Public Stigmatization Towards Mental Illness in Kampar, Perak

An exploratory study

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Abstract

This research aimed to understand how demographic variables (gender difference, age and level of education) affect level of stigmatization towards people with mental illness in Kampar, Perak. This study conducted using quota sampling as survey method to divide targeted population into different smaller group. The sample of this research involves 180 participants from three places of Kampar: Old Town, New Town and Mambang Di Awan. The results shown that there was a significant difference between gender difference in stigmatization towards mental illness, $t(178) = -1.259$, $p < 0.05$. Female participants ($M = 113.03$, $SD = 11.26$) shown higher tendency in stigmatization towards mental illness compared to male participants ($M = 110.28$, $SD = 17.45$). Besides that, there was also significant difference between education level and stigmatization towards mental illness, $F(2, 177) = 17.273$, $p < 0.05$. Primary education ($M = 118.60$, $SD = 10.97$) was the highest in CAMI scale than Tertiary education ($M = 104.12$, $SD = 15.59$). However, there is no significant difference between age groups and stigmatization towards mental illness.

Keywords: stigmatisation, community attitudes towards people with mental illness, gender differences, age group, education level

DECLARATION

We declare that the materials and data presented in this paper are the end results of our own work and that due acknowledgment has been given in the bibliography and references to ALL sources, be they printed, electronic or personal.

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Chapter 1

Introduction

Malaysia had become a modernized country over the years, but the problem arises when living standard increases. Financial burden, relationship problem or parenting issues had become stress sources for both adults and children. Malaysian Digest (2013) reported National Health and Morbidity Survey in 2011 showed 12 % Malaysian age 18-60 years old suffered some form of mental illness. Female emerges to have mental illness at 24 years old, while male started mental illness can be as early as 15 years old. Mental illness do not only affects younger age, but adult at 50 years old also likely to experienced personality changed, experience emotional disturbance. Mental illness had become the second severe illness that affects older adult, after heart disease ("More Malaysian will experience mental illness in 2020", 2013).

Mental illness had become a significant issue over the past 10 years. This situation is expected to be worsen for the next 20 years as the world continues to urbanize. In majority of Asian culture, people see mental illness as disgrace and ashamed. When public hold such attitudes, Asian family tends to cover up mental illness and often reject help from others (Hidden Casualties, 2000).

Comparing mental illness stigma in 1950 and 1996, Phelan and colleagues found public sees mental illness in a narrow and extreme way. People often classified mental illness into non-mental health term such as "problematic sorts", and also negative adjectives such as "useless" and "rude". From 1996 till now, people see mental illness in a more positive light (Phelan, Link, Stueve, & Pescosolido, 2000).

Nowadays, schizophrenia is labelled as a most discriminating disease, followed by bipolar disorder, lastly depression. The public tend to judge mental illness, according to their own moral standard by attributing it to personal factor (Arboleda-Florez & Stuart, 2012).

Stigma can be classified into enacted stigma and felt stigma. Enacted stigma happens when discriminatory behaviour or prejudice, attitude, action perform against another person. Enacted stigma happens when people living with mental illness often do not get reasonable promotion due to the prejudice from his subordinate and colleague. Felt stigma is the worry of being discriminate or marginalized. This happened when a person is not willing to have social contact with the public, because they might be received negative response and judgment from others (Eugene, 2013).

Stigma manifest through labeling, people avoid them after knowing their diagnosis or by name calling. Labeling also happened through social marginalization and rejection, where family members and friends are not willing to accept them due to their mental illness (Hanfiah & Van Bortel, 2015). Instant attitude change and social exclusion occurred when friends realized their mental condition. When people around Categorizing "ours" and " theirs", this crippled people living with mental illness for social acceptance (Dorn, Swanson, Elbogen & Swartz, 2005 as cited in Link & Phelan, 2001).

Manifestation of stigma had deterred societal function of mental illness patient. Self-stigma at individual level experienced social rejection that impedes the patient to carry out responsibility normally (Hanafiah & Van Bortel, 2015). Gray (2001) stated only 21% people with serious mental illness intend to work or looking for job, but only 13% are hired.

Context of study

Goffman defines stigma as bad virtue that are highly devalue to a person, neither due to physical disability, weakness of personality, ethnic or religion (Goffman, 2009).

Thornicroft, Rose, Kassam and Sartorius (2007), defined stigma into 3 components, namely attitudinal prejudice, behaviorally discrimination and knowledge ignorance.

Yeap and Low (2009) in their survey of 587 respondents in the Klang Valley, Malaysia found that there was a neutral response to mental illness stigma. Level of education was found significantly correlated with stigma. Stigma in Malaysian comes from insufficient knowledge about mental illness and differences in language translation and understanding. The term Schizophrenia translated to Mandarin are called " jing shen fen lie zheng", Chinese usually perceive the meaning as split personality, this term had turned schizophrenia looked serious and complex. In this research, only 7% respondents answered correctly on this mental health knowledge, hence it is important to acquire proper understanding of mental illness (Yeap & Low, 2009).

Khan, Hassali, Tahir and Khan conducted a pilot study among 100 people in Penang, Malaysia in 2011. The result showed high stigmatization of mental illness among the respondents. People attribute mental illness to lack of social support, brain chemical imbalance and superstitious factor. 55% respondents do not think people with mental illness are friendly. In addition, 30% respondents believed they are dangerous, having easily changing mood and cannot be predicted

Hence, our context of study focus on how gender, age and level of education can affect attitude toward people with mental illness.

For aspect of gender, Al-Naggaar in 2013 conducted studies in Management and Science University, Malaysia on 279 students with 191 females and 88 males. Result showed a moderate to good attitude toward people with mental illness, female noted to have more positive attitude than male. On the other hand, all respondents tend to react negatively in social Restrictiveness, questions like “I do not want people with mental illness to live in residential area that are close to my house” and “Is it difficult to make friends with mental illness people?”. Hence researcher concluded respondents have a general accepting attitude, but are very fearful towards closer social contact (Al-Naggar, 2013).

For age aspect, AR, Osman and Ainsah (2010) conducted a survey in Hospital Universiti Kebangsaan Malaysia (HUKM). Respondents were 245 patients of age from 18-65 attending primary care clinic of HUKM. Result shows age was predictive of negative attitude toward mental illness. Younger age (18-29 years) believes they will first bring people with mental illness to seek help from priest. They also believed hysteria is caused by evil spirit possession. Acceptance of mental illness is higher among middle aged (30-49years) and old age (50-65years) (AR, Osman, & Ainsah, 2010).

For aspect of education level, Siti Zubaidah and Norfazilah conducted a cross-sectional study in Johor, Malaysia in 2012. 347 respondents were people who had visited a government health clinic in Tampoi took part in the survey by answering the Community Attitudes towards the mentally ill (CAMI) questionnaire. The researchers divided education into 4 levels (illiterate, primary, secondary and tertiary) and found that there is a significant relationship between education level and degree of stigma toward people with mental illness. People with higher education have more positive attitude (benevolent), and score lower in authoritarianism and social restrictiveness (Siti Zubaidah & Norfazilah, 2014).

Problem statement

Angermayer and Mastchinger (2003) conducted 56 interviews of people living with mental illness. Most interviewees mentioned stigma is their major problem. TV drama or newspaper often portrayed people with mental illness are dangerous and randomly assault people. Such improper portrayal had negatively affected them in many ways. Mental illness stigma is a worldly problem over the years.

Public easily attribute the stigma of mental illness without recognizing the seriousness of the consequences. More problem is added up when people with mental illness not only have to deal with their treatment, but also neglected by society. They tend to delay their treatment to avoid public rejections. This eventually worsening their condition (Dinos, Stevens, Serfaty,Weich, & King, 2004).

Significance of study

Firstly, this study aimed to understand how the education level affects stigmatization toward people with mental illness. This allows the understanding of how knowledge and years of education could impact a person's view on stigmatization of mental illness. Does education produces rational thinker who explain and attribute mental illness in different ways.

Secondly, this study gives an idea how gender views stigmatization of mental illness. It helps people to understand how different gender with respective gender roles could differ in stigmatization. Females are normally perceived by society as nurturing, empathy and supportive than male. Through this study it allows us to see how gender difference could affect levels of stigmatization.

Thirdly, this study investigated on how age could affect stigmatization toward people with mental illness. This provides understanding how cumulative experience over the time impact on attitude toward people with mental illness.

