VALIDATION AND RELIABILITY OF THE MENTAL HEALTH LITERACY AND STIGMA QUESTIONNAIRE AMONG MALAYSIAN YOUNG ADOLESCENTS.

Sarbhan **Singh**[1*], Rafdzah Ahmad **Zaki**[2], Nik Daliana Nik **Farid**[2], Kushilpal **Kaur**[3]

[1]*Institute for Medical Research, National Institutes of Health, Ministry of Health Malaysia, Setia Alam, 40170 Selangor, Malaysia*

[2]*Department of Social and Preventive Medicine, Faculty of Medicine, University of Malaya, 50603 Kuala Lumpur, Malaysia*

[3]*Department of Psychiatry, Hospital Selayang, Ministry of Health Malaysia, 68100 Selangor, Malaysia*

**Corresponding author: Sarbhan Singh, Institute for Medical Research (IMR), National Institutes of Health (NIH), Ministry of Health Malaysia, Setia Alam, 40170 Selangor, Malaysia, lssarbhan@moh.gov.my*

ABSTRACT

The Mental Health Literacy and Stigma (MHLS) questionnaire has been widely used to assess Mental Health Literacy (MHL) among different populations. This instrument has been validated internationally, however to date, the validation of this questionnaire in young adolescents has yet to be conducted in Malaysia. This study aims to provide evidence of the reliability and validity of the MHLS questionnaire among Malaysian adolescents. A total of 65 students aged 12-14 years old from two public secondary schools in Kuala Lumpur participated in this study. The MHLS questionnaire underwent forward and backward translation, content validity, and pre-test process prior to reliability and validity. The data was analysed using Statistical Packages for the Social Sciences (SPSS) version 24. Internal consistency was measured by Cronbach's alpha and the reliability analysis was assessed using kappa statistic. The MHLS questionnaire demonstrated acceptable levels of Content Validity Index (CVI), Cronbach's alpha, and kappa values across all constructs. The Cronbach's alpha ranged from 0.52 to 0.76 across all constructs. Kappa values for the majority of items (60%) indicated a moderate level of agreement (0.41 and above). The MHLS questionnaire is a valid and reliable tool to examine MHL among young adolescents in Malaysia.

KEYWORDS: Mental health literacy and stigma, validation, adolescents

INTRODUCTION

With the rising prevalence of mental health disorders among adolescents (MHDs) globally and the escalating financial cost related to these disorders both at an individual and community level, the field of Mental Health Literacy (MHL) has become the focus of public health research (Kessler et al. 1999). This is because MHL is a framework consisting of three interrelated components namely, mental health knowledge (knowledge of mental illness), attitudes (stigma), and help-seeking efficacy (help-seeking intention and attitudes), which can improve mental health outcomes (Newcomb-Anjo 2018). Therefore, it is important to examine all the components of MHL simultaneously to improve MHL which in turn would reduce MHDs.

Despite there being several tools available to assess MHL there are only a few which can simultaneously assess all the components of MHL. One of them include the Mental Health Literacy and Stigma (MHLS) questionnaire developed by scholars from Australia (Reavley and Jorm 2011). The MHLS presents a scenario of a vignette suffering from MHDs based on the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria, following which participants are presented with questions in each section relating to the knowledge, help-seeking, and stigma component of MHL, which is based on the person described in the vignette. This instrument was initially used in the Australian National MHL and Stigma Youth Survey to assess the levels of MHL among the youth population (Reavley and Jorm 2011). Following this, the MHLS questionnaire has been adopted, translated, and widely used by many countries to examine MHL among adolescents (Jaladin, Yun, and Tharbe 2016; Kelly, Jorm, and Wright 2007; Lam 2014).

However, to date, there are only a few studies that have reported on validation of the MHLS questionnaire. The majority of these studies only validated the knowledge component of the MHLS questionnaire which includes knowledge about recognition of MHDs (Reavley and Jorm 2011), prevention about first aid actions, and interventions (Reavley and Jorm 2011; Wright and Jorm 2009). More specifically, the levels of internal consistency (Cronbach alpha) reported for the knowledge about recognition, first aid action, and prevention ranged from 0.52 to 0.72, 0.44 to 0.59, and 0.60 to 0.82 respectively (Reavley and Jorm 2011; Wright and Jorm 2009). To date, there is no report on the internal consistency of other components of this instrument such as the help-seeking and stigmatizing attitudes components and neither is there a report on the test re-test reliability of the MHLS.

