Faculty of Medicine and Health Sciences

Posttraumatic Stress Disorder and Depressive Symptoms: It's Prevalence and the Role of Stigma as a Mediating Factor in Help-Seeking Behaviours among University Students in Sarawak

Faizul Bin Adenan

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Posttraumatic Stress Disorder and Depressive Symptoms: Its Prevalence and the Role of Stigma as a Mediating Factor in Help-Seeking Behaviours among University Students in Sarawak

Faizul Bin Adenan

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DECLARATION

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

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Signature

Name: Faizul bin Adenan

Matric No.: 14020018

Faculty of Medicine and Health Sciences

Universiti Malaysia Sarawak

Date :

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ABSTRACT

The present study investigated Posttraumatic Stress Disorder (PTSD), depressive symptoms and its relationship with stigma and help seeking behavior among university students in Sarawak. The high prevalence of mental disorders among university students has been investigated in Malaysia but the study on PTSD is almost none. Meanwhile, an attempt was made to improve the study of depressive symptom in this study. Stigma towards mental disorders sufferers are still strong in this country including among our university students. Strong stigma may lead to unwillingness in help seeking behavior. A cross-sectional research design was conducted; a non-probability sampling was used with a total number of 624 students from 3 different higher institutions in Sarawak participated in this study. A pilot study was conducted prior to the actual study. All participants were briefed with issues of confidentiality and their rights. The Research and Ethics Committee, Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak approved this study. Results showed that at least 88% of the participant reported of having at least one direct or indirect trauma experience. The five most prevalent trauma exposure overalls (direct and indirect) were road accident (67.4%), loss of a family member (by death) 62.6%, serious illness (32.7%), almost drowning (29.9%) and divorce (28.6%). There was significantly more male than female in experiencing certain types of trauma. Results showed that 17.9% students reported exhibiting PTSD symptoms and 20% students reported having depressive symptoms. Both male and female students exhibited equal score of PTSD and depressive symptoms. Those who have PTSD tend to report significant depressive symptoms as well. Results also showed that 51.9% have high stigma. Both genders have the same score of stigma regardless of their mental health status. Of 624 participants, only 41.9% reported that they would likely to seek

help when they have personal problem. Female (75.1%) were more likely to seek help as compared to male (24.9%). The three main help sources for those who have personal and emotional problem were parent, intimate partner, and mental health professional. Those with PTSD tend to report higher score for help seeking behavior. However, students who have depressive and without depressive symptoms equally have similar score in help seeking behavior. Multiple regression analyses also show that stigma does not play a mediator role for PTSD or depressive students in help-seeking behaviors. Some implications of this research finding were discussed in relation to clinical practices and research. Several suggestions and recommendations were also presented in order to improve future research.

Keywords: PTSD, depression, university student, stigma, help seeking behavior

Simptom Gangguan Stres Pasca-Trauma (PTSD) dan Simptom Kemurungan: Kelaziman dan Peranan Stigma sebagai Faktor Penentu dalam Sikap Ingin Meminta Bantuan di Kalangan Pelajar Universiti di Sarawak

ABSTRAK

Kajian ini dijalankan adalah untuk mengkaji PTSD, kemurungan dan hubungan dengan stigma serta sikap ingin meminta bantuan di kalangan pelajar universiti di Sarawak. Kajian dalam gangguan mental telah banyak dijalankan di kalangan pelajar universiti di Malaysia namun kajian terhadap PTSD adalah kurang. Di samping itu, kajian berkenaan kemurungan turut dijalankan bagi menambah baik kajian ini. Stigma dalam kalangan penghidap gangguan mental masih kerap berlaku terutamanya pelajar universiti. Stigma yang kuat boleh menyebabkan keengganan dalam sikap ingin meminta bantuan. Satu bentuk penyiasatan keratan rentas telah dijalankan menggunakan pensampelan bukan probabiliti. Seramai 624 pelajar dari 3 buah institusi di Sarawak telah terlibat dalam kajian ini. Kajian rintis telah dijalankan terlebih dahulu sebelum kajian sebenar dijalankan. Kesemua pelajar yang terlibat telah diberi taklimat berkenaan isu maklumat sulit dan hak mereka dalam kajian tersebut. Kajian ini telah mendapat persetujuan Jawatankuasa Penyelidikan dan Etika, Fakulti Perubatan dan Sains Kesihatan, Universiti Malaysia Sarawak. Dapatan kajian menunjukkan sekurang-kurangnya 88% daripada jumlah pelajar mengalami satu trauma sama ada secara langsung atau tidak langsung. Lima kategori trauma yang paling tinggi direkodkan (secara langsung atau tidak langsung) adalah kemalangan jalan raya (67.4%), kehilangan ahli keluarga (kematian) 62.6%, penyakit yang serious/kronik (32.7%), hampir lemas (29.9%) dan penceraian (28.6%). Kajian juga menunjukkan lelaki lebih ketara mengalami trauma yang tertentu berbanding perempuan. Kajian yang dijalankan menunjukkan 17.9% pelajar mengalami tanda-tanda PTSD dan 20% pelajar mengalami

tanda-tanda kemurungan. Hasil dapatan menunjukkan rekod tanda-tanda PTSD dan kemurungan antara pelajar lelaki dan perempuan adalah sama. Penghidap PTSD juga cenderung menunjukkan tanda-tanda kemurungan. Hasil kajian merekodkan 51.9% mengalami stigma yang tinggi. Kedua-dua jantina menunjukkan hasil stigma yang sama tanpa mengira keadaan kesihatan mental. Hasil dapatan juga menunjukkan hanya 41.9% dilaporkan meminta bantuan semasa mengalami masalah peribadi daripada keseluruhan 624 pelajar. Pelajar perempuan (75.1%) lebih cenderung untuk meminta bantuan berbanding pelajar lelaki (24.9%). Ibubapa, rakan intim dan pakar kesihatan mental adalah tiga kategori sumber rujukan utama bagi mereka yang mengalami masalah peribadi. Mereka yang mengalami PTSD menunjukkan skor yang tinggi dalam sikap ingin meminta bantuan. Namun, pelajar yang mengalami kemurungan dan tidak mengalami kemurungan menunjukkan skor yang sama dalam sikap ingin meminta bantuan ini. Analisis regresi pelbagai juga menunjukkan stigma tidak memainkan peranan dalam mediator untuk PTSD atau kemurungan dalam sikap ingin meminta bantuan. Beberapa implikasi dari hasil kajian telah dibincangkan dalam amalan dan penyelidikan klinikal. Beberapa cadangan juga telah dibincangkan bagi memperbaiki kajian di masa hadapan.

Kata kunci: *PTSD, kemurungan, pelajar universiti, stigma, sikap ingin meminta bantuan*

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CHAPTER 1

INTRODUCTION

1.1 Prevalence of Mental Disorder among University Students

The high prevalence of mental disorders among university students has been documented by many studied abroad (Karam, Kypri & Salamon, 2007; Blanco et al., 2008; Stallman, 2008). More than 90% of psychological counselling centers directors expressed their concern regarding the increasing mental health problems among college students recently which include anxiety disorder, crisis requiring immediate response, psychiatric medication issues, clinical depression, learning disabilities, sexual assault on campus, self-injuries and problem related to earlier sexual abuse (Gallaher, 2015). In fact, the mental health trouble is anticipated to growth by 15% via year, and the numbers of lawsuit documenting mental health problem among university students are on the boom each year (Zivin, Eisenberg, Gollust & Golberstein, 2009). Meanwhile, a previous study has shown that majority of mental disorders have been diagnosed when patients were at the age between 15 and 24 years old. It was also discovered that a median delay of 11 years for them to get helps and used professional psychological services (Suk Kyung, Seong In, Ji Hee, Mi Kyoung, Kim & Sang Min, 2013).

In Malaysia, although it is limited, several studies were conducted to report mental health problem among university students. For example, 41.9% of medical students in Universiti Putra Malaysia exhibited some psychological disturbance symptoms (Sherina, Lekhraj & Nadarajan, 2003). Meanwhile, the prevalence of students who have mental health issues remain high since the past few years. For example, 34% of university students from five public universities reported having symptoms of mental health problem (Nordin, Talib, Yaacob & Sabran, 2010). This include the most recent mental health study that estimated

49.3% (149 students) of university students who attended Youth Health Fair program in a public university in Malaysia had symptoms of psychological stress (Phang et al., 2015).

The need to study mental health condition among Malaysia university students is also justified by the increasing enrolment of university students in these recent years. According to the Ministry of Higher Education Malaysia (2015), there are 20 public universities, 34 polytechnic schools with 96,069 students, and 94 community colleges as per December 2015 which consist 18,529 students. Meanwhile in Sarawak, there are 3 public universities, 3 polytechnic and 6 college community. As per 21 May 2014, public higher institution had enrolled 560,359 students in Malaysia, which include Sabah and Sarawak. Percentages and ratio of students by gender showed that, 61.02% (341,934) was female and the balances are male. From the total amount, 77.87% was undergraduate, 16.94% postgraduate and other 5.19% (Ministry of Higher Education Malaysia, 2015).

While the prevalence of mental disorder is continuously rising (UK Royal College of Psychiatrists, 2011), the public perceptions towards mental disorders and those who have been diagnosed with mental illness are negative (Shyangwa, Singh & Khandelwal, 2003). Studying on help seeking behavior for mental disorders among college students in the United States indicated that, stigma is still high towards people who have mental illness. Thus, many college students avoided seeking help even though they recognized they do need it (Eisenberg, Downs, Golberstein & Zivin, 2009).

A few studies to survey symptoms of mental disorders were conducted in Malaysia previously (Sherina et al., 2003; Teoh, 2010; Phang et al., 2015). These studies were rather general in reporting the actual symptoms of mental disorder among our university students. While the number of enrolments has been increasing, the prevalence of mental disorder symptoms are quite alarming, there is no study so far to systematically investigate symptoms

of depression, psychological trauma, in relation to stigma and help seeking behavior. The rationale to study these topics will be clarified in the literature review sections.

1.2 Posttraumatic Stress Disorder (PTSD)

Posttraumatic stress disorder (PTSD) is a category of mental disorder that has been classified in Diagnostic and Statistical Manual of Mental Disorder, fifth edition (DSM-5) as four clusters of symptoms; firstly, re-experiencing of the trauma, secondly, avoidance of trauma related stimulus, thirdly, negative cognitions, and finally, mood and arousal (APA, 2013). PTSD is a regular mental turmoil following awful occasion that leads into intensive fear, helplessness, or loss. PTSD genuinely disturbs a person's daily life works and regularly commonly co-exist with gloom and uneasiness. The traumatic events could be catastrophic occasion, for example, sea tempest, flood, and earthquake. They also could be human-produce factors such as war, motor vehicle accidents, death of relatives, separation, abuse and sexual maltreatment. If PTSD left untreated, it may continue for quit long time, bringing about extreme daily life dysfunctioning and difficult life challenges for both the patients and the public in general (Stein et al., 2003).

The clinical features of PTSD might be different from one individual to another. In certain people, many experienced feeling of constant threats, passionate, and social withdrawal may prevail. On other individuals, a hedonic or dysphonic temperament states and negative insights might be generally upsetting. Meanwhile for some individuals, elevated mood symptoms and reactions are prominent. Many PTSD sufferers exhibited a significant emotional numbness and feeling of detachment strongly and a few people display several of these signs (APA, 2013).

1.3 Depression

Recently, depression has become a critical public health concern in our society. It contributes to physical, financial, and relational problem for individual experiencing the condition, together with families and society (US Department of Health and Human Services, 2000; Zlotnick, Zimmerman, Wolfdorf & Mattia, 2001). Individual with depression have to struggles with chronic symptoms nearly every day including significant weight change and suicidal ideation, as indicated in DSM-5 (APA, 2013). National Institute of Mental Health United Stated (2018) describes signs and symptoms of depression as the following:

> "Persistent sad, on edge, or "empty" mood; feelings of hopelessness, or pessimism; irritability; sentiments of blame, uselessness, or defenselessness; loss of interest or joy in hobbies and exercises; diminished vitality or exhaustion; moving or talking gradually; feeling anxious or experience difficulty sitting still; trouble thinking, recalling, or deciding; trouble resting, early-morning arousing, or sleeping late; craving or additionally weight changes; thoughts of death or suicide, or suicide endeavors; aches or pains, cerebral pain, cramps, or stomach problems without a clear physical reason and/or that do not ease even with treatment".

1.4 Stigma

Stigma has been described as a sign of discredit or disgrace which distances a person from others (Bryne, 2000). Both stigma and discrimination has been seen to be huge obstacles to mental health help seeking, mental health recovery and social inclusion (Corrigan, 2008). In mental health, stigma can be described in two aspects; 1) public stigma in which the public reaction to those who have mental disorders or symptoms 2) self-stigma

is when individuals with mental illness become prejudice and dislike themselves (Corrigan & Watson, 2002). At the same time, the two aspects of both public and self-stigma can be described in three components: stereotypes, prejudice, and discrimination. Additionally, stigma also can be conceptualized as humiliating, dishonor or poor acceptance which results in social isolation, discriminated in opposition to, and being denied for their participation in social events (Bebbington et al., 2001).

There are some factors that affect help seeking behavior especially among depressed college students who are in a critical phase early adulthood (Wang, Peng, Li & Peng, 2015). Wang et al. (2015) suggested that help seeking behavior can be improved by understanding stigma. Indirectly it would help our university or college student to look for assistance a lot earlier and subsequently, to receive immediate treatment and more positive treatment outcome.

Help seeking behavior would not only be influenced by the presence of mental disorders itself, it also would be affected by presence of other aspects of stigma components such as prejudice, stereotype and discrimination by public towards those who suffer from mental illness (Corrigan, 2004). Stigma is furthermore classified into two subtypes, public stigma and perceived stigma (Griffiths, Christensen, Jorm, Evans & Groves, 2004; Corrigan, Kerr & Knudsen, 2005). Public stigma is a collection of negative interpretations and qualities for those who suffer from mental disorder. This might include their prejudices and negative stereotypes. Meanwhile, perceived stigma can be defined as the individual's perception towards public stigma (Corrigan et al., 2005). Individual or personal stigma is characterized as people demeanor towards those who have depression and perceived stigma includes public convictions about the adverse mentalities of other individuals (Griffiths et al., 2004).

1.5 Help Seeking Behaviour

Help seeking behavior is an important component in studying mental health services. Barker (2007) described help-seeking as the utilization of "formal" supports that narrowly seek services or therapies for specific sickness or ailments. Positive adolescent development outcomes are the result of adolescents who actively seeking help, having connection with other individuals and positively perceived ability and the accessibility of help either by individuals or institutions (Barker, 2007). Help seeking behavior can be divided into three categories among adolescents: 1) Help-seeking behavior for specific health needs, 2) help-seeking behavior for normative developmental needs and 3) help-seeking behavior for personal stress or problems (Barker, 2007). Help-seeking behavior may be a protective means for adolescents including their health and developmental outcomes (Barker, 2007).

Help seeking behaviors is the behavior of enthusiastically finding for help from other people (Rickwood, Deane, Wilson & Ciarrochi, 2005). It is important to seek more information and guidance from others regarding mental illness. Obtaining accurate information regarding mental illness might increase help-seeking behavior. Richwood and Thomas (2012) defined two types of help seeking behaviors. First, formal help-seeking can be considered as assistance from experts who are qualified and possess recognized professional role in giving helps and assistance, supports and/or treatment. Meanwhile, informal help-seeking can be derived from informal social setting and connections which includes family members, relatives and friends. Although the prevalence of mental health problem seems increasing, there numbers of university students who voluntarily come for treatment remain low.

1.6 Problem Statement

National Alliance on Mental Illness (2012) where conducted a survey among university students who quit going to school within the past five years. Results showed that most of them could not continue their study as a result of their mental health issue. It was estimated that 64% of them gave mental health problems as the main reason to quit college study, according to the survey. In this survey, no specific mental health symptoms were presented.

Previous study on 307 Malaysia secondary school children found quite higher rates of depressive symptoms, while primary younger students report higher rates of social issues (Teoh, 2010). It remains unclear if the higher rates of depressive symptoms are connected with children who had trauma exposure. We still do not know if children who have trauma exposure can emotionally and mentally cope with their previous history of having trauma during their adulthood. Meaning that exposure to lifetime trauma and depression during primary and secondary school has yet to be understood. This study fills in the knowledge gap. A study conducted by Meor et al. (2011) focused more on the level of mental health knowledge among students of public institutions in Malaysia. However, the study did not focus on in-depth description of stigma towards students. The participants for this study were rather small; only 30 students participated, and they only recruited University Kebangsaan Malaysia students. Therefore, more research should be conducted among wider population especially in Sarawak.

A study on stigma evidently showed that stigma towards mental disorders affect wide range of public and professionals. For example, a previous study at the Ondokuz Mayis University Medical School Department of Psychiatry, Samsun, Turkey found that final year medical students have not developed a professional attitude towards psychiatric patients.

They tend to stigmatize and refuse to develop contact and socialize with patients with mental illness (Aker, Aker, Boke, Dundar, Sahin & Peksen, 2007). Meanwhile, it is estimated that the mental health problems and psychological distress has been increasing over the past 10 years among our university students (Sherina et al., 2003; Nordin, Talib, Yaacob & Sabran, 2010; Teoh, 2010; Phang et al., 2015).

It remains unknown what types of mental disorders contribute the most in this increasing prevalence. Moreover, study should focus on university students if they have the same stigma towards mental disorders. Hence, it might indirectly contribute to the increasing prevalence of mental disorders among university students over the years.

In Malaysia, previous research investigated perceptions on stigma and discrimination experienced by mental disorders patient in the perspective of mental health professional (Hanafiah & Bortel, 2005). They interviewed 15 mental health professionals utilizing a semi-structured in Kuala Lumpur and Selangor. There were 6 females and 9 males aged between 35-65 years old with educational and training background as psychiatrists, clinical psychologists or counselors both from government and private institutions providing services such as psychiatrist treatment, psychological therapy and counseling. The result of this study suggested that the prevalence for these issues in Malaysia is still high. If stigma and discrimination is still high according to mental health professional perspectives, perhaps stigma towards mental disorders also high among our students. Unfortunately, a study among our university students in Malaysia, especially in Sarawak has not yet to be conducted.

In a study by Rickwood and Thomas (2012) showed almost half (45%) of the publications on help seeking behavior were from the USA; 15% from Australia; 8% from the UK; 6% from Canada; 4% from the Netherland; and 3% from New Zealand. A different

range of other countries made up the remaining 18% of the publications, but there were fewer than 2% of articles from any particular country. There were less articles reported studies from Malaysia which are related to help seeking behaviors, PTSD and depression. Additionally, most of these studies did not focus on university students. While help seeking behaviors are defined in many various terms in mental health services, many previous studies were conducted mostly in the Western Europe, North America and Australia (Barker, 2007). The needs to investigate help seeking behavior among our college students thus are justified.

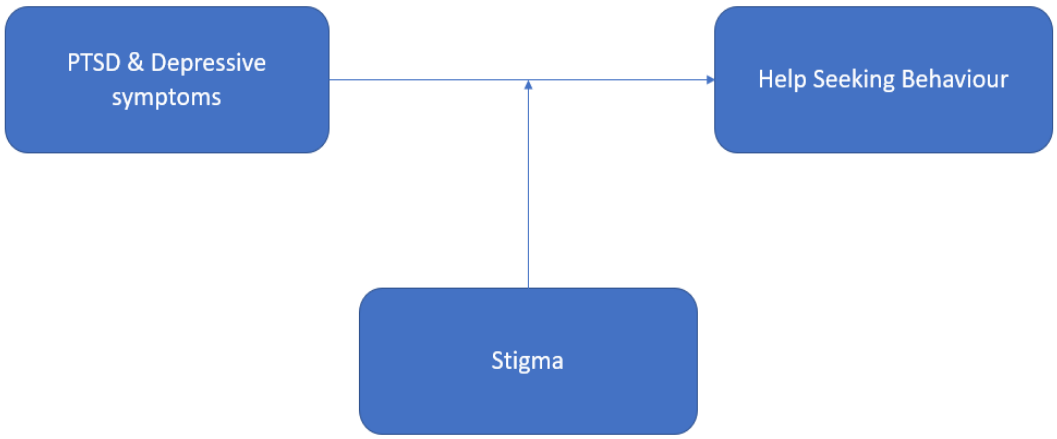

Figure 1.1: Conceptual Framework of the Study

1.7 Research Objectives

i) To determine the prevalence of PTSD and depressive symptoms among college students.

ii) To examine the prevalence of students who have stigma towards mental disorders.

iii) To examine the prevalence of students who have help seeking behavior for their mental health problems.

iv) To identify if stigma mediate help seeking behavior students among those who have symptoms of PTSD and depressive symptoms.

1.8 Research Questions

i. What is the prevalence of PTSD and depressive symptoms among University Students?

ii. What is the prevalence of students who have stigma towards mental disorders?

iii. What is the prevalence of students who would seek help for mental disorder problems?

iv. Does stigma predict on help seeking behavior among students who have PTSD and depressive symptoms?

CHAPTER 2

LITERATURE REVIEW

2.1 Lifetime Trauma Exposure

Studies on trauma exposure and its prevalence outside of Malaysia have been quite established (Elklit & Petersen, 2008; Shen, 2009; Vries & Olff, 2009; Reyes-Rodriguez, Rivera-Medina, Camara-Fuentes, Suarez-Torres & Bernal, 2013). However, studies on trauma among college students were almost rare and very limited in Malaysia as well as abroad. Some other worldwide prevalence on lifetime traumatic exposure in a university or college students was conducted in Turkey: emotional abuse and neglect (49.1%), physical abuse (46.4%), sexual abuse (22.8%), (Celik & Odaci, 2012), United States: poly-victimization/ victimization (97.4%), (Richmond, Elliott, Pierce, Aspelmeier & Alexander, 2009), Egypt: sexual abuse (29.8%), (Aboul-Hagag & Hamed, 2012), Taiwan: interparental violence and child physical maltreatment (11.3%), (Shen, 2009), Puerto Rico: death of a family member or close friend (22%), illness (10%), parental divorce (4%), (Reyes-Rodriguez et al., 2013). Most of these studies focused on reporting childhood abuse; therefore, we need to address all forms of trauma exposure incidents for better understanding of PTSD and depression among university students.

