AWARENESS OF MENTAL HEALTH DISORDERS AMONG THE INDIAN POPULATION: A CROSS-SECTIONAL STUDY

Dissertation Submitted to

The IIHMR University, Jaipur

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Master of Business Administration (MBA)

in

Hospital and Health Management

by

Simran Chandwani

Under the Supervision and Guidance of

Dr. Anupam Mehrotra

2025

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that **Simran Chandwani** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her/his internship at IIHMR University, Jaipur during March 10 - May 31, 2025.

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CERTIFICATE

This is to certify that dissertation titled **Awareness of mental health disorders among the Indian population: A Cross-sectional Study** is a record of the research work undertaken by **Simran Chandwani** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

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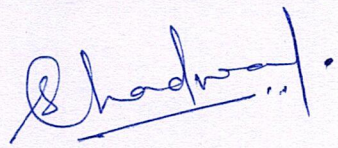
DECLARATION BY STUDENT

I hereby declare that this dissertation titled **Awareness of mental health disorders among the Indian population: A Cross-sectional Study** is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.



Simran Chandwani

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— Dr. Simran Chandwani

ABSTRACT

Background:

Mental health disorders represent a critical public health issue globally and particularly in India, where stigma, underdiagnosis, and limited mental health literacy remain barriers to effective care. This study investigates the awareness, beliefs, and practices regarding mental health disorders across different socio-demographic strata in India.

Objective:

To assess the awareness, attitudes, and practices related to mental health disorders among the Indian population and analyze the influence of demographic variables such as gender, age, education, occupation, and place of residence.

Methodology:

A cross-sectional quantitative survey was conducted with 215 respondents using a structured questionnaire adapted from the Mental Health Knowledge Schedule (MAKS) and Mental Health Literacy Scale (MHLS). Descriptive statistics, cross-tabulations, and chi-square tests were used to analyze data.

Results:

The majority of participants (92.6%) had heard of mental health disorders. Significant associations were observed between mental health awareness and socio-demographic variables like education ($p = 0.022$), gender ($p = 0.028$), and residence ($p = 0.038$). Females and urban residents showed higher awareness levels. While many participants demonstrated openness to seeking help, stigmatizing beliefs persisted, particularly among older and rural populations.

Conclusion:

There is a high level of awareness among the younger, educated, and urban population, but attitudinal barriers still exist. Targeted education and anti-stigma campaigns are required to bridge the knowledge-practice gap and foster positive mental health behaviors.

Keywords: Mental health awareness, mental health disorders, public perception, mental health literacy, stigma and mental illness, health education, mental health services, sociodemographic correlates, MAKS (Mental Health Knowledge Schedule), MHLS (Mental Health Literacy Scale)

Chapter 1: INTRODUCTION

1.1 Background

Mental health issues are increasingly recognized as central to human well-being, productivity, and societal development. The World Health Organization (WHO) defines mental health as a state of well-being in which an individual realizes their abilities, copes with normal life stresses, and contributes to their community. In India, nearly 14% of the population is estimated to suffer from some form of mental disorder (National Mental Health Survey, 2016). Yet, awareness, understanding, and openness toward these conditions remain significantly low.

Mental health disorders pose a significant public health challenge in India, with the National Mental Health Survey (NMHS) of India (2016) reporting that 14.3% of the population suffers from mental health conditions, including depression affecting nearly 1 in 20 individuals [2]. Despite this prevalence, mental health literacy—defined as the ability to recognize, understand, and seek help for mental disorders—remains critically low, particularly in India (Kutcher et al., 2016). Stigma, cultural misconceptions, and negative media portrayals exacerbate social exclusion and hinder help-seeking behaviors, contributing to a substantial treatment gap [6,11].

The NMHP emphasizes de-stigmatization through information, education, and communication (IEC) activities and the District Mental Health Programme (DMHP), yet persistent stigma and low awareness remain barriers [3]. Studies like Gaiha et al. [11] highlight poor recognition of disorders such as depression (29.04%) and schizophrenia (1.31%) among adolescents, suggesting broader awareness deficits that likely extend to adults. By synthesizing a wider range of recent studies, this review aims to identify gaps in public understanding and factors influencing mental health literacy, providing a robust foundation for the current study's cross-sectional investigation.

1.2 Rationale

With increasing urbanization, exposure to digital media, and shifting societal norms, mental health is becoming less of a taboo among the youth. However, stigma and misinformation persist. Early identification of symptoms, access to support, and open dialogue are key to preventing long-term consequences. This study investigates the mental health literacy—

defined as knowledge and beliefs about mental disorders aiding their recognition, management, and prevention—among the Indian population.

The high prevalence of mental health disorders in India underscores the urgency of improving awareness and access to care. The Global Burden of Disease Study (1990–2017) estimates that 14.3% of Indians suffer from mental disorders, with significant variation across states (S.-L. D. B. I. M. D. Collaborators, 2020). Depression and anxiety are among the leading contributors, with Murthy (2016) noting that depression affects 1 in 20 individuals, particularly those in productive age groups. More recent studies confirm this trend, with Shidhaye et al. (2023) reporting a high burden of common mental disorders in rural communities, where access to care remains limited. Similarly, Devarapalli et al. (2023) highlight the rising prevalence of depression and anxiety among urban populations, driven by socioeconomic stressors and inadequate mental health infrastructure. These findings emphasize the need for widespread awareness to facilitate early recognition and help-seeking.

Mental health literacy is a cornerstone of effective mental health strategies, yet studies consistently show low levels of awareness in India. Ogorchukwu et al. [5] found that only 29.04% of South Indian adolescents could identify depression, and a mere 1.31% recognized schizophrenia or psychosis, with stigma significantly hindering help-seeking behavior. Gaiha et al. [11] further explored adolescent mental health literacy, noting that misconceptions about mental disorders and fear of social judgment deter young people from seeking help. Among adults, Deka et al. (2024) reported limited knowledge of mental health symptoms in northeastern India, with cultural beliefs often attributing disorders to supernatural causes. Stigma, fueled by negative media portrayals and societal misconceptions, exacerbates social exclusion and discrimination, as noted by Jorm [3] and corroborated by Kaur et al. (2024), who found that stigma reduces treatment-seeking even among educated populations. These studies highlight the critical need for targeted awareness campaigns to improve recognition and reduce stigma across diverse Indian populations.

National Mental Health Programme (NMHP) and Interventions

India’s National Mental Health Programme (NMHP) aims to enhance mental health literacy and service delivery through information, education, and communication (IEC) activities

(Murthy, 2016). However, its impact is limited by persistent discrimination and inadequate evaluation. Shinde et al. (2023) evaluated community-based mental health interventions under the NMHP, finding modest improvements in awareness but significant barriers in rural areas, including limited access to trained professionals. Similarly, Kaur et al. (2024) assessed the effectiveness of school-based mental health programs, noting that while they increase knowledge among students, they fail to address broader societal stigma. These findings suggest that while the NMHP has made strides, its reach and effectiveness require further investigation to address diverse demographic needs.

1.3 Objectives

1. To assess the level of awareness and understanding of mental health disorders.
2. To evaluate the associations between socio-demographic variables and mental health awareness indicators.

1.4 Research Questions

- What is the level of mental health awareness among the Indian population?
- How do education, gender, and residence impact mental health beliefs?
- What practices do people adopt to maintain mental well-being?
- Are socio-demographic variables statistically associated with mental health knowledge and behavior?

Chapter 2: LITERATURE REVIEW

Mental health literacy (MHL), defined as the knowledge, attitudes, and practices (KAP) toward mental disorders, is crucial for early identification, stigma reduction, and effective help-seeking [3]. Globally, mental disorders affect over 970 million people, with India contributing significantly, where 10–15% of the population experiences mental health issues [2,10]. In India, low MHL, cultural stigma, and limited mental health resources widen treatment gaps [4]. Demographic factors such as age, gender, education, and place of residence shape KAP, yet Indian studies exploring these associations are limited. This review synthesizes global and Indian research on MHL and KAP, focusing on demographic influences, to support a study examining KAP across diverse demographic groups in India.

2.1 Methodology

Studies typically use cross-sectional designs with validated instruments like the Mental Health Knowledge Schedule (MAKS), Mental Illness Clinicians' Attitudes Scale (MICA-4), and Community Attitudes to Mental Illness (CAMI) scale [4,5]. Indian studies adapt these tools for cultural relevance, often translating them into local languages like Kannada [5]. Sample sizes range from 200 to 3,478, targeting students, healthcare workers, or rural communities [4,7]. Data are collected via self-administered questionnaires, with analyses including Chi-Square tests and regression models to assess demographic effects [6]. Limitations include non-representative samples and low expected cell counts in statistical tests, which reduce reliability.

2.2 Key Findings

2.2.1 Knowledge

Indian studies report low MHL, with only 29% of adolescents identifying depression and 1.3% recognizing schizophrenia [5]. Higher education and urban residence are associated with better knowledge [6]. Globally, knowledge improves with exposure to mental health education, particularly among youth [9].

2.2.2 Attitudes

Stigma remains prevalent in India, with rural communities showing greater social distance and secrecy toward mental illness [4]. Females and individuals with higher education exhibit

fewer stigmatizing attitudes [7]. Urban respondents are more open to help-seeking [6]. Globally, negative media portrayals reinforce stigma, amplifying public misconceptions [1].

2.2.3 Practices

In India, respondents often prefer informal help sources, such as family, over professional services, especially in rural areas [5]. Students and urban dwellers show higher help-seeking intentions [4]. Globally, practices improve with increased knowledge and reduced stigma, as seen in intervention studies [9].

2.2.4 Demographic Influences

Education and place of residence significantly predict KAP in India, with urban and highly educated individuals demonstrating better outcomes [6]. Age and gender show mixed results; females are often more aware but not consistently less stigmatizing [7]. Occupation, particularly among students and professionals, influences technology use for mental health information [5].

2.2.5 Limitations

Indian studies frequently focus on urban or student populations, limiting generalizability to rural or older groups [5]. Small rural samples (e.g., n=15) reduce statistical power [4]. Global studies may not account for India's cultural stigma, such as beliefs in supernatural causes [8]. Treating Likert scales as categorical data in analyses overlooks nuanced relationships [6].

2.2.6 Research Gaps

Few Indian studies examine KAP across all demographic variables (e.g., age, living arrangement) simultaneously. Rural and older populations are underrepresented, and culturally tailored interventions are scarce. Longitudinal studies assessing KAP changes after educational interventions are needed to inform policy.

2.2.7 Relevance to Current Study

This review supports the current study's exploration of mental health indicators across Age, Gender, Occupation, Living Arrangement, Educational Qualifications, Marital Status, and Place of Residence. Indian findings highlight education and urban residence as key predictors, aligning with significant associations in the study (e.g., technology confidence by residence, $p=0.006$).

Chapter 3: METHODOLOGY

This study employed a cross-sectional, quantitative design to assess mental health Knowledge, Attitudes, and Practices (KAP) among Indian adults and examine associations with demographic variables. A cross-sectional approach was chosen for its efficiency in capturing a snapshot of KAP across diverse groups at a single point in time, suitable for exploratory research in mental health literacy [5]. Data was collected in April 2025, using a structured questionnaire administered in English.