Therefore, there is an urgent need to validate the MHLS questionnaire to ensure that the results generated are valid and reliable. This study aims to validate the knowledge, help-seeking, and stigma components of the MHLS questionnaire among adolescents in Malaysia. The validation process includes a content validation and reliability analysis (internal consistency and test re-test analysis) of the MHLS questionnaire.

MATERIALS AND METHODS

Study design and participants

This is a cross-sectional study design that was conducted from May 2017 to July 2017. Participants were students recruited from secondary schools in Kuala Lumpur that were sampled using a cluster sampling method where two schools were randomly selected from the list of all the secondary schools in Kuala Lumpur which was obtained from the Ministry of Education Malaysia. At the school level, all the students were sampled universally. The inclusion criteria were participants being aged 11 to 14 years old with the ability to read and understand the Malay or English language. Parental consent forms were distributed to 613 students. A minimum sample size of 50 participants was required for the calculation of internal consistency (Javali, Gudaganavar, and Shodan 2011). An additional 20% drop-out rate was set to account for the design effects, thus the sample size was inflated to 63 participants (Mazlan and Ahmad 2013). The sample size for test-retest analysis for Cohen's Kappa statistics was derived based on the two-category response option as there were two response options in the MHLS questionnaire (Bujang and Baharum 2017). When alpha and power were fixed at 0.05 and 80%, respectively, a minimum sample size of 52 was required. A final sample of 65 participants consented to the study and was included for the analysis. All 65 participants were included for the test re-test but only 52 subjects were present during the second session.

Data collection

Data collection was conducted at each respective school at a date that was given by the school. Before data collection students were assembled and were briefed on the purpose of this study and their rights as respondents by the researcher. Following which students were given a research information sheet and consent

form which the students had to read and bring home to give their guardians or parents to read and sign if they agree to participate. Students were advised to return the consent forms to their respective school counsellors within 1 to 2 days. After 3 days the researcher receives feedback from the respective school counsellor on the number of consent forms returned. A subsequent date was set whereby the researcher distributes the MHLS questionnaire to the participant in the respective schools. All questionnaires were coded and have no personal identifiers written on them. This is to ensure the confidentially of participants is maintained. The average time taken to complete the questionnaire was 20 minutes. After the session, the researcher collects all the questionnaires from the participants. To minimise missing data, the researchers advised all participants to check their questionnaire until the end page to ensure all questions have been answered, and then the researchers checked all the returned questionnaires immediately upon collection to detect any missing data in the school itself. Test-retest reliability was conducted within a two weeks interval at the respective schools. The same procedures as above were repeated for the distribution and collection of questionnaires.

Measures

The MHLS questionnaire is a 90-item self-administered questionnaire based on a 3-point Likert scale response options, of which 55 items were regarding the knowledge component of MHLS (i.e Knowledge on recognition of disorder, first aid, interventions and preventions for mental disorder), while the help-seeking and stigma (i.e personal/perceive stigma and social distance) components comprised 16 and 19 statements, respectively (Appendix A). A translation was carried out of the MHLS questionnaire as it was initially constructed in English. It was subsequently translated into *Bahasa Malaysia* and afterward, it was back-translated into English by four Malaysian translators with a similar educational background and similar command of English and *Bahasa Malaysia* (eLearning Industry 2012). A forward and backward translation process was used as this would ensure consistency (Su and Hoe 2008). Variations in the original and back-translated versions were discussed and resolved by joint agreement involving all four translators. The final questionnaire was presented in a dual-language format (English and *Bahasa Malaysia*). The translation of the questionnaire was carried out between May and June 2017.

Analysis

Data were analysed using the Statistical Program for the Social Sciences (SPSS) version 24.0. Five psychiatrists with experience in child and adolescent psychiatry were selected as subject matter experts for the process of content validation. The subject matter experts reviewed each item in the MHLS questionnaire and provided a score on how important or relevant the item was in measuring the concept. There were four response options: not relevant, not important, relevant, and very important. Summary measuring item content validity index (I-CVI) were calculated and items with an I-CVI less than 1 were removed and those items with an I-CVI equals to 1 were retained (Terwee et al. 2007; Sangoseni, Hellman, and Hill 2013). The content validation was performed from April 2017 to May 2017. Reliability analysis was carried out using Cronbach alpha (value less than 0.5 and more than 0.5 indicate unacceptable and acceptable Cronbach alpha values respectively) and Cohen's Kappa analysis (Kappa values of less than 0, 0 to 0.2, 0.21 to 0.40, 0.42 to 0.60, 0.61 to 0.80 and 0.81 to 1.00 indicate poor, slight, fair, moderate, substantial and almost perfect agreement respectively) (Landis and Koch 1977; Gliem and Gliem 2003).