In addition, this study acknowledges mental illness stigmatization as a common social problem that should be addressed and reduced. A few research on mental illness stigmatization had been conducted in 3 states of Malaysia, including Johor, Kuala Lumpur and Penang. Hence this study investigated the public view in Kampar, Perak towards the stigmatization of mental illness.

Besides, this study reveals the different levels of stigma and attitudes toward mental illness. It allows us to understand which misconception or attitude leading to stigma toward people with mental illness. This is useful for future intervention and anti-stigma program and is a base in understanding targeted group and type of misconception.

Purpose of Study

This study aims to understand how demographic variables including gender difference, age and level of education affects level of stigmatization towards peoples with mental illness. Moreover, this study help to increase awareness through the understanding of the different levels of stigmatization that commonly held by different demographic groups. Hence, this study provide information for future research, assist in creating an equal and friendly environment for people with mental illness.

Research Questions

The research questions in this study are as follow:

1. Is there a gender difference towards stigmatization of mental illness?
2. Is there any significant difference between age and stigmatization of mental illness?
3. Is there any significant difference between level of education and stigmatization of mental illness?

Research Hypotheses

1. H_o: There is no any significant difference between gender difference and stigmatization of mental illness.

   H_1: There is a significant difference between gender difference and stigmatization of mental illness
2. H_o: There is no significant difference between age and stigmatization of mental illness.

   H_1: There is a significant difference between age and stigmatization of mental illness.
3. H_o: There is no significant difference between level of education and stigmatization of mental illness.

   H_1: There is a significant difference between level of education and stigmatization of mental illness.

Conceptual Definition

Mental illness. Szasz explained mental illness does not exist physically, but served as a metaphor. Illness is a term used by physicians to describe the biological bodily malfunction, yet mental illness is too abstract because it has no obvious physical causes. Hence it merely serves as a metaphor to describe emotional, behavioural problem that interrupted proper daily functioning

(Szasz, 2010). While Johnstone (2001) defined mental illness as a series of thoughtful, feelings and behaviour problems that affects interpersonal relationship and impact on daily life functions, such as schooling or working.

Stigma. Goffman defines stigma as picking up obvious shortcomings of others and attribute to people that are highly discrediting. Stigma can also define as people with higher power and authority continually take advantage of people with lower power by attribute negative labeling, causing loss of status and marginalization towards them (Link & Phelan, 2001). While, Crocker and Major (1989) defined stigmatization as a social category which the members hold negative attitudes and stereotypes towards people who are vulnerable (such as mental illness). People who had been judged as deviant loses self-concept and social identity during the process of stigmatization.

Public stigma. Corrigan, Young and Ben-Zeev (2010) conceptualized public stigma as a group of people stereotype and negatively attribute other's shortcoming as their fault and behave negatively towards these minority group. People generally spot people with mental illness through physical cues such as psychiatric symptoms or physical appearance.

Gender Difference. Gentile (1993) defined gender difference as a trait or condition that identify as maleness or femaleness based on the cultural influence.

Age. Santrock (2011) explained there are seven age range in human period of life. Participant of this study falls on the last 3 period, including early adulthood (20-30 years old), middle adulthood (approximately 35-45 years old to 55-65 years old) and late adulthood (approximately 60 or 70 years old until death) (Stantrock, 2011).

Level of education. There are three different education levels in this study, which are primary, secondary and tertiary education.

Primary education. Primary education fulfills through 6 years of compulsory education for children. The period of primary education started from 7 until 12 years old (Clark, 2014).

Secondary education. This category includes student who are pursuing secondary school in the progress of completing Penilaian Menengah Rendah (PMR), Sijil Pelajaran Malaysia (SPM) or The United Examination Certificate (UEC) for Independent Chinese Secondary Schools (Clark, 2014). In Addition, Students who had taken pre-university course or matriculation are considered to be in the category of senior secondary level.

Tertiary education and above. Tertiary education include people who are pursuing or those who had completed private college, community college, polytechnics, university college and university. (Clark, 2014). Besides, in our context of study, people who had received education at master degree level or Doctorate level, we classified them under this category.

Chapter 2

Literature Review

Gender Differences and Stigma towards People with Mental Illness

Lowder in 2007 examined mental illness stigma across lifespan in University of North Carolina at Wilmington. 148 respondents were young adults and psychology students. Result showed women have a more encouraging attitude (community ideology and benevolence), and scored lower in negative attitude (social restrictiveness and authoritarianism). Researchers attributed women's positive attitude to social role in society. As a wife or mother, woman tend to be more supportive towards family, loving and nurturing. Woman were also likely to attribute mental illness as something helpless to victim. Hence, women generate sympathy towards them instead of attributing fault. Besides, women often acquired tolerant method to communicate feelings differently. (Lowder, 2007).

Lopez in 1991 studied on adolescent's attitude toward mental illness. Total of 92 person (52 were girls and 37 were boys) from a public senior high school in Southwest Florida were selected and Opinions about Mental Illness (OMI) scale was used. Result found was consistent with Lowder in 2007, where there is significant effects on gender towards mental illness, girls tended to show more favorable attitude than boys. In average, boys exhibited higher authoritarianism; while girls do not see mental illness as inferior. Besides that, girls shows more benevolence than boy which is a sign of nurturance. Moreover, boys displayed higher Social Restrictiveness than girls, but both does not different in Mental Hygiene Ideology dimensions (Lopez, 1991).

On the contrary, Balan in 1996 showed there was association between sex difference and Social Restrictiveness. Female believed people with mental illness are not safe to society, and there is a need for social restriction (Balan, 1996). Balan explained woman often perceived themselves as gentle and prone to hurt, hence they are more likely to advice people with mental illness to be socially restricted to assure their own safety. Jackson and Hertheringon in 2006 also found similar findings. Female showed less favorable attitude toward people with mental illness. In this experimental research, researcher showed respondents two video. Firstly, is a video about a job interview to a normal person. Both genders showed equally positive attitude toward the job interviewee. But when they showed the second video of about a job interview to a person who had past mental illness condition, female respondents exhibited greater social distance and intolerance toward the second video (Jackson, & Heartheringon, 2006).

In contrast with previous findings, Wagner in 2012 assessed 252 college student's perception of the mental illness through online survey. With 114 male (45.2%) and 138 females (54.8%) there was no gender differences on perception towards mental illness. There was also no significant difference in social distance towards mental illness people. More males agreed on statement "mentally illness should not have equal rights compared to normal person." But overall it is still not significant to conclude there is significant difference in both group. Reavley and Jorm in 2011 conducted a research among 6019 persons through phone interviews. Respondents had been given a situation about people with mental illness. They found no significant differences in gender. Interestingly, researchers discovered female are likely to produce fears when the scenario mentioned a male character "John". Besides, both gender exhibited higher stigma and avoidance towards scenario with male character.

Age Group and stigma towards people with mental illness

A survey conducted in England on attitude towards mental illness among adults in 2012. This survey had been participated by 1727 adults through face to face interview. There are 3 age groups, 16-34 years old, 35-54 years old and 55 years old and above. This survey started in 1994 then proceed with every 3 years. They found attitude of accepting people with mental illness into society had gradually increased over the years. Since 2009, Social Restrictiveness subscale showed people's acceptance for social closeness had increased. People who responded they wish to sustain friendship with mental health people increased from 82% to 86%, and willingness to let people with mental illness living nearby had also increased from 72% to 77%. Willingness to work or employ people with mental illness arise as well, from 69% to 75% (National Mental Health Development Unit (NMHDU), England, 2013).

Looking as an overall, middle age group (35-54years old) had the most positive attitude. People who are at 55 years old and above believed women should not be so gullible married to a mental illness men, and people with mental illness should not be trusted with handling responsibility. In addition, the youngest age group (16-34) held the least tolerant attitude towards people with mental illness (Attitude to mental illness 2012 research report, 2013).

England survey result is consistent with Morrison, De Man and Drumheller findings in 1993. Morrison and colleagues also found age to be significantly correlated with authoritarianism and social restrictiveness. It can be concluded that young people are having higher authoritarianism and social restrictiveness toward people living with mental illness. The researchers explained most young people held negative view because they think people with mental illness are unforeseeable. Hence young people felt insecure to risk their own safety if

people living with mental illness are given freedom in the society (Morrison, De Man & Drumheller, 1993).