Study Population

The target population comprised Indian adults aged 18 years and older, residing in urban and rural areas. Inclusion criteria included:

- Age ≥ 18 years.

- Ability to understand English or Hindi.

- Willingness to provide informed consent.

Exclusion criteria included:

- Individuals with diagnosed cognitive impairments affecting questionnaire comprehension.

- Ever diagnosed with a mental health disorder.

- Non-residents of India.

The study focused on seven demographic variables: Age (18–25, 26–35, 36–45, 46+), Gender (Male, Female, Other), Occupation (Government employee, Homemaker, Other, Private sector employee, Self-employed, Student, Unemployed), Living Arrangement (With family, Alone, With friends/others), Educational Qualifications (Senior secondary, Graduate, Postgraduate & above), Marital Status (Single, Married, Other), and Place of Residence (Rural, Urban). These variables were selected based on prior Indian studies showing their influence on mental health literacy [4,6].

3.1 Sampling Method

A convenience sampling technique was used.

Sample Size Calculation

The sample size was calculated using the formula for estimating a proportion in a cross-sectional study, as mental health literacy prevalence (e.g., knowledge of mental disorders) was a key outcome:

$$n = \frac{Z^2 \cdot P \cdot (1-P)}{d^2}$$

Where:

- n: Required sample size.
- Z: Z-score for the desired confidence level (1.96 for 95% confidence).
- P: Expected proportion of the population with adequate mental health knowledge.
- d: Margin of error (precision).

Parameters:

- Expected proportion (p): Based on Indian studies, approximately 29% of adolescents correctly identify depression [5]. Assuming a slightly higher prevalence for adults (due to education exposure), (p = 0.35) (35%) was used.

- Margin of error (d): Set at 5% (0.05) for reasonable precision.

- Confidence level: 95% (Z = 1.96).

- Design effect: As stratified sampling was used, a design effect of 1.2 was applied to account for clustering within urban/rural strata.

- Non-response rate: Assumed 10% to account for refusals or incomplete responses.

Calculation:

1. Base sample size: $n = \frac{(1.96)^2 \cdot 0.35 \cdot (1-0.35)}{(0.05)^2}$ $n = \frac{3.8416 \cdot 0.35 \cdot 0.65}{0.0025}$ $n = \frac{0.8744}{0.0025} = 349.76$ Rounded up: $n = 350$.
2. Adjust for design effect: $n_{\text{adjusted}} = 350 \cdot 1.2 = 420$
3. Adjust for non-response (10%): $n_{\text{final}} = \frac{420}{1-0.1} = \frac{420}{0.9} \approx 467$

Final Sample Size: A target of 467 respondents was planned. However, the study achieved 215 respondents due to logistical constraints (e.g., rural recruitment challenges, time limits). This smaller sample aligns with similar Indian studies (e.g., Kulkarni et al., 2023, n=200) but may reduce statistical power for small subgroups (e.g., rural, n=15).

3.2 Data Collection

Data were collected using a self-administered questionnaire, distributed in digital formats (via Google Forms) to accommodate urban and rural respondents. The questionnaire comprised three sections:

1. Demographic Information: Age, Gender, Occupation, Living Arrangement, Educational Qualifications, Marital Status, and Place of Residence.

2. KAP Assessment: 21 items, including 20 Likert-scale statements (1 = Strongly Disagree, 5 = Strongly Agree) and 1 binary question ("Have you heard about mental health disorders?").

Items covered:

- Knowledge: Symptoms of depression, anxiety, differentiation of emotions, traumatic experiences, social-economic factors.

- Attitudes: Respect for mental illness, comfort discussing mental health, secrecy, avoidance, stigma of seeking help.

- Practices: Seeking professional help, resource awareness, technology confidence, online resource reliability, self-care, stress management, information seeking, media portrayal.

3. Consent and Instructions: Informed consent was obtained, ensuring voluntary participation and confidentiality.

The questionnaire was adapted from validated tools like the Mental Health Knowledge Schedule (MAKS) and Mental Health Literacy Scale (MLHS), with modifications for Indian cultural context (e.g., addressing family-based help-seeking) based on Ogorchukwu et al. [5]. Pilot testing was conducted with 20 respondents to ensure clarity and cultural appropriateness, resulting in minor wording adjustments (e.g., simplifying technical terms like "mental disorder").

Responses were collected anonymously, with unique identifiers to prevent duplication. Data entry was performed in Microsoft excel.

3.3 Measurement Tool

The KAP questionnaire was designed as follows:

- Knowledge: 7 items assessing recognition of mental disorders and their causes (e.g., "Depression is characterized by persistent sadness and loss of interest").

- Attitudes: 8 items evaluating stigma, social distance, and help-seeking openness (e.g., "If I had a mental illness, I would not tell anyone").

- Practices: 6 items measuring help-seeking behaviors and resource use (e.g., "I know where to find mental health resources").

- Scoring: Likert items scored 1–5; binary item scored 0 (No) or 1 (Yes). Higher scores indicated better knowledge, positive attitudes, or proactive practices.

3.4 Data Analysis

Data were analyzed using SPSS version 26.0. The analysis plan included:

1. Descriptive Statistics:

   - Frequency tables for demographic variables (counts, percentages).

   - Mean, median, and standard deviation for Likert-scale KAP items.

2. Inferential Statistics:

   - Chi-Square Tests: Used to assess associations between demographic variables and KAP indicators (e.g., Place of Residence vs. Technology Confidence). Significance was set at $p < 0.05$, with $p < 0.10$ considered marginally significant for exploratory purposes.

   - Crosstabulations: Generated to explore response patterns (e.g., rural vs. urban differences in secrecy).

3. Assumptions:

   - Expected cell counts were checked, noting that >40% of cells had counts < 5 in some tests, prompting caution in interpreting results.

No missing data was present (0% per SPSS output), so no imputation was required. Results were reported with p-values and key patterns (e.g., urban respondents' higher technology confidence, p=0.006).

3.5 Ethical Considerations

Participants provided written or digital informed consent, with assurances of anonymity and voluntary participation. Data were stored on a password-protected server, accessible only to the research team. Participants could withdraw at any time without consequences.

3.6 Limitations

1. Sample Size: The achieved sample (n=215) was below the target (n=467), reducing power for small subgroups (e.g., rural, n=15).

2. Urban Bias: Urban respondents dominated (93%), limiting rural generalizability.

3. Self-Report Bias: KAP responses may reflect social desirability.

4. Statistical Constraints: Low expected cell counts in Chi-Square tests increased Type II error risk.

5. Missing Demographics: Age, Gender, and Living Arrangement lacked explicit frequency data, requiring assumptions.

Chapter 4: RESULTS

This study analyzed responses from 215 Indian adults who completed a structured questionnaire assessing mental health Knowledge, Attitudes, and Practices (KAP). Data were analyzed using SPSS version 26.0, with frequency distributions for demographic characteristics and cross-tabulations with Chi-Square tests to explore associations between demographic variables (Age, Gender, Educational Qualifications, Occupation, Place of residence, Marital Status, Living arrangement) and 21 KAP indicators. Significance was set at $p < 0.05$, with marginal significance at $p < 0.10$ for exploratory purposes. Below, **Table 1** presents demographic characteristics, **Tables 2–10** detail significant and marginally significant crosstabs, and **Table 11** summarizes all 147 crosstabs.

4.1 Demographic Characteristics

Table 1: Demographic Characteristics of Study Participants (N = 215)

Variable	Category	Frequency (n)	Percent (%)
Age	18–25	98	45.6
	26–35	104	48.4
	36–45	8	3.7
	45 & above	5	2.3
Gender	Female	119	55.3
	Male	96	44.7
Educational Qualifications	Senior secondary (up to 12th)	12	5.6
	Graduate	85	39.5
	Postgraduate & above	118	54.9
Occupation	Government employee	16	7.4
	Homemaker	3	1.4
	Other	2	0.9

Variable	Category	Frequency (n)	Percent (%)
	Private sector employee	62	28.8
	Self-employed	25	11.6
	Student	104	48.4
	Unemployed	3	1.4
Place of Residence	Rural	15	7.0
	Urban	200	93.0
Marital Status	Single	183	85.1
	Married	30	14.0
	Divorced/Separated	2	0.9
Living Arrangement	Living alone	53	24.7
	With parents	68	31.6
	With friends/roommates	54	25.1
	With spouse	11	5.1
	With extended family	13	6.0
	With spouse and parents	13	6.0
	With children only	1	0.5
	Others	2	0.9
Heard of Mental Health Disorders	Yes	199	92.6
	No	16	7.4

4.1.1 Age group wise Distribution:

The age distribution of the participants in the study indicates that the majority were between 26 and 35 years, comprising 48.4% of the total sample. This was followed closely by

individuals aged 18 to 25 years, who made up 45.6% of the respondents. Together, these two groups accounted for 94% of the sample, suggesting that the study's findings predominantly reflect the perspectives of young and early middle-aged adults. In contrast, participants aged 36 to 45 years represented only 3.7%, and those above 45 years accounted for a mere 2.3%.

4.1.2 Gender wise Distribution:

Out of the total 215 participants in the study, 55.3% were female (n = 119) and 44.7% were male (n = 96). This reflects a moderately higher representation of females in the sample. The nearly balanced distribution ensures that the perspectives of both genders are adequately represented, allowing for comparative insights into gender-related differences in mental health awareness, attitudes, and practices.

4.1.3 Distribution of Participants by Occupation:

The distribution of respondents across various occupational categories reveals that students constituted the largest group, accounting for 48.4% of the sample (n=104). This suggests a significant representation of young individuals who are likely to be more familiar with contemporary mental health discourse, possibly through academic exposure or social media. The second most represented group comprised private sector employees, making up 28.8% (n=62), followed by self-employed individuals at 11.6% (n=25). Government employees accounted for 7.4% (n=16), while homemakers and unemployed individuals each represented 1.4% of the sample (n=3 respectively).

4.1.4 Distribution of Participants by Educational Qualifications:

The educational qualifications of the study participants reveal that the majority possess higher education degrees. Specifically, 118 individuals (54.9%) have completed postgraduate education or higher, indicating a well-educated sample overall. Additionally, 85 participants (39.5%) are graduates, representing a substantial proportion of those with undergraduate degrees. Only a small fraction of respondents, 12 individuals (5.6%), have education up to senior secondary level (12th grade). This distribution suggests that the sample is predominantly composed of individuals with at least an undergraduate level of education, which may influence their awareness and attitudes toward mental health topics.