RESULTS

Content Validation

All items in the construct of knowledge about prevention, help-seeking, and stigma components obtained an I-CVI of 1 and a mean I-CVI of 1. A total of 12 items obtained an I-CVI of less than 1, thus were removed. These 12 items were from the constructs of knowledge about recognition of disorder (6 items), knowledge about first aid for mental disorder (3 items), and knowledge about interventions for mental disorder (3 items). For the construct knowledge about recognition of the disorder, the items dropped were "schizophrenia", "psychosis", "cancer", "psychological, mental and emotional problem", "age crisis", and "has a problem". The item labelled "bulimia" was changed to "eating disorder". For the construct knowledge about first aid for mental disorder, the items dropped were "talk to him firmly about getting his act together", "make an appointment for him to see a GP if necessary: this would be with his knowledge" and "rally friends to cheer him up". For the construct knowledge about interventions for mental disorders, the items dropped were "tranquilizers", "antipsychotics" and "receiving cognitive-behavior therapy". Table 1 shows

Table 1. Number of items obtaining I-CVI = 1 and < 1 in each construct

Construct	Total item	Number of item with I-CVI = 1	Number of item with I-CVI < 1
Knowledge on recognition of disorder	12	6	6
Knowledge about first aid for mental disorder	8	5	3
Knowledge about interventions of mental disorder	30	27	3
Knowledge about prevention of mental disorder	5	5	0
Help seeking	16	16	0
Personal stigma	7	7	0
Perceived stigma	7	7	0
Social distance	5	5	0
Total	90	78	12

Note. I-CVI , Item-content validity index; =, Equals to; < , Less than.

Table 2. Cronbach alpha across constructs in the MHL and stigma questionnaire

Construct	Number of item	Minimum CITC	Cronbach's alpha
Knowledge on ability of recognition of disorder	6	0.19	0.64
Knowledge about first aid for mental disorder	5	0.10	0.52
Knowledge about interventions of mental disorder	27	0.10	0.76
Knowledge about prevention of mental disorder	5	0.15	0.52
Help seeking	16	0.11	0.63
Personal stigma	7	0.28	0.62
Perceive stigma	7	0.34	0.71
Social distance	5	0.08	0.66

Note. I-CVI , Item-content validity index; =, Equals to; < , Less than.

the number of items obtaining an I-CVI of 1 and less than 1 in each construct.

Internal consistency

The Cronbach's alpha across all constructs ranged from 0.52 to 0.76, indicating acceptable levels of internal consistency as shown in Table 2. The minimum Corrected Item-Total Correlation (CITC) ranged from 0.08 to 0.34.

Test-retest reliability analysis

The nature of the Kappa agreement values is defined as the following less than 0, 0 to 0.2, 0.21 to 0.40, 0.42 to 0.60, 0.61 to 0.80 and 0.81 to 1.00 indicate poor, slight, fair, moderate, substantial and almost perfect agreement respectively. Of the 78 items evaluated in this study, 46 items (59%) showed moderate agreement, 25 items (32%) displayed fair agreement, five items (6.4%) indicated substantial agreement and two items (2.6%) reported having slight agreement. Kappa values for the majority of items indicated a moderate level of agreement (0.41 and above). Figure 1 shows the frequency (%) of Kappa agreement across all items in the MHLS questionnaire. Twelve items obtained kappa values of less than 0.3, namely kids helpline (item 15), antidepressants (item 21), become more physically active (item 23), using alcohol to relax (item 33), smoking cigarettes to relax (item 34), using marijuana to relax (item 35), keeping regular contact with friends (item 41), the cost of seeing the person (item 49), concern that what the person might say is wrong (item 51), concern about what other people (item 52), concern about the side effects of

treatment (item 55) and thinking nothing can help (item 57). Following discussion with subject matter experts, two items were dropped, namely kids helpline (item 15) and being more physically active (item 23). Of the remaining 10 items with Kappa values <0.3, eight items were reworded, as shown in Table 3.24, and two items, namely antidepressants and thinking nothing can help, were maintained. A second test-retest was repeated for these 10 items among 30 subjects as shown in Table 3. All of the 10 items that underwent second test-retest analysis obtained Kappa values of 0.21 and above and thus were retained in the final MHLS questionnaire.