On the other hand, Maclean in 1969 studied on community attitudes toward mental illness in Edinburgh. With 446 respondents, Maclean discovered older respondents above age 50 had more negative attitude, exhibited fear, oversensitive and avoid further discussion about people living with mental illness. Similar to Lowder in 2007 and Balan in 1996, both found older adult tended to show more social restrictive and authoritarianism than younger age. Lowder explained this difference could possibly come from Cohort effect. As respondents from older adult group born in 1930- 1950, while younger adult are born in 1980-1990. Older adult are self-protective largely due to social norm in the past. Older adult tends to exhibit fear of being violence, not willing to have close contact and most of them attribute mental illness as stable factor that cannot be easily change. While, Balan explained young generation in 1990 is regularly expose to psychology related education and work such as psychologist and psychiatrist. Younger generation also no longer treat “Freudian slip”, or “unconscious” as jargon because it is too common in their daily life. Besides, it had also been noted since 1990’s deinstitutionalized had become more common in the society. People with improved mental health condition are freed and can be seen more easily in the public.

In addition, Mowbray and colleagues in 2006 explained psychiatric cases are increasing among age 15-21 years old student in secondary or tertiary education. This scenario had become more common nowadays. Open mindedness to mental illness can be due to frequent exposure to such case, when experience increases, stigma are likely to decrease. This condition is not seen in olden day back in 1930-1950. Where people with mental illness are so much lowered, and seldom been seen.

On the contrary, Salve and colleagues in 2013 found age does not have significant association with mental illness stigma (Salve, Goswani, Sagar, Nongkynrih, & Sreenivas, 2013). Consistent with Papadopoulos, Leavy and Vincent in 2002. Papadopoulos conducted research in North London Greek-Cypriot community comparing first generation (older) and second generation (younger). Result shows both the generation held equally negative attitude, describing people with mentally ill as unsafe and should stay away from them. Researcher further explained Greek-Cypriot is a community that holds strong religion identity. With such cultural influence, first and second generation are held strongly together abiding to their culture and religious belief, hence acceptance towards people with mental illness had not been changed over the years (Papadopoulos, Leavy, & Vincent, 2002).

Education level and stigma towards people with mental illness

Barke, Nyarko and Klecha in 2011 researched on stigma of mental illness in Southern Ghana. Result showed people with secondary education had more positive attitude than people with only primary education. People with higher education were less authoritarian and less social restrictive toward people with mental illness. Consistent with the findings of Balan in 1996 who conducted a survey in New Jersey to investigate Cubans' attitudes toward mental illness. Education level was also negatively correlated with Authoritarian and Social Restrictiveness. People with higher education level were less likely to see mentally ill as dangerous. Besides, Balan found education was not significantly correlated with Benevolence, Mental Hygiene Ideology and Social Restrictiveness.

Wolff and colleagues conducted research in 1996 on mental illness stigma also found low educated adult with low social class tended to have the highest stigma towards people with mental illness because they have insufficient knowledge about mental illness. Wolf and

colleagues postulated there is a possible relationship between knowledge and tolerance, because result from community attitude toward mental illness (CAMI) test shows people who have high mental illness stigma exhibited misconception in at least one subscale measured.

In addition, Sevign and colleagues in 1999 studied mental illness stigma among professionals working in psychiatric hospital in Beijing, China. Through CAMI scale, the result shows higher educated doctors tend to have more supportive attitude than nurses(lower educated) in mental health ideology section, 80% of highly educated respondents agreed on item " mental health service provided near housing area and neighborhood will not cause danger to public." Researcher further explained people different opinion might due to different level of training received. People with higher education like doctors are more likely to understand mental illness, as they studied in detail compared to nurses who only touches the surface. Besides, consistent with Balan and Barke and colleagues's findings, people who acquired higher education level tended to be less authoritative and socially restrictive (Sevigny, Yang, Zhang, Marleau, Yang, Su, & Wang, 1999).

Song and colleagues in 2005 also found people with higher education held positive attitude towards people living with mental illness, but they tend to score high in social restrictiveness. Song and colleagues explained, people with higher education believes people ought to fulfill their roles as a part of society, and they have high expectation on what one's should accomplished. Hence, they are less likely to think people with mental illness can help in giving effort to contribute in society (Song, Chang, Shih, Lin, & Yang, 2005).

On the contrary, Ukpong and Abasiubong in 2010 conducted a study in Nigerian University teaching hospital. The result showed an opposing view compared to previous findings. The result showed there was no significant relationship between education level and attitudes

toward mental illness, respondents held equally negative attitude regardless of education level. Researchers postulated education level does not directly determine level of stigma. World Psychiatric Association (WPA) introduced psychoeducation and intervention in more than 20 countries, yet it is not effective for low economic countries. In this research even though respondents who have higher education are able to identify genetic and social stress as cause of mental illness, but living in a low income country where people struggled with basic living are hard to received people with mental illness because they are often regarded as a hassle to others. In addition, Waqas and colleagues conducted research in 2014 found similar result. Waqas and colleagues explained when respondents attribute cause of mental illness using bio-psycho social model, they are more likely to have an open attitude, on the other hand, when a country's religion or traditional is strong such as Pakistan, people mostly attribute the cause of mental illness to superstition and magical view, hence they held a less tolerant attitude (Waqas, Zubair, Ghulam, Ullah, & Tariq, 2014).

Theories

Consensus Theory

A society derived from individuals and groups such as religion and social organization that work together with least disagreement between individuals. Conformity and adjustment to the norms and social value are important to maintain the harmony and societal functioning. Individuals with conflicting ideas tend to accommodate and absorb the dominant society, and fit into their social behavior (Browne, 2011).

Social Identity Theory

Henri Tafjel proposed Human have the need to acquire sense of identity and belongingness because membership provide vanity and esteem to the person (MacLeod, 2008). Hence, psychologically, people classified themselves into social group. With this self-conception, people assess themselves in terms of common attributes (Burke, 2006). People see themselves belong to in-group if they held similar social behavior, those who are dissimilar are judge as out-group. Such classification are based on styles and habits to associate with pre-determined set of goals, assumptions and threats. To enhance self-esteem, in-group have the inclination to perceive own group as interesting and superior while, judge out-group negatively with discriminatory behavior. This social categorization divided the society into “ours” and “theirs” (Trepte, 2006).

Accentuation Theory

Accentuation is the result of social categorization. When people categorized, distorted memory will influence how they think about in-group and out-group. People often use these pre-conceived ideas to judge current situation, but there are actually minimal or no difference between in-group and out-group. With these accentuated stereotypes, people tends to accentuate the difference between groups, which they often overly assume the strength of in-group (“ours”), and underestimate the good sides of out-group (theirs”) (Stroessner & Sherman, 2015).

Attribution theory

Attribution theory is a social cognitive approach developed by Weiner (Corrigan, 2000). It consist of 4 stages, these include occurrence of incident, cognitive component, feeling component and behavioral response.

Occurrence of incident happened when public noticed outward and obvious physical or behavioral symptom of people with mental illness. For example, talking to self loudly or bizarre behaviors.

Next, in the Cognitive component, people started to guess whether the mental illness symptom are controllable. Is it a potential threat or how much it will disrupt the public? Here, people process information through cognitive component pathway forming either positive or negative stereotype.

Thirdly, the person will process information in affective component. A person's affective component are based largely on the attitude they had in the previous stage.

