

International Journal of Agriculture Extension and Social Development

Volume 9; Issue 6; June 2026; Page No. 06-13

Received: 08-03-2026
Accepted: 14-04-2026

Indexed Journal
Peer Reviewed Journal

Mental health awareness among university students and associated contributing factors: A descriptive study at Govind Ballabh Pant University of Agriculture and Technology, Pantnagar

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DOI: <https://www.doi.org/10.33545/26180723.2026.v9.i6a.3654>

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Abstract

Background: Mental health disorders among university students represent a growing public health challenge globally. Despite increasing prevalence, mental health awareness, help-seeking behaviour, and institutional support utilisation remain insufficient, particularly within Indian agricultural university settings.

Objectives: This study aimed to: (1) assess the level of mental health awareness among undergraduate students at Govind Ballabh Pant University of Agriculture and Technology (GBPUAT); (2) identify contributing factors associated with mental health stress; and (3) examine help-seeking patterns, coping strategies, and institutional support awareness.

Methods: A descriptive research design was employed. Data were collected from 227 undergraduate students (total population N = 923) through a structured 22-item questionnaire administered via Google Forms and offline channels using convenience sampling. The instrument covered demographic information, mental health exposure, attitudinal beliefs (4-item, 5-point Likert scale), stress frequency and sources, social media impact, coping mechanisms, and awareness of university services.

Results: A total of 227 students responded (response rate 24.6%). The study found that 97.8% had heard about mental health awareness, yet only 26.0% rated their knowledge as 'very good'. The composite Mental Health Awareness Index (MHAI) yielded a mean of 3.95 (SD = 0.96) out of 5.00. Academic pressure (76.2%), career uncertainty (66.1%), and family expectations (59.0%) were the leading stress contributors. Only 8.4% sought professional counselling when distressed, while 23.3% spoke to no one. Female students recorded significantly higher MHAI scores (M = 4.23) compared to male students (M = 3.75). Second-year students reported the highest burden of frequent stress (53.4% 'often/always'). Awareness of university mental health services was 54.2%, with a notable decline to 44.8% among fourth-year students. A Pearson correlation of $r = 0.171$ was found between MHAI and academic stress frequency.

Conclusion: While surface-level awareness is near-universal, significant gaps in knowledge depth, professional help-seeking, and institutional service utilisation persist. Universities must implement targeted mental health literacy programmes, address stigma, and strengthen accessible counselling infrastructure.

Keywords: Mental health awareness, university students, academic stress, help-seeking behaviour, stigma, GBPUAT, Uttarakhand, descriptive study

1. Introduction

Mental health is a fundamental dimension of human well-being, enabling individuals to realise their full potential, manage daily stresses, work productively, and contribute to their communities (World Health Organization, 2022) [19]. Within the context of higher education, university students represent a particularly vulnerable population. The transition to university life is characterised by a convergence of heightened academic demands, financial pressures, social adjustments, and identity exploration — all occurring simultaneously during a developmentally sensitive period that elevates the risk of psychological distress.

The global burden of mental health disorders among university students has intensified markedly over the past decade. The Healthy Minds Study (2022) [8], one of the largest ongoing surveys of its kind, reported that 41% of over 350,000 sampled students across North America met diagnostic criteria for at least one mental health disorder. In India, where the problem is compounded by cultural stigma and limited service infrastructure, studies report depression rates of 28.5% and anxiety rates of 35% among undergraduate students (Grover *et al.*, 2020) [6]. Agricultural university settings present a unique intersection of these challenges: students face highly competitive curricula,

career uncertainties linked to a volatile agrarian economy, significant family expectations, and — for many — the added stress of rural-to-urban transition upon entering campus life.

Despite this growing burden, mental health awareness and help-seeking behaviour among students in Indian universities remain inadequate. Mental health awareness — encompassing recognition of symptoms, knowledge of causes and treatments, and attitudes that facilitate or inhibit seeking support — is a well-established precondition for timely intervention (Corrigan & Watson, 2002; Jorm *et al.*, 1997) ^[4, 11]. When awareness is low or distorted by stigma, students are significantly less likely to access care, resulting in conditions that deteriorate, adversely affect academic performance, and carry long-term consequences for individual and societal well-being (Hunt & Eisenberg, 2010; Laidlaw *et al.*, 2016) ^[9, 12].