Although studies on trauma exposure are relatively new, many researchers have conducted their research to identify the prevalence of trauma exposure among our general population. In the U.S, it is assessed that around 89.7% of the general community has experience a high-extent, potentially traumatic event (e.g., serious accident, catastrophic event, or seeing an injury) (Kilpatrick, Resnick, Milnak, Miller, Keyes & Friedman, 2013). Another study was conducted in Netherland with a sample of 1087 adult aged 18 to 80 years old. They found that the prevalence of trauma in lifetime are varied based on different types

of traumatic events. For example, some traumatic event occurred under 2% of the population (e.g., held hostage/abducted, battle experience) and others in over 20% (e.g., risk/use of physical viciousness, seeing severe traffic collisions). The most prevalent trauma exposure was unexpected death of loved one, with over half of the sample experienced this type of event. The lifetime prevalence of exposure to any trauma was 80.7% and there has been no difference between males and females (Vries & Olff, 2009).

Similar percentage was found in a study conducted by Elklit and Petersen (2008). They conducted a study on the prevalence of traumatic events exposure among representative samples from four different countries; Lithuania, Denmark, Iceland, and the Faroe Islands. Their discovered that 90% of youth experienced at least one traumatic event in their lifetime. The most well-known reported traumatic event was death of family member, threats of physical assaults, bullying, almost drowning, and motor vehicle accidents. On the other hand, a slightly lower percentage was reported in a study conducted by Ghazali et al. (2014). Approximately 77.6% of the teenagers had encountered or seen at least one traumatic event during their lifetime. The most common reported lifetime trauma by Malaysian youth were motor vehicle accidents, death of a friend or family member, almost drowning and life-threatening illness (Ghazali, Elklit, Balang, Sultan & Kana, 2014). While among teenager, trauma exposure seems quite high and death of loved one can be traumatized, therefore similar question remains unanswered among our university students.

Although previous studies on trauma exposure study among university or college students were limited, a few studies have reported various prevalence in different countries (Lawler, Ouimette & Dahlstedt, 2005; Frazier, Anders, Perera, Tomich, Tennen, Park & Tashiro, 2009; Vernon, Dillon & Steiner, 2009; Anders, Frazier & Shallcross, 2012; Bantjes et al., 2016). For example, it was estimated that 85% of young adult university students

experienced comparable traumatic events like the general population (Frazier et al., 2009). Meanwhile, recent study found that almost 89% of undergraduate and community college students had lifetime trauma experience (Anders et al., 2012). Slightly higher prevalence of trauma exposure was reported when a study was conducted among female college students. It was reported that 90.1% from a total number of 182 participants had at least one or more direct trauma experience. All studies reported high prevalence of trauma exposure a few years ago. While a few systematic studies have been conducted abroad, almost no study has been conducted so far among our university students in Malaysia.

2.1.1 Lifetime Trauma in Relation to Gender

The prevalence of trauma exposure between female and male was established previously (Kilparick et al., 2013). For example, male respondents experienced more serious danger and physical brutality, accidents, and disaster than females. Male were likely to serve in war zone and rescue work; thus, they were exposed in physical injuries, accidents and natural disasters. In contrast, more females than male experienced more sexual assaults, life-threatening illness or loss of a child. The study found that there were significant gender differences with the estimations of double rate for females compare to male to be exposed in sexual assaults, serious illnesses and a risk for losing a child because of death during birth (Vries & Olff, 2009).

Another interesting study was conducted to see if trauma victims among pathological gambler significantly high incident of suicide had than those who did not have traumatic experience. Result demonstrates that both male and female obsessive gamblers had reported equal prevalence of attempting suicide. Most significant research outcome showed that pathological gamblers with strong histories of trauma exposure have significantly attempted

to commit suicide than those who did not have trauma exposure (Kausch, Rugle & Rowland, 2006). This study indicates that trauma exposure can lead more serious risk among those who suffers from other mental illness.

2.1.2 Childhood Trauma Exposure

Childhood trauma studies are widely reported in many literatures. For example, Kaufman (1999) reported, approximately 91.5% of respondents reported that most abuse happened when they were a child. The most frequently reported type of childhood trauma was unstable and disruptive home, drug abuse which was commonly done by fathers or their stepfathers (Kausch et al., 2006). Numerous scenes of aggressive behavior occurred at home. Domestic violence occurred in a form of emotional abuse (38.5% was perpetrated by the father and 33.3% were perpetrated by the mother) and physical abuse (43.2% by the father and 27% by the mother). While, sexual maltreatment was most normally done by neighbors (22.6% of case) and by the father (12.9% of cases). Nonetheless, a wide assortment of people was adolescent, including cousins, uncle, an auntie, a mother, a stepmother, grandfathers, sisters, a non-permanent father, boys in orphanage, a family companion, teachers and a babysitter (Kausch et al., 2006).

In the meantime, clinically, maltreatment in youth had been connected to post-traumatic stress disorder, depression, self-destructive behavior, dietary problem, attention deficit hyperactivity disorder, medication and liquor issues, and sexually inappropriate and antisocial behavior (Kaufman, 1999). Clearly the childhood abuse can severely affected adulthood mental health, establishing the prevalence of childhood trauma exposure can significantly contributes to the importance of mental health promotion and intervention among our university students.

2.2 Posttraumatic Stress Disorder (PTSD)

PTSD is a serious mental disturbance as a result of experiencing traumatic event (APA, 2013). Studies on PTSD have received some highlights in Malaysia recently. For example, based on Detailed Assessment of Posttraumatic Stress (DAPS) assessment, 12 out of 64 respondents among survivors of the December 26th 2004 Malaysian tsunami disaster from several affected districts developed PTSD (Ponnusamy, Chin, Shazli, Aishvarya & Raynuha, 2009). Approximately 56 respondents (83%) was given instrumental guides, and they also received counselling and psychotherapy from different organizations and mental health professionals. This indicates that establishing high prevalence of trauma exposure and PTSD can lead to more significant application of research findings, intervention and prevention efforts.

Several studies were conducted to determine the nature of trauma exposure in relation to the development of PTSD. There are some correlations between the characteristic of parents and PTSD, symptoms of depression and anxiety among children following traumatic events. For instance, PTSD was exceedingly identified with fathers as opposed to mother mental health issues, particularly those with PTSD and depressive symptoms (Kilic, Ozguyen & Sayil, 2003). Young children who experienced death or injury of a relative were at risk to suffer from PTSD, anxiety and depression. Direct exposure to terrible traumatic incidents is significantly increase the risk to suffer from PTSD (Fan, Zhang, Yang, Mo & Liu, 2011). Different with Kolaitis et al. (2003) study, Kilpatrick et al. (2013) found that among children, PTSD strongly and significantly associated with the closeness of disaster exposure, but the children's closeness to their parents' psychological reactions to the disaster would not increase their risk to suffer from PTSD. From other perspective, it is estimated that there were 8.3% of PTSD prevalence in the general population (Kilpatrick et al., 2013).

Several studies were also conducted to report PTSD rates among college and university students. A study among 339 female students in the University of Hawaii Health Centre found that 12.2% exhibited full symptoms of DSM-IV PTSD diagnosis (Watson & Haynes, 2007). A larger number of newly matriculated students were recruited in another study. This study involved 3,014 students reported that 9% met DSM-IV-TR PTSD criteria with 66% were linked to have exposure with Criteria A PTSD diagnosis (Read, Ouimette, White, Colder & Farrow 2011). Both studies used DSM-IV as their diagnosis criteria while the current study used DSM-5 (APA, 2013) as our criteria to report PTSD symptoms.

PTSD may also associate with gender. Most studies found that female reported more PTSD symptoms than male. For example, a study found that 5.2% of the females developed PTSD while 1.8% of the male in the United States developed PTSD during their lifetime (Kessler, Chiu, Demler, Merikangas & Walters 2005). Similarly, more recent study found that the prevalence of PTSD for female was 12.8% while for male was 5.7% among general population in the USA (Kilpatrick et al., 2013). From sex differences perspective in PTSD, the study also emphasized that while males are most certain than females to be involved in at least one trauma overall, women are more likely than men to encounter a trauma related with high risk of developing PTSD (for example rape). It appears that women were more at risk of psychological distress, estimated by method for an assortment result, when exposed to disasters. A study of PTSD among university students had found similar pattern. Female reported significantly higher rate of PTSD than their male counter parts (Watson & Haynes, 2007; Read et al., 2011).

On the other hand, another study found that there were no significant differences in the PTSD between male and female respondents (Ponnusamy et al., 2009). It was recommended that although the theories of gender differences in trauma reactions including

some gender differences in brain morphology, social meanings of trauma, Ponnusamy et al. (2009) strongly believe that PTSD symptoms manifestation between gender are the same, based on their experimental proof. Another reason that can lead to differences in findings was that the instruments measuring severity of PTSD could be different (Zlotnick et al., 2001). To overcome this issue, most frequently used and validated instrument is used in this study.

Previous studies on PTSD among general population have established the fact is that males have more significant tendencies to experience trauma related to violence, war, vehicle accidents and natural disasters. On the other hand, females tend to be significantly exposed with physical and sexual assaults in their relationships, (Olff, Langeland, Draijer & Gerson, 2007; Vries & Olff, 2009). Meanwhile in Elklit and Petersen (2008) study, they estimated lifetime prevalence for male PTSD was 14.6%, while females experience PTSD more than their male counterpart within two and half time. Thus, it is sufficient to summarize that males have significantly experienced more traumatic event in motor vehicle accidents, almost being injured and faced threats to physical assaults, and near drowning. On the other hand, females reported significantly more exposure of attempted suicide, losing someone they love or close, sexual abuse, and having an absent parent.

2.3 Depression

The American Psychiatric Association reported that depression is common mental disorders and can negatively affect individual life (APA, 2013). It can affect an individual in any phase of life including among our university students (Gallagher, 2009). The impact of depression can be tremendous on the students' life. It can affect academic performance (Hysenbegasi, Hass & Rowland (2005); physical health and hopelessness

(Taliaferro, Rienzo, Pigg, Miller & Dodd, 2009); exercise motivation and self-injury (Bonne & Brausch, 2016); and ultimately suicide behaviour and attempts (Vázquez & Blanco, 2006). The causes of depression may be varied. One of the reasons is that college students realize that upon graduation job opportunities are limited which may build their anxiety and lead to feelings of constant pressure and depression (Dusselier et al., 2005).

Studies on prevalence of depression among general population has been quite established (Merikangas et al., 2010; Gray, Weller, Fristad & Weller, 2011; Thapar Collishaw, Pine & Thapar, 2012; Shin et al., 2017; Wartberg, Kriston & Thomasius, 2018). Evidently, depression has been increasingly diagnosed among the university students. For instance, the American College Health Association (ACHA) suggested that 16% of all undergraduates reported having depression while they were finishing their studies at the universities (ACHA, 2006). Also, past investigation had shown a high prevalence of psychological distress and depression among college students (Bayram & Bilgel, 2008). It was also found that ongoing pressure is significantly connected with depression. It causes lower productivity, suicide ideation and attempts (US Department of Health and Human Services, 2000). In Malaysia, Sherina et al., (2003) have investigated a prevalence of depression among students in four different universities. They found that the prevalence was 37.2% of moderate to severe symptoms of depression. Slightly higher rates were reported among Australian university students, they found that the prevalence was 39.5% (Schofiled, O'Halloran, McLean, Forrester-Knauss & Paxton, 2015). Both studies use similar instruments, DASS21. Significantly lower results were found among Spanish university students (Vazquez & Blanco, 2008). The rates of major depressive disorders were 8.7%. The difference prevalence could be due to various factors: 1) the use of different instruments. Sherina et al. (2003) used DASS21 which measures stress, depression, and

anxiety at the same time. Cut off score was not normed based on Malaysian population. 2) While Sherina et al. (2003) surveyed general depressive symptoms, Vazquez and Blanco (2008) reported Major Depressive Disorders symptoms that require the presence of suicide ideation and more chronic symptoms of depression (APA, 2013). In order to improve Sherina and colleagues' study, the present study used Center for Epidemiology Study Depression Scale (CESD) to survey depressive symptoms. The cut off score of CESD is increased from 16 to 27 after it was normed among Malaysian adolescents' study (Ghazali et al., 2016). The specificity and sensitivity of the instrument were improved when using this cut off score.

Studies on depression among college students were also commonly conducted among specific group of students. For example, in India revealed that 63.9% of the nursing students participating had some degree of depression (Chatterjee, Saha, Mukhopadhyay, Misra, Chakraborty & Bhattacharya, 2014). Similar prevalence was reported in Iran, 60% of the nursing students in their sample to be depressed (Rafati & Ahmadi, 2004). Melissa-Halikiopoulou et al. (2011) found 43% of the nursing students in their study suffered from depression. The prevalence of depression seems high among the nursing students. It does not necessarily reflect the overall prevalence percentage among college students. Other group of students should be included as well. The current study addresses this knowledge gap. All students from different faculties were included.

Several studies have reported that there are significant linked between PTSD and depression. Following trauma exposure, victims frequently reported significant symptoms of depression. For example, in China, a study report from the 2008 Wenchuan earthquake, China, showed approximately half of the sample (2,081 participants) 6 month after the earthquake disaster had symptoms of PTSD, depression, or anxiety. Specifically, the

prevalence rates of PTSD, anxiety, and depressive symptoms were 15.8%, 40.5% and 24.5% respectively. PTSD and depression were positively and significantly correlated (Fan et al., 2011). Meaning that those who have PTSD symptoms, tend to suffer from depression as well. Thus, it is important to include both PTSD and depression in this study.

Studies on gender difference in reporting depressive symptoms has been widely reported (Pohlman & Jambunathan 2007; Steptoe, Tsuda, Tanaka & Wardle, 2007; Vazquez & Blanco, 2008; Fan et al., 2011; Faramarzi, Cheraghi, Zamani, Kheirkhah, Bijani & Hosseini, 2017, Cavanagh, Caputi, Wilson & Kavanagh, 2018; Lee, Ham, Lee & Kim 2018). PTSD, anxiety, and depression were found to be reported as significantly higher prevalence rates among female adolescents. Similarly, a systematic metanalysis study reported that female exhibited significantly higher depressive symptoms than male among university students from 23 countries (Steptoe et al., 2007). The prevalence of clinical depressive symptoms was evident with significantly higher frequency among females (29.5%) than males (24.3%) among 1,500 Cypriot university students (Sokratous, Merkouris, Middleton & Karanikola, 2014). Meanwhile, study conducted by Patten, Wang, Williams, Curries & Beck (2006) and Bebbington (2015) showed that depression rates among gender become similar when ages older than 65 years. Ceyhan, Ceyhan and Kurtyilmaz (2005) study found that depression levels of university students do not change according to gender.

2.4 Stigma

Stigma on mental disorder seems to be generally recognized by the public society in the Western world. Previous studies suggested that most citizens in United States (Link, 1987; Phelan, Link, Stueve & Pescosolido, 2000) and many Western European nations (Bhugra, 1989; Brockington Hall, Levings & Murphy, 1993) have negative stigmatizing

attitudes toward mental illness. Furthermore, stigmatizing views about mental illness are not only involved to uneducated resident within the society, but also include those are well-trained professionals which came from the most mental health disciplines (Keane, 1990). Based on these literatures, study on stigma was conducted mostly more than 20 years ago. More recent study is needed to determine if stigma does affect help seeking behavior among our population or not.

Less evident related to stigma can be identified in Asian and African countries (Fabrega, 1991). Yet, it still maintains unclear whether the study by Corrigan and Watson (2002) represents a cultural range that does not promote stigma or deficiency of research in that society. The existing research shows that, while attitudes toward mental illness might difference among non-western cultures (Fabrega, 1991), the stigmas among mental illness may be less severe compare to Western cultures. Meanwhile in higher institution setting, stigma has been found to be a major barrier in help-seeking behavior. Various studies found the negative impacts of stigma on the students' willingness to ask for professional help (Eisenberg et al., 2009).

Although many studies have shown that stigma is a major barrier for help-seeking behavior, recent results from a Healthy mind study that recruited a nationally representative study of mental health and help-seeking behavior found that a majority of students who did not seek treatment had low stigma and positive beliefs about treatment (Eisenberg et al., 2012). This study highlights the most positive research finding and indicates the importance of mental health promotion among university student. Mental health promotion might be able to reduce their stigma towards receiving treatment for mental disorders. Perhaps the current study might yield to similar results.

Although stigma has been recognized as an important factor as a barrier in help seeking behavior, it still doesn't appear to be explain why our university students do not seek help when they are having mental health problems. Certainly, various barriers to experts help seeking have been mentioned in research writing. For instance, the two most basic motives for not receiving mental health treatment among college students who have depression were the belief that stress is typical during our studies years and many students perceive that they do not need any help (Eisenberg et al., 2007). Approximately 12% of university students admitted that they have stigma and feeling uncomfortable in discussing personal problems with mental health workers (Czyz, 2013).

The association between perceives need for help and actual mental health service utilization was supported in another recent study, which revealed that 50% of students with a mental health problem who perceived need for help receive treatment compared with only 11% of those did not perceive that they have a problem requiring help (Eisenberg et al., 2011).

There are significant association between perceived need for help and the number of students who are actually used mental health services. Previous study reported that 50% who acknowledged that they need help, went to seek professional helps. On the other hand, when they did not feel that they need help, only 11% of them had received professional mental health treatment (Eisenberg et al., 2011).

Many previous studies have proved that stigma towards mental illness affected the Western Society mostly (Link, 1987). Report from World Health Organization (WHO) also indicated that a lot of people having mental health problem most probably will not involve or getting help from any mental help services, because of stigma and discrimination (WHO, 2013).

Although there have been in recent historic indicating a progressively more accepting attitude toward illness (Phelan et al., 2000), stigmatizations remain prevalent throughout the world. In the United Kingdom, a survey of those with mental illness indicated that 70% experience discrimination (Chamber, 2010), while in United States, 75% of respondents with mental health issues revealed a belief that people are not compassionate toward their situation (Manderscheid, 2010).

Previous study had also demonstrated that mental illness sufferers and have negative attitudes towards their mental illness had significantly seek less help (Cooper, Corrigan & Watson, 2003). Similar association was also found in the previous study, personal stigma was significantly and negatively associated with help seeking behavior while public stigma was not associated with help seeking behavior (Eisenberg et al., 2009). Meaning that personal stigma can strongly influence the individual decision to seek help in comparison with public stigma.

Wang et al. (2015) conducted a research among Chinese undergraduate students regarding personal stigma. They found that personal stigma was negatively associated with help seeking attitudes. Meaning that participants with a perception of personal stigma on depression would be less likely to seek professional help.

2.5 Help Seeking Behaviors

Many qualitative and quantitative studies have demonstrated that youth with mental illness do not seek help professionally. The major barrier was stigma towards mental disorders and receiving treatment. Stigma has been declared by the two federal government major agencies, the Surgeon General report on Mental Health (US Public Health services, 1999) and the President's New Freedom Commission on Mental Health (New Freedom

Commission on Mental Health, 2003). They declared that stigma is a such major barrier in help seeking behaviour.

Many sexual victims did not seek professional helps, in fact, only 1 in 5 cases of sexual assaults or violence sought any type of professional help (Cuevas & Sabina, 2015). This number is low. Additionally, they also reported that 36% of the victims did not seek any help either professionally or informally. It was estimated that 41.7% of the sexual assaults' victims did not report the incident even informally. Women were candid about reasons for not seeking social services including *I didn't think of it* (26.5%), *I didn't know of any* (13.2%), *Shame* (9%), *I wanted to keep the incident private* (9%), and *No agency available in my area* (7.9%). From the study also reported the participants feel fear and shame as barriers both formal and informal help-seeking. The victim was simply lack of knowledge about existing services. It should be highlighted that most of the cases in this study only focused the women abuses as victims, but not onto the students especially in higher institutions.

Investigating further in help-seeking behaviour nature, Palmer and co-researchers (2001) found that the victims typically sought help from more than one sources. This could be interpreted in several ways: Survivors may have "shopped around" because they were not satisfied; they may seek interim help while on waiting list; or services might have been rationed. It remains unclear if similar situation happens among our college students.

In Malaysia, study was conducted to find the different methods of help-seeking among women experiencing couple violence. As a result, 6.7% of the women reported that they did not go to any institution for help. They felt the violence was normal or not serious (3.7%); they were embarrassed and felt that they would not be believed (2%), and afraid that they would bring bad names to their families (1.7%) (Tengku Hasan et al., 2015).

Study conducted by Ahrens (2006) among rape survivors showed that victims experienced negatives reactions. There were blamed, received insensitive reactions, experienced in effective disclosure and received inappropriate support. For most survivors, perhaps a severe psychological trauma causes them refused to receive treatment as a result of negative reaction they have received.

2.6 Relationship between Lifetime Trauma, Depression and PTSD

Several studies were done among victims of motor vehicle accidents, rape, domestic violence, or combat. Results showed that victims with psychological disorders (PTSD, depression, and/or social adjustment) used avoidance type coping skills (Bryant & Harvey, 1995). The current study also indicates those participants who have PTSD used maladaptive coping styles (Ponnusamy et al., 2009).

Research has also been conducted to see a relationship between social support and trauma outcome in the community. Davidson et al. (2001) conducted a population research on PTSD in North Carolina with 2,985 participants identifying social support and PTSD conditions. Despite the fact that they found no variations in quantitative social support, those with PTSD had much less social interplay (qualitative social support) and perceived inadequate social supports. Another study found that resilience to PTSD symptoms was strongly and significantly associated with individual perceptions of social supports, having more internal locus of control, used much less emotion and avoidance based of trauma coping strategies (Liederman-Cemiglia, 2001).

Previous study has shown that following exposure on trauma disasters, only some respondents fulfilled PTSD criteria diagnosis. There are no significant differences between genders in relation to PTSD symptoms, social support, adaptive and maladaptive coping

styles among victims with PTSD and those who do not suffer from PTSD. On the other hand, the relationship between PTSD symptoms and social support, significant relationship can be identified between PTSD symptoms and practical support but not with emotional support (Ponnusamy et al., 2009).

Studies also showed that adolescent who reported having experienced or witnessed domestic violence had the most occurrences of PTSD. This underlined the particularly deleterious effects of family-related violence. Multivariate analyses also revealed that adolescent who reported more than one Traumatic Event (TE) had more than nine times the odds of developing PTSD, indicating a very strong dose-effect relationship between the numbers of TEs and PTSD (Landolt, Schnyder, Maier, Schoenbucher & Mohler-Kuo, 2013).

Another study (Luterek et al., 2004) examined whether rejection sensitivity had an influence on the presence of depression among undergraduate women who had an experience childhood sexual abuse prior to arriving on campus. It is interesting that rejection sensitivity predicted the presence of depression among these students independent of their experience of childhood sexual abuse.

2.7 Shyness & Modesty Culture

'Shyness' and 'modesty' bring two meanings of either positive or negative. The negative side of 'malu' is often regarded as one of the factors cause people, especially Malays, to be passive, quiet, inferior, non-assertive and lack of courage. While the positive side often related to polite behavior hence the preservative of human dignity and the honor of the nation (Muhammad et al., 2019).