Final stage is behavioral response. After taken consideration from both cognitive and affective part, the person come to a conclusion and respond accordingly. (Corrigan, 2000)

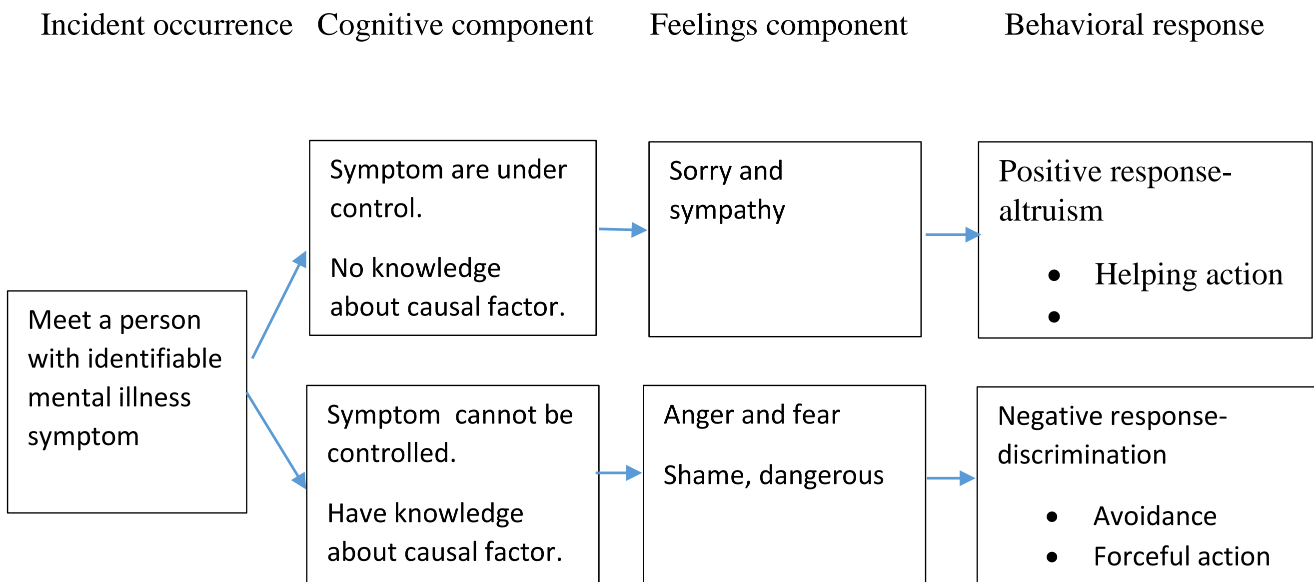

Figure 1.0 *Analytic Model from Attribution Theory that explained how behavioral response was formed.*

Theoretical framework

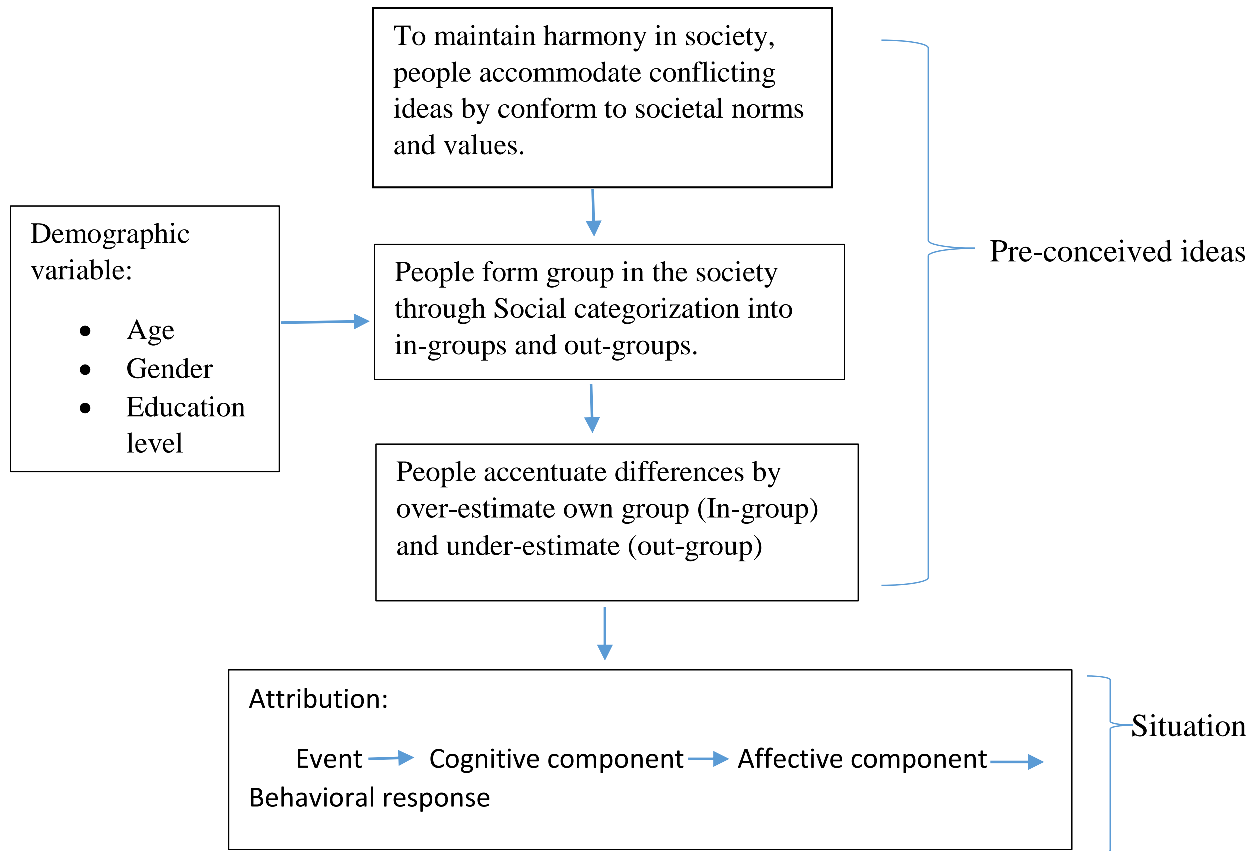

Figure 2.0 *Theoretical framework of stigma formation toward people with mental illness.*

Firstly, society always worked in harmony. To achieve this, society often conform to societal norm and values of the crowds. Individuals who have different stance and opinion tend to be ignored or overlooked by others. Hence, to be included as part of the society member, people assimilate pre-existing value and accommodate according to the dominant society.

Secondly, to be part of the society, people form groups through social categorization. People with similar character are often group together. Individuals classified their own-group as in-group, others who are dissimilar as out-group. Group is important to individuals because it fulfills esteem needs and belongingness. Hence, to maintain the membership, people will follow pre-determined rules and expectations so that they can fit into the group and accepted by others.

Demographic variables including age, gender and education levels produce different groups, and different set of norms and values. Such as society expect male to be strong and protective; people with higher education level are better at analyzing rationally.

After people categorized themselves into groups, they start to accentuate the difference between own group and others. People judge situation in a perspective where it magnified the variation between groups although the actual difference may be subtle. Individuals tend to judge out-group as negatively, and seeing own group in a more positive light. This bias is often the source of stereotype and prejudice, where people twisted their perception to fit into their assumption.

Eventually when a person encountered a situation with identifiable mental illness character, they have a readily available templates as a reference based on their own societal norms and values, how much individuals perceived out-group through accentuation and how others in their group usually response to such situation. Societal influence plays a major role in determining attitude towards people living with mental illness. On the other hand, situational factors including cognitive and affective analysis affects how a person will eventually attribute or response.

Chapter 3

Methodology

This chapter discussed research design, locations, participant, sampling method, instrument used, procedures and statistical analysis. In this research, Quota sampling method had been used to acquire information. This research invited people who are currently residing in Kampar to complete the questionnaire; this includes locals from Kampar or University student who studied in Kampar. Data is collected at surrounding university and shop houses in New Town, Old Town and Mambang Di Awan, Kampar. Community Attitude of the Mentally Ill scale (CAMI) had been used to measure the influence of demographic variables on stigma towards people with mental illness in Kampar, Perak.

Research Design

This research conducted using cross-sectional survey method. The questionnaire is a quantitative research method that consists a pre-planned set of questions used to measure feeling, attitude and opinion on a particular issue (University, 1997). This method allowed researchers to collect relevant information from a large group of people. When it is carefully administered, it generated accurate and precise information that are applicable to groups or whole population (C N Trueman, 2015).

Quota sampling method was used to select participants as it functions to produce a sample that can interpret the particular strata of the population. This method is standardized to a stratified random sample, but the quota sampling is relatively simple, as it does not utilize a sampling frame (Laerd Dissertation, 2012). Firstly, select type of groups that are needed to be stratified, for example, Gender, Age and Education level. Then further divide the targeted

population into their respective smaller group (strata), such as gender consist Female and male strata, Age consist of young adulthood, Middle adulthood and late adulthood strata and so on. Then set a number for each stratum by dividing equally. Data is collected until the quota of each stratum is achieved. In this research a total 180 participants were divided into 2 strata (Male and Female), each strata further sub-categorized into 3 strata (Young Adult, Middle Adult and Older Adult), each age group strata further sub-categorized into another 3 strata (primary education, secondary education and tertiary education).

