

1 **Title: Views of young people in Malaysia on mental health, help-seeking and unusual psychological**  
2 **experiences.**

3

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## Young people's views on mental health in Malaysia

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33

### 34 **Abstract**

35 **Aim:** Mental health problems are prevalent amongst young people in Malaysia yet access to specialist mental  
36 health care is extremely limited. More context-specific research is needed to understand the factors affecting  
37 help-seeking in youth, when mental health problems typically have first onset. We aimed to explore the  
38 attitudes of vulnerable young Malaysians regarding mental health problems including unusual psychological  
39 experiences, help-seeking and mental health treatment.

40 **Methods:** In the present study, nine young people (aged 16 to 23 years) from low-income backgrounds  
41 participated in a semi-structured interview about their perspectives on mental health problems, unusual  
42 psychological experiences and help-seeking. **Results:** Four themes were developed using thematic analysis. "*Is*  
43 *it that they [have] family problems?*" reflected participants' explanatory models of mental health problems.  
44 "*Maybe in Malaysia*" was concerned with perceptions of Malaysian culture as both encouraging of open  
45 sharing of problems and experiences, but also potentially stigmatising. "*You have to ask for help*" emphasised  
46 the importance of mental health help-seeking despite potential stigma. "*It depends on the person*" addressed  
47 the challenges of engaging with psychological therapy.

48 **Conclusions:** We conclude that young people in Malaysia may hold compassionate, non-stigmatising views  
49 toward people experiencing mental health problems and a desire to increase their knowledge and  
50 understandings. Yet societal stigma is a perceived reputational risk that may affect mental health problem  
51 disclosure and help-seeking. We suggest that efforts to improve mental health literacy would be valued by  
52 young Malaysians and could support reduced stigma and earlier help-seeking.

53

54 **Keywords:** Stigma; psychosis; youth mental health; help-seeking; early intervention

55 **Introduction**

56 Malaysia is a ethno-culturally diverse Southeast-Asian country of 32-million people with a high  
57 prevalence of mental health problems; estimated at 30-40% among adults (Institute for Public Health, 2015;  
58 Khoo, 2017; Ting & Ng, 2012). Adolescence to young adulthood is associated with elevated mental ill-health  
59 worldwide (Kessler et al., 2005) and perhaps especially so in Malaysia, where the youth prevalence of 20%  
60 (NoorAni et al., 2015) exceeds the global youth prevalence of 13.4% (Polanczyk, Salum, Sugaya, Caye, & Rohde,  
61 2015) yet access to mental health care is particularly limited by scarce resources and high stigma, especially for  
62 severe mental health problems (Hanafiah & Bortel, 2011; Institute for Public Health, 2015; Razali & Ismail,  
63 2014; Shoesmith et al., 2017). Accordingly, the mean Duration of Untreated Psychosis (DUP) in Malaysia is  
64 greater than three years (Chee, Muhammad Dain, Abdul Aziz, & Abdullah, 2010) which exceeds reported UK  
65 averages of 2-21 months (Cotter, Zabel, French, & Yung, 2017). Suggested causes of high youth prevalence in  
66 Malaysia include economic inequality, childhood adversity, and socio-familial and academic pressures (Kok &  
67 Lai, 2017; NoorAni et al., 2015).

68 In the UK and beyond, mental health stigma can reduce help-seeking due to individuals' fears about  
69 the negative consequences of disclosure and the desire to distance oneself from unattractive societal  
70 stereotypes of mental health patients (Clement et al., 2015; Plaistow et al., 2014). Context-specific research is  
71 needed to develop more accessible and acceptable mental health services, particularly for high-risk youth.  
72 Only one known study has addressed barriers to mental health help-seeking among young Malaysians,  
73 focusing on attitudes of Malaysian-Chinese high school students towards school counselling (Chen & Kok,  
74 2017). Identified barriers included self-stigma and anticipated stigma ('shameful' self); believing the problem is  
75 not serious or is one's own responsibility ('responsible' self); lacking courage ('fearful' self) or time ('busy' self)  
76 for help-seeking; concerns about counsellors' competence ('concerned' self); and the availability of alternative  
77 non-formal support ('resourceful' self).