Govind Ballabh Pant University of Agriculture and Technology (GBPUAT), Pantnagar — one of India's premier agricultural universities — enrolls over 900 undergraduate students across programmes in agriculture, fisheries, veterinary science, biotechnology, and community science. Despite this substantial student population and its unique psychosocial vulnerabilities, empirical research specifically examining mental health awareness and its contributing factors within this institution is absent from the published literature. The present study addresses this gap through a systematic, data-driven assessment of awareness, stress contributors, help-seeking patterns, and institutional support knowledge among GBPUAT undergraduates. Its findings are intended to inform evidence-based mental health programming at the university and contribute to the broader literature on student mental health in Indian agricultural higher education.

2. Review of Literature

2.1 Prevalence of Mental Health Disorders Among University Students

A robust body of international and national research documents high rates of psychological distress in university populations. Beiter *et al.* (2015) ^[2] identified academic pressure, anxiety, and depression as the most prevalent mental health concerns, with examination stress functioning as a primary trigger. The American College Health Association's National College Health Assessment (2023) ^[1] reported that 44% of students had experienced depression that impaired their ability to function at some point during the preceding year. In India, Grover *et al.* (2020) ^[6] found that nearly one-third of medical undergraduates exhibited clinically significant depressive symptoms, with comparable or higher rates anticipated in multi-disciplinary settings. The Indian Council of Medical Research (ICMR) National Mental Health Survey (2016) ^[10] estimated that the lifetime prevalence of mental disorders among young adults aged 18–29 is approximately 13.5%, with the majority of cases remaining undiagnosed and untreated.

2.2 Mental Health Awareness and Its Determinants

Mental health awareness is a multi-dimensional construct encompassing the recognition of symptoms, knowledge of causes and treatments, and attitudes that facilitate help-seeking (Jorm *et al.*, 1997) ^[11]. Corrigan and Watson (2002)

^[4] established foundational evidence that awareness interventions positively shift attitudes toward mental illness and increase help-seeking intentions — findings since replicated across culturally diverse populations. Gorczynski *et al.* (2017) ^[5] found that students with higher mental health literacy reported lower levels of stigma-related avoidance and were significantly more likely to seek professional support. Reavley and Jorm (2011) ^[14] identified mental health literacy as the single strongest predictor of appropriate help-seeking among young adults. In collectivist societies such as India, awareness is further shaped by family norms, community values, and the frequent attribution of psychological distress to spiritual or moral causes rather than biomedical ones (Salibi *et al.*, 2021) ^[16].

2.3 Contributing Factors to Stress and Mental Health Challenges

The aetiology of mental health difficulties in university students is multifactorial. Academic workload and examination pressure are the most consistently identified stressors across cultures (Pascoe *et al.*, 2020) ^[13]. Career uncertainty — particularly relevant in Indian agricultural education where employment prospects are closely linked to policy-driven sector conditions — constitutes an additional and culturally specific stressor. Financial constraints independently predict clinical anxiety, with Richardson *et al.* (2017) ^[15] documenting a 2.3-fold elevated risk of anxiety among financially stressed students. Family expectations, a significant dimension in the Indian university context, have been identified as exerting sustained psychological pressure through the threat of social disapproval and honour concerns (Gulliver *et al.*, 2010) ^[7]. Digital technology and social media have emerged as contemporary stressors through mechanisms of social comparison, cyberbullying, and FOMO (fear of missing out), with widespread student recognition of their negative mental health impact (Victor & Bogart, 2020) ^[18].

2.4 Help-Seeking Behaviour and Institutional Support

Despite the high burden of mental health difficulties, help-seeking from professional sources remains consistently low among university students globally. Hunt and Eisenberg (2010) ^[9] found that only 20–40% of students with diagnosable conditions sought professional support. In Indian contexts, this proportion is substantially lower due to compounding barriers including stigma, financial costs, lack of awareness of available services, and cultural preferences for informal family-based support (Gulliver *et al.*, 2010) ^[7]. The persistent underutilisation of university counselling services — even where they exist — points to a systemic disconnect between service availability and student awareness and willingness to engage (Thorley, 2017) ^[17].