Besides that, this research use cross sectional study to enable the comparison of several different groups of people in single time (Institute for Work & Health, Toronto, 2015). For example, we were able to compare how different gender, age group and education level could impact on attitude toward people with mental illness at a single time without bearing extra cost or follow-up. This method had been selected because it helped to describe the trend of mental illness stigma in Kampar, Perak and it consist predictive value in determining groups that are more likely to stigmatize people with mental illness. Apart from that, the self-report method had been used in conducting this research. Participants are free from fear of judgment; hence, they are likely to express their genuine opinions.

Participants and Locations

Official web portal Kampar District Council 2010 had shown Kampar is a district consists of 15074 people. 11% or 1652 people belong to 20-30 years old; 37.2% or 5614 people belong to 31-59 years old; 22.7% or 3420 people belong to age 60 and above (Local Information, 2010). We noticed local people age 20-30 years old are limited in Kampar, hence we invited Kampar university and college students who already reside in Kampar for few years to participate in our research.

Kampar, Perak consist of Old Town, New Town and Mambang Di Awan, Kampar connected side by side. Local People mostly lived and running a small business in Old Town and Mambang Di Awan, Kampar, while New Town Kampar was densely populated with non-local student who stayed a few years in Kampar.

Due to this specially, we collected local people's information from shop house attendants and eateries, shop customers in Old Town and Mambang Di Awan Kampar, these participants were mostly middle age to old age, from primary education level to secondary education level. On the other hand, we collected data from University Tunku Abdul Rahman (UTAR) and University College Tunku Abdul Rahman (TARC) in New Town Kampar, where young adult with tertiary education level was densely populated here. We targeted shop house attendants and eateries, shop customers because they were more convenient and available to participate in our research instead of house-to-house survey method.

210 participants participated in this research, but eventually only 180 participants were selected in this research study. 60 participants were invited from Old Town Kampar, 26 males and 34 females. Among the males, there were 10 early adulthood participants (5 with primary and 5 with secondary education level), 9 middle adulthood (4 with primary and 5 with secondary education level), 7 late adulthood (2 with primary, 2 with secondary and 3 with tertiary education level). Among female, 8 early adulthood (4 with primary and 4 with secondary education level), 12 middle adulthood (6 with primary and 6 with secondary education level), 14 late adulthood (5 with primary, 5 with secondary and 4 with tertiary education level).

Besides that, a total of 50 participants were from Mambang Di Awan, 28 males and 22 females. Among the males, 10 early adulthood participants (5 with primary and 5 with secondary education level), 7 middle adulthood (4 with primary and 3 with secondary education level), 11

late adulthood (4 with primary, 3 with secondary and 4 with tertiary education level). Among female, 4 early adulthood participants (2 with primary and 2 with secondary education level), 4 middle adulthood (2 with primary and 2 with secondary education level), 14 late adulthood (5 with primary, 5 with secondary and 4 with tertiary education level).

Additionally, there were a total of 70 participants from New Town Kampar, 36 males and 34 females. Among the males, 10 early adulthood with tertiary education level, 12 middle adulthood (2 with primary, 2 with secondary and 10 with tertiary education level), 12 late adulthood (4 with primary, 5 with secondary and 3 with tertiary education level). Among female, 18 early adulthood (4 with primary, 4 with secondary and 10 with tertiary education level), 14 middle adulthood (2 with primary, 2 with secondary and 10 with tertiary education level), (2 late adulthood with tertiary education level).

Instrument

Community Attitudes of the Mentally Ill Scale (CAMI) are a 40 items questionnaire used to assess how the influence of demographic variable affected stigma towards people with mental illness. This is a questionnaire that had been widely utilized by researchers, conducting research in Southern Ghana, New Jersey, Beijing, China, Taiwan, Nigerian as well as in Malaysia. This questionnaire uses ordinal scale, ranging from 1 to 5. 1 indicate strongly disagree, 2 indicate disagree, 3 indicate no answer, 4 indicate agree, and 5 indicate strongly agree. A higher value indicates stronger attitudes of those particular sub-score.

CAMI questionnaires consists 4 factors, namely Benevolence, Community Ideology, Authoritarian and Social Restrictiveness. Each factor consists 10 items. Benevolence is measured by item 2, 6, 10, 14, 18, 22, 26, 30, 34 and 38. Community Ideology is measured by item 4, 8, 12,

16, 20, 24, 28, 32, 36 and 40. Authoritarian is measured by item 1, 5, 9, 13, 17, 21, 25, 29, 33 and 37 and Social Restrictiveness measured by item 3, 7, 11, 17, 21, 25, 29, 33 and 37.

This research included Chinese version to assist participants to understand and aid in answering and expressing their views. Additionally, we explained to older adult who are illiterate to facilitate answering to our questionnaire. Refer sample questionnaire in appendix.

CAMI had a high correlation among the four sub-scales which is 0.88 (Link, Yang, Phelan, & Collons, 2004). There were 3 sub- scale in CAMI questionnaire reported satisfactory by Taylor, Dear & Hall, which had high reliability and good value of Cronbanch Alpha, Benevolence 0.76, Social Restrictiveness 0.80 and Community Mental Health Ideology 0.88. However, the coefficient for Authoritarianism is slightly lower at 0.68, but considered satisfied, it developed a reliability range from 0.69 to 0.88, construct validity showed a positive outcome as well. (Taylor & Dear, 1981)

Research Procedures

We consulted our final year project supervisor Miss Low Sew Kim to advice on sampling method and questionnaire construction before carrying out the pilot test. We first used 30 participants, which do not come from sample sizes to carry out pilot test. SPSS showed pilot test result had a good reliability, with Cronbach Alpha 0.754 and the Cronbach's Alpha based on standardized items is 0.734. We further distributed 210 sets questionnaire to collect information.

Data collection procedures took 3 weeks to complete, started on 12th October when we focused on Old Town Kampar and Mambang Di Awan Kampar, targeted at middle age adult and older adult. This had been continued until 26th October onwards, it is the time where he University student had been back to Kampar for school reopen. We gathered data mostly in New

Town Kampar targeted at young adult with tertiary education level. Participants need to sign informed consent to acknowledge their agreement to participate this research and as a promise from researcher to ensure, the confidentiality of all information provided is secure. The questionnaire consisted of two parts which are demographic variable to acquire basic information including gender, age and education level, and the second part, 40 questions of the CAMI Scale to assess stigmatization toward mental illness. The questionnaires were distributed to the participants if they agreed to participate in the study. They had been given 10 to 15 minutes to complete the questionnaire. Researchers explain to the participants the purpose of this research before participants start to answer the questionnaire. Eventually, out of 210 responses, only 180 respondents with complete answers is used to fulfil the strata until it is tallied with our pre-determined quantity. In these 180 sets of responses, we achieved 100% response rate. Then, we analysed, interpreted the information, and further used it for discussion and conclusion to explain on the findings.

Data Analysis

Statistical Package for Social Science (SPSS) 23th version had been utilized to run several tests, including t-test and one-way Anova. These tests helped to measure the differences between Independent variables, including gender, age and education level and Dependent variable which is a stigma toward people with mental illness.

Chapter 4

Finding and Analysis

Findings and analysis consist of two sections: descriptive statistics and inferential statistics. Respondent's demographic details, sum score was recorded according to its frequency, mean and standard deviation. 3 independent variables, including gender, age and education level and dependent variable (Community attitude toward mental illness) had been analysed according to the necessary statistical test

Descriptive Statistics

Table 1

Descriptive statistics for participant's gender, age groups and education level.

Gender	%	Age Groups	%	Education Level	%
Male	50.0	20-30	33.3	Primary	33.3
Female	50.0	31-59	33.3	Secondary	33.3
		60 above	33.3	Tertiary	33.3

Table 1 indicated that there were 180 respondents selected from three towns (Old Town, Mambang Di Awan and New Town Kampar). Participants had shown 100% response rate. In this research, gender, 3 age group and 3 education level were all equally distributed according to the predetermined allocated value.

In the category of gender, Male response rate was 50% or equivalent to 90 male participants, the female response rate was the remaining 50% or 90 females. For age group,

participants age 20-30 was 33% or 60 people, age 31-59 was 33% 60 people, and participant above 60 was 33% or 60 people as well. Lastly, education level category, participant with primary education altogether was 33% or 60 people, secondary was 33% or 60 people and tertiary education was 33% or 60 people as well.