78 Malaysian studies involving adult—or unknown age—mental health patients and professionals are  
79 also limited but have highlighted concerns regarding experiencing and seeking help for mental health  
80 problems relating to self-stigma and experienced stigma and discrimination, rejection by family members and  
81 broader society and social isolation (Low, Lee, & Jacob, 2017; Shoesmith et al., 2017). Mental health symptoms  
82 have been mainly described in terms of behavioural changes or unusual experiences like hearing voices, and

83 typically ascribed to psychological, spiritual and environmental causes (Shoesmith et al., 2017). Studies have  
84 suggested that traditional faith healers are commonly consulted as a first response to perceived symptoms;  
85 either to discount spiritual causes or else to provide spiritual intervention (Phang, Marhani, & Salina, 2010;  
86 Shoesmith et al., 2017). Simultaneously, concerns have been expressed about whether psychiatric or  
87 psychological treatments are helpful or 'curative' or perhaps are more akin to being imprisoned i.e. in the case  
88 of hospital-based treatment (Low et al., 2017; Shoesmith et al., 2017).

89 We aimed to explore young people's attitudes towards mental health and help-seeking in Malaysia  
90 and, in the context of potentially high stigma, attitudes regarding unusual experiences and serious socially  
91 disabling mental health problems such as psychosis. Our research question was how do young people describe  
92 their own and others' experiences of and attitudes toward mental health problems, help-seeking and  
93 treatment?

94

## 95 **Methods**

### 96 ***Design***

97 A qualitative cross-sectional design involving a qualitative semi-structured interview was used to  
98 acquire a detailed in-depth understanding of young peoples' attitudes towards mental health, help-seeking  
99 and treatment. This study was embedded in a larger pilot of the feasibility and acceptability of a social  
100 recovery measurement and treatment approach in Malaysia (Berry et al., submitted).

101

### 102 ***Participants***

103 We aimed to recruit six to ten participants as appropriate for a small-scale project (Braun & Clarke,  
104 2013). Nine young people (five male, four female,  $M^{age}=19.78$  years,  $SD=2.86$ , range 16-23) were recruited in  
105 July-September 2017 from a full residential non-government education and mental health social enterprise  
106 (NGO) and three partner organisations in Peninsular Malaysia. The referring organisations provide residential  
107 accommodation, education and vocational support for vulnerable young people living in low-income areas  
108 associated with high criminality and poor education. Inclusion criteria were: aged 16-30 years, able to provide  
109 informed consent, and identified as a vulnerable young person due to current use of a referring service.  
110 Personal experience of mental health problems and/or a related diagnosis were not part of the study's

111 eligibility criteria. Potential partner organisations and potential participants were first approached by NGO  
112 staff members. Consent to approach young people aged under 18 years was sought from caregivers although  
113 all participants, including 16 and 17-year-olds, were asked to provide their own individual written informed  
114 consent for participation in the study. Potentially interested young people were provided with information  
115 about the study. Young people who expressed interest in participating were subsequently invited to attend an  
116 interview with a researcher and an interpreter. All young people provided written informed consent before  
117 participating in the study. We sampled across major ethnic groups using a convenience sampling approach  
118 whilst maximising ethno-cultural diversity: Indigenous Orang Asli (n=2), Malay (n=2), Chinese (n=2) and Indian  
119 (n=3). Four participants were referred by the NGO's educational arm and five from partner organisations  
120 (three from looked after children's residences or orphanages, two from an education provider). No  
121 approached participants declined. One additional orphanage was approached but did not refer any potential  
122 participants, with reasons unknown. Another referred young person was not consented due to a serious  
123 learning disability negating ability to provide informed consent. Three participants identified as Christian, two  
124 as Muslim, two as Buddhist, and two as having their 'own beliefs'.

