, dan anda berminat untuk turut serta, anda dikehendaki menandatangani Borang Persetujuan atau Keizinan Peserta, pada muka surat akhir risalah ini.

Penyertaan anda dalam penyelidikan ini adalah secara sukarela. Anda tidak perlu menyertai penyelidikan ini jika anda tidak mahu. Anda juga mempunyai hak untuk tidak menjawab mana-mana soalan. Anda juga boleh menarik diri daripada penyelidikan ini pada bila-bila masa sahaja. Jika anda menarik diri, segala maklumat yang telah diperolehi sebelum anda menarik diri tetap akan digunakan dalam penyelidikan ini. Jika anda tidak mahu menyertai ataupun

menarik diri dari penyelidikan ini, tindakan anda tidak akan menjejaskan segala hak dan keistimewaan perubatan kesihatan atau pembelajaran yang selayaknya anda terima.

Penyelidikan ini telah mendapat kelulusan daripada Fakulti Perubatan dan Sains Kesihatan, UNIMAS.

7. Apakah tujuan penyelidikan ini dilakukan?

Tujuan penyelidikan ini dilakukan adalah untuk mengetahui tahap kualiti keinginan untuk membantu di kalangan remaja berumur 12 hingga 18 tahun terhadap rakan mereka yang mempunyai tanda kemurungan di bahagian Kuching

Penyelidikan ini akan berlangsung selama 6 bulan (31/01/2020 sehingga 30/06/2020). Dijangka bahawa 778 peserta akan mengambil bahagian.

8. Apakah tanggungjawab saya sewaktu menyertai penyelidikan ini?

Amat penting untuk anda menjawab kesemua soalan yang dikemukakan oleh kakitangan penyelidikan dengan jujur dan lengkap yang akan mengambil masa selama 10 minit hingga 15 minit. Untuk kajian yang melibatkan soal selidik/temu bual, anda akan diberikan borang kaji selidik untuk dijawab. Borang ini mengandungi enam (6) bahagian yang akan menanyakan tentang ciri-ciri sosio-demografi, ilmu kesihatan mental, rawatan awal kesihatan mental, kekuatan rohani dan keyakinan diri.

9. Apakah risiko dan kesan-kesan sampingan menyertai penyelidikan ini?

Penyertaan penyelidikan ini tidak akan menjejaskan pembelajaran anda di sekolah ini dan tiada risiko fizikal dan mental kepada anda. Anda berhak untuk tidak menjawab mana-mana soalan kajian jika rasa tidak selesa dengan soalan kajian tersebut.

10. Apakah manfaatnya saya menyertai kajian ini ?

Penyelidikan ini mungkin mendatangkan manfaat ataupun tiada langsung memberi apa-apa manfaat kepada diri anda sendiri. Walaubagaimanapun, segala maklumat yang diperolehi daripada penyelidikan ini akan dapat membantu dalam meningkatkan keberjayaan program kesihatan mental dan respon rawatan awal terhadap kesihatan mental di kalangan remaja.

11. Siapakah yang membiayai penyelidikan ini?

Kajian ini adalah dibawah tajaan sendiri. Anda tidak akan dibayar untuk menyertai kajian ini.

12. Adakah maklumat saya akan dirahsiakan ?

Segala maklumat anda yang diperolehi dalam penyelidikan ini akan disimpan dan dikendalikan secara sulit, bersesuaian dengan peraturan-peraturan dan/ atau undang-undang yang berkenaan. Sekiranya hasil penyelidikan ini diterbitkan atau dibentangkan kepada orang ramai, identiti anda tidak akan didedahkan tanpa kebenaran anda terlebih dahulu. Individu yang terlibat dalam kajian ini, pemantau yang berkelayakan dan juruaudit, dan pihak berkuasa kerajaan atau pengawal selia boleh memeriksa data kajian, jika sesuai dan perlu.

13. Siapakah yang perlu saya hubungi sekiranya saya mempunyai sebarang pertanyaan)?

Anda boleh menghubungi penyelidik Dr Muhammad Najib Bin Hasan di nombor telefon pada nombor telefon [+60148978539] sekiranya anda mempunyai sebarang pertanyaan atau memerlukan maklumat lebih lanjut mengenai penyelidikan ini.