Table 2

Descriptive statistics for Community Attitudes towards the Mentally Ill (CAMI) Scale: total score by gender

Gender	N	M	SD
Male	90	110.28	17.45
Female	90	113.03	11.26
Missing	0		

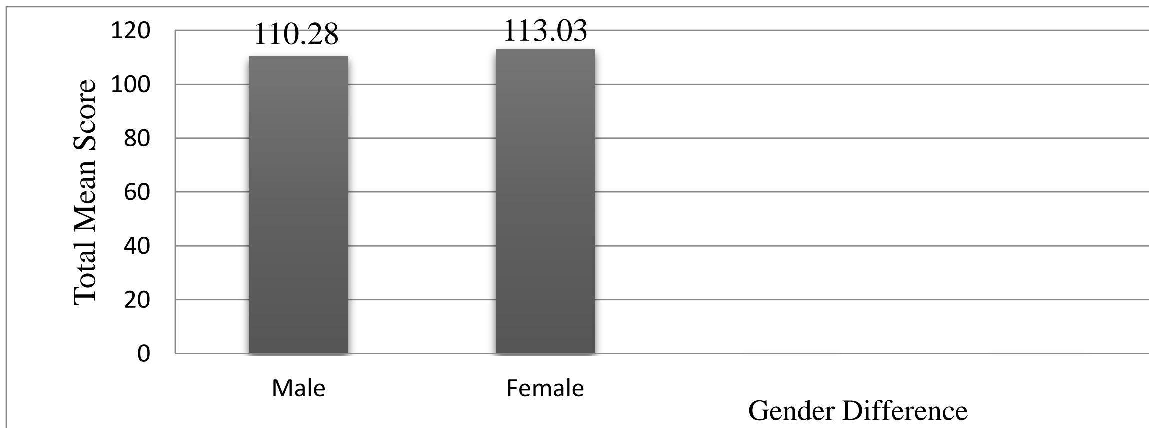

Figure 3.0: CAMI Scale total mean score by gender difference. Higher mean of male or female scores represents higher stigmatization towards mental illness.

The result had shown female participants (M=113.03, SD=11.26) scored higher than male participants (M=110.28, SD=17.45) in CAMI Scale. The higher the mean score represents higher stigmatization toward mental illness.

Table 3

Descriptive statistics for CAMI Scale: total score by age group

Age Group	N	M	SD
20-30	60	111.58	12.59
31-59	60	109.82	14.01
60 above	60	113.57	17.15
Missing	0		

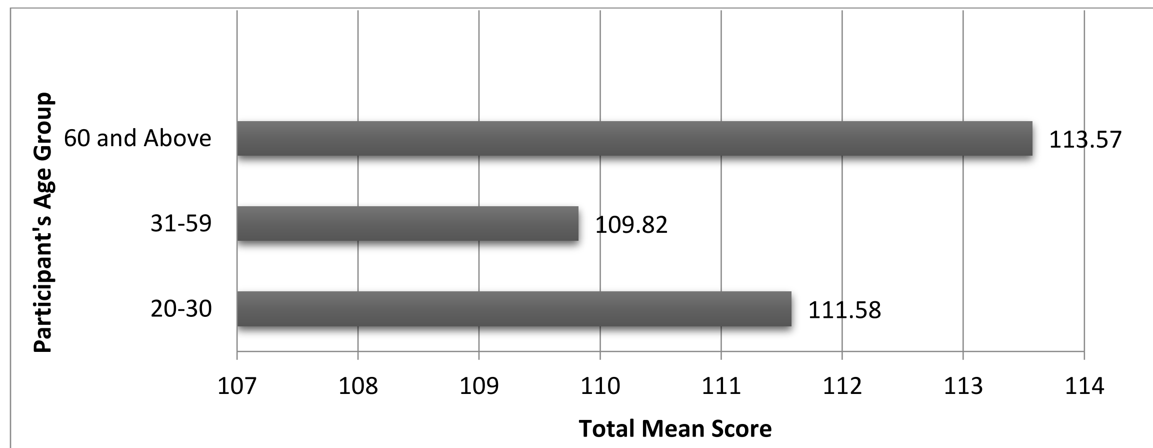

Figure 4.0: CAMI Scale total mean score by age groups. Higher mean score represents which age groups had higher stigmatization towards people with mental illness.

The result above showed that age group with 60 years above had higher scores (M=113.57, SD=17.15) than the age group with 31-59 years old (M=109.82, SD=14.01) and age

group with 20-30 years old (M= 111.58, SD=12.59) in CAMI Scale. The higher the mean score the higher the stigmatization toward mental illness.

Table 4

Descriptive statistics for CAMI Scale: total score by education level

Education level	N	M	SD
Primary	60	118.60	10.97
Secondary	60	112.25	13.64
Tertiary	60	104.12	15.58
Missing	0		

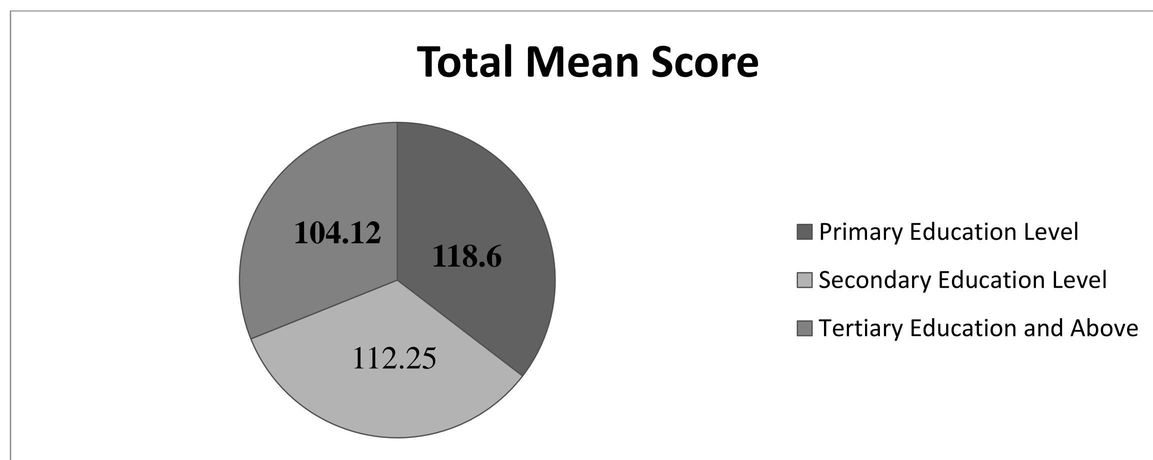

Figure 5.0: CAMI Scale total mean score by education level. Higher mean score represents which education level had higher stigmatization towards mental illness.

The result above showed that primary education had higher scores (M= 118.60, SD= 10.97) than tertiary educated participant (M= 104.12, SD=15.58) and secondary educated

participant (M= 112.25, SD=13.64) in CAMI Scale. The higher the mean score indicates the higher the stigmatization toward mental illness.

Inferential Statistics

Research question 1: Is there a gender difference towards stigmatization of mental illness?

Table 5

Differences between gender and public stigmatization towards mental illness.

Variable	M	SD	t	df	Sig.
Gender			-1.259	178	0.001
Male	110.278	17.454			
Female	113.033	11.256			

Note:* $p < 0.05$

Null Hypothesis 1, H_o: There is no any significant difference between gender difference and stigmatization of mental illness.

Research Hypothesis 1, H_1: There is a significant difference between gender difference and stigmatization of mental illness.

The findings of Independent sample t-test showed there is a significant difference between male (M =110.28, SD =17.45) and female (M =113.03, SD =11.26) in stigmatization towards mental illness; t (178) = -1.259, p < 0.05. The null hypothesis is rejected.

Research question 2: Is there any significant differences between age and stigmatization of mental illness?

Tables 6

ONE-WAY ANOVA between age and stigmatization towards mental illness

Source	Sum of squares	df	Mean square	F	Sig.
Between	422.34	2	211.17	0.976	0.379
Within	38308.30	177	216.431		
Total	38730.64	179			

*Note: $p < 0.05$

Null Hypothesis 2, H_o: There is no significant difference between age and stigmatization of mental illness.

Research Hypothesis 2, H_1: There is a significant difference between age and stigmatization of mental illness.

The result of ONE-WAY ANOVA showed there is no significant differences between age groups (early adulthood, middle adulthood and late adulthood) and stigmatization towards mental illness, $F(2, 177) = 0.976$, $p > 0.05$. Hence, Null hypothesis failed to reject. Additionally, among all the age groups, late adulthood (M =113.56, SD =17.15) scored higher in the CAMI scale than early adulthood (M =111.58, SD =12.60) and middle adulthood (M =109.82, SD = 14.02).