2.5 Research Gap and Justification

While the literature on student mental health in India is growing, studies specifically examining mental health awareness — as distinct from disorder prevalence — within agricultural and technical university settings in North India are conspicuously absent. No published study to date has examined mental health awareness among the student population of GBPUAT. Furthermore, few Indian studies integrate measurement of awareness, contributing factors,

gender differences, year-of-study effects, and institutional support knowledge within a single analytical framework. The present study was designed to address all these dimensions simultaneously.

3. Research Methodology

3.1 Research Design

A descriptive research design was employed, appropriate for systematically characterising the distribution and correlates of mental health awareness across a defined student population without experimental manipulation.

3.2 Study Setting and Population

The study was conducted at Govind Ballabh Pant University of Agriculture and Technology (GBPUAT), Pantnagar, Udham Singh Nagar, Uttarakhand — one of India's first agricultural universities, established in 1960. The university offers undergraduate programmes in agriculture, fisheries, veterinary science, biotechnology, and community science. The total undergraduate population at the time of data collection was 923 students.

3.3 Sample and Sampling Technique

Convenience sampling was employed, with participants selected on the basis of availability and voluntary willingness to respond. A total of 227 undergraduate students completed the questionnaire, representing a response rate of 24.6% of the total undergraduate population (227/923). This technique was adopted given the time constraints of the study period and the self-reported, voluntary nature of the survey instrument.

3.4 Data Collection Instrument

A structured 22-item questionnaire was developed

comprising seven thematic sections: (1) demographic profile — age, gender, programme, year of study; (2) mental health awareness exposure — Q7–Q9; (3) belief about the importance of mental health — Q10; (4) attitudinal items — four statements rated on a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree), Q11–Q14; (5) stress frequency and sources — Q15–Q16; (6) social media and mental health — Q17; and (7) institutional support awareness, help-seeking, and coping activities — Q18–Q20. An open-ended item (Q21) captured student recommendations for university-level improvements. The questionnaire was administered both online via Google Forms and offline in paper format during May 2026.

3.5 Scoring and Statistical Analysis

A composite Mental Health Awareness Index (MHAI) was computed as the arithmetic mean of the four Likert-scale items (Q11–Q14). Descriptive statistics — frequencies, valid percentages, means, and standard deviations — were computed for all variables. Gender-based sub-group analysis compared mean MHAI scores across male and female respondents. Year-of-study analysis examined stress frequency and institutional support awareness across academic cohorts. Pearson's product-moment correlation coefficient (r) was calculated to examine the association between the MHAI and academic stress frequency. All statistical computations were performed using Python 3.x.

4. Results and Findings

4.1 Demographic Profile of Respondents

Table 1 presents the complete demographic profile of the 227 student respondents.

Table 1: Demographic Profile of Respondents (N = 227)

Characteristic	Category	Frequency (n)	Percentage (%)
Age	18–21 years	130	57.3
	22–25 years	88	38.8
	Above 25 years	9	4.0
Gender	Male	134	59.0
	Female	93	41.0
Programme	BTech (all streams)	60	26.4
	Community Science	61	26.9
	BFSc (Fisheries)	33	14.5
	BVSc & AH	24	10.6
	BSc Agriculture	18	7.9
	PG (MSc/MVSc/MTech)	7	3.1
	Others / UG	24	10.6
Year of Study	1st Year	68	30.0
	2nd Year	58	25.6
	3rd Year	43	18.9
	4th Year or above	58	25.6
Total		227	100.0

Note: Age category 22–25 includes 1 respondent whose entry contained a formatting variant; both entries recorded as 22–25. Programme totals sum to 227.

The sample was predominantly male (59.0%, $n = 134$) and in the 18–21 age group (57.3%, $n = 130$). Community Science and BTech constituted the largest programme groups (26.9% and 26.4% respectively), followed by BFSc (14.5%) and BVSc & AH (10.6%). First-year students formed the largest academic cohort (30.0%), with near-

equal representation of second-year (25.6%) and fourth-year or above (25.6%) students.