BORANG PERSETUJUAN/ KEIZINAN PESERTA

Tajuk kajian : Faktor Mempengaruhi Keinginan Untuk Membantu Rakan Yang Mempunyai Tanda-tanda Kemurungan di Kalangan Remaja Di Bahagian Kuching

Dengan menandatangani di bawah, saya mengesahkan bahawa :

- Saya telah diberi maklumat tentang penyelidikan di atas secara lisan dan bertulis dan saya telah membaca dan memahami segala maklumat yang diberikan dalam risalah ini.
- Saya telah diberikan masa yang secukupnya untuk mempertimbangkan penyertaan saya dalam penyelidikan ini dan telah diberi peluang untuk bertanyakan soalan dan semua persoalan saya telah dijawab dengan sempurna dan memuaskan).
- Saya juga faham bahawa penyertaan saya adalah secara sukarela dan pada bila-bila masa saya bebas menarik diri daripada penyelidikan ini tanpa harus memberi sebarang alasan dan ia sama sekali tidak akan menjejaskan pembelajaran saya di universiti ini. Saya tidak mengambil bahagian dalam mana-mana penyelidikan lain pada masa ini. Saya juga memahami tentang risiko dan manfaat penyelidikan ini dan saya secara sukarela memberi persetujuan untuk menyertai penyelidikan ini di bawah syarat-syarat yang telah dinyatakan di atas. Saya faham saya harus mematuhi nasihat dan arahan yang berkaitan dengan penyertaan saya dalam penyelidikan ini daripada penyelidik).
- Kajian ini boleh dibentangkan di persidangan dan kajian ini juga boleh diterbitkan didalam jurnal, dengan syarat diri saya tidak akan dikenal pasti. Maklumat mengenai diri saya akan disimpan secara sulit).
- Saya faham bahawa penyelidik, pemantau dan juruaudit terlatih, pihak penaja atau gabungannya, dan pihak berkuasa kerajaan atau undang-undang, mempunyai akses langsung dan boleh menyemak laporan saya bagi memastikan penyelidikan ini dijalankan dengan betul dan data direkodkan dengan betul. Segala maklumat dan data peribadi akan dianggap sebagai SULIT.
- Saya akan menerima satu salinan 'Risalah Maklumat Peserta dan Borang Persetujuan atau Keizinan Peserta' yang telah lengkap dengan tarikh dan tandatangan untuk dibawa pulang ke rumah.

- Saya bersetuju/ tidak bersetuju* untuk doktor yang merawat keluarga saya diberitahu tentang penyertaan saya dalam penyelidikan ini. (*Potong mana yang tidak berkenaan)

Penjaga :

Tandatangan : Nombor K/P :

Nama : Tarikh :

Hubungan :

Nama Pelajar

Tandatangan : Nombor K/P:

Tarikh :

Nama : Hubungan :

Penyelidik yang mengendalikan proses menandatangani borang keizinan :

Tandatangan : Nombor K/P:

Nama: Tarikh :

Saksi tidak-berpihak/adil :

Tandatangan : Nombor K/P):

Nama : Tarikh :

APPENDIX D:

Questionnaire (Malay Version)

KOD SIRI:

TAJUK KAJIAN :

FAKTOR MEMPENGARUHI KEINGINAN UNTUK MEMBANTU RAKAN YANG MEMPUNYAI TANDA-TANDA KEMURUNGAN DI KALANGAN REMAJA DI BAHAGIAN KUCHING

Dr Muhammad Najib Bin Hasan @ Ahmad

Kursus Pascasiswazah Kesihatan Awam

UNIMAS 2019/2020

Penyelia

Prof Madya Dr Helmy Hazmi

Fakulti Perubatan dan Sains Kesihatan

Universiti Malaysia Sarawak

2019/2020

Set Bahasa Melayu

Bahagian A

Saya ingin bertanya beberapa soalan tentang peribadi anda.

Sila jawab dengan jujur dan jawab menggunakan kod nombor yang disediakan.