On the other hand, other study did also mention about the shyness among the Malay communities. It believes those traits held in high esteem within those people as the positive

value and a great benefit for life in this world and in the hereafter. Indeed, it has been part of their nature ad life in the Malay community. Thus, the nature of which embody the deep shame in their self has been appointed as one of the 26 fundamental strength of character and social nature of the Malays. The appreciation of this nature contributes to the formation of one's ethical, moral and moral values (Musa, 2008; Musa et al., 2012).

CHAPTER 3

MATERIALS AND METHODS

3.1 Research Design

The current study adopts a cross-sectional research design. In health-related and social science research, a cross-sectional study (also known as a cross-sectional analysis or prevalence study) is a type of observational study that analyzes data collected from a population, or a representative subset, at a specific point in time (Thelle & Laake, 2015). It is a descriptive study that involves special data collection, including questions about the past experienced by the participants. It may reveal how those variables are represented in a cross-section of a population. Cross-sectional research designs generally use survey techniques to gather data.

3.1.1 Participants

The total amount of the students participated in this study were 625 with age ranged from 18 to 26 years old (M = 23.34, SD = 39.12). They attended a few public universities in Sarawak with 75.5% (n = 472) were females and 24.5% (n = 153) males (refer to Table 4.1).

The sampling size was calculated using Epi Info (version 7) program based on the prevalence of 17.7% (CDC Global School-based Student Health Survey, 2012), population size of 540,638 (Malaysian Ministry of Higher Education, 2015) with worst acceptable result of 5% and confidence level of 99%, the minimum sample size required was 386 students.

3.1.2 Data Collection Procedures

A non-probability sampling was used in the present study in which participants were recruited based on their availability and willingness to participate in this study. Participants were given a brief information about the study and they were explained about their rights, the possible risks of the study and issues of confidentiality. The written consents of their participation were obtained. This study was approved by the Research and Ethics Committee, Faculty of Medicine and Health Sciences, Universiti Malaysia Sarawak.

3.2 Measures

3.2.1 Socio-Demographic Information

This questionnaire was used to gather information on age, gender, ethnicity, the university they attended, courses, and their years of study.

3.2.2 Trauma exposure

The Trauma Symptoms Checklist (TSC) (Briere & Runtz, 1989). TCS was used to measure degrees of negative affect and somatization as a result of childhood and current traumatic experiences (Krog & Duel, 2003). It consists of 32 questions and is measured on a 4-point Likert Scale. The students were asked to indicate how often during the last month they had experienced the symptoms (1 = not at all, 2 = sometimes, 3 = often, 4 = always). The scale showed good internal consistency with a Cronbach's Alpha of 0.80 for the total scale and 0.72 for negative affect and 0.62 for somatization. In the current study, the internal consistency is α =.91.

Table 3.1: Summary of 5 instrument being used

No	Instrument	Number of Items	Validity	Measurement Purposes
1.	Trauma Symptoms Checklist (TSC)	32	Internal Consistency (Cronbach's Alpha) – 0.80 Current study – Internal consistency α = .91	To measure degree of negative effect and somatization as a result of childhood and current traumatic experiences.
2.	Posttraumatic Stress Disorder Checklist for DSM5 (PCL-5)	20	Internal Consistency α = .96 Test retest validity *r* = .84 Current study – Internal Consistency α = .93	To screen PTSD symptoms that corresponds to DSM5 PTSD symptoms criteria.
3.	Center for Epidemiology Study Depression Scale (CESD)	20	Internal Consistency α = .85 to .90 Test-retest reliability .45 to .70	To measure major of depression; depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance.
4.	Depression Stigma Scale (DSS)	18	Personal Stigma Cronbach's Alpha - .75 Public Stigma Cronbach's Alpha - .77	To measure participants personal attitudes and the participants beliefs about the attitudes of others.
5.	General Help Seeking Questionnaire (GHSQ)	20	Suicidal Problem: α = .83 Test-retest reliability *r* = .88 Personal Emotional Problem: α = .70 Test-retest reliability *r* = .86	To measure help seeking intention when they have personal or emotional problem and when they have suicidal ideations.

3.2.3 PTSD Symptoms

PTSD symptoms was measured by Posttraumatic Stress Disorder Checklist for DSM-5 (PCL-5) (Weathers et al, 2013). PCL-5 consists of 20 items to screen PTSD symptoms that corresponds to the DSM-5 PTSD symptoms criteria. The response scale for each symptom ranges from 0 to 4 (0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit and 4 = Extremely). The total score range from 0 to 80 and the recommended cut-off score 33 was used to distinguish participants with and without severe symptoms of posttraumatic stress disorder (Bovin et al., 2016). PCL-5 shows good internal consistency (α = .96), test retest validity (r = .84) as well as convergent and discriminant validity (Bovin et al., 2016). In the current study, the internal consistency is α = .93.

3.2.4 Depressive Symptoms

Depressive symptoms were measured by the Center for Epidemiology Study Depression Scale (CESD). CESD consists of 20 items, comprising of six scales measuring major dimensions of depression; depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, psychomotor retardation, loss of appetite, and sleep disturbance. Response scale range between 0 to 3; 0 = Rarely or none at all times, 1 = Some or a little of the time, 2 = Occasionally or moderate amount of the time 3 = Most of the time. The high internal consistency for this scale was reported with α= .85 to .90 and test-retest reliability range from .45 to .70 (Radloff, 1977; Ghazali, Elklit, Balang & Chen, 2016). Also, the translated Malay version of CESD was found to have satisfactory properties and the cut-off score of 27 was recommended to distinguish participants with and without depression among Malaysian population (Ghazali et al., 2016).

3.2.5 Stigma

Stigma was measured by the Depression Stigma Scale (DSS). It was developed by (Griffiths, 2006). DSS has two factors: (a) personal stigma (nine items reflecting the participants personal attitudes), (b) perceived stigma (nine items reflecting the participants beliefs about the attitudes of others). Each item is scored on a 5-point scale ranging from 0 to 4. Scores on the total scale may range from 0 to 36 for the combined score of total stigma, and 0 to 18 for personal stigma and perceived stigma, respectively, with higher scores indicating perception of greater stigma (Griffiths et al., 2004). In this study the personal stigma subscale of the DSS had a Cronbach's alpha of .75; the public stigma of the DSS had a Cronbach's alpha of .77. Study among community population in Netherland (Boerema et al., 2016) showed good validity and internal consistency of the DSS personal stigma scale and perceived stigma scale.

3.2.6 Help Seeking Behaviour

Help Seeking Behaviour was measured by the General Help-Seeking Questionnaire (GHSQ). GHSQ was developed by Wilson, Deane, Ciarrochi and Rickwood (2005). The GHSQ has 20 items. The GHSQ requires participants to respond two major questions; help seeking intension when they have 1) personal or emotional problems (10 items); 2) help seeking intension when they have suicidal ideations (10 items). The total number of items was 20-items. Participants need to provide a rating for their help-seeking intentions on a 7-point scale ranging from 1 ("extremely unlikely") to 7 ("extremely likely") for each help source. Higher scores indicate higher intentions. For example, they have to answer the following question: "If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?" The answers vary including "parents",

"intimate partner", "doctor" etc. The items could be scored in two ways: first, as a single scale that included all specific help source options for suicidal and non-suicidal problems (α = .85. test-retest reliability assessed over three weeks period (r = .92). The ANOVA result confirmed that the need to distinguish between problem types, so items could be analysed as two scales, one for each problem-type: suicidal problem (α = .83, test-retest reliability assessed over a three-week period r = .88) and personal emotional problems (α = .70, test-retest reliability assessed over three-week period (r = .86; Wilson et al., 2005).

3.3 Pilot Study

A pilot study was conducted to test the reliability and validity of all measures used in this study. Thirty eights students age ranged from 18 to 22 years old (M= 19.71, SD = 1.01) were recruited from a few public universities in Sarawak. 73% were females and 26.3% were males from different ethnic groups; 73.7% were Malay, 5.3% were Ibans and other ethnic groups were 21.1%. Internal consistencies for all measures were good with Cronbach alpha ranges from .784 to .934. Analyses of the pilot study shows that the Cronbach's alpha for CESD was α = .863, GHSQ was α = .784, PCL-5 was .934 and DSS was .891. Meanwhile, the test-retest reliability for Depression Stigma Scale was r = .561 (two-tailed) and test-retest reliability for Help Seeking Behaviour (Personal Problem) was r = .832 and Help Seeking Behaviour (Suicidal) was r = .804. Therefore, the results obtained showed that, the procedure and instruments were appropriate to be used in the actual research. Construct validity (convergent) was also established to determine the validity of CESD and PCL-5. Convergent validity states to the degree to which two measures of constructs that theoretically should be related, are in fact connected (Campbell, 1959). Previous studies have demonstrated that those who reported having PTSD symptoms would also have higher score

in depressive symptoms (Ghazali et al., 2014). Pearson correlation analysis in this pilot study shows that CESD is positively correlated with PCL-5 with r = .754.

Meanwhile, the validity of GHSQ and DSS were determined by looking at its content validity. Other studies (Boerema et al., 2016) using DSS instrument showed that internal consistency of the DSS personal stigma scale was sufficient for both study (α = .70 & .77). The same study indicates regression analyses showed that personal stigma was higher in younger people. Similarly, GHSQ (Wilson et al., 2005) was found to have satisfactory reliability and validity and appears to be flexible measure of help-seeking behaviour.

3.4 Data Analysis

Data were analyzed using the IBM SPSS statistics version 24. Data checking and data cleaning were performed prior to analysis. Demographic and clinical variables were characterized with descriptive statistic. Data are shown as means (*M*) and standard deviation (*SD*). A descriptive analysis of frequency and percentage including the prevalence of trauma exposure, posttraumatic stress disorder and depression were reported. Chi-square (x^2) was used to compare proportions. Independent *t*-test was used to compared group means involved continues variables. Multiple regressions analyses were performed to see if stigma can predict on help seeking behavior among all participants, among those who have PTSD and depression, among those who do not have PTSD and depression, among those who have PTSD only and finally among those who have depression only. Statistical significance required a two-sided p-value of < 0.05. Convergent validity had been used to examine the CESD and PCL-5 construct measurement. While DSS and GHSQ used Content Validity.

CHAPTER 4

RESULTS

4.1 Prevalence

4.1.1 Demographic Characteristic

There were 645 university students aged 18 to 26 years old participated in the present study and they agreed to participate in the study, but analysis was carried out of 624 participants (96.74%) response rate who provided complete data on the variables of interest to this study. Thus, all analyses involved 624 students. From total of the number of 624 participants, 75.6% were female and 24.4% were male. Table 4.1 presents detail demographic characteristics of the 624 participants of the present study.

4.1.2 Trauma Exposure

Analysis on the overall trauma exposure indicates that at least 88% of the participant reported of having at least one direct or indirect trauma experience. The five most prevalent trauma exposure overalls (direct and indirect) were road accident (67.4%), loss of a family member (by death) 62.6%, serious illness (32.7%), almost drowning (29.9%) and divorce (28.6%). For five most common direct exposure were also road accident (46.4%), loss of a family member (by death) 44.8%, almost drowning (23%), watched other people being injured or killed (16.7) and being closed to be injured or killed (15.1%). Among the most less common directly experienced traumatic event were suicide attempt (3.4%, n =21), sexual abuse (2.2%, n =13), physical abuse (3.9%, n = 24), bullying (13.8%, n = 86) and pregnancy/abortion (2.1%, n =13).

Table 4.1: Descriptive Characteristic of Participants

Characteristic	Total sample (N)	Percentages (%)
Gender		
Female	472	75.5
Male	152	24.5
Race (%)		
Malay	316	50.7
Iban	82	13.1
Bidayuh	39	6.2
Chinese	37	5.9
Melanau	26	4.2
Indian	12	1.9
Others (Kadazan, Orang Ulu, Kenyah)	111	17.9

Analysis on direct trauma exposure indicates that, 23.1% (*n* = 144) did not have any direct traumatic experience, only 22.8% (*n* = 142) had once direct traumatic experience. About 19.2% *(n* = 120) had two, 12.7% (*n* = 79) had three, 7.4% (*n* = 46), and 14.6% (*n* = 91) had more than 5 times direct traumatic events. From the total number of 622 participant who completed indirect trauma survey, 23.1% (*n* = 144) reported have no direct traumatic experience, only 13.8% (*n* = 86) had once direct traumatic experience, 15.9% (*n* = 99) had two, 9.0% (*n* = 56) had three, 11.1% (*n* = 69), and 26.9% (*n* = 168) had more than 5 times direct traumatic events.

Another similar data analysis was also conducted to investigate the five most common indirect exposures. The result showed that road accident (49.4%), loss a family

member (by death) 45.4%, serious illness (29.5%), divorce (27.9%), and other serious accident (22.3%).

Table 4.2: Frequency of Direct and Indirect Trauma Exposure (*N = 624)*

Trauma exposure	**Direct exposure % (n)**	**Indirect exposure % (n)**	**Total Trauma Exposure % (n)**
Road Accident	46.4 (289)	49.4 (308)	67.4 (420)
Other Serious Accidents	8.0 (49)	22.3 (139)	26.5 (165)
Violent Attack	4.2 (26)	10.1 (63)	11.7 (73)
Rape	0.5 (3)	3.7 (23)	4.0 (25)
Watched other people being injured or killed	16.7 (104)	16.5 (102)	24.4 (152)
Being close to be injured or killed	15.1 (94)	11.9 (74)	21.0 (131)
Being Threatened With beating	10.4 (64)	12.4 (77)	18.5 (115)
Almost Drowning	23.0 (143)	11.9 (74)	29.9 (186)
Suicide attempt	3.4 (21)	5.6 (34)	8.5 (53)
Robbery/burglary	9.8 (61)	14.4 (89)	19.4 (121)
Pregnancy/abortion	2.1 (13)	18.0 (112)	18.1 (113)
Serious illness	8.7 (54)	29.5 (184)	32.7 (204)
Loss of a family member (by death)	44.8 (279)	45.9 (286)	62.6 (390)
Divorce	2.4 (14)	27.9 (174)	28.6 (178)
Sexual abuse	2.2 (13)	5.3 (33)	6.4 (40)
Physical abuse	3.9 (24)	10.3 (64)	12.5 (78)

Table 4.2 continued

Gross neglect in childhood	2.9 (18)	7.5 (46)	9.5 (59)
Humiliation or persecution from others (bullying)	13.8 (86)	15.9 (99)	23.4 (146)
Absence of parents /guardian	8.0 (49)	16.4 (102)	20.4 (127)
Other	2.2 (13)	1.8 (11)	3.4 (21)

4.1.3 Trauma Exposure and Gender Differences

Chi square analyses were used to see gender difference in association of lifetime trauma exposure both directly and indirectly. Table 4.3 presents the detailed findings. Results showed that there was significantly more male than female in experiencing the following trauma; road accident ($X^2 = 17.70$, $p < .001$), violent attack ($X^2 = 12.86$, $p < .001$), watched other people being injured or killed ($X^2 = 24.10$, $p < .001$), being close to be injured or killed ($X^2 = 39.34$, $p < .001$), being threatened with beating ($X^2 = 37.78$, $p < .001$), robbery/burglary ($X^2 = 6.49$, $p < .05$), serious illness ($X^2 = 8.56$, $p < .05$), physical abuse ($X^2 = 6.22$, $p < .05$) and humiliation ($X^2 = 5.95$, $p < .05$).

There were significantly more females have experienced almost drowning event ($X^2 = 17.98$, $p < .001$) than the males.

A separate analysis on indirect trauma exposure was also conducted. Results found that males have significantly experienced other serious accident ($X^2 = 6.18$, $p < .05$), watched other people being injured or killed ($X^2 = 10.45$, $p < .001$), being close to be injured or killed ($X^2 = 18.91$, $p < .001$), sexual abuse ($X^2 = 4.25$, $p < .05$) and humiliation ($X^2 = 12.48$, $p < .001$). Meanwhile, females have significantly experienced being threatened with beating ($X^2 = 14.03$, $p < .001$) and loss of a family member (by death) ($X^2 = 5.72$, $p < .05$) (refer to Table 4.3).

Table 4.3: Trauma and Negative Life Events Based on Type of Exposure and Gender, Statistical Gender Differences Based on Pearson Chi-Square Analyses (N = 624)

Trauma Exposure	**Direct Exposure**			**Indirect Exposure**		
	Females (%) (*n* = 472)	Males (%) (*n* = 152)	Chi-square (χ^2)	Females (%) (*n* = 472)	Males (%) (*n* = 152)	Chi-square (χ^2)
Road accident	41.6	61.2	17.70**	48.8	51.3	.584
Other serious accident	6.4	13.2	7.18	20.0	29.6	6.18*
Violent attack	2.5	9.2	12.86**	8.3	15.8	7.13
Rape	6	0	.975	3.8	3.3	.094
Watched Other People Being Injured or Killed	12.5	29.6	24.10**	13.8	25.0	10.45**
Being close to be injured or killed	10.0	30.9	39.34**	8.7	21.7	18.91**
Being threatened with beating	6.2	23.7	37.78**	21.1	9.6	14.03**
Almost drowning	35.5	18.9	17.98**	14.5	11.0	1.29
Suicide attempt	3.0	4.6	.941	5.5	5.9	.035

Table 4.3 continued

Robbery/burglary	8.1	15.1	6.49*	13.6	17.1	1.15
Pregnancy/abortion	2.5	.7	2.01	18.7	15.8	.653
Serious illness	6.8	14.5	8.56*	28.5	32.9	.653
Loss of a family member	45.4	42.8	.332	48.6	37.5	5.72*
Divorce	2.5	2.0	.161	29.3	23.7	1.80
Sexual abuse	2.5	1.3	.794	4.2	8.6	4.25*
Physical Abuse	2.8	7.2	6.22*	9.6	12.5	1.08
Gross neglect in childhood	2.5	3.9	.802	6.6	10.5	2.56
Humiliation/Persecution	11.9	19.7	5.95*	13.0	25.0	12.48*
Absence of Parent	7.4	9.9	.925	15.1	20.4	2.38
Others	2.5	1.3	.794	1.5	2.6	.869

* $p < .05$, ** $p < .001$

4.1.4 PTSD Symptoms

Results of PCL-5 descriptive analysis showed that 17.9% (n = 112) students reported exhibiting PTSD symptoms. The percentage of participants did not differ by gender, X^2 (1, N = 112) = 1.65, p > .05 between male (15.3%) and female (20.1%) in reporting PTSD symptoms.

4.1.5 Depressive Symptoms

Results of CESD descriptive analysis shows that 20% (n = 125) students reported having depressive symptoms. This analysis used 27 as a cut off score. The percentage of participants did not differ by gender, X^2 (1, N = 125) = 3.09, p > .05. between male (15.1%) and female (21.7%) in reporting depressive symptoms.

4.1.6 PTSD in Relation with Depressive Symptoms

Correlation Pearson analysis showed that there was a significant positive correlation between PCL-5 and CESD, r = .62, p < .001. Those who exhibits PTSD symptoms tend to suffer from depressive symptoms as well.

4.1.7 Stigma

The result showed that 51.9% (n = 324) have high stigma. Around 50.2% (n = 313) reported having high personal stigma, while 51.3% (n = 320) reported having perceived stigma. Results of DSS descriptive analysis showed that the mean score for depression stigma was M = 53.53, SD = 11.72, personal stigma was M = 25.04, SD = 6.47 and perceived stigma was M = 28.51, SD = 6.39. Results of independent t-test showed that there was no significant gender difference in total stigma score; for male M = 52.69, SD = 11.80 and for

female, M = 53.83, SD =11.70, t (623) = -1.04, p > .05, in personal stigma subscale; for male M = 24.97, SD = 6.3 and for female M =25.07 SD =6.52, t (619) = -.160, p > .05 and in perceived stigma subscale, for male M = 27.84 SD = 6.53, for female M = 28.74, SD =6.34, t (617) = -1.50, p > 0.05.

The minimum score for the overall DSS is 0 and the maximum score is 72. Both personal stigma and perceived stigma subscales minimum score is 0 and the maximum score is 36 each. The following analysis reports the descriptive results for the current study participants.

Table 4.4: The Percentage of Personal Stigma and Perceived Stigma

Personal Stigma Item	**% (n)**
People with depression could snap out of it if they wanted	40.9 (255)
Depression is a sign of personal weakness.	36.2 (226)
Depression is not a real medical illness	21.0 (131)
People with depression are dangerous	34.9 218)
It is best to avoid people with depression so that you don't become depressed yourself.	17.0 (106)
People with depression are unpredictable	45.7 (285)
If I had depression, I would not tell anyone	18.9 (118)
I would not employ someone if I knew they had been depressed	21.8 (136)
I would not vote for politician if I knew they had been depressed	41.0 (256)
Perceived Stigma Item	% (n)
Most people believe that people with depression could snap out of it if they wanted	40.9 (255)
Most people believe that depression is a sign of personal weakness	44.1 (275)
Most people believe that depression is not a real medical illness	28.0 (175)
Most people believe that people with depression are dangerous	45.8 (286)

Table 4.4 continued

Most people believe that it is best to avoid people with depression so that you don't become depressed yourself	36.5 (228)
Most people believe that people with depression are unpredictable	52.1 (325)
If they had depression, most people would not tell anyone	37.8 (236)
Most people would not employ someone they knew had been depressed	41.2 (257)
Most people would not vote for a politician they knew had been depressed	47.8 (298)

An independent *t*-test analysis was conducted to see the overall depression stigma scale, personal stigma subscale, and perceived stigma subscale on those who have PTSD and without PTSD.

There were no substantial variance in those with PTSD and without PTSD in reporting the overall depression stigma scale; those with PTSD ($M = 53.50$, $SD = 11.20$) and those without PTSD ($M = 53.56$, $SD = 12.18$), $t\ (622) = .07$, $p > .05$ Analysis on the personal stigma subscale showed that there were also no significant difference in those with PTSD ($M = 25.19$, $SD = 6.39$) and without PTSD ($M = 24.91$, $SD = 6.55$), $t\ (608) = .55$, $p > .05$. Analysis on the perceived stigma scale showed that there was also no significant difference in those with PTSD ($M = 28.29$, $SD = 5.88$) and those without PTSD ($M = 28.70$, $SD = 6.81$), $t\ (616) = .15$, $p > .05$.

Independent *t*-test analysis was also conducted to see the overall depression stigma scale, personal stigma subscale, and perceived stigma subscale on those who have depressive symptoms and those without depressive symptoms There were no significant differences for those with depressive symptoms ($M = 53.12$, $SD = 12.01$) and without depressive symptoms ($M = 5.66$, $SD = 11.66$), $t\ (621) = .46$, $p > .05$, in reporting depression stigma scale.