4.2 Mental Health Awareness — Exposure, Knowledge, and Beliefs

The vast majority of respondents (97.8%, $n = 222$) reported

having heard about mental health awareness, indicating near-universal surface-level exposure. However, only 26.0% rated their knowledge as 'very good', with 43.2% rating it 'good' and 28.2% 'average'. A small proportion (2.6%)

reported poor knowledge. When asked whether mental health is as important as physical health, 91.2% agreed, with only 4.0% disagreeing. Table 2 presents these findings in full.

Table 2: Exposure, Self-Rated Knowledge, Beliefs, and Information Sources (N = 227)

Variable	Category	N	%
Heard about mental health awareness	Yes	222	97.8
	No	5	2.2
Self-rated knowledge level	Very Good	59	26.0
	Good	98	43.2
	Average	64	28.2
	Poor	6	2.6
MH as important as physical health	Yes	207	91.2
	No	9	4.0
	Not Sure	11	4.8
Primary information source*	Social Media	155	68.3
	Internet / Articles	125	55.1
	Friends / Family	105	46.3
	Teachers / University Programmes	89	39.2
	Workshops / Seminars	47	20.7

*Multi-select item; percentages do not sum to 100.

Social media (68.3%) and internet/articles (55.1%) were the dominant information sources, far outpacing formal institutional channels. Workshops and seminars — the most structured and content-controlled communication modality — reached only 20.7% of students, representing the lowest uptake of all available channels.

4.3 Attitudinal Beliefs — Likert Scale Analysis and Composite MHAI

Students' attitudinal beliefs regarding mental health were assessed using four Likert-scale items. Table 3 presents item-level descriptive statistics and the composite Mental Health Awareness Index (MHAI).

Table 3: Attitudinal Beliefs about Mental Health — Likert Scale Results (N = 227)

Attitudinal Statement	Mean	SD	SA% (5)	A% (4)	N% (3)	D% (2)	SD% (1)
Students should openly discuss mental health issues	3.88	1.32	44.9	24.2	15.0	5.3	10.6
Seeking professional help is necessary when needed	4.04	1.12	42.3	35.2	12.8	3.5	6.2
There is still stigma associated with mental health	3.78	1.00	23.3	45.4	22.5	4.0	4.8
Universities should provide mental health support services	4.09	1.14	47.1	30.4	13.2	2.6	6.6
Composite MHAI (mean of all 4 items)	3.95	0.96	—	—	—	—	—

SA = Strongly Agree; A = Agree; N = Neutral; D = Disagree; SD = Strongly Disagree.

The composite MHAI of 3.95 (SD = 0.96) out of 5.00 reflects a moderately high overall awareness level. The item 'Universities should provide mental health support services' recorded the highest mean (M = 4.09, SD = 1.14), with 77.5% of respondents in agreement or strong agreement. The item on professional help-seeking followed closely (M = 4.04, SD = 1.12; 77.5% agreement). The stigma item recorded the lowest mean (M = 3.78, SD = 1.00), yet 68.7% acknowledged that stigma around mental health persists — a finding of direct relevance for intervention design. The

item on open discussion recorded the widest standard deviation (SD = 1.32), indicating the greatest diversity of student opinion on this dimension.

4.4 Contributing Factors to Stress

Students were asked to identify from a provided checklist all factors that contributed to stress in their lives. Table 4 presents the frequency and percentage of each reported stressor.

Table 4: Contributing Factors to Stress among University Students (Multi-Select, N = 227)

Stress Factor	n	% of Respondents	Rank
Academic pressure	173	76.2	1
Career uncertainty	150	66.1	2
Family expectations	134	59.0	3
Examinations	131	57.7	4
Financial problems	123	54.2	5
Lack of sleep	109	48.0	6
Social relationships	103	45.4	7

*Multi-select item; percentages do not sum to 100.

Academic pressure was the most prevalent stressor, reported by 76.2% of respondents. Career uncertainty (66.1%) and

family expectations (59.0%) ranked second and third, reflecting the specific psychosocial context of an

agricultural university where career pathways are uncertain and familial investment in education is high. Examinations (57.7%) and financial problems (54.2%) were each reported by over half of all students. Lack of sleep (48.0%) and social relationship difficulties (45.4%) affected nearly half the sample, underscoring the multi-dimensional nature of the stress burden.

4.5 Frequency of Academic Stress

Table 5 presents the distribution of self-reported academic stress frequency across the sample.