	Soalan	Respon	
1.	Berapakah Umur anda?	.....tahun	
2.	Anda berada di tingkatan berapa?	Tingkatan	
3.	Apakah jantina anda?	Lelaki =1 Perempuan =2	
4.	Apakah kaum anda?	Melayu=1 Iban=2 Cina=3 Bidayuh=4 India=5 Lain-Lain..... (jelaskan)=6	
5.	Apakah Agama anda?	Islam=1 Kristian =2 Hindu =3 Buddha =4 Tiada agama =5 Lain-lain.....(nyatakan)=6	
6.	Berapakah orang ahli keluarga anda?	.....	
7.	Pernahkah anda mempunyai pengalaman bersama rakan atau keluarga yang mempunyai gangguan mental?	Ya =1 Tidak =2	

Bahagian B

Arahan: Berikut ialah pernyataan-pernyataan yang berkaitan dengan pengalaman kerohanian anda di mana anda mungkin atau tidak mungkin mengalaminya. Sila pertimbangkan kekerapan anda mengalami pengalaman tersebut dan cuba abaikan sama ada anda rasa, harus atau tidak harus mempunyai pengalaman tersebut. Terdapat beberapa pernyataan yang menggunakan perkataan "Tuhan". Sekiranya perkataan ini tidak selesa bagi anda, anda boleh menggantikan perkataan yang sama maksud dengan ilahi atau suci bagi anda.

Sila tanda (/) bagi Jawapan yang anda rasakan betul.

Tidak pernah	Sekali-sekala	Beberapa hari	Kebanyakan hari	Setiap hari	Banyak kali sehari
1	2	3	4	5	6

	Pernyataan	Respon					
		1	2	3	4	5	6
1.	Saya merasakan kewujudan Tuhan						
2.	Saya merasai wujud hubungan antara saya dengan semua kehidupan						
3.	Semasa beribadah, atau semasa saya berhubung dengan Tuhan, saya berasa gembira yang membawa saya keluar daripada kesulitan kehidupan seharian saya.						
4.	Saya mendapat kekuatan melalui agama atau kekuatan rohani saya						
5.	Saya menjumpai keselesaan melalui agama atau kekuatan rohani						
6.	Saya dapat menikmati ketenangan jiwa atau keharmonian yang mendalam						
7.	Saya meminta bantuan daripada Tuhan semasa melakukan aktiviti seharian						
8.	Saya merasa tuhan membimbing saya dalam melakukan aktiviti seharian						
9.	Saya boleh merasa tuhan menyayangi saya secara langsung						
10.	Saya merasa tuhan menyayangi saya melalui orang lain						
11.	Saya tersentuh secara rohani terhadap keindahan ciptaan tuhan						
12.	Saya rasa bersyukur atas nikmat yang saya kecapi						
13.	Saya tidak mementingkan diri sendiri dalam membantu orang lain						
14.	Saya boleh menerima orang yang melakukan perbuatan yang salah						

15.	Saya ingin berasa rapat dengan Tuhan						

		Tidak rapat	Agak rapat	Rapat	Sangat rapat
16.	Adakah anda merasa diri anda rapat dengan tuhan?				

Bahagian C . Sila tandakan (/) bagi jawapan untuk soalan dibawah

		Betul	Salah	Tidak Tahu
1	Mereka yang mempunyai kemurungan selalu bercakap secara merepek dan bercelaru			
2	Mereka yang kemurungan mungkin berasa bersalah walaupun sesuatu perbuatan itu bukan kesalahan mereka			
3	Bertindak secara melulu adalah antara tanda utama seseorang mempunyai kemurungan			
4	Tiada keyakinan diri dan rasa rendah diri adalah tanda-tanda kemurungan			
5	Tidak memijak retakan pada laluan pejalan kaki semasa berjalan adalah satu tanda kemurungan			
6	Seseorang yang murung selalunya mendengar suara yang sebenarnya tidak wujud			
7	Kurang tidur merupakan tanda kemurungan.			
8	Hilang selera makan merupakan tanda kemurungan			
9	Kemurungan tidak memberi kesan kepada daya tumpuan seseorang			
10	Mempunyai personaliti yang pelbagai merupakan tanda kemurungan			
11	Seseorang akan berasa cepat marah disebabkan kemurungan.			
12	Ahli Psikologi Klinikal boleh memberikan ubat kemurungan			
13	Kemurungan tahap sederhana boleh menggangu kehidupan seseorang sama seperti penyakit pekak.			
14	Kebanyakan orang yang mempunyai kemurungan perlu dimasukkan ke hospital			
15	Ramai orang yang terkenal mempunyai kemurungan			
16	Rawatan tanpa ubat lebih berkesan daripada ubat antidepresi			
17	Kaunseling adalah salah satu rawatan kemurungan			
18	Terapi tingkahlaku dan kognitif adalah salah satu rawatan kemurungan			
19	Kaunseling adalah sama berkesan seperti rawatan terapi tingkahlaku dan kognitif dalam merawat kemurungan			