Research question 3: Is there any significant differences between level of education and stigmatization of mental illness?

Table 7

ONE-WAY ANOVA between education level and stigmatization towards mental illness

Source	Sum of squares	df	Mean square	F	Sig.
Between	6324.81	2	3162.40	17.27	0.000
Within	32405.83	177	183.08		
Total	38730.64	179			

*Note: $p < 0.05$

Null Hypothesis 3, H_o: There is no significant difference between level of education and stigmatization of mental illness.

Research Hypothesis 3, H_1: There is a significant difference between level of education and stigmatization of mental illness.

The result of ONE-WAY ANOVA showed there is significant differences between education level (primary, secondary and tertiary education level) and stigmatization towards mental illness, $F(2, 177) = 17.273$, $p < 0.05$. Hence, Null hypothesis is rejected. Furthermore, Primary education (M =118.60, SD = 10.97) was the highest in CAMI scale than Secondary Education (M =112.25, SD = 13.64) and Tertiary education (M = 104.12, SD = 15.59).

Chapter 5

Discussion and Conclusion

This chapter explained statistical result on how gender, age group and education level affected on public stigmatization toward people with mental illness.

Gender versus Public Stigmatisation toward Mental Illness

This had been assessed using Independent sample t-test. The result showed there is a significant difference between male (M = 110.28, SD = 17.45) and female (M = 113.03, SD = 11.26) in stigmatization towards mental illness; $t(178) = -1.259$, $p < 0.05$. The null hypothesis is rejected. Female showed higher stigmatization toward people with mental illness.

In Malaysia context, Al-Naggar (2013) carried on in Kuala Lumpur found similar findings where female had a higher stigma. Al-Naggar explained female generally has a restrained attitude towards people with mental illness, but the female tends to avoid close social contact with them.

Similar to Al-Naggar’s finding, Jackson and Heatherington (2006) found female expressed obvious social distance and intolerance towards people who exhibited obvious mental illness symptoms. Exhibition of intolerance and keeping a social distance help to ensure female safety regardless of potential harm a person with mental illness might cause.

Besides that, there are several results consistent with our findings, which found female has a more positive attitude than male (Barke, Nyarko & Klecha, 2011; Pankhurst, 2009; Balan, 1996). Balan explained female often see themselves physically as gentle and weaker, which creates them feel they couldn’t protect themselves when danger happened. When female think of

people with mental illness, they will automatically assume them as frightening and dangerous. Hence, the stigma is deepened and often thinks it is better to draw a distance from people with mental illness to protect themselves.

This research finding is in contrast with another finding which found male tend to have a higher stigma compared to female due to societal values and norms (Nii Munteh, 2014; Lowder, 2007). Researcher explained female tends to exhibit understanding and empathy character, while male are more likely to be conservative (Lowder, 2007). Female tend to see people with mental illness are a group of people who are marginalized by the society, more care and support are needed to be given to them. Hence, female showed more empathy towards people with mental illness and carrying lesser stigma. Lowder's findings in 2007 is not applicable to this research findings probably because female does show empathy and support toward people with mental illness but this is measured according to their own safety. Female understands the difficulties and hardships encountered by people with mental illness, but they will not risk everything to support. Because females are well aware that they are relatively weak physically and unable to protect themselves from any dangerous unforeseen even.

Besides, Asian's women are influenced by cultural value for being submissive and conforming to the authority, this is different from the western white woman, which emphasize a stronger sense of equality and assertiveness (Boggs, 2011). Asian's culture is not accustomed with female taking initiative in public or acting overt behaviour to help out because the female are seen to be more reserved. Any action deviated from social norms often raised attentions and negative comments. Hence, there are more cons than pros if females initiate to support and able to empathize people with mental illness although they are.

Age Group versus Public Stigmatisation toward Mental Illness

ONE-WAY ANOVA had been conducted, which found there is no significant differences between age groups (early adulthood, middle adulthood and late adulthood) and stigmatization towards mental illness, $F (2, 177) = 0.976$, $p > 0.05$. Hence, Null hypothesis failed to reject. In another word, there are no differences between early adulthood, middle adulthood and late adulthood in stigmatization towards mental illness.

This finding is similar to Papadopouls, Leavy and Vincent 2002. Research findings on the Greek-Cypriot community, it was reported that there was no significant difference between age differences and stigmatization toward mental illness. Regardless of age group, strong religious beliefs act as a confounding variable that play a vital role which exceeded the impact of age on the level of stigma. Greek Cypriot communities were taught to follow religious belief and customs since young. Hence, religious belief outweighs age factor on influencing mental illness stigma. Additionally, Gore (2012) in Spalding University also found similar finding. In our context, research found no significant differences between age and stigmatization, both held equally moderate stigma. Religious does impact on mental illness stigma. Our participant's religion includes Muslim, Buddhism, Christianity and Hinduism. These 4 religions emphasize humble and kind acts. People of all ages had been encouraged to attend religious services regularly. Young children had been cultivated positive values since younger and older age group were continued to attend religious services to meet the spiritual and social needs. Religious belief plays a vital role influencing the age of the participant. Stigma is in moderate level due to more positive religion, belief as compared to Greek-Cypriot community, religion belief which judge people with mental illness negatively.

On the contrary, previous findings from Malaysia by AR, Osman and Ainsah (2010) found middle age and older age held higher stigma compare to younger age groups. However, our research finding is also in contrast with several findings, which showed there was age differences in stigmatization toward mental illness (Park, 2013; Mowbray et al., 2006). The older age group held highest stigma while youngest age group held least stigma toward people with mental illness. This is perhaps young generation is frequently exposed to mental illness and had contributed to a more positive attitude; oldest age group held highest stigma because people with mental illness back in the 1950 era were seldom noticeable. Less exposure often causes less understanding and more misconception. Although our research found no significant difference, but the older age group stigma was still slightly higher than middle age and young age. Because exposure level was different from the past and now, but older age group stigma fell to a level similar to younger age because older age adult had seen more mental illness cases over the years, increasing exposure causes them to have a more accepting attitude.

In contrast, several researches found young adult had the highest stigma toward people with mental illness, (Pankhurst, 2009; Ahn, 2013; Morrison et al., 1993) Morrison and colleagues in 1993 found respondents particularly scored high in social restrictiveness and authoritarianism. Morrison and colleagues explained young adults often think people with mental illness as horrifying that might cause danger to them, hence young adults believed people with mental illness should not be allowed to expose or present in the public. This is different from our research findings because residents in Kampar district are more to rural area. Although residents have heard about the existence of many mental illness cases from social media, but most people seldom, have a chance to personally meet people with mental illness who exhibited overt

dangerous behaviour. Hence, this phenomenon does not raise alertness and extreme sense of dangerousness in any age group.

Education Level versus Public Stigmatisation toward Mental Illness

This had been assessed using ONE-WAY ANOVA, results showed that there is significant differences between education level (primary, secondary and tertiary education level) and stigmatization towards mental illness, $F (2,177) = 17.273$, $p < 0.05$. Hence, Null hypothesis is rejected. Education level effects of stigmatization towards people with mental illness. Tertiary education and above ($M = 104.12$, $SD = 15.58$) showed the lowest stigmatization toward mental illness, secondary education is ($M = 112.25$, $SD = 13.64$) and primary education showed the highest stigma ($M = 118.60$, $SD = 10.97$).

In Malaysia, Siti Zubaidah and Norfazilah (2012) found people with lower education tend to have a higher stigma due to insufficiency of knowledge about mental illness. Apart from this, several researchers also found similar findings, where lower education does contribute to higher stigma (Ahn, 2013; Pankhurst, 2009; Wolff et al., 1996). This is applicable to this research because people with tertiary education had exposed more to psychological related field such as psychology and counseling courses offered in universities and colleges. This includes 24 institutions that offer counseling courses and 42 institutions offering psychology in Malaysia (Hotcourses Malaysia, 2015) Moreover, counseling services are widely available to students in an educational setting nowadays, consultation for individual counseling or group counseling are readily available to acquire information nowadays. In 1960, ministry of education Malaysia implements counseling service in school, but the person in charge had to play 2 roles, as a teacher and as a counselor. In 1996, government implements full time counselor policy and later on 2000 onwards, ministry of education make it compulsory for every school to have at least one

full time counselor providing counseling service (See & Ng, 2010). Hence, people who received many years of studies, especially those acquired tertiary education had exposed and acquired information over the years, having more accurate information about mental illness, how it is form and how common it affects to surrounding people. Thus, this increases the openness and accurate understanding to mental illness.