Table 5: Frequency of Academic Stress (N = 227)

Stress Frequency	N	%	Cumulative%
Always	27	11.9	11.9
Often	63	27.8	39.6
Sometimes	83	36.6	76.2
Rarely	36	15.9	92.1
Never	17	7.5	99.6
Total	227	100.0	—

A combined 39.6% of students reported experiencing academic stress 'often' or 'always', confirming that chronic stress is a widespread phenomenon within this population. Only 7.5% reported never experiencing academic stress. Year-of-study analysis (Table 6) reveals that second-year students bear a disproportionate burden of frequent stress.

Table 6: Academic Stress Frequency by Year of Study

Year of Study	N	Often / Always Stressed	% Often / Always
1st Year	68	25	36.8
2nd Year	58	31	53.4
3rd Year	43	17	39.5
4th Year or above	58	17	29.3

Second-year students exhibited the highest burden of frequent stress (53.4%), notably higher than all other year groups. First and third-year students recorded broadly comparable levels (36.8% and 39.5% respectively), while fourth-year and above students reported the lowest frequency (29.3%), suggesting that academic stress may diminish as students develop coping strategies and clarity over their academic trajectories in the later years of study.

4.6 Social Media and Mental Health

When asked whether social media use and screen time affect mental health, 68.3% (n = 155) responded 'Yes', 25.1% (n = 57) 'Maybe', and only 6.6% (n = 15) 'No'. The combined positive response (Yes + Maybe) of 93.4% indicates near-universal student perception of social media's mental health impact, consistent with emerging literature on digital stress, social comparison, and FOMO among young adults (Victor & Bogart, 2020) ^[18].

4.7 Awareness of University Mental Health Support Services

A majority of respondents — 54.2% (n = 123) — reported awareness of mental health support services available at their university, while 45.8% (n = 104) reported no awareness. Table 7 presents awareness levels by year of study.

Table 7: Awareness of University Mental Health Services by Year of Study

Year of Study	n	Aware (Yes)	% Aware
1st Year	68	39	57.4
2nd Year	58	31	53.4
3rd Year	43	27	62.8
4th Year or above	58	26	44.8
Total	227	123	54.2

Third-year students recorded the highest awareness of university support services (62.8%), while fourth-year and above students recorded the lowest (44.8%). The decline in awareness among the most senior students is a counter-intuitive and concerning finding — it suggests that university mental health service communication is neither cumulative nor adequately sustained across the student lifecycle. More than one in three students in every year group remains unaware of available support.

4.8 Help-Seeking Behaviour and Coping Strategies

When distressed, the majority of students turned to friends (58.6%, n = 133) or family (44.5%, n = 101) for support. However, 23.3% (n = 53) reported speaking to no one, and only 8.4% (n = 19) sought support from a professional counsellor. Tables 8 and 9 present full results for help-seeking preferences and coping activities respectively.

Table 8: Help-Seeking Behaviour When Distressed (Multi-Select, N = 227)

Person Approached	N	% of Respondents
Friends	133	58.6
Family	101	44.5
No one	53	23.3
Professional counsellor	19	8.4

*Multi-select item.

Table 9: Coping Activities Employed by Students (Multi-Select, N = 227)

Coping Activity	N	% of Respondents
Listening to music	153	67.4
Talking to friends	111	48.9
Hobbies	95	41.9
Exercise	86	37.9
Meditation / Yoga	54	23.8

*Multi-select item; percentages do not sum to 100.

Informal and largely passive coping strategies dominated, with listening to music (67.4%) as the most widely used activity. Only 23.8% practised meditation or yoga despite its well-established efficacy for stress reduction. The prevalence of speaking to no one (23.3%) and the minimal engagement with professional counselling (8.4%) together point to a significant unmet need for both formal support services and structured psycho-educational programming on effective coping.

4.9 Gender Differences in Awareness Scores

Gender-based sub-group analysis of the four Likert-scale items revealed consistent and statistically meaningful differences between male and female respondents across all dimensions. Table 10 presents item-level and composite mean scores by gender.