125

## 126 ***Procedure***

127         The current study was part of a larger pilot focused on the feasibility of a social recovery approach in  
128 Malaysia (Berry et al., submitted). Ethical approval was provided by the University of Sussex (CB/321/8) and  
129 relevant local consents were obtained in recognition of the UK ethical approval. After providing written  
130 informed consent, participants engaged in one session in which data were collected for the larger pilot (Berry  
131 et al., submitted) and present study. Participants first completed assessments of their time use and mental  
132 health, including anxiety, depression, and unusual experiences. Although we did not specifically screen for  
133 psychopathology, most participants indicated significant social and mental health needs on a battery of self-  
134 report measures. Three quarters (n=7, 77%) reported structured activity that was below the UK normative  
135 level (64 hours of structured activity per week; Short, 2006) for a similar age cohort, with one-third (n=3) also  
136 scoring below the clinical threshold for being at risk of social disability (45 hours of structured activity per  
137 week; Hodgkins et al., 2015). In addition, four participants (44%) scored above an established clinical cut-off  
138 for psychosis risk (Prodromal Questionnaire; Ising et al., 2012)) and six participants (75%) scored in the

139 borderline (37.5%) or 'abnormal' (37.5%) range for emotional and behavioural problems (Strengths and  
140 Difficulties Questionnaire (Goodman, 2001)). Comparison of SDQ scores with a larger population of  
141 adolescents from low-income areas of Greater Kuala Lumpur (Abdul Kadir, Mustapha, Abdul Mutalib, & Yakub,  
142 2015) suggests our sample reflects the larger target population but may have particularly pronounced  
143 emotional (37.5% 'abnormal') and peer problems (25% abnormal). More information about the sample is  
144 presented in our companion paper (Berry et al., submitted)

145 A subsequent semi-structured qualitative interview (16-42 minutes duration) was completed by the  
146 English-speaking first author with an interpreter providing forward-backward interpretation. All interpreters  
147 (N=6) were NGO staff (therapists and/or programme directors), allowing for signposting or treatment provision  
148 if necessary. Interviews were audio-recorded using a digital recorder with participant permission and the  
149 English content was transcribed verbatim. Data collection was conducted over two weeks in September 2017.  
150 The qualitative semi-structured interview schedule (see Table 1 for examples) was derived from the PRODIGY  
151 trial of Social Recovery Therapy for 16-25 year olds with social disability and complex mental health problems  
152 (Gee et al., 2016; Notley et al., 2015). The current paper reports data related to experiences of and attitudes  
153 towards mental health problems, unusual experiences, help-seeking and treatment.

154

### 155 ***Analysis***

156 A seven-step thematic analysis (Braun & Clarke, 2006, 2013) was undertaken with a critical realist  
157 epistemological stance (Bhaskar, 2014; Fletcher, 2017). The first step involved the transcription of all  
158 interviews by the first author (Braun & Clarke, 2013). Step two involved re/reading all transcripts and noting  
159 potentially interesting features of the data (Braun & Clarke, 2006, 2013).

160 Steps three (coding) involved 'complete' coding; paying attention to all 'units' of data (Braun & Clarke,  
161 2013). Researcher reflections and responses were noted in brackets on the transcripts. At least two authors  
162 independently coded 80% of the transcripts and noted salient features and candidate themes. Within the  
163 critical realist epistemic position—in which the perception of the ontologically true reality occurs through the  
164 lens of human interpretation (Bhaskar, 2014; Fletcher, 2017)—inter-rater reliability was not sought; rather  
165 independent coding was used to increase analytic credibility by combining alternate perspectives into the final

166 results. Two independent coders had acted as interpreters and their analytic involvement allowed an  
167 additional credibility check for data transcription and comprehension.

168 Searching for themes (step four) involved considering the presence of shared ideas, descriptions and  
169 meanings across participants (Braun & Clarke, 2006, 2013). Under the critical realist approach, the data were  
170 interrogated for 'demi-regularities', noting instances of contradiction and divergence and considering potential  
171 explanatory socio-cultural mechanisms (Fletcher, 2017). Steps five (reviewing themes) and six (defining and  
172 naming themes) involved focusing on themes reflecting a Central Organising Concept (Braun & Clarke, 2013).  
173 We sought to name themes using participant quotes in order to foreground their perspectives from the outset.  
174 All authors reviewed the thematic framework for coherence and parsimony. Stages five and six were also  
175 influenced by reviewer and editor comments on the initial manuscript.