Analysis on the personal stigma subscale showed that there were also no significant differences for those with depressive symptoms (M = 24.86, SD = 6.65) and those without depressive symptoms (M = 25.10, SD = 6.43), t (617) = .37, p > .05.

Analysis on the perceived stigma scale showed there were also no significant differences for those with depressive symptoms (M = 28.17, SD = 6.37) those without depressive symptoms (M = 28.60, SD = 6.40), t (615) = .83, p > .05.

Further investigation showed that participant personally believed that "people with depression were unpredictable" (45.7%, n = 285), followed by "people with depression could snap out of it if they wanted" (40.9%, n = 255) and "I would not vote for politician if I knew they had been depressed" (41.0%, n = 256).

In term of perceived stigma, participant think that most people believe that people with depression are unpredictable (52.1%, n = 325), followed by most people would not vote for a politician they knew had been depressed (47.8%, n = 298), and most people believe that people with depression are dangerous (45.8%, n = *286*).

Additional analysis was also done. A regression analysis was conducted to see if stigma can predict on help seeking behavior: 1) among all participants, 2) among those who have PTSD and depressive symptoms, 3) among those who do not have PTSD and depressive symptoms, 4) among those who only have PTSD, and 5) finally among only those who have depressive symptoms.

Result showed that this model is significant predictors for help seeking behaviour (F (5, 602) = 2.563, p < .05) which accounted 13% of the total variance (R = .144, R^2 = .021, R^2 adjusted = .013 among all participants. Linear regression analyses further found that gender (t = 2.327, p < .05) is predictive factor for help seeking behaviour. Females

significantly seek help more than males. Overall, stigma is not a predictive factor for help seeking behaviors.

The analysis revealed that this model is not significant predictors for help seeking behaviour (F (5, 101) = 1.888, $p > .05$) which accounted 39% of the total variance (R = .290, R^2 = .084, R^2 adjusted = .039 among those with PTSD and depressive symptoms participants. Linear regression analyses further found that stigma (t = 1.418, $p > .05$) is not predictive factor for help seeking behaviour.

The analysis revealed that this model is not significant predictors for help seeking behaviour (F (5, 300) = 1.889, p = .967) which accounted 13% of the total variance (R = .056, R^2 = .003, R^2 adjusted = .013 among those who do not have PTSD and depressive symptoms. Linear regression analyses further found that depression stigma (t = .470, $p >$ .05) is not a predictive factor for help seeking behaviour.

The analysis revealed that this model is not significant predictors for help seeking behaviour (F (5, 174) = 2.147, $p > .05$) which accounted 31% of the total variance (R = .241, R^2 = .058, R^2 adjusted = .031 among those who have PTSD only. Linear regression analyses further found that stigma (t = .229, $p > .05$) is not predictive factor of help seeking behavior.

The analysis revealed that this model is not significant predictors for help seeking behaviour (F (5, 9) = .880, $p > .05$) which accounted 45% of the total variance (R = .573, R^2 = .328, R^2 adjusted = .045 among those who have Depression only. Linear regression analyses further found that gender (t = .219, $p >$.05) is not predictive factor for help seeking behaviour.

4.1.8 Help Seeking Behaviour among University Students

HSB personal problem. Of 624 participants, only 41.9% (n = 253) reported that they would likely to seek help when they have personal problem.

HSB Suicidal. Of 624 participants, 51.3 % (*n* = 313) reported that they would likely to seek help if they have suicidal behavior. Descriptive analysis of each HSB suicidal items shows that most students would likely seek help from parent (69.0%, *n* = 431), (64%, *n* = 400) seek help from intimate partner and 55.0% (*n* = 344) seek help from mental health professional.

Results also showed that 21% participants with personal or emotional problems and 26% participants with suicidal thoughts would not seek help from anyone if they have personal emotional problems or suicide thoughts (see Table 4.5).

Results of HSB independent *t*-test analysis indicated that there was significant gender differences male (*M* = 75.69, *SD* = 16.26) and female (*M* = 71.89, *SD* = 16.58), *t* (622) = 2.47, *p* < .001 in reporting help seeking behaviour. Female (75.1%) were more likely to seek help as compared to male (24.9%). Detail analyses showed that there were also significant differences in gender for reporting help seeking behaviour which included experiencing suicidal thought, male (*M* = 38.34, *SD* = 9.63) and female (*M* = 36.00, *SD* = 9.92), *t* (609) = 2.52, *p* < .001. However, there were no significant in gender differences for reporting help seeking behaviour if they have personal or emotional problem, male (*M* = 37.48, *SD* = 8.31) female (*M* = 36.20, *SD* = 8.01), *t* (602) = 1.66, *p* > .01.

Table 4.5: Help Source among Those Who Have Personal and Emotional Problem

Item	**Individual with personal or emotional problem**	**Individual with suicidal thought**
	% (n)	**% (n)**
Intimate partner	73.9 (229)	66.8 (207)
Friend (not related to you)	43.2 (134)	44.5 (138)

Table 4.5 continued

Parent	71.9 (223)	67.7 (210)
Others relative/family member	46.5 (144)	50.0 (155)
Mental health professional	51 (158)	54.5 (169)
Phone helpline	14.8 (46)	18.7 (58)
Doctor/GP	38.7 (120)	41.9 (130)
Minister or religious leader	34.8 (108)	38.4 (119)
I would not seek help from anyone	21.0 (65)	25.5 (79)
I would seek help from another not list above	15.8 (49)	11.6 (36)

The three main help sources for those who have personal and emotional problem were parent (M = 5.33, SD = 1.68), intimate partner (M = 4.93, SD = 1.65) and mental health professional (M = 4.14, SD = 1.80). For those who have suicidal thought, they would seek help from similar help source as those with personal and emotional problems, parent (M = 5.06, SD = 2.03), intimate partner (M = 4.73, SD = 1.91) and mental health professional (M = 4.32, SD = 1.90) (see Table 4.5).

There were significant differences in those with PTSD (M = 74.37, SD = 18.15) and without PTSD M = 71.46, SD = 14.95) in reporting help seeking behavior, t (622) = 2.20, p < .05. Participants with PTSD symptoms reported having more significantly help seeking behavior.

There were significant differences in those with PTSD (M = 37.71, SD = 8.81) and those without PTSD (M = 35.46, SD = 7.27), t (602) = 3.44, p < .001 in reporting personal and emotional problem help seeking behavior. However, for those who have suicidal thought, there were no significant difference in help seeking behaviour, between those with

PTSD (M = 37.01, SD = 10.48) and those without PTSD (M = 36.20, SD = 9.34), t (609) = 1.02, $p > .05$.

There was no significant difference in those with depressive and without depression symptoms when reporting help seeking behaviour, t (621) = .01, $p > .05$, with depressive symptoms (M = 72.81, SD = 19.07) and those without depressive symptoms (M = 72.82, SD = 15.93). Also, there were no significant different in reporting help seeking behaviour for those who have personal and emotional problem, t (601) = .77, $p > .05$, with depressive symptoms (M = 37.04, SD = 9.07) and those without depressive symptoms (M = 36.40, SD = 7.86), and those who have suicidal thought, t (608) = .15, $p > .05$, depressive symptoms (M = 36.46, SD = 11.13) those without depressive symptoms (M = 36.61, SD = 9.58).

Chi square analyses were also conducted to see differences in help seeking behavior when they encountered with personal problems among the four group of participants: 1) PTSD and depressive symptoms. 2) PTSD only, 3) depressive symptoms only, and 4) None PTSD and none depressive symptoms. There was no difference in their help seeking behaviour when they encountered with personal problems, X^2 = 12.05, $p > .05$. However, those with PTSD symptoms reported to be more likely in seeking help for their personal problems (32.4%), followed by those with PTSD and depressive symptoms (21.7%) and those with only depressive symptoms (3.2%). A similar result pattern was obtained with regards to their help seeking behavior when they had suicidal thoughts. Those with PTSD symptoms reported to be more likely in seeking help when they have suicidal thoughts (30.7%), followed by those with PTSD and depressive symptoms (20.1%) and those with only depressive symptoms (2.6%).

4.1.9 Stigma as a Mediating Factor for Help Seeking Behavior

The mediator roles of stigma on help seeking behaviour with PTSD or Depression were also investigated according to the mediation model (Baron & Kenny, 1986). Mediator is a process or means by which the independent variable impacts on dependent variable. In this study, the independent variable is stigma and the dependent variable is help seeking behaviour (Figure 4.1). A multiple regression analysis was conducted to see if stigma has a significant impact on help seeking behaviour among different groups of participants including participants who reported having PTSD and depressive symptoms.

Mediator Role of Stigma

The result indicated that the psychological symptoms (i.e., PTSD and depression) had insignificant relationship with help seeking behaviors (Table 4.6 and Table 4.7). From the analysis, depression stigma does not play the mediator role for PTSD or depression in help-seeking behaviors.

In regard to path C', the result indicated that PTSD symptoms were not significantly associated with help seeking behaviors. The details information as showed in Table 4.7 for mediating effect of PTSD and depression on help seeking behaviors.

Table 4.6: Pearson Correlation Analysis for Depression Stigma, PTSD, Depression and Help Seeking Behaviors

	Help seeking behaviour
PTSD	.105*
Depression	-.008
Depression Stigma	-.320

Note. * $p < .05$, ** $p < .001$.

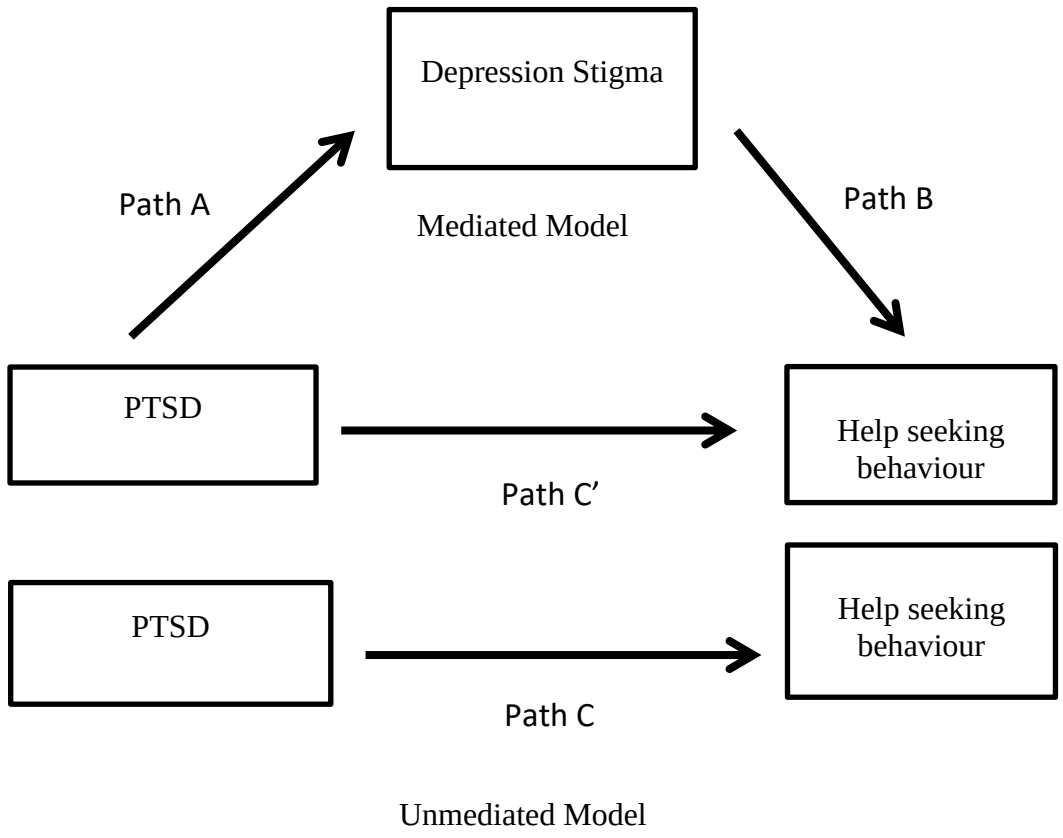

Figure 4.1: The Mediated and Unmediated Model of depression stigma on help seeking behaviour with PTSD / Depression

Table 4.7: Mediating Effect of PTSD and Depression on Help seeking behavior.

Factors	R^2	R^2_{adj}	**Coefficient**	***t*-value**	**Sobel's test**
PTSD					0.0021
Path A	.000	.002	-.00006	.002	
Path B	.002	.000	.056	.996	
Path C'	.013	.009	.107	2.634*	
Path C	.011	.009	.107	2.634*	
Depression					0.55
Path A	.001	-.001	.034	-6.662	
Path B	.002	.000	.056	.996	
Path C'	.002	-.002	**-.012**	.164	
Path C	.000	-.002	**-.014**	.190	

Note. The coefficient of Path C larger than Path C' indicated that PTSD is a partial mediator

*$p < .01$; ** $p < .001$.

CHAPTER 5

DISCUSSION

5.1 Research Finding

5.1.1 Lifetime Trauma Exposure

It was found that 88% of the participants reported having at least one direct or indirect trauma experience. The five most prevalent trauma exposure overalls (direct and indirect) were road accident, loss of a family member (by death), serious illness, almost drowning, and divorce. Similarly, five most common direct exposure were also road accident, loss of a family member (by death), almost drowning, watched other people being injured or killed and being closed to be injured or killed. This study is consistent with the previous studies (Tomoda et al., 2000; Richmond, Elliott, Pierce, Aspelmeier & Alexander, 2009; Aboul-Hagag & Hamed, 2012; Celik & Odaci, 2012; McGowan & Kagee, 2013; Reyes-Rodriguez et al., 2013; Ghazali et al., 2016). McGowan and Kagee (2013) as well as Tomoda et al. (2000) conducted a study among undergraduate university students at Tokyo Metropolitan University (49 male & 67 female) and showed that 20.7% (n = 24) reported having symptoms of major depression within 12 months prior to the study. Finding by Ghazali et al. (2016) among participants who have experienced flood in Malaysia also showed that five most prevalence trauma exposure were similar with the other studies (Richmond et al., 2009; Celik & Odaci, 2012; Aboul-Hagag & Hamed, 2012; Reyes-Rodriguez et al., 2013). Similarly, Breslau (2001) reported that 89.6% experienced of his participants had at least one traumatic event and over one-third experienced three or more traumatic events. When comparison made between previous study and current finding result, those discovery is not that surprise. It seems like every one of us exposes to some sort of traumatic event in our lifetime.

Study conducted by McGowan and Kagee (2013) showed that 20% participants reported traumatic exposure occurred while they were registered student. This finding highlights the importance of early intervention. It is crucial to treat trauma as early as possible before the students graduate as the impact to their mental health is tremendous. Using McGowan and Kagee (2013), this finding estimate that 124 participants in this study had trauma exposure while they were in campus. It is crucial to highlight that trauma exposure is more common than we expected among university students. While we focus so much attention on anxiety and depression among university students (Nelson & Gregg, 2012; Amarasuriya, Jorm & Reavley, 2015; Giovanni, 2018), psychological trauma is almost completely neglected. Moreover, the most recent data reported by Malaysian Department of Higher Educations (2015) indicated that in 2014 enrolment, there were 560, 359 students in Malaysian higher education system including both private and governments institutions. Thus, it is estimated that 112,071 had trauma exposure and 20% (n = 22,414) of them might have trauma exposure when they were in campus (McGowan & Kagee, 2013). Intervening the most recent trauma is important in PTSD recovering process according to the United States National Institute of Mental Health (2016).

Finding also suggested that 77% have direct traumatic experience at least once in their lifetime. It was also estimated that 14.6% had more than 5 times direct traumatic events. The percentage of the current finding is slightly lower than the previous findings (Kilpatrick et al., 2013; Frazier et al., 2009). Kilpatrick et al. (2013) estimated that 89.7% of American adult populations (N = 2,952) had at least one criterion A of DSM-5 trauma exposure in their lifetime. Meanwhile Frazier et al. (2009) estimated that 99% of their university students (N =1,528) reported having traumatic event in their lifetime. Firstly, the minor discrepancies of the current findings with the other studies might be due to the smaller number of the

participants. Secondly, Kilpatrick et al. (2013) surveyed wider range of population while the current study only focused on the university students. Thirdly, they used different instrument. They include none DSM-5 Criterion A traumatic events such as "someone said hurtful things", "Broken an important promise", "close other unsupportive", "someone excluded participant", "Deceived about something important", "Cheated by romantic partner", "Intense homesick for extended period". Furthermore, their studies only included female students. When only criterion A DSM-5 was calculated in their study, the prevalence was 85% which is closer with the current study.

The most common reported trauma was road accident. This finding is not surprising. Recent data on Malaysian road accident as reported by the International Traffic Safety Data and Analysis Group (2017) indicated that the highest fatalities group age in motor vehicle accidents in 2015 were among those who were 21-25 years old (n = 828) and 16-20 years old (n = 934) group categories. These groups remain the highest fatalities in road accidents since 2012 to 2015 and they were among the group age included in this study. The Malaysian Institute of Road Safety Research (2012) additionally reported that an average of 18 individuals die on Malaysian road daily. They predicted that this number might increase to 29 individuals by the year 2020.

While drowning was included as the third life threatening trauma in this study, other studies do not report similar findings (Kilpatrick et al., 2013; Frazier et al., 2009). However, this study is consistent with the findings reported by Ghazali et al. (2016). They also found that drowning as one of the most progressive finding in traumatic event. Perhaps this is because both studies were conducted in the state of Sarawak. Geographically, many rural settlements or population are occupying the riverbanks. Also, it is very common, river and water transportation remain frequently use in this state. Thus, the risk of drowning possibly

high and becomes the most commonly reported traumatic event among our population. This finding highlights the importance of promoting safety awareness among our children and adolescents while they are using river, water transportation as well as recreation.

Losing a family member and divorce were also reported among the most traumatized event among university students. It should be noted that losing family members by death and divorce is not considered as a traumatic event by the DSM-5. These variables were included in the current study because it was among commonly reported "other traumatic event" in the pilot study. The term trauma remains publicly confusing. While DSM-5 focuses and defines traumatic event as a life-threatening event for self and our love one, many have commonly defined trauma as "a deeply distressing or disturbing experience" (dictionary). Perhaps, in the future study, focus should be given on researching trauma as it has been defined by DSM-5 since we use DSM-5 to screen PTSD symptoms. This finding is consistent with the previous study.

Death of someone close including family member, conflict in love affair or crisis in romantic relationship, physical illness of family and friends, parental divorce, sexual trauma, force abortion, accident, suicide and physical assaults or robbery are among frequently reported lifetime trauma among our university students (Kelly et al., 1995). Although divorce and losing the loved one might not be included as traumatic event in DSM-5, counsellors and practitioners serving the university students in campus have to assume these events are among the major issues faced by our university students. The current study has also found that the most common traumatic experience was suicide attempt, sexual abuse, physical abuse, bullying and pregnancy/abortion. Although the number was low in this study, the increasing numbers have become a concern for many government agencies and NGO in our country. It is reported that 2,780 cases of child abuse which 733 of them were

victims of sexually abuse (UNICEF Malaysia, 2010). Similarly, there were more than 19,000 cases of teenage pregnancy recorded in Malaysia between 2009 and 2011 (Suan, Ismail & Ghazali, 2015) and Sarawak was found to have the highest number of this incident. Meanwhile, study on bully has indicated that the rates have increased in the most recent years (UNICEF Malaysia, 2010).

Findings from this study have also shown that generally male experienced more trauma than female in certain type of trauma exposure. The types of trauma that was significantly experienced by male were physical violence and accidents. This includes road accident, violent attack, witnessed an injury or murder, being close to be injured or killed, being threatened with beating, robbery/burglary, serious illness, physical abuse and humiliation. It is speculated that boys since they were young, they were taught by their families, schools and societies that being a man means being tough, powerful and intimidating. The construction of masculinity by their social environment shaped and indirectly guided the boys to response more aggressively than the female (Deschenes & Esbensen, 1999).

Findings on indirect trauma exposure also suggested that more male experienced other serious accident, watched other people being injured or killed, being close to be injured or killed, sexual abuse and humiliation. Only being threatened with beating and loss of a family member (by death) reported female more than male in indirect trauma exposure. Comparing different traumatic experience between gender, women was considered to be more aggressive, withdrawn, and have more attention problems. This is consistent with the previous study (Hoffman, 2002) study in which female university students reported significantly higher cases of forceful sex (such as assault and rape). Similar findings were also reported by Ruggiero et al. (2003) and Lauterbach and Vrana (2001).

There are some implications on future research and clinical practice for these findings. With regards to trauma exposure studies it should be considered as important as depression and anxiety as well. More studies should be carried out to find trauma related variables among university students. Further studies related to trauma among university students are vital in improving trauma related mental health awareness. Practitioners who work with university students should concern the importance of assessing psychological trauma exposure as one of their mental health screening process before counselling sessions. This seems particularly important because the higher prevalence of trauma exposure in campus as indicated in the previous and this study. Mental health promotion related to trauma should be added to create awareness among our students.

5.1.2 PTSD Symptoms

The prevalence of PTSD symptoms was 17.9%. This result seems low from the previous findings Elhai et al. (2012) with 59% respondent fulfil for PTSD diagnosis. This discrepancy perhaps because of the different instrument used in both studies. While Elhai et al. were using PTSD symptoms-based scale, the current study used PCL-5. When the current study was compared with the study conducted by Terhakopian et al. (2008), the prevalence of PTSD symptoms was 15%. It should be noted that during their study, they used DSM-IV as their criteria (Terhakopian, Sinaii, Engel, Schnurr & Hoge, 2008). Moreover, previous study (Watson & Haynes, 2007) also reported that when self-reported worst events were evaluated, many participants did not meet the criteria of PTSD diagnosis. The prevalence rates decrease to 6% for lifetime events and 8% for recent event (Watson & Haynes, 2007). For the future study, perhaps PCL-5 can be used with some improvement. Participants would be instructed to specify the worst traumatic event in evaluating possible PTSD symptoms. With that, more accurate PTSD prevalence can be reported. It is crucial

for the clinician or counsellor in university setting to understand the nature of PCL-5 usage. The understanding of the assessment might help to improve the client quality of life during their university studies. At the same time, the assessment can help university management for plan and organized some allocation budget to enhance the publication of counselling services within the campus. Also, the statistic throughout the study based on the result might help to improve knowledge about the PTSD current study and findings.