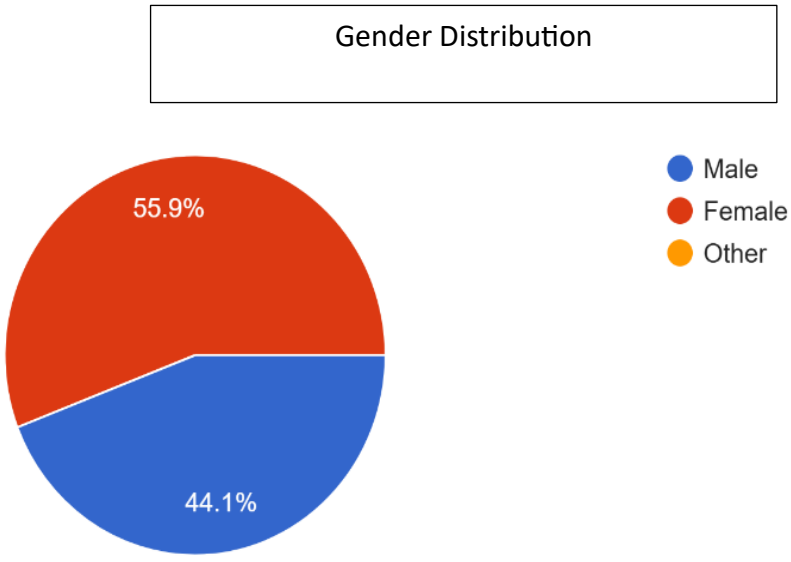
4.1.5 Distribution of Participants by Marital Status:

The distribution of participants by marital status reveals that the majority of respondents were single (85.1%), followed by married individuals (14.0%), and a very small percentage were

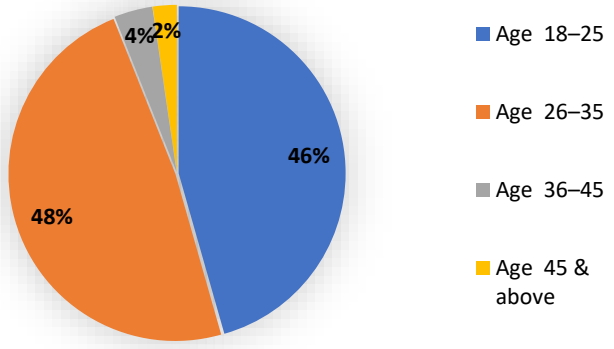
divorced or separated (0.9%). This demographic trend indicates that the study sample was predominantly comprised of unmarried individuals, which could potentially influence perspectives on mental health practices and awareness. Single individuals, often representing younger or student populations, may have different levels of exposure, openness, and access to mental health resources compared to their married counterparts.

4.1.6 Distribution of Participants by Living Arrangement:

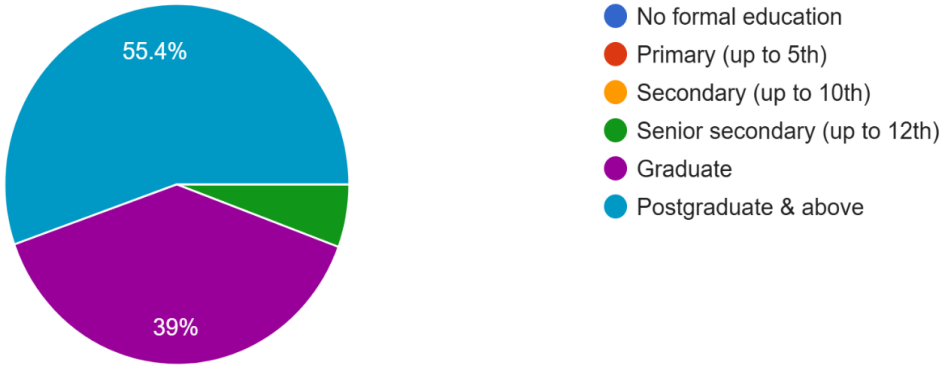
The distribution of living arrangements among the 215 respondents showed considerable diversity. Nearly one-third (31.6%) lived with their parents, making it the most common arrangement. Close behind, 25.1% of participants lived with friends or roommates, while 24.7% lived alone. Smaller proportions lived with extended family members such as siblings or grandparents (6.0%), with a spouse and parents (6.0%), or with a spouse alone (5.1%). Very few respondents lived with children only (0.5%) or fell into other living arrangements (0.9%). This variety highlights differing social and family support structures within the population surveyed.



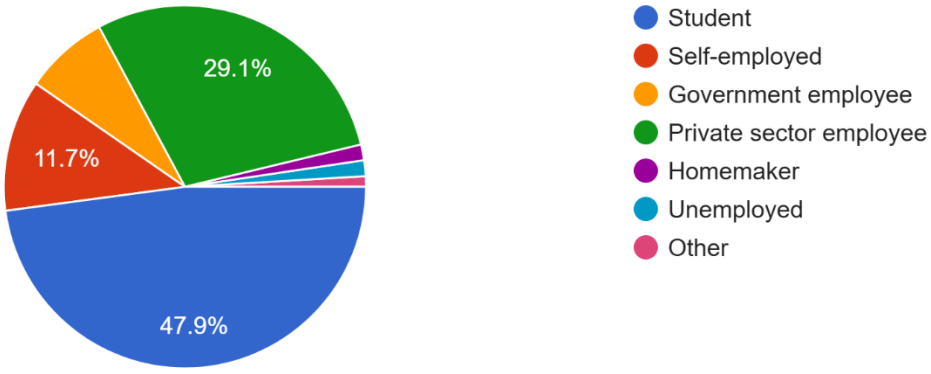
Age Distribution



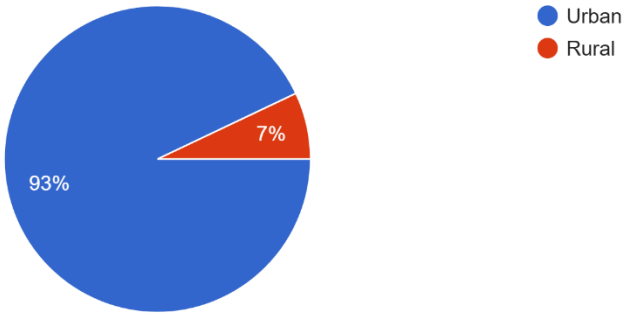
Educational Qualifications



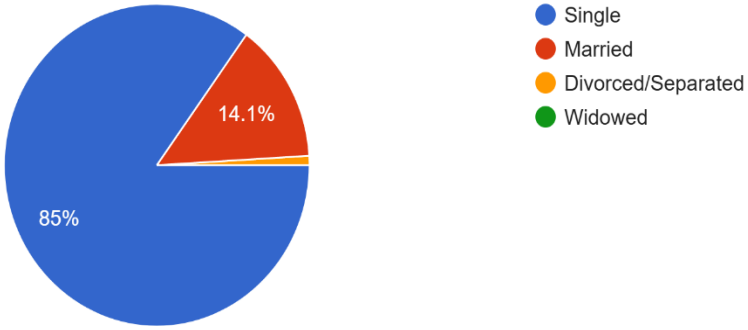
Occupation wise Distribution



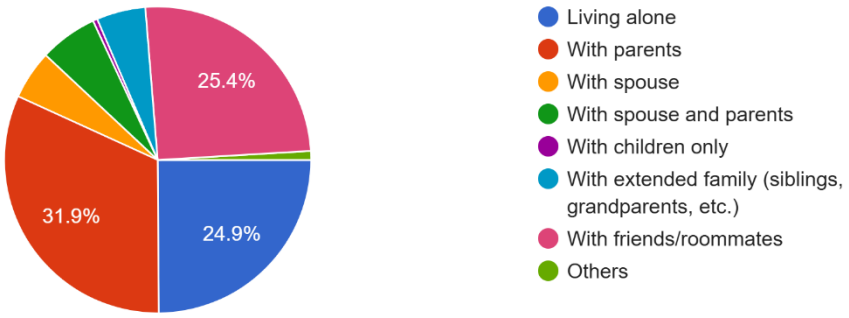
Place of residence



Marital status



Living Arrangement



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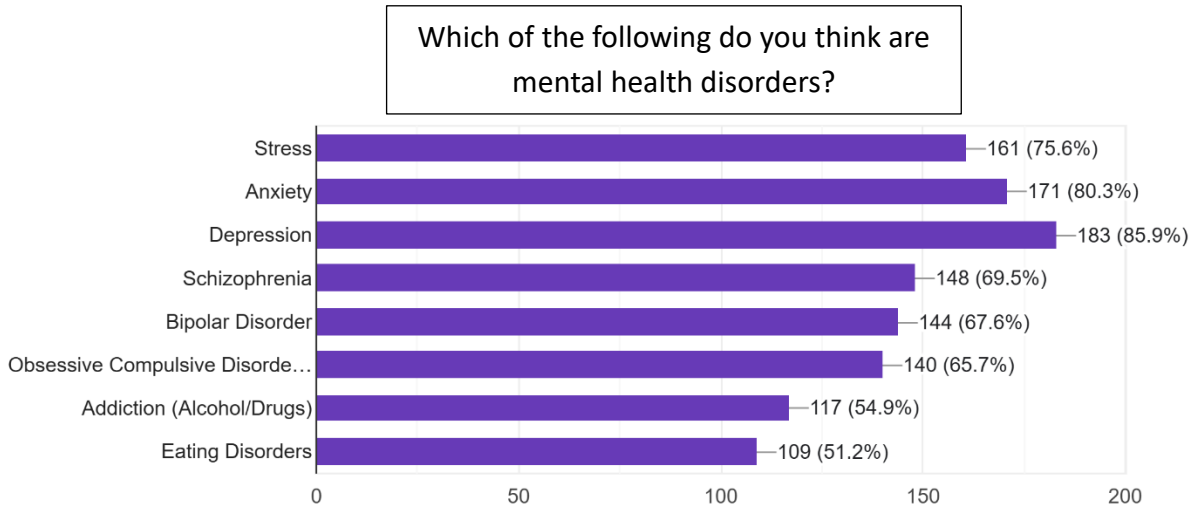

This multiple-response question assessed participants' ability to recognize different conditions as mental health disorders. As shown in the chart, the majority of respondents were able to correctly identify depression (85.9%) and anxiety (80.3%) as mental health disorders, reflecting a strong public awareness of these commonly discussed conditions. Stress was also identified by 75.6% of participants, although it is often considered a symptom or contributing factor rather than a diagnosable disorder in itself. Recognition of more complex psychiatric disorders such as schizophrenia (69.5%), bipolar disorder (67.6%), and obsessive-compulsive disorder (OCD) (65.7%) was slightly lower, suggesting a moderate level of awareness. Notably, only 54.9% and 51.2% of respondents identified addiction (alcohol/drugs) and eating disorders as mental health conditions, respectively, indicating a significant gap in knowledge.

Significant and Marginally Significant KAP Findings

Cross-tabulations revealed nine significant ($p < 0.05$) or marginally significant ($p < 0.10$) associations between demographic variables and KAP indicators, detailed in **Tables 2–10**. These focus on Place of Residence, Living Arrangement, and age, which showed notable patterns. Non-significant crosstabs are summarized in **Table 11**.