176

## 177 **Results**

178 Four overarching themes were identified: 1. *"Is it that they [have] family problems?": Making sense of mental*  
179 *health problems*; 2. *"Maybe in Malaysia": Cultures of sharing and shame*; 3. *"You have to ask for help"*; 4. *"It*  
180 *depends on the person": Engagement in treatment is perceived as challenging and is not always beneficial*. The  
181 themes are presented below with illustrative quotes.

182

### 183 ***"Is it that they [have] family problems?": Making sense of mental health problems***

184 Participants reported limited knowledge of mental health problems yet were able to generate varied  
185 ideas regarding the nature of and possible explanatory models for mental health problems. Participants  
186 generally reported limited personal experience, knowledge and awareness of mental health problems:  
187 *"...never encounter this kind of thing...I have no idea"* (Participant 2; P2). However, direct and indirect  
188 experiences emerged on further probing. One participant described moving from a position of unfamiliarity to  
189 one of greater understanding upon leaving her village and engaging with people outside of her immediate  
190 cultural community:

191 *"Before I didn't know about mental health, I think the mental health like the 'crazy people' and I*  
192 *think...they might like not really [be] okay...so the people will call them...'mental problems'...but now when I*  
193 *came here, I learnt a bit about mental health so I know...what is the mental health". (P3)*

194 Despite a self-identified lack of knowledge, participants were nevertheless able to share ideas about  
195 causes of mental health problems. Two participants described mental health problems as related to individual  
196 thinking styles: "...a person that think different like" (P8); "...the way you think is like an illness" (P9). Other  
197 participants identified an influence of something external or 'other'; conceptualising mental health problems  
198 as spiritual in nature or as responses to trauma or drug use. These ideas were partially based on observations  
199 of friends and relatives:

200 *"Voices if like their families' voice, is it that they family problems? Maybe they are mental because of*  
201 *their problems in past...trauma". (P5)*

202 *"Most of the time when the person suffer from mental illness, he or she may have experienced*  
203 *something which is very harsh to her". (P9)*

204 *"My friend...overdose, overdose...too much drugs...hear voices, someone screaming". (P7)*

205 *"I did have a cousin, she said she can see something...different from others...they bring her to temple,*  
206 *you know, all the Chinese believe and say then she actually has...like a sixth sense". (P9)*

207 One participant also showed an awareness of severe mental health problems like schizophrenia, and  
208 positioned people experiencing this kind of problem as potentially dangerous. The participant also invoked a  
209 sense of public and police powerlessness with respect to resolving issues involving people with serious mental  
210 health problems:

211 *"[W]hen he and his friends went out to town and everything...when he saw [a] guy like...yeah 'crazy*  
212 *people'...he say...like even though they with many friends they feel scared because...that person can harm*  
213 *him...since they are not sane, the police can't do...cannot charge him obviously...so yeah, that person can do*  
214 *anything to them". (Interpreter/P7)*

215

### 216 ***"Maybe in Malaysia": Cultures of sharing and shame***

217 Participants expressed competing cultural discourses in Malaysian society. These encompassed  
218 representations of mental health problems as a deficit or weakness, acceptance of other people and their  
219 experiences, and a cultural emphasis on providing others with emotional support. Some participants suggested  
220 that disclosing mental health problems is not acceptable within Malaysian society, in which the dominant  
221 discourse equates mental health problems with weakness:



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222 *"[I]n Malaysia...it's quite uncommon...[people] don't really want to let other people know they have*  
223 *mental health problems, they are scared to be viewed [by] their weakness...maybe in Malaysia, they are quite*  
224 *close-minded." (P2)*

225 One participant cautioned against a perceived tendency for Malaysians to publicise mental health  
226 problems too widely: *"...not show off to other people you know is good...[Malaysians make bad things go] viral,*  
227 *you know?...Yeah yeah tell everyone" (P6)*. Irrespective of the commonality or otherwise, disclosure was  
228 thought to potentially incite stigma-related discrimination, including changes in other people's views of the  
229 individual and also in the experience of more direct discriminatory behaviours: *"They feel like something*  
230 *strange...they think I am strange person" (P8); "Maybe they would spread news about me like...bad image or*  
231 *something" (P2)*. Intimate established relationships were positioned as more accepting: *"I think most of the*  
232 *people share mostly to their family or their friends, close friends" (P9)*.