20	Terapi tingkah laku dan kognitif mempunyai kesan yang sama seperti ubat anti depresi dalam merawat kemurungan tahap ringan dan sederhana			
21	Vitamin adalah rawatan yang paling membantu merawat kemurungan selain ubat antidepresi.			
22	Seseorang yang mengambil ubat antidepresi perlu berhenti sebaik sahaja beliau merasakan dirinya telah pulih			
23	Ubat antidepresi boleh menyebabkan ketagihan			
24	Ubat antidepresi akan memberi kesan yang serta merta.			

Bahagian D

Sila baca kisah mengenai Adam/ Sarah dan jawab soalan berdasarkan kisah tersebut

Kisah Adam/ Sarah

Adam/ Sarah adalah remaja berumur 16 tahun. Dia telah berasa sedih dan gusar untuk beberapa minggu. Dia terasa dirinya penat sepanjang masa dan mempunyai masalah untuk tidur pada waktu malam.Adam/ Sarah hilang selera makan dan berat badannya mulai susut. Dia tidak dapat menumpukan perhatian pada pembelajarannya dan prestasinya dalam peperiksaan semakin merosot. Dia tidak mampu membuat sebarang apa-apa keputusan,dan kerja-kerja seharian juga terasa sukar untuk dilakukan. Ibu bapa dan rakan-rakan Adam/Sarah amat bimbang akan keadaannya .Adam/ Sarah berkata bahawa dia tidak akan berasa gembira lagi dan percaya bahawa keluarga nya akan lebih gembira tanpa kehadiran beliau.

1.Apakah yang anda rasakan masalah yang dihadapi oleh Adam/ Sarah?

Pilih satu sahaja

☐ Kanser ☐ Schizophrenia ☐ Kemurungan ☐ Masalah makan

☐ Tekanan ☐ Tiada Masalah ☐ Kurang pasti ☐ Lain-Lain_____

2.Sekiranya Adam / Sarah adalah seorang rakan saya, saya akan membantu dia.

O Amat setuju
O Setuju
O Neutral
O Tidak setuju
O Amat tidak setuju

3.Jika saya adalah rakan kepada Adam / Sarah, saya akan ;

kamu boleh memilih lebih dari satu jawapan

O A. Memberitahu dia apa yang boleh dilakukan untuk mengatasi masalah yang dihadapinya
O B. Mengajak Adam/ Sarah untuk keluar bersama dan melakukan sesuatu yang seronok bersama-sama.
O C. Mengabaikan dia kerana merasakan bahawa dia hanya inginkan perhatian
O D. Memberitahu dia bahawa saya tidak ingin berkawan dengannya lagi sekiranya dia masih bersifat begitu sepanjang masa.
O E. Elakkan dari bercakap mengenai bunuh diri kerana ia mungkin mempengaruhinya
O F. Memberitahu Adam/ Sarah yang saya mengetahui dia mempunyai masalah dan ingin memastikan bahawa dia dalam keadaan baik
O G. Mencadangkan kepadanya untuk memberitahu golongan professional seperti kaunselor ,doktor atau ahli psikologi tentang masalah yang dihadapinya..
O H. Mencadangkan kepada Adam / Sarah supaya memberitahu masalahnya kepada orang dewasa seperti ibu bapa dan guru.

O I. Bertanya kepada Adam/ Sarah adakah dia berfikir untuk membunuh diri

O J. Menggalakkan Adam/ Sarah untuk bertanggungjawab dan menyelesaikan masalahnya sendiri

O K. Mendengar masalah yang dihadapi oleh Adam / Sarah

O L. Tidak berbuat apa-apa

O M.Lain-Lain (sila nyatakan)

_____

4. Sekiranya Adam/ Sarah adalah rakan, adakah anda berasa yakin untuk membantu dia?

O Tidak yakin sama sekali
O Sedikit Yakin
O Sederhana yakin
O Yakin
O Amat Yakin

5. Siapakah di antara senarai dibawah yang anda rasa "MEMBANTU", "MERBAHAYA" atau "TIDAK MEMBANTU DAN TIDAK MERBAHAYA" untuk masalah yang dihadapi oleh Adam/ Sarah?