Table 2: Place of Residence by Confidence in Using Technology for Mental Health Information (N = 215)

Place of Residence	**Confidence Level (1 = Strongly Disagree, 5 = Strongly Agree)**					**Total**
	1	2	3	4	5	

Place of Residence	Confidence Level (1 = Strongly Disagree, 5 = Strongly Agree)					Total
Rural	1	2	8	2	2	15
Urban	4	9	32	75	80	200
Total	5	11	40	77	82	215
Chi-Square Test	Value = 17.626, df = 4, p = 0.001*					

*Note: *p < 0.01. 2 cells (20%) have expected count < 5; minimum expected count = 0.35.

Urban respondents were significantly more confident than rural counterparts. 80 urban respondents rated 5 (strongly agree), while only 2 rural respondents did so.

Residence had no impact on attitudes, stigma, or basic knowledge. Digital divide remains a critical barrier. Urban dominance (93% of sample) limits the generalizability.

Table 3: Living Arrangement by Perception of Media Portrayal of Mental Health Issues (N = 215)

Living Arrangement	Media Portrayal Accuracy (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
Living alone	12	17	14	9	1	53
With parents	7	16	27	8	10	68
With friends/roommates	7	12	24	9	2	54
With spouse	0	3	4	1	3	11
With extended family	1	4	1	4	3	13
With spouse and parents	1	3	5	3	1	13
With children only	0	0	0	1	0	1
Others	0	0	0	2	0	2

Living Arrangement	Media Portrayal Accuracy (1 = Strongly Disagree, 5 = Strongly Agree)					Total
Total	28	55	75	37	20	215
Chi-Square Test	Value = 44.605, df = 28, p = 0.024*					

*Note: *p < 0.05. 26 cells (65%) have expected count < 5; minimum expected count = 0.09.

Those living with parents or extended family viewed media portrayals more positively, possibly due to group exposure to traditional media and lack of critical scrutiny.

Marginally Significant:

Actively Seeking Information (p = 0.097): Participants living alone or with parents were more proactive in seeking mental health information.

Interpretation: Living with supportive family may promote interest in mental health. Those living alone might seek information due to a sense of autonomy or isolation. These findings support family-targeted IEC.

Table 4: Age by Confidence in Using Technology for Mental Health Information (N = 215)

Age Group	Confidence Level (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	3	4	20	44	27	98
26–35	2	4	17	30	51	104
36–45	0	2	3	2	1	8
45 & above	0	1	0	1	3	5
Total	5	11	40	77	82	215
Chi-Square Test	Value = 24.808, df = 12, p = 0.016*					

*Note: *p < 0.05. 12 cells (60%) have expected count < 5; minimum expected count = 0.12.

Younger age groups, especially 26–35, demonstrated higher technological confidence, likely due to digital nativity and education exposure. The 36+ age group scored lower, indicating digital inclusion gaps that could hinder access to online mental health resources.

Table 5: Age by Secrecy About Mental Illness (N = 215)

Age Group	If I Had a Mental Illness, I Would Not Tell Anyone (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	31	30	15	14	8	98
26–35	33	21	19	20	11	104
36–45	4	1	3	0	0	8
45 & above	5	0	0	0	0	5
Total	73	52	37	34	19	215
Chi-Square Test	Value = 18.930, df = 12, p = 0.090**					

*Note: **p < 0.10 (marginal). 10 cells (50%) have expected count < 5; minimum expected count = 0.44.

Youth (18–25) were more likely to agree they would keep mental illness a secret. This highlights a psychological barrier among the youth, possibly stemming from stigma, peer pressure, or fear of social judgment in educational or workplace settings.

Linear Trends (p-values):

- Mental disorders are common (p = 0.038)
- Recognizing anxiety signs (p = 0.031)
- Willingness to seek professional help (p = 0.033)
- Knowing where to find mental health resources (p = 0.066, marginal)

These trends show that mental health awareness and openness improve with age. Older adults, despite lower digital confidence, demonstrate greater familiarity with symptoms and care-seeking.

Table 6: Living Arrangement by Actively Seeking Mental Health Information (N = 215)

Living Arrangement	Actively Seek Information (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	

Living Arrangement	Actively Seek Information (1 = Strongly Disagree, 5 = Strongly Agree)					Total
Living alone	3	2	12	21	15	53
With parents	1	5	8	28	26	68
With friends/roommates	0	9	14	21	10	54
With spouse	0	1	0	3	7	11
With extended family	1	2	3	1	6	13
With spouse and parents	0	1	2	7	3	13
With children only	0	0	0	1	0	1
Others	0	0	0	1	1	2
Total	5	20	39	83	68	215
Chi-Square Test	Value = 33.792, df = 28, p = 0.097** (Likelihood Ratio p = 0.097)					

*Note: **p < 0.10 (marginal). 27 cells (67.5%) have expected count < 5; minimum expected count = 0.02.

Table 7: Age by Understanding Mental Health Disorders Are Common (N = 215)

Age Group	Mental Health Disorders Are Common (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	3	4	8	23	60	98
26–35	1	2	4	13	84	104
36–45	0	0	1	2	5	8
45 & above	0	0	0	2	3	5
Total	4	6	13	40	152	215

Age Group	Mental Health Disorders Are Common (1 = Strongly Disagree, 5 = Strongly Agree)	Total
Chi-Square Test	Value = 12.723, df = 12, p = 0.389, Linear-by-Linear = 4.305, p = 0.038*	

*Note: *p < 0.05 (Linear-by-Linear). 13 cells (65%) have expected count < 5; minimum expected count = 0.09.

Table 8: Age by Recognizing Anxiety Disorder Signs (N = 215)

Age Group	Recognize Anxiety Signs (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	4	10	23	36	25	98
26–35	3	7	11	48	35	104
36–45	0	0	2	2	4	8
45 & above	0	0	1	3	1	5
Total	7	17	37	89	65	215
Chi-Square Test	Value = 12.085, df = 12, p = 0.439, Linear-by-Linear = 4.668, p = 0.031*					

*Note: *p < 0.05 (Linear-by-Linear). 12 cells (60%) have expected count < 5; minimum expected count = 0.16.

Table 9: Age by Seeking Professional Help for Mental Health Challenges (N = 215)

Age Group	Would Seek Professional Help (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	4	3	14	41	36	98
26–35	1	4	14	25	60	104

Age Group	Would Seek Professional Help (1 = Strongly Disagree, 5 = Strongly Agree)					Total
36–45	0	0	2	4	2	8
45 & above	0	0	0	1	4	5
Total	5	7	30	71	102	215
Chi-Square Test	Value = 16.843, df = 12, p = 0.156, Linear-by-Linear = 4.529, p = 0.033*					

*Note: *p < 0.05 (Linear-by-Linear). 14 cells (70%) have expected count < 5; minimum expected count = 0.12.

Table 10: Age by Knowing Where to Find Mental Health Resources (N = 215)

Age Group	Know Where to Find Resources (1 = Strongly Disagree, 5 = Strongly Agree)					Total
	1	2	3	4	5	
18–25	3	10	30	34	21	98
26–35	3	6	17	32	46	104
36–45	0	1	3	3	1	8
45 & above	0	0	2	2	1	5
Total	6	17	52	71	69	215
Chi-Square Test	Value = 17.472, df = 12, p = 0.133, Linear-by-Linear = 3.375, p = 0.066**					

*Note: **p < 0.10 (Linear-by-Linear, marginal). 12 cells (60%) have expected count < 5; minimum expected count = 0.14.

4.2 Summary of All Crosstabs

Table 11: Summary of All Cross-Tabulations (N = 215)

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
Gender	Heard of MH Disorders	0.003	1	0.956
	MH Disorders Common	4.186	4	0.381
	MH Illness = Weakness	2.796	4	0.592
	Identify Depression	1.484	4	0.829
	Recognize Anxiety	2.502	4	0.644
	Differentiate Emotions	2.966	4	0.564
	Trauma Causes MH Illness	6.196	4	0.185
	Social/Economic Factors	3.770	4	0.438
	Respect for MH Illness	4.600	4	0.331
	Comfort Talking MH	2.216	4	0.697
	Secrecy About MH Illness	3.561	4	0.469
	Avoid MH Illness People	1.783	4	0.776
	Seeking Help = Weakness	4.148	4	0.386
	Would Seek Professional Help	2.947	4	0.567
	Know MH Resources	1.523	4	0.823
	Confident Using Technology	4.216	4	0.378
	Online Resources Reliable	2.095	4	0.718
	Manage Own MH	4.127	4	0.389
	Actively Seek MH Info	1.058	4	0.901
	Stress Management	3.127	4	0.536

Demographic Variable	**KAP Indicator (Abbreviated)**	X^2	*df*	*p-value*
	Media Portrayal Accurate	5.243	4	0.263
Occupation	Heard of MH Disorders	3.158	6	0.789
	MH Disorders Common	18.480	24	0.780
	MH Illness = Weakness	25.177	24	0.395
	Identify Depression	17.903	24	0.806
	Recognize Anxiety	20.256	24	0.678
	Differentiate Emotions	18.198	24	0.792
	Trauma Causes MH Illness	20.048	24	0.690
	Social/Economic Factors	20.079	24	0.689
	Respect for MH Illness	22.048	24	0.574
	Comfort Talking MH	15.768	24	0.894
	Secrecy About MH Illness	25.733	24	0.367
	Avoid MH Illness People	24.056	24	0.458
	Seeking Help = Weakness	24.013	24	0.460
	Would Seek Professional Help	19.894	24	0.698
	Know MH Resources	18.054	24	0.800
	Confident Using Technology	22.678	24	0.536
	Online Resources Reliable	26.212	24	0.341
	Manage Own MH	22.142	24	0.570
	Actively Seek MH Info	21.080	24	0.633
	Stress Management	20.652	24	0.655
	Media Portrayal Accurate	31.294	24	0.145

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
Educational Qualifications	Heard of MH Disorders	0.803	2	0.669
	MH Disorders Common	4.978	8	0.759
	MH Illness = Weakness	8.250	8	0.410
	Identify Depression	5.256	8	0.730
	Recognize Anxiety	2.966	8	0.936
	Differentiate Emotions	6.054	8	0.642
	Trauma Causes MH Illness	4.465	8	0.813
	Social/Economic Factors	5.258	8	0.729
	Respect for MH Illness	2.865	8	0.938
	Comfort Talking MH	7.245	8	0.510
	Secrecy About MH Illness	7.054	8	0.530
	Avoid MH Illness People	6.393	8	0.603
	Seeking Help = Weakness	6.751	8	0.562
	Would Seek Professional Help	7.297	8	0.505
	Know MH Resources	5.224	8	0.733
	Confident Using Technology	4.355	8	0.824
	Online Resources Reliable	4.056	8	0.852
	Manage Own MH	4.317	8	0.827
	Actively Seek MH Info	7.159	8	0.520
	Stress Management	3.142	8	0.926
	Media Portrayal Accurate	7.473	8	0.487