233 However, wider stigma concerns were balanced against other views of Malaysian culture as accepting  
234 of disclosure: *"Any kind of problem that you have...I can share that, yeah he will share" (Interpreter/P7)*

235 Some participants acknowledged a sense of confusion or 'strangeness' when encountering other  
236 people with unusual beliefs that they themselves did not share: *"I feel like very strange...it really doesn't exist*  
237 *ghosts in this world... might be they believe, might be their opinion...I don't think so" (P8)*. However,  
238 participants expressed compassionate views towards people with unusual psychological experiences and  
239 mental health problems, and did not appear to conflate personal and 'illness' identity;

240 [Interviewer] *"...a type of mental health problem...where people maybe see strange things, they might*  
241 *hear voices, noises. They might have beliefs, maybe about aliens, or demons...Have you met anyone like that*  
242 *before?"*

243 P8: *"I met them... in the community... mostly all girls [Ia] mostly all like sisters... my sisters... sister's*  
244 *friends... but I put [their problems] aside, I don't think...I don't think [of] them as that way, so I think they are*  
245 *normal person to me, like a friend" (P8)*

246 Participants emphasised their willingness to listen and offer support to friends, family and generalised  
247 'others': *"I hope that they would talk to me if they need...if they need help or anything" (P2)*. This willingness  
248 came with the caveat that they may lack the requisite knowledge or vocabulary to offer the most appropriate  
249 response; *"I think it's okay...but sometimes wrong [to talk to people with mental health problems]...because*  
250 *I'm not psychologist...sometimes we use the wrong word to them" (P3)* or take the most appropriate action to

251 really understand the person's difficulties; *"[I]t is better to see counsellor first, better than talk to anyone*  
252 *else...because the counsellor can ask people around him about the issues"* (Interpreter/P6).

253 . Some participants disclosed emotional problems and identified normalising responses from others, with  
254 acceptance from 'higher-status' individuals perceived as especially helpful by one participant:

255 *"Sometimes when I told that I got nervous, then they they said "[D]on't worry, because we are same".*  
256 *If he higher than me but...because he said "We are all human being" and then I feel better".* (P1).

257

### 258 ***"You have to ask for help"***

259 Participants suggested that mental health stigma can obstruct help-seeking, while also emphasising  
260 that obtaining support for psychological difficulties is of key importance—especially for serious problems.

261 Stigma was clearly identified as a barrier to formal help-seeking; potentially preventing or delaying disclosure  
262 and help-seeking:

263 *"[M]ost of the people I would say they will think 'Oh to consult psychologists is because they have*  
264 *mental illness', they will come, this kind of thought will come to their mind... [whether help-seeking is*  
265 *acceptable] depends on the person".* (P9)

266 *"[feel] ashamed or something"* (P2)

267 Yet participants emphasised the importance of help-seeking for emotional or mental health problems:

268 *"That is the...important one, you have to ask for help"* (P1). Help-seeking was expressed as an agentic act,

269 involving an active process of asking for help and being willing to directly and actively confront their problems:

270 *"[T]hose people who are willing to face their problems, they would go to the therapy...but some might*  
271 *be escaping, they don't want to face their problem and they would refuse to go".* (P2)

272 Both formal and informal help-seeking seemed to be contingent on the nature of the problem, with

273 severe and acute problems more likely to generate disclosure both to professionals and more generally to

274 other people:

275 *"[H]e didn't share to anyone those feelings [of nervousness or shyness] ...this kind of situation is quite*  
276 *normal so he rarely shares with other people unless the things that will be serious for him"* (Interpreter/P5)

277 *"If I really have those symptoms then maybe I would tell my friends then, if my symptoms getting*

278 *serious then I probably would consult [professionals]"* (P9)

279 One participant endorsed others' formal help-seeking, although seemed sceptical that anything could  
280 really impact on his own mental health: *"It's a good thing as well...[getting professional help] would be*  
281 *okay...yeah [I would] still be their friend...[My mental health is] in the middle...no, I not in control...I don't think*  
282 *other people are in control... maybe is luck... not sure"* (P8).