In reporting PTSD symptoms, both males and female's participant have equal score of PTSD symptoms. Meaning that, both genders have equal prevalence of PTSD symptoms among our university students. This finding contradicts with many previous findings in which females reported having twice more prevalence of PTSD than males (e.g. Kilpatrick et al., 2013). One reason is that the current study specifically recruited university students while Kilpatrick et al. (2013) surveyed the United States general population. When compared to the study conducted by Lawler et al. (2005) using the same instrument, they reported PTSD prevalence as 13%. It should be highlighted that they were using DSM-IV criteria with the cut off score of 44. The current study used significantly lower cut off score of 33 to match with DSM-5 criteria. Thus, the current study reported slightly higher prevalence. It is speculated that when the same criteria and cut off score is used, the prevalence rate could be quite similar.

5.1.3 Depressive Symptoms

The present study also found that 20% of participants reported having depressive symptoms. This finding similar with the previous findings reported by McGowan and Kagee (2013) and Tomoda et al. (2000). In their study among undergraduate University students at Tokyo Metropolitan University (49 male & 67 female) were found to have Major Depressive Episode within 12 months prior to the study. Meanwhile, Bayram and Bilgel (2008),

Eisenberg et al. (2007) and Said et al. (2013) found that internationally, the rates of depression among university student range from 14% (Eisenberg, Golberstein & Gollust, 2007) to 39% (Mikolajczk, Maxwell, Naydenova, Meier & El Ansari, 2008). Finding by Stallman (2010) on estimates of psychological distress also showed similar to this study finding (19%). On the other hand, a cross-sectional study surveying 1, 017 Malaysia university students reported a prevalence of 30% using same questionnaire (CESD) (Islam, Low, Tong, Yuen & Abdullah, 2018). This could be due to the lower cut off score they used in their study. Many previous studies using CESD used cut off score of 16 and higher to determine depressive symptoms (Roth, Ackerman, Okonkwo & Burgio, 2008).

There might be many reasons for the students feel depress along the university time. In Ceyhan et al. (2005) study most of the students depress because they have too much responsibilities. For example, they have to adapt to the new situations, establishing social relationships with friends and others, becoming members of different groups, and undergoing professional development. Some of these adjustments are emotionally and mentally challenging, such as anxiety about the future, they are worried about finding a job after graduation. Similarly, Iga (1981) reported that the intense preparation of college entrance examination perhaps responsible to the high suicide rates among young Japanese. Persistent stressful events and adjustments can lead to depression and affect both genders equally among our students in campus.

The percentage of having depressive symptoms between male and female students was equal. These studies consistent with this study finding. In Mellin (2008) study, there were no significant effects for gender, even prior to the regression analysis. Similarly, study conducted by Ceyhan et al. (2005) among what population and Islam et al. (2018) among undergraduate Malaysian students. Chen et al. (2013) study among undergraduate in China

also found that there was no significant differences between depression levels of females & males. Sarokani et al. (2013) who did systematic review on depressive symptoms among undergraduate students suggested that both male and female students have equal experience and pressure in the university life. Thus, it is not surprising that in this study the prevalence of depressive symptoms is equal in both genders.

5.1.4 PTSD in Relation to Depressive Symptoms

Finding from the current study also suggested that students who reported having PTSD symptoms strongly and significantly related with depressive symptoms as well. Meaning that, depression is common among PTSD sufferers. This finding is consistent and had been well documented in many previous studies among general population (Fan et al., 2011; Gros, Price, Magruder & Frueh, 2012; Fu et al., 2013; Kilpatrick et al., 2013; Bantjes et al., 2016). Although PTSD can cause significant mental dysfunctioning, functional disturbance and morbidity as a remarkable diagnosis (Stein, McQuaid, Pedrelli, Lenox & McCahill, 2000), yet both depression and PTSD frequently take place. For example, in the previous study had shown that any related significant symptoms of depression will affect between 30% and 50% PTSD sufferers (Nixon, Resick & Nishith, 2004). Thus, any related practitioner should realise that client having PTSD will have depression symptoms at the same time. Proper assessment to evaluate PTSD and depression must be in order to avoid any misinterpretation and bring harm to the client. While in university setting, the awareness such as talk and campaign for both illnesses were important for their guideline when they are in campus.

For example, Bantjes et al. (2016) found that South African university students who suffer from PTSD symptoms significantly reported having depressive symptoms as well. Moreover, they also found that symptoms of depression and exposure to trauma strongly and

significantly predict suicide ideation among their university students. Scant literatures have shown that this finding is not new, but it highlights the importance of identifying students who have suffered both; PTSD and depressive symptoms. They might be a risk of having suicidal ideation. It was found that more severe depressed patients who also had PTSD, still have significant suicide ideation, even though after symptoms of depression being controlled in the statistical analysis (Oquendo, Friend, Halberstam, Brodsky, Burke, Grunebaum, Malone & Mann, 2003; Oquendo, Brent, Birmaher, Greenhill, Kolko, Stanley et al., 2005). Meaning that if PTSD alone can strongly lead to suicide attempt or ideation, depression can cause make it worst. Mental health educations are important so that students are aware the different symptoms and most of all the important of seeking help when they have both depression and PTSD at the same time. Nevertheless, the entire practitioner such as social worker should equip themselves with the knowledge. Keep update with the recent study regarding these issues might help as they can prepare appropriate therapy for victims. Future study also needs to consider those with lifetime history of PTSD were significantly more likely to have a suicide attempts (Oquendo et al., 2005), regardless to any groups with the suicidal ideation or intent too.

5.1.5 Stigma

The percentage of participants having high stigma is high (51.9%). These include personal stigma subscale (50.2%) and perceived stigma subscale (51.3%). This is consistent with the previous studies (Eisenberg et al., 2009, Givens et al., 2002; Vogel et al., 2007) that stigma is as a major deterrent to help seeking on college campuses. The general society usually has negative conceptualization to those who suffer from psychological disorders. The negative perception can lead to their social withdrawal, emotional stress and dysfunctioning at work and social affairs (Crisp, Gelder, Rix, Meltzer & Rowlands, 2000).

The present study also found that most of the university students believed that people with depression were unpredictable and dangerous. They personally believed that people with depression will bring harm to others and will not be cured. This is not consistent with Girma et al. (2013) study that showed that depression is treatable mental condition. Further investigation also showed that as compared to personal stigma, perceived stigma had been proved as important barriers to participants' help-seeking behaviour. This is reliable with others finding (Givens et al., 2002; Vogel et al., 2007; Eisenberg et al., 2009; Gulliver et al., 2010) among college students in which stigma had been labelled as negative impact on help-seeking behaviour, help-seeking attitudes, and even students' perception of need for help. According to Elliot and Doane (2015), students worried if they reveal more about their mental illness to others, they would experience more discrimination. Wang et al. (2015) suggested that in Malaysia, negative social perception toward mental illness for both depression and PTSD would decrease help seeking behavior. Refusing treatment can further worsen their mental illness.

In contrast of the above findings, a previous study reported that stigma was not the main barrier for help seeking behavior among university students (Czyz et al., 2013). Only 12% of their university students reported that stigma as a barrier for their help-seeking behavior. As a result, participants who have stigma preferred to find help from their own family member or friends and reluctant to seek professional helps. Wang, Fick, Adair and Lai (2007) studied stigma on mental disorders among teenagers. They found that girls preferred to seek help from their friends when they have emotional problems instead of boys whereas significantly less girls seek helps to their family member as compared to boys.

Findings from the present study found that there was no significant gender difference in the overall stigma score. Further analyses were also found that there were no significant

gender differences in personal stigma and perceived stigma. Stigma towards mental illness affects both genders equally. Khan, Kausar, Khalid and Farooq (2015) study showed that both women and men experienced discrimination and stigma. Unfortunately, women were diagnosed with depression are likely to be experiencing more discrimination and internalized stigma in comparison to men. The same study also indicates that generally women have greater level of psychological stress in comparison to the men. As a result, they are prone to experience greater level of stigma discrimination then men. In contrast, a study among Canadian's attitudes toward depression, found that men held more stigmatizing attitudes toward mental illness than women (Wang and colleagues, 2007). Further study should examine on the adverse effect of stigma as it will affect quality of life, self-esteem and sense of wellbeing (Fennell, 2004). Wang et al. (2007) also reported that boys and girls differences in negative mental health attitudes environment and readiness to use mental health services already exist at initial stages in adolescence. Therefore, it's very crucial to understand that stigma experienced by gender might requires different approaches and treatment options in the future.

Findings also suggested that there was no significant distinction between those who have PTSD and those who do not have PTSD in reporting depression stigma scale. In reporting personal stigma and perceived those with PTSD and those without PTSD reported equal score of these two additional stigma scales. Also, in reporting depression stigma scale, personal stigma, and perceived stigma, both who have depressive symptoms and who do not have depressive symptoms report their all stigma scores equally. Meaning that, regardless if they have depressive symptoms or not, whether they have PTSD or not, their stigma is the same. Stigma can worsen mental disorders further when patients particularly university

students refused to seek help. Stigma also might affect the family members' willingness to seek help and treatment.

Hence more mental health literacy should be given to the university students to decrease their stigma toward mental illness in Malaysia. Information related to mental disorders should be promoted among the university student. The cultural aspects, childhood experiences and parental way of teaching might affect the university student in a way how they treat and see stigma toward help seeking behavior. In addition, student's peers among themselves also play important role by enhancing the positive attitudes in daily communication. Indeed, mass media also should encourage the non-stigma poster or announcement especially in social media medium. Facebook, Instagram and twitter among the higher user among youngster that can be used to promote non stigma for mental health.

Stigma not only debilitates individual help seeking behaviour but also burden the society as untreated mental illness may bring adverse as a whole (Hanafiah et al., 2005). It is therefore the dissemination of accurate information regarding mental health to the community is crucial. More public talk, awareness booth and campaign should be organized by any of organization, not only form the government itself, especially for Ministry of Health. Involving of mass media, for example youtube to spread the accurate information. School counsellors can do more frequently sharing with the student especially in primary school level. The involvement of all party is really crucial as they can provide more information about the mental health. At the same time, they can distribute any require information on how to seek treatment from the medical professional or NGO that can give advice for them. The implementation of a national anti-stigma campaign should also introduce. Eliminating stigma can help those who suffer from mental illness to seek professional helps. Different genders experienced stigma differently. It needs different

approach in reducing stigma-related issues and perhaps require different treatment approach for different genders.

5.1.6 Help Seeking Behaviour

Findings showed that gender is a significant predictor for help seeking behaviors. The model is significant predictors for help seeking behaviors among all participants. This finding is consistent with the study that was conducted by Dharitri et al. (2015). They found that gender plays an important role in family institution. It was found that female family members (75.1%) were more likely to seek help as compared to male (24.9%). This result similar to Turan and Erdur-Baker study (2014). However, when experiencing suicidal thought, male students significantly seek helps more than the female. On the other hand, when they have personal or emotional problem, the likelihood for both male and female to seek helps is the same. From the result, more efforts should be given to our male students. More mental health promotions and help-seeking behavior should be conducted among male students. Perhaps more studies should be conducted to see what are the different related factors that can motivate male students to seek help.

A complete analysis was done among these four groups of participants; participants who exhibiting PTSD and depressive symptoms, those without PTSD and depressive symptoms, those who exhibited only PTSD and those who only exhibit depressive symptoms. Results showed that other variables were not significant predictors for help seeking behavior.

Results have found that only 42% of participants tend to ask for help when they have personal issues or conflicts. This percentage is quite alarming. Meaning that majority of our young and well-educated population would not seek help when they have problems.

From the present result, only 51.3% reported they tend to ask for help if they have suicidal ideation or intention. It is estimated that the remaining 48.7% would not be likely to seek helps. Surprisingly, among those who are willing to seek helps, many of them had preference to seek help from parents, followed by intimate partner and the last person they would seek help would be mental health professional. This study similar to Drum et al. (2009) and Bilican (2013). Bilican (2013) found that more students in Turkish college prefer talking to friends and family.

Meanwhile, Benson (1990) who study help seeking behaviour among adolescents who are younger than the current study participants reported that adolescents prefer to seek help from their friends first (38%), and only 25% would seek help from their parents. Similarly, Rickwood and Braithwaite (1994) reported that 86% of adolescent would seek help from friends and family, whereas only 14% seek help from mental health professionals. This difference could be due to the fact is that college students have recognized that getting help from the professionals are their better choices. In Malaysia, family members especially parents and intimate partner were the main source to seek for help when the university students encountered both personal emotional problems and/or those with suicidal thoughts.

Results also showed that 21% participants with personal and emotional problem and 25% participants with suicidal thought would not seek for help from anyone if they have personal emotional problem or suicidal thoughts. This finding is similar to Wang et al. (2005) and Ciarrochi et al. (2003). The university students prefer intimate partner (including best friends) and professionals than seeking helps from their parents. Perhaps more peers counselling groups should be formed. Similarly, program related to peers counselling should empowered and strengthened. Thus, more peer counsellor members should be recruited and trained in campus.

Findings also suggest that although participants prefer to seek help from intimate partners and mental health professionals than their parents, they recognized the first source of helps are their parents. The three main help sources for those who have personal and emotional problem and suicide thought were parent, intimate partner and mental health professional. Current finding inconsistent with Czyz (2013) study, as the most detailed explanation behind not seeing emotional wellness expert's because of recognition they did not bother with the treatment for their minor issues and feel discomfort discussing problems.

Participants who have PTSD symptoms would be bound to look for assistance in comparison with the individuals who do not had PTSD symptoms. Similarly, further investigation demonstrated that when participants have personal and emotional problems, those who exhibit PTSD symptoms would significantly to seek more help. On the other hand, when they have suicidal behavior, both PTSD and none PTSD participants would likely to seek help. The result showed participant with mental illness have tendencies to seek for help with regards they have PTSD or no and also for the suicidal behavior.

Different results were found among those who exhibited depressive symptoms. Participants who have depressive symptoms and who do not have depressive symptom, would likely and equally to seek help. Similarly, when they have suicide behavior and personal emotional problems, both group of depressive and who do not have depressive symptoms would likely to seek help. Current study similar to Nagai (2015) study which showed that those who have higher depression score were predicted to have more help seeking-behaviors. The study also suggested that those who have suffered from depression can cause them to also suffer from severe distress. As a result they eventually feeling motivated to seek for help. Unfortunately, it is crucial to understand that there are many people who do not receive any helps if they are experiencing severe depression (Naguma et

al., 2006). Even though those with severe depression symptoms are likely to seek help compared with these with low depression symptoms, yet not all people can seek or access enough help.

Findings also show that when compared among the following groups of participants 1) PTSD and depressive symptoms, 2) PTSD only, 3) Depressive symptoms only, and 4) None PTSD and none depressive symptoms, their likelihood to seek helps is equal. In other words, their health conditions do not significantly influence them to seek help. It also showed that participant can go and seek help without considering their mental health status.

5.1.7 Stigma as Mediating Factor of Help Seeking Behaviour

Result showed that stigma does not play any significant effect to the help seeking behaviour among the university students. This finding is similar with the longitudinal study conducted by Golberstein and Gollust (2009). They found that perceived public stigma was no significant associated with help-seeking behavior over the two-year period among college students. They concluded that stigma did not appear to pose a substantial barrier to help seeking behavior particularly among college students. Essentially, results showed that reducing public stigma on mental disorders may not lead to significant increases in help-seeking behavior, at least among college students. However, it does not mean that reducing stigma is not crucial, because other components of stigma may affect help seeking and stigma may have other negative consequences, including lowering self-esteem or negatively affect personal and social relationships. Perhaps longitudinal research is needed to see if these findings can be applied to different populations and if other contributing factors including stigmatizing attitudes or self-stigma, can lead to more significant barriers to mental health services and other help seeking behavior.

On the contrary, different results were suggested by a previous study. For example, Andrew, Issakidis and Carter (2001) suggest that social support play an important role in help seeking behaviour. They believe that many people cannot find help if they continuously having serious issues, and these people failed to establish adequate social support network. Their view is consistent with the fact is that high stigma on mental disorders could prevent people from seeking more help especially among those who are severely affected. The current study does not investigate the different level of mental disorder severity. Thus, perhaps in the future, comparison should be done if stigma is indeed affected between different level of mental disorders and help seeking behaviour among university students.

5.2 Suggestion and Recommendation

This study has implications for both university counselling service and research centre in higher learning institution. Evidently, further research should be conducted to focus more on trauma exposure among university students. While it seems that almost everyone had at least one trauma exposure during their lifetime, currently almost no program has been conducted to bring awareness on the impact of trauma exposure to university students' mental health. Regular screening in identifying students with potential trauma exposure especially during their childhood experience should also be conducted. This can be done by providing an ongoing training regarding the impact of repeated trauma exposure to the university counsellors.

Similarly, the prevalence of depressive symptoms is high among our university students. Moreover, trauma exposure has a strong relationship with PTSD symptoms. While research on PTSD and depressive symptoms among general populations is growing and increasing, literatures on PTSD and depression among university students remains limited

and receive less attention from our researchers. University leaders and mental health providers in campus can work collaboratively to provide additional and staff training particularly academic members who frequently interact with our students regarding trauma exposure and its consequence to students' mental health. More resources and screening tools should be made available for those who are at risk. Once identified, early intervention and treatment can be provided, thus, trauma can be more manageable.

Study on stigma, help seeking behaviour, PTSD and depression among university students in Sarawak is not available. Findings from this study give strong indications that more intervention should be used among university counsellors and therapists in the university setting. AHRQ (2012) examined the prevalence of traumatic events among college students and found that lifetime prevalence ranged from 39% to 84%. They recommended that help providers must focus on the psychological intervention such as psychological briefing which includes Critical Incident Stress Debriefing (CISD) and Critical Incident Stress Management (CISM), Psychological First Aid (PFA), Eye Movement Desensitization and Reprocessing (EMDR) and Cognitive-Behavioral Therapy (CBT).

It is crucial to understand that university students who are affected need further counselling and psychological assistant. The university social and learning environment should encourage students learn more about their mental health needs and we need to create a supportive environment for student. In addition, university need to provide more detailed information on the mental health condition most prevalence such as how to respond to student in crisis, how student can access counselling and guidance services.

Psychosocial counselling, targeted intervention population, support group or focus group might be beneficial for the students. Counsellors, social workers or mental health

providers in the university system must play their role to encourage the student's involvement in group support activities. Negative perception or stigma towards these services may lead to unsuccessful planned by the university especially for student's wellbeing.

Research should also be focus on how to reduce stigma on mental disorders among the university students. It seems like stigma affect higher education students as well. Mental health promotion should bring more awareness that mental disorders are treatable. They should also be aware that person with mental disorder can live a normal life as long as they have insights and they are willing to adhere professional treatment plan. Reducing stigma can increase help-seeking behaviour (Cheng, Wang, McDermott, Kridel & Rislin, 2018). They also found that mental health literacy is essential to improve help-seeking behaviour among college students.

It is proposed that in the future, larger scale of research can be conducted that would cover nationwide population among our university students. Some other possible factors that contribute to depression can also be included. Nevertheless, students who had unresolved issues may have biases toward researches and hoped to receive help through participating. By then, researcher should more aware and prepare the procedure more detail in order the students understand the limit for every data collection process.

The future studies also might examine the findings in more university setting (not only in public university in Sarawak). Further research should also focus on their socioeconomic status, family background and residential area, and more larger participants should be included in future studies.

5.3 Limitation of Study

The present study had some limitations. This study adopted a cross-sectional research design. The present findings only yielded the significant relationships between variables investigated. Thus, there is no causal conclusion can be reported or drawn. Secondly, the current study used self-reporting method, thus perhaps the findings may be subjected recall bias. This study recruited students or participants from only three universities in Sarawak. Findings might be useful and applicable in the development of effective intervention in university student setting in Sarawak only. Fourth, the finding may not be generalized to the whole nation since the study only recruited participants from Sarawak. Nevertheless, the results from this study contribute the growing knowledge in the literature that students with PTSD, depressive symptoms, stigma and also help seeking behaviour among our population. Future study should consider other mental and physical health factors like stress, anxiety, morbidity and disability to encourage broader knowledge. Most of the factors were comorbidity and it might bring consequences to the number of PTSD and depression among university students.

5.4 Conclusion

This study contributes tremendously to the body of knowledge on the university students' mental health. The high prevalence of PTSD and depressive symptoms among the students in university in Sarawak in the present study highlighted many important findings. The prevalence of PTSD symptoms and exposure to lifetime trauma are quite alarming. Similar to the general population studies, this study found that participants who reported having PTSD symptoms, also suffers from depressive symptoms. The percentage of PTSD and depressive symptoms are similar between female and male students indicating that the

life challenges they have gone through in college and university's life are indeed very challenging for both female and male students. While improving the methodological weakness of the previous studies on university and college student prevalence of depressive symptoms among our university students is quite high. Similarly, the stigma towards mental disorder is still high while their willingness to see help is significantly low. More awareness on PTSD, depressive symptoms, stigma towards mental disorders and the importance of help seeking behavior should be promoted. Centre for student counseling services for every university should strategize more appropriate program to help all the students. Continuous awareness might reduce the stigma and create positive environment within the campus compound. Hence, early detection of student having PTSD and depressive symptoms can help them to live a better life in future.

REFERENCES

Aboul-Hagag, K. E., & Hamed, A. F. (2012). Prevalence and pattern of child sexual abuse reported by cross sectional study among the university students, Sohag University, Egypt. *Egyptian Journal of Forensic Sciences, 2,* 89-96.

Agency for Healthcare Research and Quality (AHRQ). (2012). *Interventions for the prevention of Posttraumatic Stress Disorder (PTSD) in adults after exposure to psychological trauma*. Retrieved from https://effectivehealthcare.ahrq.gov/sites/default/files/pdf/ptsd-adults-trauma.

Ahrens, C. E. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *Journal Community Psychology, 38,* 263-274.

Aker, S., Aker, A. A., Boke, O., Dundar, C., Sahin, A. R., & Peksen, Y. (2007). The attitude of medical students to psychiatric patients and their disorder and the influence of psychiatric study placements in bringing about changes in attitude. *Journal of Psychiatry Relation Science, 44,* 204-212.

Amarasuriya, S. D., Jorm, A. F., & Reavley, N. J. (2015). Prevalence of depression and its correlates among undergraduates in Sri Lanka. *Asian Journal of Psychiatry, 15*, 32-37.

American College Health Association (ACHA). (2006). *American College Health Association National College Health Assessment*. Retrieved from https: //www.acha.org/documents/ncha/ACHACHA_Reference_Group_ExecutiveSummary_Spring2005.pdf.

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Arlington, VA.

Andrews, G., Issakidis, C., & Carter, G. (2001). Shortfall in mental health service utilization. *British Journal of Psychiatry, 179*, 417–425.

Aydin, G., & Demir, A. (1989). Prevalence of depressive symptoms among METU students. *Journal of Human Sciences, 8*, 27-40.