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
Place of Residence	Heard of MH Disorders	0.001	1	0.975
	MH Disorders Common	5.480	4	0.241
	MH Illness = Weakness	2.249	4	0.690
	Identify Depression	3.159	4	0.532
	Recognize Anxiety	3.216	4	0.522
	Differentiate Emotions	2.595	4	0.628
	Trauma Causes MH Illness	4.111	4	0.391
	Social/Economic Factors	2.041	4	0.728
	Respect for MH Illness	5.103	4	0.277
	Comfort Talking MH	2.426	4	0.658
	Secrecy About MH Illness	2.139	4	0.710
	Avoid MH Illness People	2.860	4	0.582
	Seeking Help = Weakness	2.572	4	0.632
	Would Seek Professional Help	3.170	4	0.530
	Know MH Resources	4.087	4	0.394
	Confident Using Technology	17.626	4	0.001*
	Online Resources Reliable	1.322	4	0.857
	Manage Own MH	3.247	4	0.517
	Actively Seek MH Info	4.057	4	0.398
	Stress Management	1.955	4	0.744
	Media Portrayal Accurate	3.375	4	0.497

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
Marital Status	Heard of MH Disorders	0.418	2	0.811
	MH Disorders Common	9.260	8	0.321
	MH Illness = Weakness	6.784	8	0.560
	Identify Depression	5.139	8	0.742
	Recognize Anxiety	7.404	8	0.493
	Differentiate Emotions	5.614	8	0.689
	Trauma Causes MH Illness	7.135	8	0.522
	Social/Economic Factors	5.076	8	0.750
	Respect for MH Illness	7.516	8	0.482
	Comfort Talking MH	6.058	8	0.641
	Secrecy About MH Illness	9.133	8	0.331
	Avoid MH Illness People	6.384	8	0.604
	Seeking Help = Weakness	7.150	8	0.520
	Would Seek Professional Help	10.184	8	0.252
	Know MH Resources	5.496	8	0.703
	Confident Using Technology	9.029	8	0.340
	Online Resources Reliable	6.273	8	0.617
	Manage Own MH	8.169	8	0.417
	Actively Seek MH Info	8.305	8	0.404
	Stress Management	5.835	8	0.667
	Media Portrayal Accurate	6.779	8	0.561

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
Living Arrangement	Heard of MH Disorders	8.305	7	0.308
	MH Disorders Common	28.184	28	0.451
	MH Illness = Weakness	27.232	28	0.508
	Identify Depression	25.250	28	0.614
	Recognize Anxiety	24.599	28	0.649
	Differentiate Emotions	21.258	28	0.811
	Trauma Causes MH Illness	30.345	28	0.346
	Social/Economic Factors	22.141	28	0.771
	Respect for MH Illness	24.192	28	0.669
	Comfort Talking MH	25.159	28	0.615
	Secrecy About MH Illness	22.571	28	0.750
	Avoid MH Illness People	24.181	28	0.670
	Seeking Help = Weakness	25.444	28	0.600
	Would Seek Professional Help	28.349	28	0.441
	Know MH Resources	23.548	28	0.707
	Confident Using Technology	30.135	28	0.356
	Online Resources Reliable	34.857	28	0.174
	Manage Own MH	26.749	28	0.532
	Actively Seek MH Info	33.792	28	0.097**
	Stress Management	33.006	28	0.236
	Media Portrayal Accurate	44.605	28	0.024*
Age	Heard of MH Disorders	2.832	3	0.418

Demographic Variable	KAP Indicator (Abbreviated)	X^2	*df*	*p-value*
	MH Disorders Common	12.723	12	0.389
	MH Illness = Weakness	18.341	12	0.106
	Identify Depression	7.392	12	0.831
	Recognize Anxiety	12.085	12	0.439
	Differentiate Emotions	7.992	12	0.786
	Trauma Causes MH Illness	10.025	12	0.614
	Social/Economic Factors	13.765	12	0.316
	Respect for MH Illness	7.765	12	0.803
	Comfort Talking MH	9.582	12	0.653
	Secrecy About MH Illness	18.930	12	0.090**
	Avoid MH Illness People	14.573	12	0.266
	Seeking Help = Weakness	15.543	12	0.213
	Would Seek Professional Help	16.843	12	0.156
	Know MH Resources	17.472	12	0.133
	Confident Using Technology	24.808	12	0.016*
	Online Resources Reliable	11.589	12	0.479
	Manage Own MH	14.103	12	0.294
	Actively Seek MH Info	11.081	12	0.522
	Stress Management	9.940	12	0.621
	Media Portrayal Accurate	13.233	12	0.352

*Note: *$p < 0.05$; **$p < 0.10$ (marginal). Linear-by-Linear Association p-values reported where significant.

Of the 148 crosstabs, 9 were statistically or marginally significant and 138 were non-significant, likely due to sample skew toward urban, young, and highly educated individuals. The most impactful variables were age, residence, and living arrangement.

Youth: address stigma and secrecy, promote professional help-seeking.

Rural populations: address digital access gaps.

Solitary or family-living individuals: leverage motivation for self-learning or familial support.

4.3 Interpretation

The results provide a nuanced understanding of mental health literacy among 215 Indian adults, highlighting demographic influences on KAP. The sample's composition—94% aged 18–35, 93% urban, 94.4% with graduate or postgraduate qualifications, 48.4% students, and 85.1% single—reflects a young, educated, urban cohort with high baseline awareness (92.6% had heard of mental health disorders). This aligns with studies noting elevated mental health literacy in urban Indian populations [5,6]. However, the underrepresentation of rural (7%) and older respondents (6% aged 36+) limits generalizability.

4.3.1 Sociodemographic variables v/s Knowledge indicators

- **Age Group and Awareness of Mental Health Disorders**

When examining the association between age and awareness of mental health disorders, it was observed that in the 18–25 years age group, 89.8% of participants reported having heard about mental health disorders, while 10.2% had not. In the 26–35 years category, awareness was slightly higher, with 95.2% reporting familiarity and only 4.8% lacking awareness. Among those aged 36–45 years, 87.5% were aware and 12.5% were not. In the 45 years and above group, all participants (100%) reported having heard of mental health disorders.

- **Gender Differences in Awareness of Mental Health Disorders**

The results indicate a statistically significant association between gender and awareness of mental health disorders ($\chi^2 = 4.062$, $df = 1$, $p = 0.044$), suggesting that gender influences the likelihood of having heard about mental health disorders.

Among females, a striking 95.8% (114 out of 119) reported that they had heard about mental health disorders, while only 4.2% had not. In contrast, among males, 88.5% (85 out of 96) were aware, while 11.5% were not. This finding suggests that females in the sample were more likely to be aware of mental health disorders compared to males. The significant p-

value indicates that this difference is unlikely to be due to chance, and may reflect underlying factors such as differential exposure to mental health education, openness to health information, or societal roles in caregiving and health-seeking behaviors.

- **Gender Differences in Understanding That Mental Health Disorders Are Common and Can Affect Anyone**

The chi-square test reveals a statistically significant association between gender and understanding that mental health disorders are common and can affect anyone ($\chi^2 = 10.859$, $df = 4$, $p = 0.028$). This suggests that gender plays a role in how participants perceive the prevalence and universality of mental health disorders.

Among female participants, a substantial 78.2% (93 out of 119) strongly agreed with the statement, while another 16.8% either agreed or were neutral. Whereas, among male participants, 61.5% (59 out of 96) strongly agreed, and 20.8% agreed, while 17.7% were neutral or disagreed to some extent. These results suggest that females are more likely than males to recognize that mental health disorders are common and non-discriminatory.

- **Occupation and Awareness of Mental Health Disorders**

Among government employees (n=16), all respondents (100%) reported having heard about mental health disorders, reflecting a high level of awareness in this group. Similarly, private sector employees also demonstrated strong awareness, with 95.2% (n=59 out of 62) responding affirmatively. Among self-employed individuals, 92% (n=23 out of 25) had heard about mental health disorders. Students, the largest group in the sample, showed a high level of awareness as well—90.4% (n=94 out of 104) reported having heard about mental health disorders. In contrast, lower awareness was observed among homemakers, where only 66.7% (n=2 out of 3) responded positively.

Overall, 199 out of 215 respondents (92.6%) had heard about mental health disorders, indicating a generally high level of mental health awareness across occupational groups, with particularly strong awareness among those in formal employment and educational settings.

- **Occupation and Awareness of Mental Health Resources or Support in the Community**

Among government employees, the majority (15 out of 16) reported higher levels of agreement, suggesting strong awareness of local mental health resources, possibly due to better access through workplace programs or institutional information channels. Private

sector employees also showed relatively high awareness, with 41 out of 62 respondents choosing either "4" or "5." This indicates that structured workplace environments may be contributing positively to the dissemination of mental health information. Similarly, self-employed individuals reported a fair level of awareness, though a few responses in lower categories suggest variability depending on individual exposure and networks. Students, while showing a broad spread of responses, also leaned positively.

However, homemakers, those unemployed, and respondents from other occupational categories demonstrated lower awareness.

- **Educational Qualifications and Awareness of Mental Health Disorders**

The crosstab analysis of educational qualifications and awareness of mental health disorders shows that the majority of participants across all education levels have heard about mental health disorders. Among graduates, 80 out of 85 reported awareness, while among those with postgraduate and higher education, 110 out of 118 were aware. For participants with senior secondary education (up to 12th grade), 9 out of 12 had heard about mental health disorders. There is a trend indicating that higher educational qualifications may be associated with greater awareness of mental health disorders, the association is not statistically significant at the 5% level in this sample.

- **Educational Qualifications and Understanding That Mental Health Disorders Are Common and Can Affect Anyone**

Among graduates, the majority (60 out of 85) strongly agreed with this statement (rating 5), while 18 selected a rating of 4. Similarly, participants with postgraduate and above qualifications showed strong agreement, with 88 out of 118 choosing rating 5 and 18 rating 4. For those with senior secondary education, responses were more evenly distributed, though 4 out of 12 strongly agreed.

The Pearson Chi-Square test value of 17.880 with 8 degrees of freedom yielded a p-value of 0.022, indicating a statistically significant association between educational qualifications and understanding that mental health disorders are common and can affect anyone. This suggests that higher educational attainment is linked with greater awareness and acceptance of the prevalence and universality of mental health disorders among the study participants.

- **Relationship Between Place of Residence and Awareness of Mental Health Resources in the Community**

The data indicated noticeable differences in awareness of mental health resources based on place of residence. Among the 15 rural respondents, the majority 53.3% gave a neutral response, while 26.7% agreed, and 13.3% strongly agreed, indicating limited but moderate awareness. In contrast, among the 200 urban participants, 33.5% agreed and another 33.5% strongly agreed that they know where to find mental health resources, suggesting a higher level of awareness.

- **Association Between Marital Status and Awareness of Mental Health Disorders**

The association between marital status and awareness of mental health disorders highlights generally high levels of awareness across all categories. Among single individuals, who constituted the majority of the sample (85.1%), 93.4% reported having heard about mental health disorders. In comparison, 86.7% of married participants indicated awareness, while the remaining 13.3% had not heard about such conditions. Notably, both respondents who identified as divorced or separated (0.9% of the sample) demonstrated complete awareness. However, awareness remains high across all groups, indicating a positive trend in public knowledge irrespective of marital status.