283

284 ***"It depends on the person": Engagement in treatment is perceived as challenging and is not***  
285 ***always beneficial***

286 Participants endorsed psychological therapy as a potentially helpful approach for improving general  
287 wellbeing and addressing specific problems. However, participants also recognised that psychological therapy  
288 can be a challenging endeavour. Participants exhibited some knowledge of psychological therapy and shared  
289 some suggested benefits with respect to understanding and being able to help with both specific problems and  
290 broader changes in ways of thinking:

291 *"[W]e would ask the person to consult a psychologist...or talk to a person who really can help...a*  
292 *doctor... psychologist can help I think"* (P3).

293 *"I have heard of a counsellor...a counsellor solves a problem while the person is having trouble with*  
294 *their problems"* (P8)

295 *"I think [therapy] is helpful because...even though the normal people also can go to the therapy*  
296 *and and share their problem with them and maybe their problem better...because they can help the people*  
297 *that...always have problem, or people not have problem, but if they want to be different...thinking like"* (P3).

298 One participant positioned psychological therapy as effecting meaningful change and contrasted this  
299 with the more temporary or superficial 'fix' associated with medication: *"Medication, I don't think that can*  
300 *actually cure the illness, it's just help to stop it from hap...stop it for temporarily"* (P9). Yet participants  
301 appeared to perceive the benefits of psychological therapy as contingent on the agentic act of truly engaging  
302 with the process; something that was seen to be a challenging and potentially painful process for client and  
303 possibly even for the therapist:

304 *"For some people, [therapy]will settle their problems and some of them not say because...even say the*  
305 *certain thing it will come back to them"* (P5).

306 *"Malaysian people are very strange...not everybody would talk...some they are very*  
307 *rude...[Psychologists in Malaysia] would need to be brave...sometimes [Malaysian people] might hurt*  
308 *them...with their words or actions...If the psychologist say something good, they might not want to think*  
309 *twice...because of trauma"* (P5).

310 Thus, there appeared to be some sense in which the establishment of a positive alliance with a  
311 therapist might be challenging for young Malaysians. In keeping with this, one participant appeared to be  
312 suspicious of psychologists and their practices:

313 *"As a psychologist for her, she feels that it is a person who goes in the brain and they they kind of take*  
314 *informations"* (Interpreter/P4)

315 *"I can't believe psychology...because it's the lies. The man, the psychology one...the girl tell her story*  
316 *but the guy go tell all round tell all the story...tell all the stories about her...and so she, she felt sad...now I know*  
317 *this, I don't like psychology"* (P4).

318 One participant similarly positioned spiritual treatments as not universally 'curative' although did not  
319 explicitly cite any relation to potential difficulties in engaging with the treatment:

320 *"[I]t depends on the person...some will think is helpful but some will think it's not helpful...A lot of*  
321 *Chinese people they go to temple and...you have to, to drink [traditional medicine], some people would think*  
322 *helpful, some would be nothing"* (P9).

323

## 324 **Discussion**

325 We present the first known study exploring young Malaysians' experiences of and attitudes toward  
326 serious socially disabling mental health problems, unusual psychological experiences, help-seeking and  
327 treatment. Our findings suggest that vulnerable young people in Malaysia who do not identify as having  
328 experienced mental health problems may have limited knowledge of mental health problems and unusual  
329 psychological experiences yet appear to hold compassionate views towards people with these problems. Some  
330 participants suggested that openly sharing any problems was culturally endorsed whereas others identified  
331 mental health stigma as a genuine reputational risk. The discrepant empirical realities in the self-identification  
332 as never having experienced mental health problems—despite contrary assessment scores (Berry et al.,  
333 submitted) and emergent qualitative descriptions of mental distress—may reflect sociocultural causal