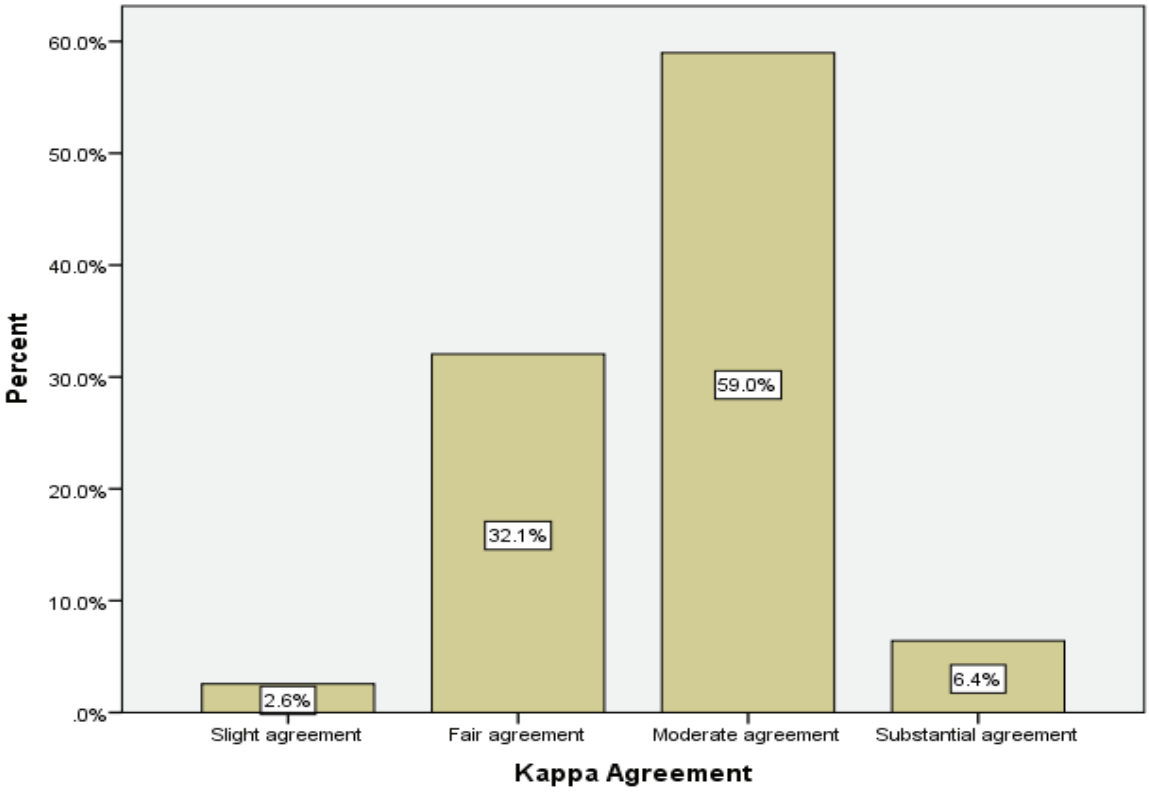

Figure 1. Frequency of Kappa agreement across items in the MHLS questionnaire

Table 3. Items reworded and subjected to a second test re-test reliability analysis

Original item	Reworded item
Using alcohol to relax	Drinking alcohol to relax
Smoking cigarettes to relax	Smoking cigarettes
Using marijuana to relax	Using marijuana
Keeping regular contact with friends	Keeping regular communication with friends
The cost of seeing the person	Not enough money to get help
Concern that what the person might say is wrong	Concern if the person gives wrong information
Concern about what other people might think of you seeing the person	Concern about what other people might think of you for seeking the person for help
Concern about the side effects of treatment	Concern about the side effects of treatment. Example itchiness/ stomach pain

Table 3 presents the values of Kappa based on each item as well as the repeat Kappa values for the 12 items that were subjected to a second test-retest.

DISCUSSION

To date, this is the first paper to report on the validation and reliability of the MHLS questionnaire among young adolescents in Malaysia. The majority of the items in the MHLS questionnaire were retained after the process of content validation, however, there were 12 items considered not appropriate and therefore removed from the knowledge about recognition and intervention constructs. Similar findings have been reported in Sri Lanka (Amarasuriya, Jorm, and Reavley 2015; Attygalle, Perera, and Jayamanne 2017). In contrast, most developed countries using the MHLS questionnaire have retained all labels with regards to recognition of the disorders faced by the characters in the vignette. This difference could be mediated by several reasons, first it is probably because the MHLS questionnaire was designed in Australia, which is a developed nation, and therefore the labels would have been designed to suit similar populations and elements of culture (Reavley and Jorm 2011). Also, variation in views of mental health experts in specific cultural contexts could result in these findings (Amarasuriya, Jorm, and Reavley 2015; Attygalle, Perera, and Jayamanne 2017). In addition, variation in the number of subject matter experts involved in the content validation process also affects the inclusion or exclusion of items, where in the involvement of more mental health experts in the process of content validation, the less probability of an item being excluded (Chepko 2015).