4.3.2 Sociodemographic variables v/s Attitude indicators

- **Age Group and Belief That Mental Illness Is a Sign of Personal Weakness**

Perceptions of mental illness as a sign of personal weakness varied across age groups. Among participants aged 18–25 years, 32.7% strongly agreed with the statement. Similarly, in the 26–35 years group, 35.6% strongly agreed. In the 36–45 years group, responses were more polarized: 12.5% strongly agreed, whereas 50% strongly disagreed with the belief that mental illness is a sign of weakness—suggesting stronger rejection of the stigma in this age group. For participants 45 years and above, 60% strongly agreed. Notably, none in this group disagreed or strongly disagreed, indicating a more stigmatized view toward mental illness in older adults. Overall, younger and middle-aged adults showed more variability in responses, with a notable proportion disagreeing or strongly disagreeing with the stigma. In contrast, older individuals tended to either agree or remain neutral, with few expressing strong disagreement.

- **Age Group and Belief That Traumatic Life Experiences Can Lead to Mental Illness**

Belief in the link between traumatic life experiences and the development of mental illness was overwhelmingly positive across all age groups. Among participants aged 18–25 years, 57.1% strongly agreed and 29.6% agreed with the statement, indicating that over 86% recognized trauma as a contributing factor to mental illness. In the 26–35 years group, the trend was similar: 59.6% strongly agreed and 29.8% agreed, amounting to nearly 90% expressing some level of agreement. Among those aged 36–45 years, half (50%) strongly agreed and 25% agreed, indicating a total of 75% agreement. In the 45 years and above category, responses were more varied. While 20% strongly agreed and 60% agreed with the statement.

Overall, belief in the role of trauma in mental illness was strongest among the 18–35 age groups, where nearly 9 in 10 participants expressed agreement. These findings suggest a widespread awareness across all age groups about the impact of traumatic experiences on mental health, with younger adults showing the strongest consensus.

- **Age Group and Belief in the Impact of Social and Economic Factors on Mental Health**

The belief that social and economic factors influence mental health was strongly endorsed by participants across all age groups, particularly among younger adults. In the 18–25 years age group, 39.8% strongly agreed and 36.7% agreed with the statement, making a combined 76.5% who acknowledged the impact of socio-economic conditions on mental health. Among those aged 26–35 years, 42.3% strongly agreed and 37.5% agreed, with a total of 79.8% expressing agreement. In the 36–45 years group, agreement was more evenly distributed: 25% strongly agreed and 25% agreed, for a total of 50% agreement. In the 45 years and above group, 80% either strongly agreed or agreed with the statement.

Overall, the results indicate a broad consensus across age groups that social and economic determinants significantly influence mental health, with the strongest affirmation seen in the 18–35 age range.

- **Age-wise Perspectives on Equality of Respect for Mental and Physical Illness**

A strong majority of participants across all age groups agreed that individuals with mental illnesses deserve the same respect as those with physical illnesses. In the 18–25 years group,

60.2% strongly agreed, whereas among those aged 26–35 years, support was even stronger, with 66.3% strongly agreeing. In the 36–45 years group, 62.5% strongly agreed and for the 45 years and above group, 80% strongly agreed. Overall, these findings reflect high levels of positive attitudes toward individuals with mental illnesses across all age groups, with the strongest endorsement observed among the 26–35 and 45+ age groups. This suggests that while respect for those with mental illnesses is widely supported, younger adults (18–25) still show slightly more variability in their attitudes compared to their older peers.

- **Age Group and Comfort in Discussing Mental Health with Close Friends or Family**

Comfort levels in discussing mental health with close friends or family varied across age groups, with a generally positive but mixed trend. Among participants aged 18–25 years, 32.7% strongly agreed and another 32.7% agreed that they felt comfortable talking about their mental health, totaling 65.4% expressing comfort. In the 26–35 years group, 40.4% strongly agreed and 29.8% agreed, with a combined 70.2% reporting comfort in sharing mental health concerns with close contacts. Among those aged 36–45 years, the distribution was more balanced. Only 12.5% strongly agreed, and 37.5% agreed, together accounting for 50% who felt comfortable. In the 45 years and above category, 60% strongly agreed and 40% agreed, showing full agreement that they feel comfortable discussing mental health with close family or friends.

Overall, the majority of participants, especially in the younger (18–35) and older (45+) groups, felt comfortable talking about mental health with close contacts.

- **Age and Perceptions of Seeking Professional Help as a Sign of Weakness**

Across all age groups, there was a strong rejection of the belief that seeking professional help for mental health is a sign of weakness. Among individuals aged 18–25 years, a significant majority—59.2%—strongly disagreed with this belief, while another 12.2% disagreed. In the 26–35 years group, the rejection of this stigma was even more pronounced: 66.3% strongly disagreed and 10.6% disagreed, resulting in 76.9% of this group opposing the belief that seeking help is a sign of weakness. Among the 36–45 years age group, 37.5% strongly disagreed and 25% disagreed, although this group showed smaller numbers overall, the majority were still against the stigma. The oldest group, 45 years and above, showed similar

patterns with 80% strongly disagreeing and 20% strongly agreeing, with no responses in the middle categories. This shows that nearly 74% of the sample outright rejected this stigma.

- **Age and Willingness to Seek Professional Help for Mental Health Challenges**

Overall, there was a strong positive inclination across all age groups toward seeking professional help for mental health challenges, with clear age-wise variations.

In the 18–25 years age group, 36.7% strongly agreed and 41.8% agreed that they would seek professional help, meaning a combined 78.5% were positively inclined. Among participants aged 26–35 years, 57.7% strongly agreed and 24.0% agreed to seeking professional help, totaling an even higher 81.7% with a proactive attitude. In the 36–45 years group, 25.0% strongly agreed and 50.0% agreed—adding up to 75.0% expressing willingness to seek help. The 45 years and above group had the strongest affirmation: 80.0% strongly agreed and 20.0% agreed. Notably, no participant in this group expressed disagreement or neutrality, reflecting a unanimous willingness to seek professional help.

- **Association Between Age Group and likelihood to Disclose Mental Illness**

When asked whether they would keep a mental illness secret, responses varied by age group but tended toward nondisclosure concerns. In the 18–25 years group, 31.6% strongly disagreed with the statement (indicating they would disclose), 30.6% disagreed, and 15.3% were neutral. However, 14.3% agreed, and 8.2% strongly agreed that they would not tell anyone if they had a mental illness. This suggests that around 22.5% of young adults might be reluctant to disclose.

Among participants aged 26–35 years, a slightly lower proportion, 31.7% strongly disagreed and 20.2% disagreed, with 18.3% neutral. Still, about 19.2% agreed and 10.6% strongly agreed with non-disclosure, showing some hesitation in sharing mental health issues.

For the 36–45 years group, most participants strongly disagreed (50%), indicating a preference for disclosure, while 12.5% disagreed and 37.5% were neutral. None expressed agreement to withholding information.

In the 45 years and above group, 100% strongly disagreed with not telling anyone, showing a complete willingness to disclose.

- **Gender Differences in the Belief That Mental Illness Is a Sign of Personal Weakness**

The chi-square test yielded a value of $\chi^2 = 8.548$ with $df = 4$ and a $p\text{-value} = 0.073$, which indicates the result is marginally close to significance, suggesting a potential trend worth noting.

Among females, 42.0% (50 out of 119) strongly disagreed with the statement, indicating that they do not believe mental illness is a sign of weakness. Among males, only 24.0% (23 out of 96) strongly disagreed, with higher proportions spread across other responses (indicating stronger agreement with the belief). This trend implies that females are more likely to reject the stigma that mental illness equates to personal weakness, whereas males demonstrated a more distributed response, with some leaning toward agreement.

- **Gender and Attitudes Toward Equal Respect for Mental and Physical Illnesses**

The Pearson chi-square test shows a statistically significant association between gender and this belief ($\chi^2 = 15.401$, $df = 4$, $p = 0.004$). This indicates that attitudes toward respect for individuals with mental illness differ significantly by gender.

Looking at the distribution, among females, a strong 74.8% (89 out of 119) strongly agreed with the statement, and another 14.3% selected "4" — suggesting an overwhelming majority (nearly 89%) of women support equal respect for mental and physical illnesses. Whereas, among males, only 50.0% (48 out of 96) strongly agreed, while 28.1% selected "4". Thus, while about 78% of males showed agreement overall, their intensity of agreement was notably lower than that of females.

- **Gender and Comfort Discussing Mental Health with Close Friends or Family**

Among females, 38.7% (46 out of 119) strongly agreed and 35.3% (42 out of 119) selected “4”. This means approximately 74% of women felt comfortable or very comfortable discussing their mental health with close ones. Among males, 33.3% (32 out of 96) strongly agreed and 27.1% (26 out of 96) selected “4”, totaling about 60.4% showing comfort.

While both genders exhibit a general willingness to talk about their mental health, females were noticeably more comfortable and expressive about discussing mental health issues with family or close friends than males.

- **Gender and the Willingness to Disclose Mental Illness**

Among females, 36.1% (43 out of 119) strongly disagreed with the statement, indicating they would be willing to disclose a mental illness. Among males, 31.3% (30 out of 96) strongly disagreed. Thus, fewer males than females showed outright willingness to disclose, though the difference is not very large. In summary, both genders show a sizable proportion willing to share if they had a mental illness, but females demonstrate slightly more openness toward disclosure.

- **Gender and the Belief that Seeking Professional Help for Mental Health Problems Is a Sign of Weakness**

The chi-square test indicates a statistically significant difference between genders (χ^2 = 11.042, p = .026), suggesting gender influences beliefs about seeking professional help and weakness.

Among females, a substantial 70.6% (84 out of 119) strongly disagreed with the statement, indicating most women do not consider seeking professional help as a sign of weakness. Among males, 52.1% (50 out of 96) strongly disagreed, which is lower than females. In summary, while the majority of both genders reject the idea that seeking help is a weakness, females are more confident and less stigmatizing in this belief compared to males, who show somewhat more ambivalence or stigma around professional mental health support.

- **Gender and Willingness to Seek Professional Help for Mental Health Challenges**

Among females (119 participants), 51.3% (61) strongly agreed (rating 5) that they would seek professional help, and another 33.6% (40) agreed (rating 4). Together, this means approximately 85% of females are willing to seek professional help. Among males (96 participants), 42.7% (41) strongly agreed and 32.3% (31) agreed, totaling about 75% of males showing willingness to seek professional help.

This data suggests that females are more likely than males to seek professional help.