334 mechanisms (Fletcher, 2017). For example, modern Malaysia marries more traditionally collectivistic cultures  
335 which emphasise conscientiousness and the desire to 'save face' (Mastor, Jin, & Cooper, 2000; Santos,  
336 Varnum, & Grossmann, 2017) with increasingly wide-spread social media use. The latter encourages open,  
337 expressive and disclosive communication and gives voice to difference and dissent (Kutty & Sreeramareddy,  
338 2014; Willnat & Aw, 2014). Participants' apparent curiosity regarding mental illness—despite associated  
339 stigma—seems to reflect the cultural importance placed on education and learning (Verbik & Lasanowski,  
340 2007).

341           Most participants emphasised their willingness to support others affected by mental health problems.  
342 Help-seeking was an agentic act and seeking professional support became more important and more likely as  
343 the problems' severity increased. Psychological therapy was positioned as more beneficial than medication or  
344 informal support, especially for serious problems. Nevertheless, psychological therapy was presented as  
345 something challenging, with full engagement in the potentially painful process underpinning potential  
346 benefits.

347           Our findings resonate with previous research involving Malaysian-Chinese students (Chen & Kok,  
348 2017). Our participants echoed concepts of 'shameful' and 'fearful' selves, in suggesting that people with  
349 mental health problems might feel ashamed and want to 'hide' from their problems. The 'concerned' self was  
350 reflected by one participant who considered psychologists untrustworthy. Current participants did not suggest  
351 that individuals should take sole personal responsibility for mental health problems ('responsible' self) but did  
352 endorse support-seeking from friends or family for less severe problems ('resourceful' self). Our findings  
353 reflect a clear awareness of societal stigma in keeping with that reported by Shoesmith et al. (2017) who  
354 interviewed adult patients and their relatives, mental health professionals, faith healers, and 'village-heads' in  
355 an East Malaysian state in Borneo. Our findings also support previous suggestions of limited mental health  
356 literacy amongst Malaysians (Furnham & Hamid, 2014; Yeap & Low, 2009), although our participants seemed  
357 clearly interested in developing their knowledge and understandings of mental health problems. Targeting  
358 young people in Malaysia directly with educational awareness-raising campaigns could capitalise on this  
359 interest. Such campaigns could counteract the perspective that formal mental health treatment is purely for  
360 treating acute and severe problems—potentially thus invoking an extremely high threshold for help-seeking—  
361 and instead support early intervention. This could help to reduce the long average DUP (Chee et al., 2010) as  
362 long as service capacity is increased to be able to support early intervention service provision. Appropriate

363 early intervention might include assessments of mental health and unusual experiences, as young people in  
364 Malaysia appear to find completing such assessments psychoeducational in their own right (Berry et al.,  
365 submitted).

366

367 **Limitations**

368         Whilst efforts were made to represent young people from different ethnic and cultural communities,  
369 the generalisability of the current findings are limited by the small convenience sample. We recruited diverse  
370 participants as we felt that ethno-cultural diversity may give rise to differing perspectives that were interesting  
371 and relevant to our analytic goal, yet we did not *a priori* aim to pursue thematic saturation. The inclusion of  
372 additional participants, therefore, may have yielded alternative perspectives. The relatively short duration of  
373 interviews may have reflected some loss of richness in the data. The relatively short duration of interviews,  
374 and use of interpreters, might have affected the richness of available data. The brevity of interviews may  
375 reflect participants' characteristic use of 'Malay English', which is typically very efficient, i.e. shortened and  
376 simplified in sentence construction, compared to British English (Yamaguchi & Deterding, 2016). The identity of  
377 the researcher as a White British female may also have impacted on the study. In the context of stigma  
378 concerns, the perception of the interviewer as being 'outside' participants' own communities may have  
379 elicited relatively open responses, which may have contributed to the participants' apparent movement from  
380 denial to sharing of mental health knowledge and experience. Recruiting from an NGO working with  
381 vulnerable young people may have resulted in participants who were more accepting of mental health  
382 problems than the wider youth community. Moreover, whilst the focus on perspectives of vulnerable young  
383 people is a key strength of this work, yet the family, peer and community contexts are clearly important and  
384 likely to impact on young people's attitudes and behaviours. Further exploration involving parents and other  
385 important community figures and 'culture-carriers' like teachers is warranted to produce a more complete  
386 picture of culturally-relevant approaches to early intervention in youth mental health. The current findings  
387 reflect attitudes toward mental health help-seeking in a vulnerable population. Current participants appear to  
388 show indicators of risk in relation to mental health and social disability and may have need of mental health  
389 support, yet do not report mental health problems or experience of formal help-seeking or treatment.  
390 Exploring perspectives of other groups, including young people accessing formal treatment, and identifying  
391 attitudinal predictors of help-seeking intention and behaviour would be worthy future endeavours.