Sila tandakan (/) pada setiap pilihan di bawah

	Membantu	Tidak membantu/ tidak merbahaya	Merbahaya
a. Kaunselor			
b. Doktor			
c. Ahli psikologi			
d. Kawan karib			
e. Ahli keluarga			
f. Ibu Bapa			
g. Guru			
h. Imam, ustaz, paderi, agamawan			

6. Berdasarkan senarai dibawah, pilih HANYA SEORANG individu yang benar-benar boleh membantu Adam/ Sarah?

O Kaunselor
O Doktor
O Ahli psikologi
O Kawan Karib
O Ahli keluarga
O Ibu Bapa
O Guru
O Imam/ ustaz / paderi/agamawan

7. Sekiranya saya mempunyai masalah seperti Adam/ Sarah, saya akan ....

(anda boleh pilih lebih daripada satu jawapan)

O Akan menyelesaikan masalah itu sendiri

O Akan bercakap berkenaan masalah itu kepada rakan.

O Akan meminta bantuan professional seperti kaunselor, doktor atau ahli psikologi

O Memberitahu masalah tersebut kepada orang dewasa (ibu, bapa, guru)

O Menambah baik cara pemakanan sendiri

O Mendapatkan tidur yang cukup dan baik

O Meluangkan lebih banyak masa bersama kawan-kawan

O Cuba untuk melakukan senaman dengan lebih banyak

O Mencari maklumat tentang masalah saya di laman sesawang *(internet)*

O Tidak membuat apa-apa

O Lain-lain (sila nyatakan):_____

Bahagian E

1. Sila nyatakan sama ada anda setuju atau tidak dengan penyataan dibawah ;

		Amat Setuju 1	**Setuju 2**	**Neutral 3**	**Tidak Setuju 4**	**Amat tidak setuju 5**
a	Orang yang mempunyai masalah seperti Adam/ Sarah boleh menyelesaikan masalah nya sekiranya dia mahu.					
b	Masalah Adam/ Sarah adalah tanda bahawa dia mempunyai jati diri yang lemah					
c	Masalah Adam/Sarah bukan suatu penyakit					
d	Orang yang mempunyai masalah seperti Adam/ Sarah adalah merbahaya					
e	Adalah lebih baik untuk mengelakkan diri dari orang yang mempunyai masalah seperti Adam/ Sarah supaya kita tidak mempunyai masalah yang sama					
f	Seseorang yang mempunyai masalah seperti Adam/ Sarah adalah seorang yang perbuatannya tidak dapat diduga.					
g	Sekiranya saya mempunyai masalah seperti Adam/ Sarah, saya tidak akan memberitahu perkara tersebut kepada sesiapa					

2.Soalan dibawah adalah mengenai apakah perasaan anda tentang meluangkan masa bersama Adam/ Sarah

Adakah anda ingin;

		Pasti ya 4	**Mungkin ya 3**	**Mungkin tidak 2**	**Pasti Tidak 1**
a	Keluar bersama Adam/ Sarah pada hujung minggu?				
b	Membuat projek kelas bersama Adam/Sarah?				
c	Mengajak Adam/Sarah ke rumah anda?				
d	Berkunjung ke rumah Adam/Sarah?				
e	Menjadikan Adam/Sarah kawan rapat?				

Bahagian F : Bahagian ini bertanyakan berkenaan pengalaman anda bersama rakan yang pernah mempunyai gangguan mental.

DEFINISI

Masalah gangguan mental *berlaku apabila terdapat perubahan yang besar kepada cara berfikir,perasaan dan tingkahlaku seorang yang normal, yang akan memberi kesan kepada keupayaan seseorang untuk melakukan aktiviti seharian secara normal.Gangguan mental termasuklah penyakit mental yang pernah didiagnos oleh doktor , masalah mental yang tidak pernah diketahui atau masalah ketagihan dadah dan arak.*

Krisis gangguan mental *adalah apabila seseorang mempunyai risiko untuk mendatangkan bahaya kepada diri nya sendiri atau kepada orang lain seperti keinginan membunuh diri, mencederakan diri sendiri, mabuk disebabkan arak atau dadah atau pengalaman dibuli.*

1. Dalam 12 bulan yang lalu, adakah anda pernah menemui seseorang sebaya anda (13-18 tahun) yang anda rasakan mempunyai masalah gangguan mental atau mempunyai krisis gangguan mental?