- **Occupation and the Belief: "Mental Illness Is a Sign of Personal Weakness"**

The analysis of the association between occupation and the belief that *mental illness is a sign of personal weakness* reveals a statistically significant relationship (χ^2 = 44.496, p = .007). Among government employees, responses were mixed, with some expressing strong disagreement with the stigma and others leaning towards agreement. Private sector

employees showed a more favorable attitude overall, with a large proportion (29 out of 62) strongly disagreeing with the statement, although a notable number still held stigmatizing views. Students, who formed the largest group in the sample, also predominantly rejected the idea that mental illness is a sign of weakness, though some displayed uncertainty or partial agreement. On the other hand, self-employed individuals demonstrated more divided opinions, with responses spread across the scale and a slightly higher proportion showing agreement, suggesting a relatively greater level of stigma in this group. Homemakers, unemployed individuals, and those categorized as "other" comprised small subgroups, but responses from these participants reflected a range of beliefs, with some endorsing the stigma. Overall, the findings highlight that occupational background can influence beliefs about mental health, with those in more structured or institutional employment, such as students and private sector employees, generally exhibiting more progressive views.

- **Occupation and the Statement: "If I Had a Mental Illness, I Would Not Tell Anyone"**

The cross-tabulation between occupation and the statement *"If I had a mental illness, I would not tell anyone"* provides insight into the varying levels of openness across employment groups. A significant portion of government employees indicated they would be open about their mental illness, with 6 respondents strongly disagreeing and only 2 strongly agreeing with the statement. Private sector employees showed a similar trend, with 26 out of 62 strongly disagreeing.

Among students, responses were widely distributed, though the largest group (32 out of 104) strongly disagreed with hiding their mental illness. Self-employed individuals exhibited a more cautious approach, with fewer strongly disagreeing and a greater spread across the neutral and agreement categories—highlighting possible concerns about professional or social repercussions.

- **Occupation and Belief that Seeking Professional Help for Mental Health Problems Is a Sign of Weakness**

Among government employees, a strong majority (10 out of 16) strongly disagreed with the statement, indicating that they largely reject the stigma associated with seeking help. Similarly, private sector employees showed high levels of disagreement, with 44 out of 62 respondents strongly rejecting the idea that seeking help is a sign of weakness.

Students, the largest occupational group in the sample, also demonstrated progressive attitudes: 62 out of 104 strongly disagreed with the statement, showing an encouraging trend among younger individuals toward destigmatizing help-seeking behavior.

Self-employed individuals and homemakers presented more mixed attitudes. In general, individuals employed in structured work environments and students tend to reject the notion that seeking help is a sign of weakness.

- **Occupation and Willingness to Seek Professional Help for Mental Health Challenges**

Among government employees, the willingness to seek professional help is strong, with 11 out of 16 respondents selecting "5" (strongly agree) and 4 selecting "4," indicating a generally proactive attitude. Private sector employees also displayed high levels of agreement, with more than 80% (51 out of 62) indicating agreement (levels 4 or 5).

Students, the largest occupational group in the study, also show a positive trend. A combined 81 out of 104 respondents selected either "4" or "5," indicating that younger individuals—likely more exposed to mental health education—are open to seeking help.

Self-employed individuals presented moderate agreement, with 21 out of 25 selecting "4" or "5".

- **Educational Qualifications and Beliefs About Mental Illness as a Sign of Personal Weakness**

Among graduates (n = 85), 25.9% (22 individuals) strongly disagreed with this belief, while others were distributed across the spectrum, with 18.8% disagreeing somewhat, and smaller percentages agreeing to varying degrees. For participants with postgraduate and above qualifications (n = 118), a higher proportion, 43.2%, strongly disagreed, indicating lower stigma in this group. Meanwhile, those with senior secondary education or below (n = 12) showed less strong disagreement, with 25% somewhat disagreeing and some agreement present as well.

The Chi-Square test ($\chi^2 = 16.595$, df = 8, p = .035) confirms a statistically significant association between educational level and the belief that mental illness is a sign of personal weakness. Overall, the data suggest that individuals with higher educational qualifications

are less likely to view mental illness as a personal weakness, reflecting lower stigma among more educated participants.

- **Educational Qualifications and Beliefs About Seeking Professional Help for Mental Health Problems as a Sign of Weakness**

Among graduates (n = 85), 58.8% strongly disagreed with the statement, while smaller proportions expressed mild disagreement (14.1%). Participants with postgraduate and above qualifications (n = 118) showed even stronger rejection of this stigma, with 66.1% strongly disagreeing and 7.6% somewhat disagreeing. Conversely, among those with senior secondary education (n = 12), a smaller proportion (50%) strongly disagreed, with 33.3% somewhat disagreeing.

The Chi-square test result ($\chi^2 = 15.178$, df = 8, p = .056) suggests that although a clear trend exists—whereby higher education is associated with lower agreement to the stigma—the association is not statistically significant at the conventional 0.05 level, but is near-significant, indicating a potential trend worth further exploration.

- **Place of Residence and Belief in Equal Respect for People with Mental Illnesses Compared to Those with Physical Illnesses**

The analysis of responses based on place of residence showed a generally positive attitude towards equitable treatment for individuals with mental illnesses. Among the 15 rural participants, nearly half (46.7%) strongly agreed with the statement, while 4 (26.7%) selected 4. Among the 200 urban participants, a larger majority expressed strong agreement: 130 (65%) chose score 5, and 40 (20%) chose score 4. While both rural and urban groups demonstrated support for equal respect towards mental and physical illnesses, urban residents showed a stronger inclination toward strongly agreeing.

- **Relationship Between Place of Residence and Willingness to Disclose Mental Illness**

The analysis revealed a significant association between place of residence and participants' willingness to disclose a mental illness. Among the 15 rural respondents, the majority (60%) selected score 2 (disagreeing), while 3 (20%) strongly disagreed (score 1). In contrast, among the 200 urban participants, 70 (35%) strongly disagreed (score 1), and 43 (21.5%) disagreed (score 2). Notably, urban respondents were more likely to express higher reluctance (scores 4 and 5) compared to rural ones. The Chi-square test value was 12.253 with p = 0.016,

indicating a statistically significant association between place of residence and attitudes toward disclosing mental illness.

- **Relationship Between Marital Status and Willingness to Disclose Mental Illness**

Regarding the statement "If I had a mental illness, I would not tell anyone," the responses varied across marital status groups. Among divorced or separated individuals (0.9% of the sample), both respondents strongly disagreed with the statement. Among married participants (14% of the sample), a majority also disagreed, with 43% strongly disagreeing and 23% somewhat disagreeing. In contrast, among single participants (85.1% of the sample), a notable proportion expressed reluctance to disclose mental illness, with approximately 32% strongly agreeing and another 25% somewhat agreeing that they would not tell anyone if they had a mental illness.

- **Relationship Between Living Arrangement and Comfort Discussing Mental Health with Close Friends or Family**

The data on comfort levels discussing mental health with close friends or family varied across different living arrangements. Among those living alone (53 respondents), 21 individuals (39.6%) strongly agreed that they feel comfortable talking about their mental health, while 13 (24.5%) somewhat agreed. Those living with parents (68 respondents) showed a similar pattern, with 22 (32.4%) strongly agreeing and 26 (38.2%) somewhat agreeing. Individuals living with friends or roommates (54 respondents) had 18 (33.3%) strongly agreeing and 18 (33.3%) somewhat agreeing. Respondents living with extended family (13) also reported comfort but in smaller numbers, with 6 (46.2%) strongly agreeing. In contrast, those living alone and in other arrangements had a more mixed response, with some expressing discomfort or neutrality.

- **Association Between Living Arrangement and Beliefs About Seeking Professional Help for Mental Health Problems as a Sign of Weakness**

Among those living alone (53 respondents), a majority of 34 individuals (64.2%) strongly disagreed with this belief, indicating a more positive attitude towards seeking professional help. Similarly, respondents living with parents (68) also showed strong disagreement, with 51 (75.0%) strongly disagreeing. Participants living with friends or roommates (54) had 31 (57.4%) strongly disagreeing, while those living with extended family (13) showed

somewhat mixed responses but still had nearly half (6 respondents, 46.2%) strongly disagreeing.

In contrast, smaller groups such as those living with spouse and parents (13) and others (2) showed more varied opinions, with some agreeing or being neutral. The chi-square test indicated a statistically significant association between living arrangement and attitudes towards seeking professional help for mental health ($\chi^2 = 47.643$, df = 28, p = .012), suggesting that where a person lives may influence their perception of professional mental health support.

- **Perception of Media Portrayal of Mental Health Issues by Living Arrangement**

The perception of how accurately media and movies portray mental health issues varies across different living arrangements. Among those living alone (53 participants), a notable portion expressed skepticism or disagreement, with 12 (22.6%) strongly disagreeing (1) and 17 (32.1%) somewhat disagreeing (2). Only 10 (18.9%) rated this portrayal positively (4 or 5). Participants living with parents (68) showed a more balanced view, with 23 (33.8%) disagreeing (rating 1 or 2) but a considerable number, 18 (26.5%), agreeing that media portrayals are accurate (rating 4 or 5). Those living with friends or roommates (54) had a mixed perspective, with 19 (35.2%) disagreeing and 11 (20.4%) agreeing. Smaller groups such as those living with extended family, spouse, or spouse and parents showed a somewhat more positive perception, with some participants rating accuracy higher (ratings 4 and 5).

The chi-square test indicates a statistically significant association between living arrangement and views on media accuracy in portraying mental health issues (χ^2 (28) = 44.605, p = 0.024). This suggests that where people live may influence their perception of how well media represents mental health, with those living alone tending to be more critical compared to others living with family or roommates.

4.3.3 Sociodemographic variables v/s Practice indicators

- **Age and Confidence in Using Technology to Seek Mental Health Information**

Confidence in using digital tools to access mental health information varied significantly across age groups, with a clear trend of greater confidence among younger participants.

In the 18–25 years group, 27.6% strongly agreed and 44.9% agreed that they were confident using a computer or phone to find information about mental illness. Participants aged 26–35

years showed slightly higher levels of confidence, with 49.0% strongly agreeing and 28.8% agreeing—adding up to 77.8% expressing confidence. In contrast, confidence levels were lower in the 36–45 years group. Only 12.5% strongly agreed and 25.0% agreed. For the 45 years and above group, 60.0% strongly agreed or agreed. Despite the small sample size, the data suggest a mixed level of digital confidence among older adults.

Overall, 73.9% of the total sample (across all age groups) reported confidence (either agree or strongly agree), 18.6% were neutral, and only 7.4% expressed a lack of confidence.

The Pearson chi-square test yielded a statistically significant result ($\chi^2 = 24.808$, df = 12, p = .016), indicating a significant association between age and digital confidence. Younger individuals (particularly those aged 18–35) are significantly more confident in using digital tools to seek mental health information, while confidence tends to decline with age.

- **Age-wise Differences in Practicing Stress Management Techniques**

Across the total sample of 215 individuals, a majority demonstrated moderate to strong engagement in stress management practices. However, variations were observed across different age groups.

In the 18–25 years group, 35.7% agreed and 16.3% strongly agreed that they practiced stress management techniques when overwhelmed. In the 26–35 years group, the results were slightly more favorable: 31.7% agreed and 27.9% strongly agreed. Among those aged 36–45 years, 25.0% agreed and another 25.0% strongly agreed, suggesting that 50.0% of this group reported using stress management techniques. In the 45 and above group, 40.0% agreed and 20.0% strongly agreed, totaling 60.0% positive responses.