The Cronbach's alpha across all constructs of the MHLS questionnaire ranged from 0.52 to 0.76, indicating acceptable levels of internal consistency. This study reported Cronbach alpha values of 0.64, 0.52, 0.76, 0.52 for the ability to recognise a disorder, first aid, intervention, and prevention knowledge constructs, respectively. Similar findings of the internal consistencies were also reported for the validation of the knowledge component of the MHLS questionnaire among adolescents in Portugal, with internal consistency values of 0.50, 0.59, 0.72, 0.60 (Loureiro et al. 2013). There were slight variations in regards to these internal consistency values for several reasons. The first reason is that the sample size used in this study is much smaller than that used in Portugal. This study reported the Cronbach alpha as a measure of internal consistency for all the components in the MHL and stigma questionnaire, unlike in the Portugal study where the internal consistency of the recognition of disorders knowledge construct was measured using the Kuder-Richardson formula (KR-20) (Kuder and Richardson 1937). This study reported a much lower Cronbach alpha value for constructs about stigma component, specifically personal stigma (0.62) and perceived stigma (0.71) compared to the Cronbach alpha values of 0.77 and 0.82 reported by studies conducted in Australia (Griffiths, Christensen, and Jorm 2008). This variation could be due to the use of older participants in the Australian study, Cronbach alpha values of a scale tend to be higher when assessed among older individuals due to their higher educational achievements and levels which results in better understanding and comprehension of the items in a questionnaire (Ursachi, Horodnic, and Zait 2015).

Overall, the test-retest reliability (kappa statistics) results showed fair to a moderate agreement for most of the items, except for two items regarding knowledge about interventions for depression: the 'kids help line' (Item 15) and 'being more physically active' (Item 23). Young adolescents in Malaysia may not be familiar with the term 'kids help line' or the role that physical activity plays on depression, therefore creating a sense of hesitancy when answering these items. A lack of familiarity of these items would result in adolescents guessing the responses of these items at both assessment intervals (T1 and T2) therefore resulting in a lack of consistency and reliability for these items. It could also be possible that these adolescents following the first test session (T1), get clarification of these items and upon the re-test session (T2), they would provide a different response to these items, therefore, resulting in an inconsistent result across T1 and T2 for these items. The 'kids help line' is commonly used in Western settings (Childline Malaysia 2010), but within the Malaysian context, more common terms are 'Child Helpline' or 'Talian Nur' (International Telecomunication Union 2013). It is also possible that Asian adolescents have limited knowledge regarding the use and availability of helplines, as suggested by the International Statistics of Child Helplines, which reported the relatively higher use of helplines among children and adolescents in Western countries compared to South East Asian countries such as Thailand, Singapore and Indonesia (Childline Malaysia 2010). The NHMS 2017 reports that the majority of Malaysian adolescents are not physically active, which could be a reflection of poor adolescent understanding about the role of physical

activity in health (Institute for Public Health 2017). It is unclear whether a shortened test-retest period (less than two weeks) would improve reliability analysis. A two-week test-retest interval was selected in this study to avoid having the participants remember the subject responses, which is common in short test-retest intervals (Streiner and Norman 2003), however, it is plausible that a longer period may have eliminated this potential source of bias. Future studies should aim to examine the factor analysis of the MHLS questionnaire in order to extend the validation work of this instrument.

CONCLUSION

The MHLS instrument demonstrated acceptable levels of Content Validity Index (CVI), Cronbach's alpha values were acceptable across all constructs, and kappa values indicated moderate level of agreement. Thus, this is a valid and reliable instrument to assess MHL among Malaysian adolescents. Therefore, this instrument can be used during the school based mental health programs to examine MHL among adolescents in Malaysia. In addition, using this validated tool would enable the early detection of adolescents with low levels of MHL which would then promote the institution of early interventions to improve MHL.

ETHICAL DECLARATIONS

The study was registered with National Medical Research Register (NMRR-18-719-40569). Ethics approval was obtained from University of Malaya Research Ethical Committee (UM.TNC 2/UMREC). Permission to use the school was approved by the Malaysian Ministry of Education, Kuala Lumpur State Education Department and respective School Principals. Written consent was obtained from the participant's guardians. Permission to use, validate and modify MHLS questionnaire was obtained from the original authors.