Bantjes, J. R., Kagee, A., McGowan, T., & Steel, H. (2016). Symptoms of posttraumatic stress, depression, and anxiety as predictors of suicidal ideation among South African university students. *Journal of American College Health, 64*(6), 429-437.

Barker, G. (2007). *Adolescents, social support and help-seeking behavior consultation with recommendation for actions*. World Health Organization. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/43778/9789241595711_eng.pdf.

Baron, R. M., & Kenny, D. A. (1986). The moderator-mediator variable distinction in social psychological research: conceptual, strategic, and statistical considerations. *Journal of Personality and Social Psychology, 51*(6), 1173-1182.

Bayram, N., & Bilgel, N. (2008). The Prevalence and socio-demographic correlations of depression, anxiety and stress among a group of university students. *Social Psychiatry and Psychiatric Epidemiology, 43*, 667-672.

Bebbington, P., Dunn, G., Jenkins, R., Lewis, G., Brugha, T., Farrell, M., & Meltzer, H. (2003). The influence of age and sex on the prevalence of depression conditions: A report from the National Survey of Psychiatric Morbidity. *Psychological Medicine, 28*(1), 9-19.

Benson, P. L. (1990). Help-seeking for alcohol and drug problems: To whom do adolescents turn? *Journal of Adolescent Chemical Dependency, 1*(1), 83–94.

Bernat, J. A., Ronfeldt, H. M., Calhoun, K. S., & Arias, I. (1998). Prevalence of traumatic events and peritraumatic predictors of posttraumatic stress symptoms in non-clinical

sample of college students. *Journal of Traumatic Stress, 11,* 645-664.

Bhugra, D. (1989). Attitudes toward mental illness: a review of the literature. *Acta Psychiatric Scandinavia, 80,* 1-12.

Binelli, C., Ortiz, A., Muniz, A., Gelabert, E., Ferraz, L., Filho, A. S., Crippa, J. A. S., Nardi, A. E., Subira, S., & Martin, S. R. (2012). Social anxiety and negative early life events in university students. *Journal of the Brazilian Psychiatric Association, 34*(1), 69-80.

Bilican, F. I. (2013). Help-Seeking attitudes and behaviors regarding mental health among Turkish college students. *International Journal of Mental Health, 42,* 43-59.

Blanco, C., Okuda, M., Wright, C., Hasin, D.S., Grant, B.F., Liu, S., & Wofson, M. (2008). Mental health of college students and their non-college attending peers. *Achieves of General Psychiatry,* 65, 1429-1437.

Boerema, A, M., Van Zoonen, K., Cuijpers, P., Holtmaat, C. J. M., Mokkink, L. B., Griffiths, K. M., & Kleiboer, A. M. (2016). Psychometric properties of Dutch Depression Stigma Scale (DSS) and associations with personal and perceived stigma in depressed and community sample. *PLos One, 11*(8), 1-16.

Boone, S. D., & Brausch, A. M. (2016). Physical activity, exercise motivations, depression, and nonsuicidal self-injury in youth. *Suicide and Life-Threatening Behavior, 46*(5), 625-633.

Bovin, M. J., Marx, B. P., Weathers, F. W., Gallagher, M. W., Rodriguez, P., Schnurr, P. P., & Keane, T. M. (2016). Psychomtetric properties of the PTSD Checklist for diagnostic and statistical manual of mental disorder-fifth edition (PCL-5) in veterans. *Psychological Assessment, 11,* 1379-1391.

Briere, J., & Runtz, M. (1989). The Trauma Symptoms Checklist (TSC-33): Early data on a new scale. *Journal of Interpersonal Violence, 4*, 151-163.

Bryant, R. A., & Harvey, A. G. (1995). Avoiding coping style and posttraumatic stress disorder. *Journal of Behavior, Research and Therapy, 33,* 631-635.

Brockington, I. F., Hall, P., Levings, J., & Murphy, C. (1993). The community's tolerance of the mentally ill. *British Journal of Psychiatry, 162,* 93-9.

Byrne, P. (2000). Stigma of mental illness and ways of diminishing it. *Advances in Psychiatric Treatment, 6*, 65-72.

Campbell, D. T. (1959). Methodological suggestions from a comparative psychology of knowledge processes. *Inquiry, 2*(1-4), 152-182.

Cavanagh, A., Caputi, P., Wilson, C. J., & Kavanagh, D. J. (2016). Gender differences in self-reported depression and co-occurring anxiety and stress in a vulnerable population. *Australian Psychologist, 51*(6), 411-421.

Centre for Disease Control. (2012). *CDC Global School-based Student Health Survey*. Retrieved from https://www.cdc.gov/gshs/countries/seasian/ pdf/2012yseh_f actsheet.pdf.

Çelik, C. B., & Odaci, H. (2012). The effect of experience of childhood abuse among university students on self-perception and submissive behavior. *Children and Youth Services Review, 34,* 200-204.

Ceyhan, E., Ceyhan, A. A., & Kurtyilmaz, Y. (2005). Depression among Turkish female and male university students. *Social Behavior and Personality, 33*(4), 329-340.

Chambers, A. (2010). Mental Illness and the developing world. Retrieved from https://www.theguardian.com/commentisfree/2010/may/10/mental-illness-developing-world.

Chatterjee, S., Saha, I., Mukhopadhyay, S., Misra, R., Chakraborty, A., & Bhattacharya, A. (2014). Depression among nursing students in an Indian government college. *British Journal of Nursing, 23*(6), 316-20.

Cheng, H. L., Wang, C., McDermott, R. C., Kridel, M., & Rislin, J. L. (2018). Self-stigma, mental health literacy, and attitudes toward seeking psychological help. *Journal of Counseling & Development, 96*(1), 64-74.

Chen, L., Wang, L., Qiu, X. H., Yang, X. X., Qiao, Z. X., Yang, Y. J., et al. (2013). Depression among Chinese university students: prevalence and socio-demographic correlates. *PLoS One. 8*(11). doi: 10.1371/journal.pone.0058379.

Ciarrochi, J., Deane, F. P., Rickwood, D., & Wilson, C. J. (2005). Measuring help-seeking Intentions: Properties of the general Help-Seeking Questionnaire. *Canadian Journal of Counseling, 39*(1), 15-28.

Ciarrochi, J., Wilson, C. J., Deane, F. P., & Rickwood, D. (2003). Do difficulties with emotions inhibit help-seeking in adolescence? The role of age and emotional competence in predicting help-seeking intentions. *Counseling Psychology Quarterly, 16,* 103-120.

Cooper, A. E., Corrigan, P. W., & Watson, A. C. (2003). Mental illness stigma and care seeking. *The Journal of Nervous and Mental Disease, 191*(5), 339–341.

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59,* 614-625.

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. *World Psychiatry, 1*(1), 16-20.

Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma if mental illness: Explanatory models and methods for change. *Applied and Preventive Psychology, 11,* 179-190.

Corrigan, P. W., & Rusch, N. (2011). Mental illness stereotypes and clinical care. Do people avoid treatment because of stigma? *Journal Psychiatric Rehabilitation Skills, 6,* 312-334.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I., & Rowlands, O. J. (2000). Stigmatisation of people with mental illness. *The British Journal of Psychiatry, 177,* 4-7.

Cuevas, C. A., & Sabina, C. (2015). The experience of sexual victimization and help-seeking among Latino Women. *Cultural, Diversity Ethnic Minority Psychology, 21*(1), 19-30.

Czyz, E. K., Horwitz, A. G., Eisenberg, D., Kramer, A., & King, C. A. (2013). Self –reported barriers to professional help seeking among college students at elevated risk for suicide. *Journal of American College Health, 61,* 398-406.

Davidson, J. R., Hughes, D., Blazer, D. G., & George, L. K. (2001). Posttraumatic stress disorder in the community: An epidemiological study. *Psychological Medicine, 21*, 713-721.

Department of Higher Education, Planning, Research and Policy Coordination Division, Ministry of Education Malaysia. (2014). National Education Statistic: Higher Education Sector 2013. Retrieved from http://www.mohe.gov.my/ web statistik/perangkaan 2010.pdf.

Deschenes, E. P., & Esbensen, F. A. (1999). Violence and gangs: Gender differences in perceptions and behavior. *Journal of Quantitative Criminology, 15*(2), 63-96.

Dharitri, R., Rao, S. N., & Kalyanasundaram, S. (2015). Stigma of mental illness: An interventional study to reduce its impact in the community. *Indian Journal of Psychiatry, 57*(2), 165-173.

Drum, D. J., Brownson, C., Burton, D. A., & Smith, S. E. (2009). New data on the nature of suicidal crises in college students: Shifting the paradigm. *Professional Psychology Research Practice, 40,* 213-222.

Dusselier, L., Dunn, B., Wang, Y., Shelly, M. C., & Whalen, D. F. l. (2005). Personal, health, academic, and environmental predictors of stress for residence hall students. *Journal of American College Health, 54*(1), 15-24.

Eisenberg, D., Golberstein, E., & Gollust, S. E. (2007). Help-seeking and access to mental health care in a university student population. *Medical Care, 45,* 594-601.

Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66,* 522-541.

Eisenberg, D., Speer, N., & Hunt, J. B. (2012). Attitudes and beliefs about treatment among college students with untreated mental health problems. *Psychiatric Services, 63,* 711-713.

Eisenberg, D., Hunt, J., Speer, N., & Zivin, K. (2011). Mental health service utilization among college students in the United States. *The Journal of Nervous and Mental Disease, 199,* 301-308.

Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review, 66,* 552-541.

Elhai, J. D., Miller, M. E., Ford, J. D., Biehn, T. L., Palmieri, P. A., & Fueh, B. C. (2012). Posttraumatic stress disorder in DSM-5: Estimates of prevalence and symptoms structure in a nonclinical sample of college students. *Journal of Anxiety Disorder, 26,* 58-64.

Elklit, A., & Petersen, T. (2008). Exposure to traumatic events among adolescents in four nations. *Torture, 18*(1), 2-11.

Elliot, M., & Doane, M. J. (2015). Stigma Management of Mental Illness: Effects of Concealment, Discrimination, and Identification on Well-Being. *Journal of Self and Identity, 14*(6), 654-674.

Fan, F., Zhang, Y., Yang, Y., Mo, L., & Liu, X. (2011). Symptoms of posttraumatic stress disorder, depression, and anxiety among adolescents following the 2008 Wenchuan earthquake in China. *Journal of Traumatic Stress, 24*(1), 44-53.

Fabrega, H. (1991). The culture and history of psychiatric stigma in early modern and modern western societies: a review of recent literature. *Comparative Psychiatry, 32*(2), 97-119.

Faramazi, M., Cheraghi, M., Zamani, M., Kheirkhah, F., Bijani, A., & Hosseini, S. R. (2017). Gender-specific predictors of depressive symptoms among community elderly. *Journal of Research in Health Sciences, 17*(2), 1-6.

Fennell, M. J. V. (2004). Depression, low self-esteem and mindfulness. *Behaviour Research and Therapy, 4*(9), 1053-1067.

Frazier, P., Anders, S., Perera, S., Tomich, P. L., Tennen, H., Park, C., & Tashiro, T. (2009). Traumatic events among undergraduate students: prevalence and associated symptoms. *Journal of Counseling Psychology, 56*(3), 450-460.

Fu, Y., Chen, Y., Wang, J., Tang, X., He, J., Jiao, M., Yu, C., You, G., & Li, J. (2013). Analysis of prevalence of PTSD and its influencing factors among college students after the Wenchuan Earthquake. *Journal Child and Adolescent Psychiatry and Mental Health, 7*(1), 92-143.

Gallagher, R. P. (2009). *National Survey of Counseling Center Directors 2008*. Retrieved from http://dscholarship.pitt.edu/28169/1/2008_National_Survey_of_Counseling_Center_Directors.pdf.

Gallagher, R. P. (2011). *National Survey of Counseling Center Directors*. Retrieved from http://dscholarship.pitt.edu/28174/1/survey_2011.pdf.

Gallagher, R. P. (2015). *National Survey of College Counseling Centers 2014.* Retrieved from https://core.ac.uk/download/pdf/43007621.pdf.

Ghazali, S. R., Elklit, A., Balang, R. V., Sultan, M. A., & Kana, K. (2014). Preliminary findings on lifetime trauma prevalence and PTSD symptoms among adolescents in Sarawak Malaysia. *Asian Journal of Psychiatry, 11,* 45-49.

Ghazali, S. R., Elklit, A., Sultan, M. A., Balang, R. V., & Chen, Y. Y. (2016). Lifetime trauma exposure, gender, and DSM–5 PTSD symptoms among adolescents in Malaysia. *Traumatology, 23*(3), 235-239.

Girma, E., Tesfaye, M., Froeschl, G., Moller-Leimkuhler, A. M., Muller, N., & Dehning, S. (2013). Public stigma against people with mental illness in the Gilgel Gibe Field Research Center (GGFRC) in Southwest Ethiopia. *PLos One 8*(12), 1-9. Doi:10.1371/journal.pone.0082116.

Givens, J. L., & Tija, J. (2002). Depressed medical students' use of mental health services and barriers to use. *Academic Medicine, 77,* 918-921.

Golberstein, E., Eisenberg, D., & Gollust, S. E. (2009). Perceived stigma and help-seeking behavior: Longitudinal evidence from the Healthy Minds Study. *Psychiatric Service, 60*(9), 1254–1256.

Griffiths, K. M., Christensen, H., Jorm, A. F., Evans, K., & Groves, C. (2004). Effects of web-based depression literacy and cognitive-behavioral therapy intervention on stigmatizing attitudes to depression: Randomized controlled trial. *The British Journal of Psychiatry, 185*, 342-349.

Gray, L. B., Weller, R. A., Fristad, M., & Weller, E. B. (2011). Depression in children and adolescents two months after the death of a parent. *Journal of Affective Disorders, 135*, 277–283.

Gros, D. F., Price, M., Magruder, K. M., & Frueh, B. C. (2012). Symptoms overlap in posttraumatic stress disorder and major depression. *Psychiatry Research, 196*(2-3), 267-270.

Grzywacz, R. (2012). The issue of stress in the environment based on student surveys. *Family Medicine, 2*, 36-43.

Gulliver, A., Griffith, K. M., & Christensen, H. (2010). Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review. *Biomed Central Psychiatric, 10*,113-118.

Hanafiah, A. N., & Bortel, T. V. (2005). A qualitative exploration of perspectives of mental health professionals on stigma and discrimination of mental health in Malaysia. *International Journal of Mental Health Systems*, *9*(1), 1–12.

Hisli, N. (1988). A study of the validity of the Beck Depression Inventory. *Turkish Journal of Psychology, 6*, 118-126.

Hoffman, W. A. (2002). The incidence of trauma events and trauma-associated symptoms /experiences amongst tertiary students. *South Africa Journal of Psychology*, *32*(4), 48-53.

Hysenbegasi, A., Hass, S. L., & Rowland, C. R. (2005). The impact of depression on the academic productivity of university students. *The Journal of Mental Health Policy and Economics, 8*(3), 145-51.

Iga, M. (2017). Suicide of Japanese youth. *Suicide Life Threat Behavior, 11*(1), 17-30. International Traffic Safety Data and Analysis Group. (2017). Road safety annual report. Retrieved from https://www.itf-oecd.org/road-safety-annual-report-2017.

International Traffic Safety Data and Analysis Group. (2018). Road safety annual report. Retrieved from https://www.itf-oecd.org/sites/default/files/docs/irtad-road-safety-annual-report-2018_2.pdf.

Islam, Md. A., Low, W. Y, Tong, W. T., Yuen, C. C. W., & Abdullah, A. (2018). Factor associated with depression among university students in Malaysia: A Cross-sectional Study. *KnE Life Sciences, 4*(4), 415-427. http://doi.org/10.18502/kls.v4i4.2302.

Karam, E., Kypri, K., & Salamoun, M. (2007). Alcohol use among college students: An international perspective. *Current Opinion in Psychiatry, 20,* 213-221.

Kaufman, J. (1999). Neurobiological correlates of child abuse. *Biological Psychiatry*, *45*, 1235-1236.

Kausch, O., Rugle, L., & Rowland, D. Y. (2006). Lifetime histories of trauma among pathological gamblers. *The American Journal on Addiction, 15*, 35- 43.

Keane, M. (1990). Contemporary beliefs about mental illness among medical students: implications for education and practice. *Academic Psychiatry*, *14*, 172-177.

Kelly, W. E., Kelly, K. E., Brown, F. C., & Kelly, H. B. (1999). Gender differences in depression among college students: A multicultural perspective. *College Student Journal*, *33*, 72-77.

Kelly, A. E., Coenen, M. E., & Johnston, B. L. (1995). Confidants' feedback and traumatic life events. *Journal of Traumatic Stress*, *8*, 161-169.

Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archive of General Psychiatry, 62*(6), 617-627.

Khan, N., Kausar, R., Khalid, A., & Farooq, A. (2015). Gender differences among discrimination & stigma experienced by depressive patients in Pakistan. *Pakistan Journal of Medical Sciences*, *31*(6), 1432-1436.

Kilic, E. Z., Ozguven, H. D., & Sayil, I. (2003). The psychological effects of parental mental health on children experiencing disaster. The experience of Bolu earthquake in Turkey. *Family Process, 42*, 485-495.

Kilpatrick, D. G., Resnick, H. S., Milanak, M. E., Miller, M. W., Keyes, K. M., & Friedman, M. J. (2013). National estimates of exposure to traumatic events and PTSD prevalence using DSM-IV and DSM-5 criteria. *Journal of Traumatic Stress, 26*(5), 537-547.

Kolaitis, G., Kotsopoulus, J., Tsiantis, J., Haritaki, S., Rigizou, F., Zacaharaki, L., & Katerlos, P. (2003). Posttraumatic stress reactions among children following the Anthen's earthquake of September. *European Child & Adolescent Psychiatry*, *12*, 273-280.

Krog, T., & Duel, M. (2003). Trauma Symptom Checklist (TSC). *Psykologisk Studieskriftserie*, *6*, 1-162.

Landolt, M. A., Schnyder, U., Maier, T., Schoenbucher, V., & Mohler-Kuo, M. (2013). Trauma exposure and posttraumatic stress disorder in adolescent: A national survey in Switzerland. *Journal of Traumatic Stress, 26,* 209-216.

Lauterbach, D., & Vrana, S. (2001). The relationship among personality variables, exposure to traumatic events, and severity of posttraumatic stress symptoms. *Journal of Traumatic Stress, 14,* 29-45.

Lawler, C., Ouimette, P., & Dahlstedt, D. (2005). Posttraumatic stress symptoms, coping, and physical health status among university students seeking health care. *Journal of Traumatic Stress, 18*(6), 741-750.

Lee, G., Ham, O. K., Lee, B. G., & Kim, A. M. (2018). Differences in factors associated with depressive symptoms between urban and female adolescents in Korea. *Journal of Korean Academy of Nursing, 48*(4), 475-484.

Lembaga Kaunselor Malaysia. (2017). *Laporan tahunan 2017*. Retrieved from http://www.lkm.gov.my.

Link, B. G. (1987). Understanding labeling effects in the area of mental disorders: A assessment of the effects of expectations of rejection. *American Sociological Review, 52*(1), 96-112.

Luterek, J. A., Heimberg, R. G., Harb, G. C., & Marx, B. P. (2004). Interpersonal rejection sensitivity in childhood sexual abuse survivors: Mediator of depressive symptoms and anger suppression. *Journal of Interpersonal Violence, 19*(1), 90-107.

Manderscheid, R. W. (2010). Evolution and integration of primary care services with specialty services. In Levin, B. L., Hennessy, K., & Petrila, J. (Eds). Mental Health Services: *A Public Health Perspectives (3rd ed.,* pp.389-400). New York, NY: Oxford University Press.

McGowan, T. C., & Kagee, A. (2013). Exposure of traumatic events and symptoms of post-traumatic stress among South African university students. *South African Journal of Psychology, 43*(3), 372-339.

Melissa-Halikiopoulou, C., Tsiga, E., Khachatryan, R., & Papazisis, G. (2011). Suicidality and depressive symptoms among nursing students in Northern Greece. *Health Science Journal, 5*(2), 90-7.

Mellin, E. A. (2008). Rejection sensitivity and college student depression: Findings and implications for counseling. *Journal of College Counseling, 11*(1), 32–41.

Meor Safari, I. N., Kassim, N., Iskandar, F., Mohamed, M. H., & Abdullah, Y. (2011). Level of knowledge on mental health among IPTA students: Case study in UKM, Bangi. *Journal Personal Student, 14*, 37- 44.

Merikangas, K. R., He, J. P., Burstein, M., Swanson, S. A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., & Swendsen, J. (2010). Lifetime prevalence of mental disorders in US adolescents: results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A). *Journal of American Academic Child Adolescent Psychiatry, 49*(10), 980-989.

Mikolajczyk, R. T., Maxwell, A. E., Naydenova, V., Meier, S., & El Ansari, W. (2008). Depressive symptoms and perceived burdens related to being a student: Survey in three European countries. *Clinical Practice and Epidemiology in Mental Health, 4*(1), 19. doi:10.1186/1745-0179-4-19.

Ministry of Higher Education Malaysia (2015). Amanah Tahun Baharu 2016. Retrieved from http://www.mohe.gov.my/amanat-2016/teks-ucapan-atb-2016.

Ministry of Education Malaysia. (2014). *Quick Facts 2014 Malaysia Educational Statistics.* Retrieved from http://emisportal.moe.gov.my.

Mollica, R. F., McDonald, L. S., Massagli, M. P., & Silove, D. M. (2004). *Measuring trauma, measuring torture. Instruction and Guidance on the utilization of* the *Harvard Program in Refugee Trauma's Version of The Hopkins Symptoms Checklist-25 (HSCL-25) & The Harvard Trauma Questionnaire (HTQ)*. Retrieved from http://hprt-cambridge.org/.

Muhamad, Z., Abdullah, A., & Ab Razak, R. (2019). Sifat malu dalam kerangka akhlak melayu (Shyness and Modesty in the Malay Ethical Framework). *Jurnal Hadhari: An International Journal, 11*(2), 231 – 244. Retrieved from http://ejournal.ukm.my/jhadhari/article /view/36896.

Musa, H. (2008). Hati budi melayu pengukuhan menghadapi cabaran abad ke-21. Serdang: Penerbit Universiti Putra Malaysia.

Musa, H., Said, N. S., Rodi, R. R., & Karim, S. S. A. (2012). Hati budi melayu: Kajian keperibadian social melayu ke arah penjanaan melayu gemilang. *GEMA online Journal of Language Studies, 12*(1), *163-182.*

Nagai, S. (2015). Predictors of help seeking behavior: Distinction between help-seeking intentions and help-seeking behavior. *Japanese Psychological Research, 57*(4), 313–322.