Untuk soalan ini, kami hanya ingin mengetahui golongan remaja yang sebaya anda yang pernah anda bantu.

Sila jangan masukkan golongan dewasa..

O Ya
O Tidak
O Tidak Pasti
O Saya tidak mahu menjawab soalan ini

*SEKIRANYA ANDA MENJAWAB "YA", SILA JAWAB SOALAN KE 8 SEHINGGA 12.
*SEKIRANYA ANDA MENJAWAB **"TIDAK" / "TIDAK PASTI" /"TIDAK MAHU MENJAWAB"**, SOAL SELIDIK ANDA TAMAT DISINI.

2.Berapa orang rakan sebaya dengan anda yang kamu ketahui mempunyai masalah gangguan mental atau krisis gangguan mental?

Hanya jawab soalan ini sekiranya anda menjawab "YA" pada soalan 7 Bahagian F.

O 1
O 2
O 3
O Lebih dari 3 (sila jelaskan)_____

Sekiranya anda pernah berjumpa dengan rakan sebaya anda yang anda rasa mempunyai masalah gangguan mental, sila jawab soalan dibawah mengenai rakan tersebut.

Sekiranya anda pernah berjumpa lebih dari seorang, sila hanya pilih seorang yang paling rapat dengan anda dan jawab soalan di bawah berdasarkan orang tersebut.

3. Adakah anda pernah memberi sebarang bantuan kepada mereka?

O Ya
O Tidak
O Tidak Pasti

Berikut merupakan soalan mengenai perkara yang kamu pernah lakukan untuk membantu orang tersebut.

Hanya jawab soalan ini sekiranya anda menjawab "YA" pada soalan 7 Bahagian F.

4.Apa yang anda telah lakukan untuk membantu orang tersebut?

Nota : anda boleh pilih lebih dari satu soalan

O A. Memberitahu dia apa yang boleh dilakukan untuk mengatasi masalah tersebut.

O B. Mengajaknya untuk keluar bersama dan melakukan sesuatu yang seronok bersama.

O C. Abaikan dia kerana dia hanya inginkan perhatian

O D. Memberitahu dia bahawa saya tidak ingin berkawan dengannya lagi sekiranya dia masih bersifat begitu sepanjang masa.

O E. Elakkan bercakap mengenai bunuh diri kerana ia mungkin mempengaruhinya untuk membunuh diri.

O F. Memberitahunya yang saya mengetahui yang dia mempunyai masalah dan ingin memastikan bahawa dia dalam keadaan baik

O G. Mencadangkan kepada dia untuk memberitahu kaunselor / doktor/ ahli psikologi tentang masalah yang dihadapinya.

O H. Mencadangkan kepada beliau mnenceritakan masalahnya kepada orang yang lebih dewasa seperti ibu bapa dan guru.

O I. Bertanya kepadanya adalah dia berfikir untuk membunuh diri / melakukan sesuatu yang buruk kepada diri sendiri

O J. Menggalakkan dia untuk bertanggungjawab dan menyelesaikan masalahnya sendiri

O K. Mendengar masalah beliau

O L. Tidak berbuat apa-apa

O M. Lain-Lain (sila nyatakan)

5. Adakah anda rasa membantu mereka merupakan tanggungjawab anda?

O Ya

O Tidak

O Tidak Pasti

6. Sekiranya tidak, sila nyatakan siapakah yang perlu bertanggungjawab?

_____

APPENDIX E:

Gantt Chart

The Gantt chart of the research project

	September 19	October 19	November 19	December 19	January 20	February 20	March 20	April 20	May 20	June 20	July 20	August 20	September 20
Preparation of research proposal	√	√	√	√									
Research proposal defend				√									
Ethic Defend					√								
ERAS Application					√								
Pilot Study					√								
Data Collection					√	√	√	√					
Analysis of Data									√	√	√		
Write up										√	√	√	
Submission													√

APPENDIX F:

University Malaysia Sarawak (UNIMAS) Ethics Committee approval letter

. ..kulti Perubatan dan Sains Kesihatan
Faculty of Medicine and Health Sciences

UNIMAS/NC-21.02/03-02 Jld.4 (44)

22 Januari 2020

Dr Muhammad Najib Bin Hasan@Ahmad
Fakulti Perubatan Dan Sains Kesihatan
Universiti Malaysia Sarawak
94300 Kota Samarahan,
Sarawak.