CONFLICT OF INTEREST

The authors have no conflicts of interest to declare. All authors have read and approved the final version of the manuscript

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Appendix A. Mental Health Literacy and Stigma questionnaire

Senario/Scenario:

Ali ialah seorang lelaki yang berumur 15 tahun, dia berasa amat sedih dan sengsara selama beberapa minggu. Ali berasa letih dan mempunyai masalah tidur pada waktu malam. Ali telah hilang selera makan dan telah kehilangan berat badan. Ali tidak dapat menumpukan perhatian pada pelajarannya dan markahnya telah merosot. Ali mengelak daripada mengambil apa apa keputusan, malahan tugasan hariannya kelihatan terlalu banyak untuk dihadapinya. Ibubapa dan rakan rakan Ali amat risau dengan Ali

Ali is a 15-year-old boy who has been feeling unusually sad and miserable for the last few weeks. Ali is tired and has trouble sleeping at night. Ali doesn't feel like eating and has lost weight. Ali can't keep his mind on his studies and his marks have dropped. Ali puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about Ali.

Knowledge on recognition of disorder

1. Apakah yang anda fikir adalah masalah yang dihadapi oleh Ali?
What do you think is wrong with Ali?

Kenyataaan ***Statement***	**Ya / Yes**	**Tidak / No**	**Tidak Tahu/ Don't Know**
Kemurungan/ Depression	1	2	3
Penyakit Minda /Mental illness	1	2	3
Masalah Pemakanan /Eating disorder	1	2	3
Stress/ Stress	1	2	3
Penyalahgunaan dadah / Substance abuse	1	2	3
Tiada apa apa /Nothing	1	2	3

Knowledge about first aid for mental disorder

2. Berikut adalah senarai tindakan-tindakan yang anda boleh cuba untuk membantu Ali. Adakah anda berpendapat tindakan yang disenaraikan dibawah membantu atau berbahaya kepada Ali sekiranya anda melakukannya?
The following are a list of action you could do to try and help Ali. Do you think it would be helpful or harmful for Ali if you were to do these things?

Tindakan ***Action***	**Membantu** ***Helpful***	**Berbahaya** ***Harmful***	**Tidak Tahu/ Don't Know**
Mendengar dan memahami masalahnya. *Listen to his problems in an understanding way.*	1	2	3
Mencadangkan supaya dia mendapatkan bantuan professional *Suggest he seek professional help.*	1	2	3
Tidak menghiraukannya sehingga dia berjaya menangani masalahnya *Ignore him until he gets over it.*	1	2	3
Memastikan dia sibuk agar dia tidak akan terfikir masalahnya. *Keep him busy to keep his mind off problems*	1	2	3
Menggalakkan dia menjadi aktif secara fizikal *Encourage him to become more physically active*	1	2	3

Knowledge about interventions of mental disorder

3. Terdapat beberapa orang yang dicadangkan dapat membantu Ali. Berikut adalah senarai beberapa orang yang berkemungkinan untuk membantu Ali. Adakah anda berpendapat bahawa orang – orang yang tersenarai dibawa dapat

membantu atau berbahaya kepada Ali?
There are a number of different people who could possibly help Ali, below are a list of them, do you think the following people would be helpful or harmful for Ali?

Senarai Orang ***List Of People***	**Membantu** ***Helpful***	**Berbahaya** ***Harmful***	**Tidak Tahu** ***Don't Know***
Doktor atau Doktor Keluarga *Doctor or family doctor*	1	2	3
Guru/ Teacher	1	2	3
Ahli psikologi / Psychologist	1	2	3
Doktor Psikiatri / Psychiatrist	1	2	3
Ahli keluarga yang rapat *Close family member*	1	2	3
Rakan yang rapat *Close friend*	1	2	3

4. Pada pendapat anda adakah senarai ubatan di bawah dapat membantu atau berbahaya kepada Ali?
Do you think the following medicines are likely to be helpful or harmful for Ali?

Tindakan ***Action***	**Membantu** ***Helpful***	**Berbahaya** ***Harmful***	**Tidak Tahu/** ***Don't Know***
Vitamin / Vitamin	1	2	3
Ubat mengurangkan kemurungan/ Antidepressants	1	2	3
Pill Tidur / Sleeping pill	1	2	3

5. Pada pendapat anda adakah tindakan berikut akan membantu atau berbahaya kepada Ali?
Do you think the following are likely to be helpful or harmful for Ali?