Naganuma, Y., Tachimori, H., Kawakami, N., Takeshima, T., Ono, Y., Uda, H., Hata, Y., Nakane, Y., Nakane, H., Iwata, N., Furukawa, T. A., & Kikkawa, T. (2006). Twelve-month use of health services in four areas in Japan: Findings from the World Mental Health Japan survey 2002-2003. *Psychiatry and Clinical Neurosciences, 60*, 240–248.

Nam, S. K., Choi, S. I., Lee, J. H., Lee, M. K., Kim, A. R., & Lee, S. M. (2013). Psychological factors in college students' attitudes toward seeking professional

psychological help: A meta-analysis. *Professional Psychology: Research and Practice, 44*(1), 37-45.

National Alliance on Mental Health (NAMI). (2012). *College Students Speak: A Survey on Mental Health.* Retrieved from https://www.nami.org/About-NAMI/Publications-Reports/Survey-Reports/College-Students-Speak_A-Survey-Report-on-Mental H.pdf

National Institute of Mental Health. (2018). *Depression*. Retrieved from https://www. nimh.nih. gov/health/topics/depression/index.shtml.

National Institute of Mental Health. (2016). *Post-traumatic stress disorder*. Retrieved from https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.html.

New Freedom Commission on Mental Health. (2003). *Achieving the promise: Transforming mental health care in America, executive Summary*. Retrieved from https://govinfo. library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf.

Nixon, R. D. V., Resick, P. A., & Nishith, P. (2004). An exploration of comorbid depression among female victims of intimate partners violence with posttraumatic stress disorder. *Journal of Affect Disorder, 82*(2), 315-320.

Nolen-Hoeksema, S. (2001). Gender differences in depression. *Current Directions in Psychological Science, 10*, 173-176.

Nordin, M. D., Talib, M. A., Yaacob, S. N., & Sabran, M. S. (2010). A study on selected demographic and mental health of young adult in public health learning institutions in Malaysia. *Global Journal of Health Science, 2*(2), 104-110.

Olff, M., Langeland, W., Draijer, N., & Gerson, P. (2007). Gender differences in posttraumatic stress disorder. *Psychological Bulletin, 133*, 183-204.

Online, R., Wilson, C. J., Deane, F. P., Ciarrochi, J. V., & Rickwood, D. (2005). Measuring help seeking intentions: Properties of the general help seeking questionnaire. *Canadian Journal of Counselling, 39*(1), 15-28.

Oquendo, M., Brent, D. A., Birmaher, B., Greenhill, L., Kolko, D., Stanley, B., Zelazny, J., Burke, A. K., Firinciogullari, S., Ellis, S. P., & Mann, J. J. (2005). Posstraumatic stress disorder comorbid with major depression: Factors mediating the association with suicidal behavior. *American Journal of Psychiatry, 162*(2), 560-566.

Oquendo, M., A., Friend, J. M., Halberstam, B., Brodsky, B. S., Burke, A. K., Grunebaum, M. F., Malone, K. M., & Man, J. J. (2003). Association of comorbid posttraumatic stress disorder and major depression with greater risk for suicidal behavior. *American Journal of Psychiatry, 160*(3), 580-582.

Palmer, S. E., Brown, R. A., Rae-Grant, N. I., & Loughlin, M. J. (2001). Survivors of childhood abuse: Their reported experiences with professional help. *Social Work, 46*(2), 136-145.

Patten, S. B., Wang, J. L., Williams, J. V., Curries, S., & Beck, C. A. (2006). Descriptive epidemiology of major depression in Canada. *Canadian Journal of Psychiatry, 51*, 84-90.

Peltzer, K. (1998). Traumatic experiencing and post traumatic psychological symptoms in South African university students. *Central African Journal of Medicine, 44*, 280-283.

Phang, C. K., Sherina, M. S., Zubaidah, J. O., Noor Jan, K. O. N., Firdaus, M., Siti Irma, F. I., & Normala, I. (2015). Prevalence of psychological stress among undergraduate

students attending a health programme in a Malaysian University. *Pertanika Journal Science and Technology, 23*(1), 29-35.

Phelan, J. C., Link, B. G., Stueve, A., & Pescosolido, B. A. (2000). Public conceptions of mental illness in 1950 and 1996: What is mental illness and is it to be feared? *Journal of Health and Social Behaviour, 41*(2), 188-207.

Pinquart, M., & Sörensen, S. (2006). Helping caregivers of persons with dementia: Which interventions work and how large are their effects? *International Psychogeriatrics, 18*, 577-595.

Piumatti, G. (2018). Motivation, health-related lifestyles and depression among university students: A longitudinal analysis. *Psychiatry Research, 260*, 412-417. Pohlman, H., & Jambunathan, J. (2007). Stress, depression and coping in infertile men and women. *Perinatology: Journal of Perinatal & Neonatal Care, 9*(6), 254-260.

Ponnusamy, S., Chin, H. Y., Shazli, E. G., Aishvarya, S., & Raynuha, M. (2009). Posttraumatic stress disorder (PTSD) symptoms, coping styles and social support among survivors of the December 26th, 2004 Malaysia tsunami disaster. *ASEAN Journal of Psychiatry, 10*(1), 32-42.

Radloff, L. S. (1977). The CES-D Scale. A self-report Depression Scale for research in the general population. *Applied Psychological Measurement, 1*(3), 385-401.

Rafati, F., & Ahmadi, J. (2004). Depression in nursing students of Shiraz University of Medical Sciences. *Journal of Research in Medical Sciences, 9*(1), 39-41.

Read, J. P., Uimette, P., White, J., Colder, C., & Farrow, S. (2011). Rates of DSM-IV-TR trauma exposure and posttraumatic stress disorder among newly matriculated college students. *Psychological Trauma: Theory, Research, Practice and Policy, 3*(2), 148-156.

Reyes-Rodriguez, M. L., Rivera-Medina, C. L., Camara-Fuentes, L., Suarez-Torres, A., & Bernal, G. (2013). Depression symptoms and stressful life events among college students in Puerto Rico. *Journal of Affective Disorder, 145*(3), 324-330.

Richmond, J. M., Elliot, A. N., Pierce, T. W., Aspelmeier, J. E., & Alexander, A. A. (2009). Polyvictimization, childhood victimization, and psychological distress in college women. *Child Maltreatment, 14*(2), 127-147.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4*(3) 218-251.

Rickwood, D. J., & Braithwaite, V. A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social Science & Medicine, 39*(4), 563-572.

Rickwood, D. & Thomas, K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychology Research and Behavior Management, 5*, 173-183.

Roth, D. L., Ackerman, M. L., Okonkwo, O. C., & Burgio, L. D. (2008). The four-factor model of depressive symptoms in dementia caregivers: A structural equation model of ethnic differences. *Psychology and Aging, 23*, 567–576.

Royal College of Psychiatrists. (2011). Mental Health of students in higher education, college report CR166. Retrieved from website http://www.rcpsych.ac.uk/ usefulresources/ publications/ collegereports/cr/cr166.aspx.

Ruggiero, K. J., Del, B. K., Scotti, J. R., & Rabalais, A. E. (2003). Psychometrics properties of the PTSD Checklist-Civilian Version. *Journal of Traumatic Stress, 16,* 495-502.

Said, D., Kypri, K., & Bowman, J. (2013). Risk factors for mental disorder among university students in Australia: Findings from web-based cross-sectional survey. *Social Psychiatry and Psychiatric Epidemiology, 48*(6), 935-944.

Schofield, M. J., O'halloran, P., McLean, S. A., Forrester-Knauss, C., & Paxton, J. S. (2015). Depressive symptoms among Australian university students: Who is at risk? *Australian Psychologist, 51*(2), 135-144.

Shamsuddin, K., Fadzil, F., Ismail, W. W. S., Shah, S. A., Omar, K., Muhammad, N.A., Jaffar, A., Ismail, A., & Mahadevan, R. (2013). Correlates of depression, anxiety and stress among Malaysian university students. *Asian Journal of Psychiatry, 6*(4), 318-323.

Shen, A. C. T. (2009). Long-term effects of interparental violence and child physical maltreatment experiences on PTSD and behavior problems: A national survey of Taiwanese college students. *Child Abuse & Neglect, 33*, 148-160.

Sherina, M. S., Lekhraj, R., & Nadarajan, K. (2003). Prevalence of emotional disorder among medical student in a Malaysian University. *Asia Pacific Family Medicine, 2*(4), 213 – 217.

Shin, C., Kim, Y., Park, S., Yoon, S., Ko, Y. H., Kim, Y. K., Kim, S. H., Jeon, S. W., & Han, C. (2017). Prevalence and associated factors of depression in general population of Korea: Results from the Korea National Health and nutrition examination survey, 2014. *Journal of Korean Medical Science, 32*(11), 1861-1869.

Shyangwa, P. M., Singh, S., & Khandelwal, S. K. (2003). Knowledge and attitude about mental illness among nursing staff. *Journal of Nepal Medical Association, 52*(187), 102-110.

Sokratous, S., Merkouris, A., Middleton, N., & Karanikola, M. (2014). The prevalence and socio-demographic correlates of depressive symptoms among Cypriot university students: a cross-sectional descriptive co-relational study. *BMC Psychiatry, 14*, 235-249.

Steptoe, A., Tsuda, A., Tanaka, Y., & Wardle, J. (2007). Depressive symptoms, socio-economic background, sense of control, and cultural factors in university students from 23 countries. *International Journal of Behavioral Medicine, 14*(2), 97-107.

Stallman, H. M. (2008). Prevalence of psychological distress in university students: Implication for service deliveries. *Australian Family Physician, 37*, 673-677.

Stallman, D., Kypri, K., & Bowman, J. (2013). Risk factors for mental disorder among university students in Australia: Findings from web-based cross-sectional survey. *Social Psychiatry and Psychiatric Epidemiology, 48*(6), 935-944.

Stein, M. B., McQuaid, J. R., Pedrelli, P., Lenox, R., & McCahill, M. E. (2000). Posttraumatic stress disorder in the primary care medical setting. *General Hospital Psychiatry*, *22*, 261-269.

Stein, D. J., Bandelow, B., Hollander, E., Nutt, D. J. A., Pollack, M. H., Swinson, R. P., & Zohar, J. (2003). World council of anxiety WCA recommendations for the long-term treatment of posttraumatic stress disorder. *CNS Spectrum, 8*(8), 31-39.

Suan, M., Ismail, A. H., & Ghazali, H. (2015). A Review of teenage pregnancy research in Malaysia. *Medical Journal Malaysia, 70,* 214-219.

Taliaferro, L. A., Rienzo, B. A., Pigg, R. M. Jr, Miller, M. D., & Dodd, V. J. (2009). Associations between physical activity and reduced rates of hopelessness, depression, and suicidal behavior among college students. *Journal of American College Health*, *57*(4), 427-436.

Tengku Hassan, T. N. F., Ali, S. H., & Salleh, H. (2015). Voice from Asian Feminist Activism. Patterns of help-seeking among women experience intimate partner violence in Malaysia. *Asian Journal of Women Studies, 21*(1), 77-92.

Teoh, H. J. (2010). A Survey of Urban Child and Adolescent Mental Health Problems in an Urban Malaysian Population. *Malaysian Journal of Psychiatry, 19*(1), 1-13.

Terhakopian, A., Sinaii, N., Engel, C. C., Schnurr, P. P., & Hoge, C. W. (2008). Estimating population prevalence of posttraumatic stress disorder: An example using the PTSD checklist. *Journal of Traumatic Stress, 21*(3), 290-300.

Thapar, A., Collishaw, S., Pine, D. S., & Thapar, A. K. (2012). Depression in adolescence. *Lancet, 379*(9820), 1056-1067.

Thelle, D. S., & Laake, P. (2015). Research in medical and biological sciences (2nd ed.). San Diego, United States: Elsevier Science Publishing Company Incorporation.

Tomoda, A., Mori, K., Kimura, M., Takahashi, T., & Kitamura, T. (2000). One-year prevalence and incidence of depression among first-year university students in Japan: a preliminary study. *Psychiatry and Clinical Neurosciences, 54*(5), 583–588.

Trochim, W. M. (2019). The Research Methods Knowledge base, 2nd Edition. Retrieved from http://www.socialresearchmethods.net/kb/.

Turan, N., & Erdur-Baker, O. (2014). Attitudes towards seeking psychological help among a sample of Turkish university students: the roles of rumination and internal working models. *British Journal of Guidance & Counselling, 42*, 86-98.

UK Royal college of Psychiatrists. (2011). *Mental Health of Students in Higher Education College*. Report CR 166 Royal College of Psychiatrist. Retrieved from http://www.rcpsych.ac.uk.

US Department of Health and Human Services. (2000). *Healthy People 2010, 2nd ed. US Government Printing Office, Washington.* Retrieved from https://www.cdc.gov/ nchs/ data/hpdata2010/hp2010_general_data_issues.pdf

US Public Health Service. (1999). *The surgeon General's Call to Action to Prevent Suicide.* Washington, DC: US Public Health Service. Retrieved from https://profiles.nlm. nih. gov/ ps/access/nnbbbh.pdf.

UNICEF Malaysia. (2010). *Child Abuse in Malaysia*. Retrieved from http:// ww.unisef.org/malaysia.

Vázquez, F. L., & Blanco, V. (2006). Symptoms of depression and related factors among Spanish University students. *Psychological Reports, 99*(2), 583-590.

Vernon, L. L., Dillon, J. M., & Steiner, A. R. W. (2009). Proactive coping, gratitude, and posttraumatic stress disorder in college women. *Anxiety, Stress & Coping, 22*(1), 117-127.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counselling: the mediating roles of self-stigma and attitudes toward counselling. *Journal of Counselling Psychology, 54*(1), 40-50.

Vries, G. J. D., & Olff, M. (2009). The lifetime prevalence of traumatic events and posttraumatic stress disorder in the Netherlands. *Journal of Traumatic Stress, 4*(22), 259-267.

Wang, P. S., Lane, M., Olfson, M., Pincus, H. A., Wells, K. B., & Kessler, R. C. (2005). Twelve-month use of mental health services in the United States. *Archives of General Psychiatry, 62,* 629-640.

Wang, X., Peng, S., Li, H., & Peng, Y. Y. (2015). How depression stigma affects attitude help seeking: The mediating effect of depression somatization. *Social Behavior and Personality, 43*(6), 945-954.

Wang, J., Fick, G., Adair, C., & Lai, D. (2007). Gender specific correlates of stigma toward depression in a Canadian general population sample. *Journal Affect Disorder, 103*(1-3), 91-97.

Watson, S. B., & Haynes, S. N. (2007). Brief screening for traumatic life events in female university health service patients. *International Journal of Clinical and Health Psychology, 7*(2), 261-282.

Wartberg, L., Kriston, L., & Thomasius, R. (2018). Depressive symptoms in adolescents: prevalence and associated psychological features in a representative sample. *Deutsches Aerzteblatt International, 11*(33-34), 549-555.

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5)*. Washington: National Center for PTSD.

Weiden, P. J., & Olfson, M. (2001). Cost of relapse in schizophrenia. *Schizophrenia Bulletin, 21*, 419–429.

World Health Organization. (2005*). Mental Health-Facing the Challenges, Building Solutions: Report from the WHO European Ministerial Conference. World Health Organization.* Retrieved from http://www.euro.who.int/ data/assets/pdf_file/0008/96452/E87301.pdf.

World Health Organization. (2013). *The European Mental Health Action Plan. Report from World Health Organization Regional Office for Europe.* Retrieved from http://www.euro. who. Int /en/who-we-are/governance.

Wilson, C. J, Deane, F. P., Ciarrochi, J., & Rickwood, D. (2005). Measuring help-seeking intentions: Properties of the general Help-Seeking Questionnaire. *Canadian Journal of Counselling, 39*(1), 15-28.

Zivin, K., Eisenberg, D., Gollust, S. E., & Golberstein, E. (2009). Persistence of mental health problems and needs in a college student population. *Journal of Affective Disorder*, *117*(3), 180-185.

Zlotnick, C., Zimmerman, M., Wolfdorf, B. A. & Mattia, J. I. (2001). Gender differences in patients with posttraumatic stress disorder in a general psychiatric practice. *American Journal of Psychiatric, 158*(11), 1923-1926.

APPENDICES

Appendices A

Participant Information

Research Title:
"Posttraumatic Stress Disorder (PTSD) & Depression: The Impact of Stigma on Mental Disorder on Help-Seeking Behaviors among University Students in Sarawak"

Institution:
University Malaysia Sarawak

Researcher:
Faizul Bin Adenan

Supervisor:
Professor Dr Siti Raudzah Ghazali

Address:
Faculty of Medicine and Health Sciences, University Malaysia Sarawak, 94300 Kota Samarahan Sarawak

19 May 2016

Dear participant,

Background of the study
Many people especially university student doesn't know the existing of the PTSD and depression symptoms among them. Therefore, the study investigate are there any impact on stigma on mental disorder on help seeking behavior. For the purpose of this study, you are invited and selected to participate in this study. Several questionnaires will be administered by the researcher from Faculty of Medicine and Health Science, UNIMAS.
The aim of this study is to investigate the association between Posttraumatic Stress Disorder, Depression, impact of Stigma on Mental Disorder and also help-seeking behaviour among the university students.

Procedure

If you agree to volunteer in this study, you will be asked to complete several questionnaires in an environment that you feel comfortable. You will be asked to fill in some basic demographic information such as age, gender, ethnicity, and your previous experience regarding the significant event of PTSD and depression symptoms. This will take approximately 15 minutes to 25 minutes to complete.

Potential risk for the research

According to previous experience, there is a minimal risk to participate in this study. You might feel uncomfortable or distressed as the questions asked about your past traumatic experience or when you do not understand the question. If you experience the above situation in which feeling uncomfortable or distressed during the study, the study will be temporary stop, a debriefing will be given and you can continue to complete the study as you wish. There may or may not be any benefits to you. Information obtained from this study will help to improve the treatment plan or management of other participant with the same condition.

Withdrawing from the study

You may withdraw from this study at any time prior to the completion of the study without feeling wrong, prejudiced, and worried toward the researcher. You do not have to provide any explanation for your decision to withdraw. If you choose to withdraw, all information gathered from you as part of the study will be destroyed. If you were affected by any of the issues raised in this study and/or if thinking about any negative experience you have had, please contact the direct line: 082-222000 or 082-416550. In case the researchers are busy or away and do not pick up your phone, please leave your message and the researchers will contact you as soon as possible.

Further Contact details

If you have any concerns or complaints or having any further questions about any aspect of this research, you may contact:

Researcher :	Faizul Bin Adenan Faculty Medicine and Health Sciences 019-8352684 faizuladenan@gmail..com	Supervisor :	Dr. Siti Raudzah binti Ghazali, Ph.D. Faculty Medicine and Health Sciences Tel: 082-222143 gsraudzah@fmhs.unimas.my

As part of the research protocol, we will do our best to answer your question.

Voluntary basis

Once again, participation in this study is a voluntary basis, therefore, you as a participant you have the rights to withdraw from the study as mentioned above. No one can force to have your participation.

Confidentiality

Your participation in this study will be kept strictly confidential. Questionnaire results, and all other information you provide regarding your identity will be kept under lock and key. Any quotations for your interview used in this study will be carefully selected so as to provide no indications of your identity. Your anonymity in all aspects of this research is assured. When publishing or presenting the study results, your identity will not be revealed without your expressed consent. Individuals involved in this study and in your medical care may inspect and copy your medical records, where appropriate and necessary.

There is some financial compensation avaliable for this study. Your free and voluntary participation in this research is highly valuable and appreciated. You can obtain the compensation once you have completed the study.

If you are interested in the participation of the study, please sign your signature below and the following written consent form.

Researcher:	_____	Participant name:	_____
Signature:	_____	Signature:	_____

Appendices B

Written Consent Form

Research Title:

"*Posttraumatic Stress Disorder (PTSD) & Depression: The impact of stigma on mental disorder on help-seeking behavior among university students in Sarawak*"

I,_____ (name) have read or have been read for me this consent form and understand the terms of study participation it describes with clear explanation given by _____(researcher) regarding the study that **I** will participated in.

I have had sufficient time to consider participation in the study and have had the opportunity to ask questions and all my questions have been answered satisfactory. I have read or have been read for me about the consent form and understand that I will be provided with an explanation of the risk of the research. Thus, I **agree / disagree** to participate in this study. I understand that participation in this research is not required and is voluntary and will give full co-operation to the researcher. I understand that certain facts about the study might withhold from me and I understand that I may withdraw from the research at any time, for any reason and that all of my information will be removed from the study. The withdrawal will not affect my future treatment.

I understand that study staff, qualified monitors and auditors, the sponsor or its affiliates, and governmental or regulatory authorities, have direct access to my medical record in order to make sure that the study is conducted correctly and the data are recorded correctly. All personal details will be treated as STRICTLY CONFIDENTIAL. I understand that the questionnaire results obtained was only used for research purpose. My anonymity in all aspects of this research is assured. I will receive a copy of this subject information/ informed consent form signed and dated to bring home.

Participant name:	_____	No IC:	_____
Signature:	_____	Date:	_____
Researcher name:	_____	No IC:	_____
Signature:	_____	Date:	_____

Appendices C

(Letter of Permission and Approvals)

11 April 2016

Timbalan Naib Canselor
(Hal Ehwal Pelajar)
Universiti Malaysia Sarawak
Kota Samarahan 94300
Sarawak, MALAYSIA

Melalui:
Prof. Dr. Siti Raudzah Ghazali
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak

Tuan,

Memohon Kebenaran Menjalankan Penyelidikan Di Universiti

Dengan segala hormatnya memohon pihak tuan merujuk perkara di atas.

Saya merupakan pelajar Sarjana Sains Fakulti Perubatan dan Sains Kesihatan, Universiti Malaysia Sarawak, ingin mejalankan kajian bertajuk "*Posttraumatic Stress Disorder (PTSD) & Depression: The impact of stigma on mental disorder on help-seeking behavior among university students in Sarawak*" Kertas kerja penyelidikan ini telah dipersetujui oleh Jawatankuasa Etika Fakulti Perubatan dan Sains Kesihatan, UNIMAS.

Sehubungan itu, saya ingin memohon kebenaran dari pihak tuan untuk menjalankan penyelidikan di beberapa fakulti di Universiti yang akan dipilih secara rawak. Aktiviti penyelidikan tersebut adalah melibatkan pengumpulan data menggunakan instrumen kajian iaitu kertas soal selidik yang akan diberikan kepada 500 orang pelajar dari fakulti-fakulti yang akan dipilih nanti.