Table 10: Gender-wise Comparison of Attitudinal Awareness Scores (Mean, 1–5 Scale; Male n = 134, Female n = 93)

Attitudinal Statement	Male Mean	Female Mean	Difference (F–M)
Students should openly discuss mental health issues	3.62	4.25	+0.63
Seeking professional help is necessary when needed	3.82	4.35	+0.53
There is still stigma associated with mental health	3.66	3.96	+0.30
Universities should provide mental health support services	3.90	4.37	+0.47
Composite MHAI	3.75	4.23	+0.48

Female students recorded consistently higher mean scores on all four attitudinal dimensions and on the Composite MHAI (Female: M = 4.23 vs. Male: M = 3.75; difference = +0.48). The largest gender gap was observed on the item regarding open discussion of mental health issues (Female: M = 4.25, Male: M = 3.62; difference = +0.63), indicating that female students are significantly more comfortable with the idea of mental health disclosure — a pattern consistent with international literature attributing greater emotional expressiveness and lower stigma in women (Hunt *et al.*, 2010) [9]. Given that male students constitute 59.0% of the sample, this gap represents a substantial population-level challenge for mental health programming.

4.10 Correlation between MHAI and Academic Stress Frequency

A Pearson's product-moment correlation analysis between the Composite MHAI and academic stress frequency (n = 226) yielded $r = 0.171$, indicating a small but statistically positive relationship. This finding suggests that students with higher mental health awareness scores also tend to report higher frequency of academic stress — consistent with the hypothesis that mental health literacy enhances self-awareness and recognition of one's own stress responses (Jorm *et al.*, 1997) [11]. While the correlation is modest in magnitude, its positive direction rules out the concern that awareness training may produce complacency and confirms that awareness and experienced stress are not inversely related in this population.

4.11 Student Recommendations for Universities

In response to the open-ended item (Q21), 20.7% of students recommended the introduction or strengthening of mental health awareness programmes and workshops, 14.5% called specifically for dedicated counselling services, 7.5% identified the need for better overall support systems, and 6.6% prioritised stress management programmes. One quarter of respondents (25.1%) offered no specific suggestion, reflecting either satisfaction with current provision or disengagement from the question — itself a finding of relevance for student voice in institutional planning.

5. Discussion

The findings of this study present a nuanced picture of mental health awareness at GBPUAT that is simultaneously encouraging and deeply concerning. The near-universal exposure to mental health concepts (97.8% having heard about mental health awareness) and the moderately high MHAI score of 3.95 out of 5.00 indicate that students at this institution are not starting from a position of total ignorance. The strong consensus that mental health is as important as physical health (91.2% agreement) and that universities have a responsibility to provide support services (77.5%

agreement) reflects a student body that is broadly receptive to mental health-supportive institutional policies.

However, this surface-level awareness masks critical deficiencies. The gap between the 97.8% who have heard about mental health awareness and the mere 26.0% who rate their knowledge as 'very good' — with 28.2% rating it only 'average' — reveals that exposure has not translated into genuine literacy. This is a well-documented phenomenon in mental health education: mass-media and social media exposure generates familiarity with terminology without necessarily building the substantive understanding needed to recognise symptoms, reduce stigma, or seek help appropriately (Gorczyński *et al.*, 2017) [5].

The dominance of social media (68.3%) and informal internet sources (55.1%) as the primary conduits of mental health information, compared to structured institutional channels such as workshops (20.7%), represents a significant quality-control gap. While social media can democratise access to mental health content, it is also an unregulated space prone to oversimplification, stigmatising portrayals, and algorithmically amplified anxiety-provoking content. The low reach of formal university-based communication channels suggests a critical failure of institutional health promotion that goes beyond mere absence of programmes.

The identification of academic pressure (76.2%), career uncertainty (66.1%), and family expectations (59.0%) as the dominant stressors maps closely onto the structural characteristics of agricultural higher education in India, where academic demands are intense, employment prospects in the sector are variable, and family investment in education creates a burden of expectation that students carry throughout their studies. The distinct stress peak among second-year students (53.4% 'often/always' stressed) — higher than all other year groups including first-year students — is a finding that merits specific institutional attention and may reflect the loss of orientation-year support structures combined with the full weight of academic demands in the second year.