Tindakan ***Action***	**Membantu** ***Helpful***	**Berbahaya** ***Harmful***	**Tidak Tahu** ***Don't Know***
Menyertai latihan bersantai *Participate in relaxation training*	1	2	3
Mengamalkan meditasi *Practicing meditation*	1	2	3
Mendapatkan akupunktur *Getting acupuncture*	1	2	3
Bangun awal setiap pagi dan keluar dalam cahaya matahari *Getting up early each morning and getting out in the sunlight*	1	2	3
Menerima kaunseling *Receiving counselling*	1	2	3
Mencari laman web yang memberi maklumat mengenai masalahnya *Search web sites that provide information about his problem*	1	2	3
Membaca buku membantu diri, berkaitan dengan masalahnya *Reading a self-help book on his problem*	1	2	3
Menyertai kumpulan sokongan dengan orang-orang yang mempunyai masalah yang sama *Join a support group of people with similar problems*	1	2	3

Pergi ke Pusat Kesihatan Mental *Going to a local mental health service*	1	2	3
Meminum alcohol/arak untuk berehat *Drinking alcohol to relax*	1	2	3
Menghisap rokok *Smoking cigarettes*	1	2	3
Menggunakan ganja *Using marijuana*	1	2	3
Mengurangkan meminum alkohol *Cutting down on drinking of alcohol*	1	2	3
Mengurangkan menghisap rokok *Cutting down on smoking cigarettes*	1	2	3
Mengurangkan penggunaan ganja *Cutting down on use of marijuana*	1	2	3

Knowledge about prevention of mental disorder

6. Berikut adalah pekara yang boleh dilakukan oleh Ali untuk mengurangkan risiko masalahnya. Pada pendapat anda jika seseorang muda mengamalkan pekara dibawah adakah ia akan mengurangkan risiko mereka mendapat masalah seperti yang dihadapi oleh Ali?

The following are things Ali might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would reduce their risk of developing a problem like Ali?

Perkara ***Matters***	**Ya/ Yes**	**Tidak/ No**	**Tidak Tahu** ***Don't Know***
Sentiasa aktif dalam aktiviti fizikal *Keeping physically active*	1	2	3
Mengelakkan keadaan yang mungkin memberi tekanan *Avoiding situations that might be stressful*	1	2	3
Sentiasa berkomunikasi dengan rakan-rakan *Keeping regular communication with friends*	1	2	3
Sentiasa bersama dengan keluarga *Always spend time with family*	1	2	3
Membuat masa tetap untuk aktiviti santai *Making regular time for relaxing activities*	1	2	3
Sentiasa aktif dalam aktiviti fizikal *Keeping physically active*	1	2	3

Help seeking

7. Jika anda mempunyai masalah seperti Ali, adakah anda akan mendapatkan bantuan?
If you are having a problem like Ali would you seek help?

1. Ya / Yes
2. Tidak / No (Pergi ke Soalan No 10/Go to Question No 10)
3. Tidak Tahu / Don't Know (Pergi ke Soalan No 10/Go to Question No 10

8. Kepada siapakah anda akan pergi untuk mendapatkan bantuan?
Who would you go to seek help from?

Kenyataaan *Statement*	**Ya/ Yes**	**Tidak/ No**	**Tidak Tahu** ***Don't Know***
Keluarga (Ibubapa, Penjaga), ahli keluarga) *Family (Parents, Guardian, Family Member)*	1	2	3
Kaunselor/ Doktor Psikiatri *Counselor / Psychiatrist*	1	2	3
Guru / *Teacher*	1	2	3
Rakan / *Friend*	1	2	3

9. Apakah yang akan menghalang anda daripada mendapatkan bantuan dari individu atau perkhidmatantertentu?
What might stop you from seeking help from this certain person or service?