Tempoh penyelidikan untuk mengumpulkan data data adalah seperti butiran di bawah:

Tarikh : _____2016 hingga _____2016
Tempoh : _____bulan
Bentuk penyelidikan : Mengumpul data menggunakan instrumen kajian iaitu kertas soal selidik

Secara ringkasnya, tujuan kajian ini dijalankan adalah untuk mengenal pasti tahap stigma dan keperluan membantu dari orang lain dikalangan pelajar universiti awam di Sarawak.

Tinjauan literatur juga menunjukkan stigma dkalangan pelajar university awam kita sangat tinggi terhadap pelajar lain yang mempunyai PTSD dan kemurungan. Adalah diharapkan hasil daripada kajian ini, banyak aktiviti yang memberi manfaat kepada kesihatan mental pelajar universiti dapat dijalankan terutama sekali sekiranya tanda-tanda trauma dapat dikesan lebih awal.

Segala pertanyaan serta perkara yang bersangkut-paut dengan penyelidikan tersebut, pihak tuan boleh merujuk terus kepada saya untuk tindakan selanjutnya.

Besarlah harapan saya, sekiranya permohonan ini mendapat pertimbangan yang sewajarnya daripada pihak tuan dan kerjasama yang diberikan didahului dengan ucapan terima kasih.

Sekian.

Yang benar,

Faizul Bin Adenan,
Pelajar Sarjana Sains (by Research)
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak

KEMENTERIAN PENDIDIKAN TINGGI
MINISTRY OF HIGHER EDUCATION
Bahagian Perancangan, Penyelidikan Dan Penyelarasan Dasar
Aras 13, No. 2, Menara 2, Jalan P5/6
Presint 5, 62200 PUTRAJAYA
MALAYSIA

Tel : 03-8870 6000
Faks : 03-8870 6809
Web : http://www.mohe.gov.my

Rujukan Kami : KPT.600-8/2/5 Jld. 3 (6)
Tarikh : 14 Disember 2016

En. Faizul bin Adenan
Universiti Teknolcgi Mara Kampus Mukah
96400 Mukah
SARAWAK
E-mel : faizuladenan@gmail.com

Tuan,

Permohonan Untuk Menjalankan Kajian Di IPTA / IPTS Di Bawah Kementerian Pendidikan Tinggi

Dengan segala hormatnya saya diarah merujuk perkara di atas.

2. Dimaklumkan bahawa Kementerian ini tiada halangan mengenai permohonan untuk menjalankan kajian bertajuk :

"Posttraumatic Stress Disorder (PTSD) and Depression: The Impact of Stigma on Mental Disorders on Help-Seeking Behaviors among University Students in Sarawak"

3. Permohonan ini adalah berdasarkan kepada cadangan penyelidikan yang dikemukakan tuan ke Kementerian ini. **Walau bagaimanapun, kebenaran secara bertulis untuk mendapatkan dan menggunakan sampel kajian perlu diperoleh daripada Naib Canselor / Rektor / Presiden / Ketua Eksekutif / Pengarah / Dekan Fakulti di IPTA / IPTS yang berkenaan.**

4. Tuan adalah diminta untuk mengemukakan senaskah laporan akhir kajian ke Kementerian ini setelah kajian tersebut selesai dilaksanakan untuk tujuan rekod. Selain itu, sekiranya sebahagian atau sepenuhnya hasil dapatan kajian tersebut hendak dibentangkan di mana-mana forum atau seminar atau untuk diumumkan kepada media massa, kebenaran bertulis hendaklah dipohon terlebih dahulu daripada Kementerian ini.

Sekian, terima kasih.

"BERKHIDMAT UNTUK NEGARA"

Saya yang menurut perintah,

(NOR SALIMAH BINTI MUSA)
Bahagian Perancangan, Penyelidikan dan Penyelarasan Dasar
b.p. Ketua Setiausaha
Kementerian Pendidikan Tinggi

14 Disember 2016

YBhg Prof Mohd Fadzil bin Abd Rahman
Timbalan Naib Canselor (Hal Ehwal Pelajar)
Universiti Malaysia Sarawak
94300 Kota Samarahan
Sarawak, Malaysia

Melalui:
Prof. Dr. Siti Raudzah Ghazali
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak

YBhg Prof.

Memohon Kebenaran Menjalankan Penyelidikan Di Universiti Malaysia Sarawak (UNIMAS)

Dengan segala hormatnya perkara di atas adalah dirujuk.

Saya, Faizul Bin Adenan, merupakan pelajar Sarjana Sains Fakulti Perubatan dan Sains Kesihatan, Universiti Malaysia Sarawak, ingin melalankan kajian bertajuk *"Posttraumatic Stress Disorder and Depression: The Impact of Stigma in Mental Disorder on Help-Seeking Behaviors among University Students in Sarawak"*. Kertas kerja penyelidikan ini telah mendapat kebenaran daripada Jawatankuasa Mesyuarat Etika Perubatan (Fakulti Perubatan dan Sains Kesihatan, UNIMAS) dan juga daripada Kementerian Pengajian Tinggi Malaysia.

Sehubungan itu, saya ingin memohon kebenaran dari pihak Prof Dato Dr. untuk menjalankan penyelidikan di beberapa fakulti yang akan dipilih secara rawak. Aktiviti penyelidikan ini melibatkan pengumpulan data menggunakan instrumen kajian iaitu kertas soal selidik yang akan diberikan kepada 200 orang pelajar dari fakulti-fakulti yang akan dipilih nanti. Kajian ini akan dijalankan di UiTM Sarawak.

Tempoh penyelidikan untuk mengumpulkan data data adalah seperti butiran di bawah:

Tarikh : 16 Disember 2016 hingga 16 June 2017
Tempoh : 6 bulan
Bentuk penyelidikan : Mengumpul data menggunakan instrumen kajian iaitu kertas soal selidik

Secara ringkasnya, tujuan kajian ini dijalankan adalah untuk mengenal pasti kadar dan jumlah pelajar yang mengalami *Posttraumatic Stress Disorder (PTSD)* dan *Depression* di universiti awam di Sarawak. Pada masa yang sama, kajian ini dapat mengenal pasti peratusan stigma pelajar terhadap kesihatan mental secara umumnya. Selain itu, kajian ini turut memperlihatkan kadar *Help-Seeking* Behavior di kalangan pelajar university awam terhadap stigma dalam kesihatan mental secara

khususnya. Adalah diharapkan hasil daripada kajian ini, banyak aktiviti yang memberi manfaat kepada kesihatan mental remaja kita dapat dijalankan terutama sekali sekiranya tanda-tanda trauma dapat dikesan lebih awal.

Untuk pengetahuan, penyertaan para pelajar adalah secara sukarela. Segala peraturan mengenai etika penyelidikan akan dipatuhi termasuk hak peserta untuk mengetahui maklumat lanjut mengenai kajian dan kerahsiaan maklumat yang diberikan adalah terjamin.

Bersama surat ini disertakan senarai target responden dan juga instrumen-instrumen yang yang akan digunakan untuk tujuan kajian ini.

Segala pertanyaan serta perkara yang bersangkut-paut dengan penyelidikan tersebut, pihak tuan boleh merujuk terus kepada saya atau Penyelia saya iaitu Prof Dr. Siti Raudzah Ghazali untuk pertanyaan lanjut (019-8597933; 082-581841).

Besarlah harapan saya, sekiranya permohonan ini mendapat pertimbangan yang sewajarnya daripada pihak Prof Dato Dr. dan kerjasama yang diberikan didahului dengan ucapan terima kasih.

Sekian.

Yang benar,

Faizul Bin Adenan,
Pelajar Sarjana Sains (Penyelidikan)
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak

TINDAKAN	
Kepada: Sdr Faizul Adenan.	
(✓) Diluluskan	( ) Sila bincang
( ) Sila urus	( ) Edarkan
( ) Sila jawab	( ) Makluman
( ) Sila hadir/wakil	( ) Failkan
Catatan	
Tandatangan/Cop/Tarikh 29/10/14	

Timbalan Naib Canselor (HEP&A)
Universiti Malaysia Sarawak

s.k. Dekan PPP

MEMO

PEJABAT TIMBALAN REKTOR PJI

Prof. Madya Dr. Hjh. Rasidah Hj. Mahdi, UiTM (Sarawak)

Tel: 082-677470 / 678190

- ☐ Untuk tindakan/ *For your action, please*
- ☐ Untuk perhatian dan simpanan/ *For your attention and retention*
- ☐ Untuk makluman/ *For your information*
- ☐ Sila kembalikan dengan iringan komen/ *Please return with your comment*
- ☐ Dikembalikan seperti dikehendaki/ *Returned as requested*
- ☐ Sila bincang/ *Please discuss*
- ☑ Diluluskan/ *Approved*
- ☐ Sila hadir dan wakil/ *Please attend*

Perkara/Subject:
Memohon Kebenaran Menjalankan Penyelidikan di Universiti Teknologi MARA (UiTM) Sarawak

Tarikh/ Date: 26/12/2016

RQM NO: 366/2016

Catatan/ Remarks:
Diluluskan dan sila kutip tanpa mengganggu proses mengajaran dan pelajaran.

PM. DR HJH RASIDAH MAHDI
Timbalan Rektor
Penyelidikan & Jaringan Industri
Universiti Teknologi MARA Sarawak

Lain-Lain Staf / Nota:
En. Faizul Adenan

Ketua Bahagian/ Head of Dept
PM Dr Rasila Hj Suhaini, TR(A) (7799/8156)
PM Wan Akil Tuanku Abdullah, TR(HEP) (8081)
En Nor Amiuddin Mokhtaruddin, Timbalan Pendaftar Kanan (7700)
Tn.Hj.Ahmad Zuki Hasan, Timbalan Bendahari (8155)
Pn. Norhayati Ismail,Timb.K.Pustakawan (8218)
En.Lukmanulhakim Adhar, Jurutera Kanan (7222/8222)

KAMPUS SAMARAHAN 1

Bahagian Pentadbiran
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En. Adzwa Kamri, Peg. Belia & Sukan (7391)
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Ust. Mohd Ilyas M. Saleh, Peg. Hal Ehwal Islam (7055)

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Pn. Aiza Johari, ILD (7418)
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Puan Adiana Mohamad Ibrahim, Setiausaha (7511)

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En. Mohd Farizan Jamil, Pengurus (7028)

Jawatankuasa OSE
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KEKITA
Pn.Siti Nursarjana Molin, Setiausaha (8286)

PEWAM
Pn. Fazila Maliki, Setiausaha (7306)

KAMPUS MUKAH

Tn.Hj Khalik Hj Ibrahim, Penolong Rektor (084-876111)

KPP (Pengurusan Perniagaan)
En. Mohamad Musa Bohari

KK (Sains & Teknologi)
En. Mohd Syukrie Abu Talib

KAMPUS SAMARAHAN 1

Ketua Pusat Pengajian (KPP)/ Koordinator Kursus (KK)

KPP (Sains Sukan & Sains Kesihatan):
Cik Norazlin Abdullah (7025)

KPP (Perakaunan & Pengurusan Maklumat):
Cik Dayang Nazari Awang Drahman (7530)

KPP (Seni Lukis, Seni Reka, Senibina Perancangan & Ukur):
Dr Siti Akhtar Mahayuddin (7687)

KPP (Perladangan & Agroteknologi):
Dr Abdul Rahman Saili (7870)

KPP (Pengurusan Perniagaan):
Pn.Norzaihan Hashim (7471)

KPP (Pusat Pengajian Siswazah):
Dr. Thalany Kamri (7384)

KK
PM. Dr. Corina Joseph (S. Penyelidikan) (7378)
Pn. Voreen Nity Mathew (P/Siswazah, DBA& MBA)(7382)

Setiausaha Pejabat
Pejabat Timbalan Rektor PJI

- Urusan Tiket / Hotel
- Scan / Emel
- Tindakan
- Rekod / Fail

KAMPUS SAMARAHAN 2

Prof Madya Dr Firdaus Abdullah
Penolong Rektor

Bahagian Pentadbiran
Pn. Norhayati Umar, Pen. Pendaftar Kanan (8060)

Bahagian HEA
En.Mohamad Syafie Hamdin, P.Pendaftar (8165)

Bahagian HEP
Pn.Atikawati Ahmad Razali, Pen.Pendaftar Kanan(8005)

Bahagian Kewangan
Pn.Aniza Abu Bakar, Pen.Bendahari (8144)
Cik Nur'aishah Suhaimi, Pen Bendahari (8143)

Bahagian Pengurusan Fasiliti
En.Muhammad Faizal Shamsulbahri, Jurutera (8223)

Unit Polis Bantuan
ASP/PB Mazlan Takap, Peg.Keselamatan (8131)

KPP (Sains Gunaan):
Dr.Mohammad Isa Mohamadin (8294)

KPP ACIS & Pengurusan Halal:
Pn.Sharifah Anom Omar (8395)

KPP InED:
En.Adib Sarkawi (8320)

KPP (Sains Komputer & Pengurusan Pelancongan)
Cik Adeline Engkamat (8305)

KPP (Sains Sosial & Kemanusiaan):
Cik Zolina Mohd Desa (8241)

KK
Cik Norlida Haji Nawawi (Bahasa)(8316)

KPP (Kejuruteraan)
Pn. Maureen Noging (8213)

Bahagian Penyelidikan & Jaringan Industri
Dr. Leong Siew Ho, UPenerbit (8411)
PM. Dr Margaret Chan, NPRDC (7731)
Dr. Azilawati Banchit, RMU (7803)
Dr. Jabbar Abdullah , MASMED (7638/8184)
Dr.Jati Kasuma Ali, Tunas Mekar (7461)
Dr. Julaili bin Idris, RIBU
Ust Dr. Hadenan B. Towpek, PPIB (8086)
Pn.Sarah Jaya, ICAN (7627)
Pn. Lenny Yusrina Bujang Khedif, UCTC (8316)
En. Mohd Zakey Ramlee, Peg. Eksekutif (8054)
Pn. Memon Dollah, Kerani (7729/8061)
En. Mohd Aziz Padie, Kerani (8574)
En. Razif Yassim Baki, Pembantu Operasi (7729)

12 April, 2016 (v)

UNIVERSITI PUTRA MALAYSIA
BERILMU BERBAKTI

FAKULTI SAINS PERTANIAN & MAKANAN
FACULTY OF AGRICULTURE AND FOOD SCIENCES

Rujukan : UPM/FSPM/BHEP/100-4/2
Tarikh : 4 Januari 2017

Faizul Bin Adenan
Pelajar Sarjana Sains (Penyelidikan)
Fakulti Perubatan dan Sains Kesihatan
Universiti Malaysia Sarawak
94300 Kota Samarahan
Sarawak

Tuan,

KELULUSAN MENJALANKAN PENYELIDIKAN DI UNIVERSITI PUTRA MALAYSIA KAMPUS BINTULU SARAWAK (UPMKB)

Dengan segala hormatnya merujuk kepada perkara di atas.

Sukacita dimaklumkan bahawa pihak Universiti Putra Malaysia Kampus Bintulu Sarawak (UPMKB) tiada halangan untuk membenarkan tuan untuk menjalankan penyelidikan kajian bertajuk *"Posttraumatic Stress Disorder and Depression: The Impact of Stigma in Mental Disorder on Help-Seeking Behaviors among University Students in Sarawak"* di mana tempoh penyelidikan untuk mengumpulkan data bermula pada 16 Disember 2016 hingga 15 June 2017.

Sehubungan itu, pihak UPMKB ingin menetapkan beberapa peraturan dan syarat mengenai etika penyelidikan sepanjang proses penyelidikan ini. Etika dan syarat adalah seperti butiran berikut:

i. **Segala dapat kajian yang diterbitkan secara bertulis dan tidak bertulis hendaklah tidak menggunakan nama universiti dalam apa-apa bentuk perkaitanan yang membabitkan universiti.**
ii. **Sekiranya maklumat perlu dikeluarkan dari responden kajian, penyelidik perlu mendapat kebenaran bertulis dari responden dan mestilah menjaga etika kerahsiaan sepanjang proses kajian.**
iii. **Semua dapatan kajian yang lengkap, penyelidik perlu diberi satu salinan lengkap hasil kajian kepada pihak UPMKB bagi rujukan dan semakan kami.**

Bersama ini disertakan nama dua orang pegawai yang boleh dihubungi untuk membantu pihak tuan sepanjang penyelidikan tersebut.

En. Muhammad Abdul Rahim bin Habib K.B.;P.A
Pegawai Psikologi
Bahagian Hal Ehwal Pelajar
Fakulti Sains Pertanian dan Makanan
Universiti Putra Malaysia Kampus Bintulu Sarawak

Appendix D

Approval from the Ethic Committees

Fakulti Perubatan dan Sains Kesihatan
Faculty of Medicine and Health Sciences

UNIMAS/NC-21.02/03-02 Jld. 2 (50)

10 November 2016

En. Faizul Bin Adenan
Fakulti Perubatan Dan Sains Kesihatan
Universiti Malaysia Sarawak
94300 Kota Samarahan,
Sarawak.

En,

Kelulusan Etika Perubatan Untuk Kajian:
- Posttraumatic Stress Disorder (PTSD) And Depression: The Impact Of Stigma On Mental Disorders On Help-Seeking Behaviors Among University Students In Sarawak.

Dengan segala hormatnya perkara tersebut di atas adalah dirujuk.

Sukacita dimaklumkan bahawa kertas kerja penyelidikan seperti di atas yang dijalankan oleh En. Faizul Bin Adenan yang diselia Prof Dr Siti Raudzah Ghazali telah **diluluskan dalam Mesyuarat Etika Perubatan Fakulti 04/2016 pada 9 November 2016.**

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

Sekian, terima kasih.

Yang benar,

Tan Sri Prof Datu Dr Mohamad Taha Arif
Pengerusi
Jawatankuasa Etika Perubatan
Fakulti Perubatan dan Sains Kesihatan

cj/Kelulusan mesyuarat etika perubatan

www.unimas.my

Appendices E

Instruments

Participant Background & Information

Name:	
Gender:	☐ Male ☐ Female
Age:	
Race:	☐ Malay ☐ Chinese ☐ Indian ☐ Bidayuh ☐ Iban ☐ Melanau ☐ Others, Please justify: _____
Home Address:	
Status:	☐ Single ☐ Married ☐ Divorce ☐ Separate ☐ Widow/Widower
Religion:	☐ Muslim ☐ Buddha ☐ Hindu ☐ Christian ☐ Others, Please justify: _____
Siblings:	☐ No Siblings ☐ Have Siblings, Please Justify:_____ Siblings include me ☐ Others, Please justify: _____
University:	
Courses:	
Faculty:	
Years of Study:	☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Trauma Symptom Checklist – 40

(Briere & Runtz, 1989)

How often have you experienced each of the following in the last month? Please circle one number, 0-3.

Symptom	Never - - - - - - - - - - - Often			
	0	1	2	3
1. Headaches				
2. Insomnia				
3. Weight loss (without dieting)				
4. Stomach problems				
5. Sexual problems				
6. Feeling isolated from others				
7. "Flashbacks" (sudden, vivid, distracting memories)				
8. Restless sleep				
9. Low sex drive				
10. Anxiety attacks				
11. Sexual overactivity				
12. Loneliness				
13. Nightmares				
14. "Spacing out" (going away in your mind)				
15. Sadness				
16. Dizziness				
17. Not feeling satisfied with your sex life				
18. Trouble controlling your temper				
19. Waking up early in the morning				
20. Uncontrollable crying				
21. Fear of men				
22. Not feeling rested in the morning				
23. Having sex that you didn't enjoy				
24. Trouble getting along with others				
25. Memory problems				
26. Desire to physically hurt yourself				
27. Fear of women				
28. Waking up in the middle of the night				
29. Bad thoughts or feelings during sex				
30. Passing out				
31. Feeling that things are "unreal"				
32. Unnecessary or over-frequent washing				
33. Feelings of inferiority				
34. Feeling tense all the time				
35. Being confused about your sexual feelings				
36. Desire to physically hurt others				
37. Feelings of guilt				
38. Feeling that you are not always in your body				
39. Having trouble breathing				
40. Sexual feelings when you shouldn't have them				

Center for Epidemiology Study Depression Scale (CESD)					
INSTRUCTIONS: For each statement, please circle the number in the column that best describes how you have been feeling in the past week.					
		Rarely	Sometimes	Occasionally	Most
1	I was bothered by things that usually don't bother me.	0	1	2	3
2	I did not feel like eating; my appetite was poor.	0	1	2	3
3	I felt that I could not shake off the blues, even with the help from family or friends.	0	1	2	3
4	I felt that I was just as good as other people.	3	2	1	0
5	I had trouble keeping my mind on what I was doing.	0	1	2	3
6	I felt depressed.	0	1	2	3
7	I felt that everything I did was an effort.	0	1	2	3
8	I felt hopeful about the future.	3	2	1	0
9	I thought my life had been a failure.	0	1	2	3
10	I felt fearful.	0	1	2	3
11	My sleep was restless.	0	1	2	3
12	I was happy.	3	2	1	0
13	I talked less than usual.	0	1	2	3
14	I felt lonely.	0	1	2	3
15	People were unfriendly.	0	1	2	3
16	I enjoyed life.	3	2	1	0
17	I had crying spells.	0	1	2	3
18	I felt sad.	0	1	2	3
19	I felt that people dislike me.	0	1	2	3
20	I could not get "going".	0	1	2	3

Depression Stigma Questionnaires(DSQ)

*Questions **1 to 18** contain statements about depression. Please indicate how strongly **you personally** agree or disagree with each statement.*

1 People with depression could snap out of it if they wanted.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

2 Depression is a sign of personal weakness.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

3 Depression is not a real medical illness.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

4 People with depression are dangerous.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

5 It is best to avoid people with depression so that you don't become depressed yourself.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

6 People with depression are unpredictable.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

7 If I had depression I would not tell anyone.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

8 I would not employ someone if I knew they had been depressed.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

9 I would not vote for a politician if I knew they had been depressed.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

*Now we would like you to tell us what you think **most <u>other</u> people** believe. Please indicate how strongly you agree or disagree with the following statements.*

10 Most people believe that people with depression could snap out of it if they wanted.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

11 Most people believe that depression is a sign of personal weakness.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

12 Most people believe that depression is not a real medical illness.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

13 Most people believe that people with depression are dangerous.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

14 Most people believe that it is best to avoid people with depression so that you don't become depressed yourself.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

15 Most people believe that people with depression are unpredictable.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

16 If they had depression, most people would not tell anyone.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

17 Most people would not employ someone they knew had been depressed.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0

18 Most people would not vote for a politician they knew had been depressed.

Strongly agree ☐ 4

Agree ☐ 3

Neither agree nor disagree ☐ 2

Disagree ☐ 1

Strongly disagree ☐ 0