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**Conclusions and implications**

Young people in Malaysia may perceive themselves as having limited detailed knowledge about serious mental health problems and unusual psychological experiences, yet formal and informal help-seeking are both nevertheless endorsed as credible and necessary. This is despite societal stigma around mental health, suggesting that young people can make a distinction between 'unhelpful' attitudes and practices in the prevailing discourse and their own agentic views about supporting their own and others' emotional well-being. We suggest that despite potentially high stigma in Malaysia—especially regarding schizophrenia and psychosis—young people appear curious and eager to discuss their own mental health and increase their knowledge and understandings about mental health problems and unusual experiences. Our findings also suggest that help-seeking behaviours appear to be contingent on the perceived severity of problems. A key implication of this study concerns the potential to harness young people's curiosity about mental health problems and unusual psychological experiences. Context-specific mental health awareness campaigns may be positively received by young people and could be used to counteract mental health stigma and promote help-seeking for vulnerable groups. The apparent willingness of young people to support friends and family with psychological difficulties also raises the prospect of directly involving young people as positive mental health schema 'culture carriers' within communities, i.e. disseminating and promoting non-stigmatising messages and encouraging help and support-seeking across generations. At the same time, service development is needed to strengthen capacity within the formal mental health care sector, which should be integrated with appropriate community-led interventions and screening programmes.

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420 **Conflict of interest**

421 The authors report no conflicting interests.

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536 **Table 1: Examples from semi-structured interview schedule**

Topic	Example question	Example prompts
<b>Mental health problem experiences</b>	<b>In your own words, could you tell me about your experiences of psychological difficulties?</b>	<ul style="list-style-type: none"> <li>• <i>first experiences (such as hearing things that others don't, feeling paranoid)</i></li> <li>• <i>progression of experiences or symptoms</i></li> <li>• <i>problems with relationships/social life/school/work</i></li> <li>• <i>stigma (ideas and understandings of mental health problems and unusual experiences, encountering other people with mental health problems)</i></li> </ul>
<b>Mental health problem experiences/ stigma</b>	<b>How do your psychological difficulties affect you as a person?</b>	<ul style="list-style-type: none"> <li>• <i>affect on beliefs about self</i></li> <li>• <i>other people's responses</i></li> <li>• <i>affect on time use, activity, family life</i></li> <li>• <i>affect on values and goals</i></li> </ul>
<b>Mental health problem experiences/ stigma</b>	<b>What was it like for you when we asked you about your thoughts and experiences, hearing voices, feeling afraid of other people etc.?</b>	<ul style="list-style-type: none"> <li>• <i>experience of being asked about problems with mood, anxiety, beliefs about self, unusual experiences</i></li> <li>• <i>is it okay to share these types of experiences?</i></li> <li>• <i>what factors affect how okay it is to share these kinds of experiences?</i></li> <li>• <i>who can these experiences be shared with, if anyone?</i></li> </ul>
<b>Mental health treatment</b>	<b>Could you tell me, again in your own words, about any involvement with mental health services?</b>	<ul style="list-style-type: none"> <li>• <i>understandings of mental health treatment</i></li> <li>• <i>engagement with services</i></li> <li>• <i>relationships with staff</i></li> </ul>

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