Tindakan ***Action***	**Membantu** ***Helpful***	**Berbahaya** ***Harmful***	**Tidak Tahu** ***Don't Know***
Tidak cukup duit untuk mendapatkan bantuan *Not enough money to get help*	1	2	3
Risau bahawa orang akan ada tangappan negatif terhadap anda *Concern that the person might feel negatively about you*	1	2	3
Risau sekiranya individu tersebut memberi maklumat yang salah *Concern that person might give wrong information*	1	2	3
Risau dengan pandangan masyarakat sekeliling sekiranya anda berjumpa orang lain untuk mendapat bantuan *Worried about what other people might think of you for seeking the person for help*	1	2	3
Individu atau perkhidmatan adalah terlalu jauh untuk mendapatkannya *The person or service is too far to travel to*	1	2	3
Amat sukar untuk mendapat temujanji *It is too difficult to get an appointment*	1	2	3
Risau akan kesan negatif rawatan; contohnya gatal-gatal/ sakit perut *Concern about the negative effects of treatment: Example itchyness/stomach pain*	1	2	3
Tidak suka pada jenis rawatan yang diberikan *Not liking the type of treatment that is likely to be offered*	1	2	3
Merasakan tiada apa yang boleh membantu masalah anda *Feeling that nothing can help your problem*	1	2	3
Perlu menunggu untuk temujanji *Having to wait for an appointment*	1	2	3
Terlalu malu *Too embarrassed/shy*	1	2	3

Personal stigma

10. Berikut merupakan beberapa kenyataan yang berkaitan dengan masalah Ali. Sila pilih samada **ANDA SENDIRI** setuju atau tidak setuju dengan kenyataan berikut.
*The next few questions contain statements about Ali's problem. Please indicate how strongly **YOU PERSONALLY** agree or disagree with each statement.*

Kenyataan ***Statement***	**Setuju** ***Agree***	**Tidak Setuju** ***Disagree***	**Tidak Tahu** ***Don't Know***
Ali boleh sihat daripada masalahnya sekiranya dia mahu *Ali could snap out of it if he wanted.*	1	2	3
Masalah Ali adalah petanda kelemahan peribadi *Ali's problem is a sign of personal weakness.*	1	2	3
Masalah Ali bukanlah penyakit perubatan sebenar *Ali's problem is not a real medical illness.*	1	2	3
Ali adalah berbahaya kepada orang lain *Ali is dangerous to others.*	1	2	3
Adalah lebih baik untuk mengelakkan Ali supaya anda tidak mengalami masalah yang sama seperti Ali *It is best to avoid Ali so that you don't develop this problem yourself.*	1	2	3
Anda tidak akan memberitahu sesiapa sekiranya anda mempunyai masalah seperti Ali *You would not tell anyone if you had a problem like Ali's*	1	2	3

Perceived stigma

11. Apakah pendapat anda berkaitan dengan kepercayaan **ORANG RAMAI** terhadap Ali

*We would like you to tell us what you think **MOST OTHER PEOPLE** believe about Ali.*

Kenyataan ***Statement***	**Setuju** ***Agree***	**Tidak Setuju** ***Disagree***	**Tidak Tahu** ***Don't Know***
Kebanyakan orang percaya bahawa Ali boleh sihat daripada masalahnya jika dia mahu *Most other people believe that Ali could snap out of it if he wanted.*	1	2	3
Kebanyakan orang percaya bahawa masalah Ali adalah petanda kelemahan peribadi. *Most people believe that Ali's problem is a sign of personal weakness*	1	2	3
Kebanyakan orang percaya bahawa masalah Ali bukan penyakit perubatan sebenar. *Most people believe that Ali's problem is not a real medical illness.*	1	2	3
Kebanyakan orang percaya bahawa Ali adalah berbahaya kepada orang lain *Most people believe that Ali is dangerous to others*	1	2	3
Kebanyakan orang percaya bahawa adalah lebih baik untuk mengelakkan Ali supaya tidak mengalami masalah yang sama seperti Ali *Most people believe that it is best to avoid Ali so that they don't develop this problem themselves.*	1	2	3
Kebanyakan orang percaya bahawa masalah Ali menyebabkan dirinya menjadi tidak menentu. *Most people believe that Ali's problem makes him unpredictable*	1	2	3
Kebanyakan orang tidak akan memberitahu orang lain sekiranya mempunyai masalah seperti Ali *Most people would not tell anyone if they had a problem like Ali's*	1	2	3

Social distance

12. Bagaimanakah perasaaan anda untuk meluangkan masa dengan Ali?
How would you feel about spending time with Ali?

Kenyataan ***Statement***	**Setuju** ***Agree***	**Tidak Setuju** ***Disagree***	**Tidak Tahu** ***Don't Know***
Keluar bersama Ali pada hujung minggu. *To go out with Ali on the weekend.*	1	2	3
Bekerjasama dengan Ali dalam satu projek. *To work on a project with Ali.*	1	2	3
Menjemput Ali ke rumah anda. *To invite Ali around to your house.*	1	2	3
Pergi ke rumah Ali. *Go to Ali house.*	1	2	3
Memupuk persahabatan yang rapat dengan Ali. *To develop a close friendship with Ali.*	1	2	3