The most alarming finding of this study is the disjunction between awareness and action in the domain of professional help-seeking. Despite moderately high awareness scores and near-universal recognition of mental health's importance, only 8.4% of distressed students sought support from a professional counsellor. One in four students (23.3%) spoke to no one at all when experiencing distress. This pattern of silent suffering — well-documented in Western university settings (Hunt & Eisenberg, 2010) [9] — is likely amplified in the GBPUAT context by cultural norms of self-reliance, family-centred support preferences, and the persistent stigma that 68.7% of students themselves acknowledge. The fact that 45.8% of students remain unaware of available university mental health services — including 55.2% of fourth-year students — confirms that awareness of services

and willingness to use them are both barriers that require simultaneous intervention.

The gender disparity in MHAI scores (Female: 4.23, Male: 3.75; difference = +0.48) is consistent with international evidence that female students demonstrate higher mental health literacy, more positive attitudes toward professional help, and lower stigma-related barriers (Hunt *et al.*, 2010)^[9]. In a population where male students constitute 59.0% of the total, this gap translates into a population-level unmet need that targeted gender-sensitive programming must address. The social media finding — 93.4% perceiving its impact on mental health as real or possible — further underlines the need for digital literacy components in university mental health curricula.

6. Conclusion

This study provides the first systematic empirical examination of mental health awareness and contributing factors among undergraduate students at GBPUAT, Pantnagar. The findings reveal a student population characterised by near-universal exposure but insufficient depth of knowledge, high prevalence of multi-domain stress with a distinctive peak in the second year, significant gender disparities in awareness and attitudes, worrying levels of professional help non-seeking, and inadequate institutional communication of available support services.

Mental health at GBPUAT — as at agricultural universities more broadly — cannot be treated as a peripheral welfare issue or an individual responsibility. The data presented in this study make clear that it is a structural concern requiring a coordinated, university-wide response that integrates curricular intervention, peer-based outreach, gender-sensitive programming, digital communication strategy, and strengthened professional counselling services. The students surveyed have expressed both the need and the desire for such support: 77.5% agree that universities should provide mental health services. The institutional obligation is now to meet that expectation with meaningful and sustained action.

7. Recommendations

The following evidence-based recommendations are proposed for institutional implementation:

- Establish a fully staffed, visible, and accessible Mental Health Cell at GBPUAT with at minimum one full-time trained counsellor. Communicate its existence systematically through orientation programmes, departmental inductions, university portal, social media channels, and hostel noticeboards.
- Introduce a mandatory one-credit Mental Health Literacy module for all first-year students across all programmes, covering stress recognition, coping strategies, help-seeking pathways, and digital well-being.
- Design and implement a targeted second-year mental health intervention — including peer mentoring and structured stress management workshops — recognising this cohort's disproportionately high stress burden (53.4% frequently stressed).
- Develop gender-sensitive mental health campaigns specifically addressing the lower awareness, higher stigma barriers, and lower help-seeking intentions observed among male students (MHAI: 3.75 vs. female

4.23).

- Leverage students' primary information channel — social media — through official university accounts, deploying evidence-based, destigmatising content, mental health challenges, and peer advocate campaigns.
- Implement annual structured mental health screening for all registered students to enable early identification of at-risk individuals and facilitate timely, voluntary referral to counselling.
- Explore formal partnerships with national mental health helplines (iCall, Vandrevalla Foundation Helpline 1860-2662-345, NIMHANS) to extend the range and quality of student support beyond in-house institutional capacity.
- Incorporate digital literacy and responsible social media use components into the mental health curriculum, given that 93.4% of students perceive social media as impacting mental health.

8. Limitations of the Study

The following limitations are acknowledged. First, convenience sampling limits the representativeness of findings and may introduce selection bias toward students with higher engagement or stronger opinions on mental health. Second, the cross-sectional design precludes causal inference; the positive correlation between MHAI and stress frequency, for example, may reflect reverse causation or a shared third variable. Third, self-reported data are susceptible to social desirability bias, particularly on sensitive topics such as help-seeking and stigma. Fourth, the study is confined to a single institution, restricting direct generalisability to other Indian universities. Fifth, the programme categories, while accurately reflecting the diversity of GBPUAT's student body, involved some interpretive grouping of inconsistently entered responses. Future research should employ validated instruments such as the Mental Health Knowledge Schedule (MAKS) or the General Health Questionnaire (GHQ-12), stratified random sampling, and longitudinal or comparative designs across multiple institutions.

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