Additionally, people with only primary education usually received minimal education, equip only with basic knowledge and simple language. Mental health had not been included in the education system. Hence, people who received only primary education tends to fixate their knowledge on what they have learnt in primary education instead of adjusting their world view.

Yeap and Low (2009) also found similar findings. They concluded lacks of knowledge are a major factor that affects the level of stigma. For example, schizophrenia among the Chinese are known as “Jing Shen Fen Lie Zheng”. Lay people usually misunderstand it as “split mind” which seemed to be dangerous that made them unable to accept people with mental illness.

On the other hand, this finding is in contrast with Ukpong and Abasiubong (2010), which found that people generally held highly negative stigma toward mental illness regardless of education level. In this research, Ukpong and Abasiubong further explained this result as an economic relationship. This research had been conducted in the low economic country- Nigeria where people are striving for financial and survival issues; hence, people with mental illness are viewed as creating more harm than good.

If this explanation is applied in Malaysian context, it explained why Malaysia showed a moderate level of stigma, and showed differences in education level. Overall, Malaysia is regarded as an economically stable country; people generally are self- sufficient with basic living.

Malaysia statistic showed unemployment rate Malaysia in 2015 is 3.2%, it is an East Asian Country that played an important role in manufacturing (The Heritage Foundation, 2015). Additionally, people with tertiary and above education tends to have higher self-support ability, hence this encouraged people to extend their help to people in need including people living with mental illness.

Limitations

There were several limitations of this study.

Firstly, the finding of this research is affected by the limited external validity. The data collected focused mainly on 3 towns in Kampar district, which is New town Kampar, Old town Kampar and Mambang Di Awan. Information gathered from these three places might not be accurately represented of people stigmatization of mental illness.

Apart from this, limited sample size is another weakness of this research. This research collected only 180 samples due to time constraint. With such limited quantity, it is difficult to generalize the result to the whole population in Kampar.

Besides that, many people, especially those in their late adulthood refused to participate in this research whenever the word “survey” and “mental illness” is mentioned. Misconception and conservatives make the people unapproachable to further share their opinion on mental illness. Some participants started to hesitate when they found this survey consisted of 40 items which are quite time consuming.

Next is the weakness of survey quota sampling design method. The questionnaire is distributed after the strata are allocated according to the predetermined number, then conveniently distributed to the people around. This research method is fast and easy to collect

data, but sample bias occurred (Baltimore County Public Schools Towson, 2010). Because researcher likely to have personal judgment and discrimination when distributing the data. Researchers are less likely to distribute to middle age male who sits in a gang at the coffee shop, with tattoo over the body. This inadvertently makes female researchers avoid seeking the opinion of their research. In such way, a bias result is produced, where researcher selectively chooses the participant according to people's appearance. Hence, skewed data collection happened and misrepresentation of data affected the result produced (Convenient sampling net, 2015).

Additionally, most research on Stigmatization toward mental illness contained further analysis on 4 subscales. This provided a detailed description on which characteristic or attitude people held. This research only provided a general idea on how demographic variables could impact the level of mental illness but does not include further analysis. Hence, information is limited to provide readers to understand more about stigmatization towards mental illness.

Moreover, this research does not the assess relationship between demographic variables and stigmatization toward mental illness. This research provides an overview about the differences, yet lack in showing the relationship about the variables.

Secondly, the limitation due to language barrier. This research used English and mandarin version CAMI questionnaires. Different languages used in questionnaires produced different interpretations and understandings on the items. Additionally, some participants who used Malay as their primary language encountered difficulties in fully understand the English version questionnaire, because the English version CAMI questionnaire was not direct and easy especially for those who only received primary education.

Thirdly, this research does not exclude other confounding variables that could affect the result, such as participant's exposure to mental illness. People's responses were likely to be affected by their experience. Apart from that, some participants held different understanding about the term mental illness. Some participants automatically assumed people with mental illness are "mad people", some participant automatically assumed people with mental illness are less severe, similar to those depressed patients.

Fourth, this research might be affected by Halo effect or impression management. Although we do not conduct interviews with the participant, but researcher usually stand aside to wait for the participant to complete the questionnaire. In such case, participants are awkward and felt being watched by others when answering the items, hence it affects how much they are willing to reveal and portray themselves. Additionally, some participants who used different mother tongue, such as Cantonese or Malay required the researcher to explain the meaning of the items. This makes them more conservatives when sharing their own thoughts and feeling, especially negative view to avoid judgment.

Fifth, in our literature review, we covered research within the past 10 years. Yet, there is lack of comparison between the past research which could serve as an important clue to see the overall trend over these 20 to 30 years. Besides, our literature review covered only from limited countries. Hence, we are unable to compare stigmatization toward mental illness between western and Asian Countries. Comparing Asian and Western countries facilitate researcher to postulate how different cultural values and societal norms could impact on mental illness stigma.

Recommendation

It is important to increase the sample size so that it can accurately represent the level of public stigmatization toward mental illness. Kampar consist estimate 15074 people, all towns in Kampar should be included in producing the findings. With the confidence level of 95% and marginal error 5%, it is estimated that 375 samples are needed to produce a result that can be generalized to the Kampar population (Select Statistical Services Limited, 2015). It is suggested that Stratified random sampling should be used to produce a more accurate answer. It reduced errors raised by a quota sampling method. By using stratified random sampling, it reduced the possible selection bias (Daniel, 2011).

Besides that, it is encouraged to use a shortened version of Community Attitude toward the Mentally Ill questionnaire to assess public stigmatization. Moreover, Attribution questionnaire (AQ-27) is recommended to be used, because it is relatively shorter, consist only 27 items with the reliability of Cronbach Alpha 0.88, this questionnaire consist 9 stereotypes using 9 point Likert scale (Sousa, Marques, Rosario, & Queiros, 2012). This is important because participant of all ages are invited to take this questionnaire. A shorter version and simpler form are highly needed for older participants to understand and to assess their opinion more accurately.

Apart from that, it is important to brief the participant on how we define " people with mental illness", including what is it about, the severity level in this research context instead of let the participant answer straight away based on their past impression and experience without detailed briefing.

The research could assess people thought and behaviour in more details through interviews or situational observation that allows people to reflect their actual opinion. Because questionnaire only tells, what a person assume instead of what a person will actually behave in a situation. Besides, assessing in such way could minimize the language barrier caused by questionnaire.

Recommendation for Future Research

Besides, it is recommended future research on stigmatization toward mental illness can be analysed in more detailed, which revealed the subscale score or what attitude people generally held to facilitate understanding and provide other information on tackling stigmatization toward mental illness issues. Besides, testing of the relationship between demographic variable is lacking in this research. Other demographic variables, including the influence of past experience, religiosity and the presence of the health care centre surround on stigmatization toward mental illness is worth exploring.

Besides, this research could only provide a general idea on public thought about mental illness. Respondents answer does not directly predict their actual behaviour. Hence, further assessment or quantitative study such as interview or situational observation is worth studied.

Implication of Study

This research provides an overview of current Kampar district stigmatization level toward mental illness; this increased the awareness and understanding about stigmatization toward mental illness and reminds the existence of mental illness stigma that should not be ignored.

Additionally, the findings showed there is a significant difference in gender and educational level in stigmatization toward mental illness. This result is able to provide a targeted group for people who would like to organize anti-stigma campaigns and those who would like to formulate new intervention. This assists them to focus on female, and people with primary education who held a high level of stigmatization toward mental illness.

Finally, this research can be used for mental health practitioners to compare their findings that had been carried out in other states in Malaysia or comparison between countries to generalize their findings, to increase their knowledge on which demographic variable affects mental illness stigma.

Conclusion

This study showed there is no significant differences between age (young adult 20-29years, middle adulthood 31-59 years, and older adult 60 years and above) and stigmatization toward mental illness. The result depicted there is a significant difference between gender (males and females) in stigmatization toward mental illness, which female showed higher stigma; the result also found there is a significant difference between education level (primary education, secondary education and tertiary education level), those who received only primary education showed the highest stigma, followed by secondary education level and lastly, tertiary education level.

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