Dr,

Kelulusan Mesyuarat Etika Perubatan Untuk Kajian:
- Helping Intention Of Adolescent Toward Peers With Depressive Symptoms In Kuching Division.

Dengan segala hormatnya perkara di atas dirujuk.

Sukacita dimaklumkan bahawa kertas kerja penyelidikan seperti di atas yang dijalankan oleh Dr Muhammad Najib Bin Hasan@Ahmad dan diselia oleh Prof Madya Dr Helmy Hazmi telah diluluskan dalam Mesyuarat Jawatankuasa Etika Perubatan Fakulti bil 01/2020 pada 7 Januari 2020.

Sehubungan itu, penyelidikan tersebut boleh dimulakan dan diharap ia dapat dijalankan seperti yang dirancang.

Yang benar,

Professor Dr Lela Hj Su'ut
Pengerusi
Jawatankuasa Etika Perubatan
Fakulti Perubatan dan Sains Kesihatan

APPENDIX G:

Permission Letter from Ministry of Education

KEMENTERIAN PENDIDIKAN MALAYSIA
BAHAGIAN PERANCANGAN DAN PENYELIDIKAN DASAR PENDIDIKAN
ARAS 1-4, BLOK E8
KOMPLEKS KERAJAAN PARCEL E
PUSAT PENTADBIRAN KERAJAAN PERSEKUTUAN
62604 PUTRAJAYA

TEL 0388846591
FAKS 0388846579

Ruj. Kami : KPM.600-3/2/3-eras(6451)
Tarikh : 28 Januari 2020

MUHAMMAD NAJIB BIN HASAN @ AHMAD
NO. KP : 880605525693

NO 15, TIYA RESIDENCY, LORONG PUSTAKA 2E, PETRAJAYA
KUCHING 93050 KUCHING
SARAWAK

Tuan,

KELULUSAN BERSYARAT UNTUK MENJALANKAN KAJIAN :
FAKTOR MEMPENGARUHI KEINGINAN UNTUK MEMBANTU RAKAN YANG MEMPUNYAI TANDA-TANDA KEMURUNGAN DI KALANGAN REMAJA DI BAHAGIAN KUCHING, SARAWAK

Perkara di atas adalah dirujuk.

2 Sukacita dimaklumkan bahawa permohonan tuan untuk menjalankan kajian seperti di bawah telah diluluskan dengan syarat :

" MURID TINGKATAN 3 DAN 5 TIDAK DILIBATKAN DALAM KAJIAN INI "

3. Kelulusan adalah berdasarkan kepada kertas cadangan penyelidikan dan instrumen kajian yang dikemukakan oleh tuan kepada bahagian ini. Walau bagaimanapun kelulusan ini bergantung kepada kebenaran Jabatan Pendidikan Negeri dan Pengetua / Guru Besar yang berkenaan.

4. Surat kelulusan ini sah digunakan bermula dari **30 Januari 2020** hingga **30 Jun 2020**

5. Tuan dikehendaki menyerahkan senaskhah laporan akhir kajian dalam bentuk *hardcopy* bersama salinan *softcopy* berformat pdf dalam CD kepada Bahagian ini.Tuan juga diingatkan supaya mendapat kebenaran terlebih dahulu daripada Bahagian ini sekiranya sebahagian atau sepenuhnya dapatan kajian tersebut hendak diterbitkan di mana-mana forum, seminar atau diumumkan kepada media massa.

Sekian untuk makluman dan tindakan tuan selanjutnya. Terima kasih.

"BERKHIDMAT UNTUK NEGARA"

Saya yang menjalankan amanah,

Ketua Sektor
Sektor Penyelidikan dan Penilaian
b.p. Pengarah
Bahagian Perancangan dan Penyelidikan Dasar Pendidikan
Kementerian Pendidikan Malaysia

salinan kepada:-

JABATAN PENDIDIKAN SARAWAK

* SURAT INI DIJANA OLEH KOMPUTER DAN TIADA TANDATANGAN DIPERLUKAN *