When viewed overall, 33.5% of respondents agreed and 22.3% strongly agreed—indicating that 55.8% of the entire sample actively practiced stress management. These results reflect that over half of the respondents reported engaging in stress management practices when overwhelmed, with slightly higher participation in the 26–35 and 45+ age groups. However, the notably high percentage of neutral responses—especially among younger individuals—suggests a potential gap in consistent or confident use of stress management techniques, highlighting an area for future intervention or mental health education.

- **Gender and Active Seeking of Information to Learn More About Mental Health**

For females (119 participants), 37.0% (44) strongly agreed (rating 5) and 37.8% (45) agreed (rating 4), indicating that about 75% of females actively seek information about mental health. For males (96 participants), 25.0% (24) strongly agreed and 39.6% (38) agreed, meaning approximately 64.6% of males actively seek information, which is lower compared to females. This suggests that females are more proactive than males in seeking information to learn about mental health.

- **Gender and Practice of Stress Management Techniques When Feeling Overwhelmed**

Among females (119 participants), 26.9% (32) strongly agreed (rating 5) and 32.8% (39) agreed (rating 4) that they practice stress management techniques, totaling about 60% of females who regularly use such methods. Among males (96 participants), 16.7% (16) strongly agreed and 34.4% (33) agreed, making approximately 51% of males who regularly practice stress management techniques. This indicates that females tend to practice stress management techniques slightly more frequently than males, though a considerable portion of both genders are neutral or inconsistent in their use of such strategies when feeling overwhelmed.

- **Occupation and Engagement in Self-Management of Mental Health (e.g., Self-Care, Mindfulness, Exercise)**

Among government employees, most respondents reported actively managing their mental health, with 15 out of 16 selecting either “4” or “5.” Similarly, private sector employees showed a positive trend, with 42 out of 62 respondents indicating moderate to high engagement in mental health management (selecting “4” or “5”). Among students, there is a notable inclination towards self-care, with 76 out of 104 selecting “4” or “5,” indicating that many young adults are actively adopting mental health management strategies, possibly influenced by educational campaigns or peer networks. Self-employed individuals also demonstrated moderate engagement, with 22 out of 25 choosing “4” or “5,” showing a relatively strong commitment to managing their mental health despite potentially variable work environments. Overall, the data indicates that the majority of respondents across occupations recognize the importance of managing their mental health and take active steps to do so, though there is some variability, particularly in smaller or less structured occupational categories.

- **Occupation and Practice of Stress Management Techniques When Feeling Overwhelmed**

Among government employees, the majority reported practicing stress management techniques moderately to frequently. Private sector employees showed a wide distribution of responses, but a significant number (51 out of 62) reported moderate to high engagement (scores 3, 4, or 5) in stress management. This indicates a reasonable awareness and practice of stress-relief techniques within this group, although some variability exists possibly due to differing job stress levels. For students, there is a strong tendency to practice stress management, with 93 out of 104 selecting options 3, 4, or 5, highlighting that young adults are likely aware and actively employing coping mechanisms during stressful times. Self-employed individuals also reported moderate to high engagement in stress management, with 23 out of 25 responding with scores 3, 4, or 5, reflecting a good degree of self-regulation despite potentially less structured work settings. In contrast, smaller groups such as homemakers, others, and the unemployed showed varied but generally lower levels of stress management practice, with some respondents indicating low engagement (scores 1 or 2).

The Chi-Square test indicates a statistically significant association between occupation and practicing stress management techniques (χ^2 (24) = 37.387, p = 0.040), suggesting that occupation influences how individuals manage stress.

- **Educational Qualifications and Engagement in Personal Mental Health Management (e.g., Self-Care, Mindfulness, Exercise)**

A significant relationship was found between educational qualifications and self-reported mental health management behaviors (χ^2 = 16.241, df = 8, p = .039), indicating that education level may influence the likelihood of individuals engaging in mental health-promoting activities such as self-care, mindfulness, and exercise.

Among graduates (n = 85), the majority reported proactive mental health practices: 49.4% selected response level 4 and 32.9% selected level 5, indicating strong engagement in mental health self-management. Whereas, among postgraduates and above (n = 118), responses were similarly positive. 36.4% chose both levels 4 and 5, showing strong commitment to self-care. In contrast, individuals with senior secondary education (n = 12) showed lower levels of engagement in such practices. Half of them (50%) selected level 3, indicating moderate engagement, while 41.7% reported high engagement.

These findings suggest that higher education is positively associated with greater involvement in personal mental health management.

- **Relationship Between Place of Residence and Engagement in Mental Health Self-Care Practices**

The analysis reveals notable differences in mental health practices among urban and rural participants. Among rural respondents (n = 15), the majority (53.3%) agreed that they actively engage in self-care activities, while 20% strongly agreed. In contrast, a higher proportion of urban residents (n = 200) reported strong engagement in such practices, with 34% strongly agreeing and 41% agreeing. Overall, 74.9% of all respondents indicated positive engagement in mental health management, suggesting growing awareness and adoption of self-care techniques across both groups. However, urban residents demonstrated a slightly higher inclination toward stronger agreement, possibly reflecting greater access to mental health resources, digital tools, and wellness programs.

- **Association Between Marital Status and Practice of Stress Management Techniques When Feeling Overwhelmed**

When asked about practicing stress management techniques when feeling overwhelmed, responses varied by marital status. Married participants (14% of the sample) showed a more balanced distribution, with about 37% agreeing or strongly agreeing that they practice such techniques, while a smaller number disagreed or were neutral. Single individuals (85.1% of the sample) demonstrated a wide range of responses: approximately 56% agreed or strongly agreed that they use stress management methods, but a notable portion were neutral or disagreed, reflecting some variability in coping strategies. Overall, most respondents across all marital statuses reported engaging in stress management practices to some extent when overwhelmed, with single participants showing the greatest variability in their responses.

- **Practice of managing own mental health (e.g., self-care, mindfulness, exercise) by Living Arrangement**

Among those living alone (53 respondents), most individuals reported moderate to high engagement in such activities, with 18 (34.0%) selecting a 4 and 19 (35.8%) selecting a 5, indicating frequent practice of mental health management techniques. Participants living with parents (68) also showed strong engagement, with 30 (44.1%) rating 4 and 25 (36.8%) rating 5. Similarly, those living with friends or roommates (54) reported moderate to frequent self-care, with 27 (50.0%) rating 4 and 11 (20.4%) rating 5. Individuals living with extended

family (13) had a slightly more varied distribution, but 5 (38.5%) rated 5 and 3 (23.1%) rated 4, reflecting positive mental health practices.

- **Implications**

The findings highlight urban residence, younger age, and living arrangements as key influences on mental health literacy. Urban and younger respondents' technological confidence supports online interventions (e.g., mobile apps), while rural and older groups need offline approaches (e.g., community workshops). Family-oriented households' trust in media suggests culturally sensitive campaigns could reduce stigma. The trend toward secrecy among youth underscores the need for stigma-reduction programs in educational settings. Future studies should oversample rural and older populations, use larger samples to address cell count issues, and explore ordinal analyses for Likert data.

Chapter 5: DISCUSSION

This chapter interprets the findings of the present study in light of existing literature. It evaluates how the findings align with or deviate from contemporary mental health research, explores possible reasons for observed patterns, and outlines the implications for public health, mental health literacy campaigns, and future research.

5.1 Interpretation in the Context of Recent Research

5.1.1 Awareness and Knowledge

The finding that over 90% of respondents had heard of mental health disorders aligns with the increased visibility of mental health in India, particularly since the COVID-19 pandemic. Roy et al. [6] noted that the pandemic catalyzed widespread discussion around mental well-being in India, especially on digital platforms. Similarly, Gaiha et al. [11] observed that among urban youth, awareness campaigns and social media significantly boosted mental health literacy.

However, this awareness was not uniformly matched by deep understanding. For instance, while recognition of anxiety symptoms showed linear improvement with age, younger participants struggled more with symptom identification. This mirrors findings by Shidhaye et al. (2023), who found that while Indian students were aware of mental health concepts, they often lacked nuanced understanding of symptoms and disorders.

5.1.2 Attitudes and Stigma

This study found a marginally significant trend where younger respondents preferred secrecy about their mental health, a finding supported by Shrivastava et al. [7], who reported that adolescents and young adults often internalize stigma due to societal pressure, peer judgment, or lack of safe disclosure environments.

Interestingly, no significant gender differences were found in attitudes or stigma-related items, diverging from earlier findings by Deka et al. (2024), which noted that women were generally more empathetic and open to mental health conversations. This discrepancy may be due to the sample's urban, educated skew, reflecting evolving gender norms in mental health perceptions.

5.1.3 Practices and Help-Seeking Behavior

Willingness to seek professional help increased linearly with age, consistent with the trend that older adults may have greater exposure to real-life mental health situations or medical systems. Devarapalli et al. (2023) reported a similar pattern in Hyderabad, where older participants showed more positive attitudes toward psychiatrists and counseling services.

Kulkarni et al. [4] emphasized that while students are digitally active, their help-seeking is constrained by fear of institutional or parental judgment. This study also found that younger participants were less confident in using digital tools, suggesting a gap in digital mental health education**.**

5.1.4 Technology and Digital Divide

A key finding was the significant association between place of residence and confidence in using technology for mental health support. Urban respondents were far more confident than rural ones, reflecting India's digital divide. As noted in the National Mental Health Survey (2016), rural areas face both infrastructural and informational deficits, which Kulkarni et al. [4] reaffirmed.

With the rise of digital mental health platforms in India (e.g., MANAS App by the Ministry of Health and Family Welfare), ensuring equitable access is crucial. Ogorchukwu et al. [5] stressed that without parallel offline awareness campaigns, digital platforms risk excluding vulnerable populations.

5.2 Implications for Policy and Practice

The results have several practical implications:

- Tailored IEC Campaigns: Targeted messaging for youth addressing stigma and secrecy is essential. IEC materials should include narratives that normalize disclosure and therapy.
- Engaging Family Networks: Living arrangement influenced media perception and information-seeking. Campaigns should involve family units to maximize collective impact.
- Youth-Centric Interventions: Colleges and universities must embed mental health literacy in orientation programs.
- Resource Accessibility: Younger respondents were less aware of where to find mental health resources. Integrating resource directories into school curricula, workplaces, and social media can address this.

5.3 Comparison with Other National Programs

The National Mental Health Programme (NMHP) and its subcomponent, the District Mental Health Programme (DMHP), aim to reduce stigma and increase mental health awareness. However, Shinde et al. (2023) argue that the impact remains limited in rural areas due to staffing shortages and cultural barriers. This study reaffirms the need for decentralization and community-based models that address both access and acceptability.

Additionally, India's Tele-MANAS initiative, designed to expand tele-mental health services, risks exclusion if digital confidence remains low among youth and rural populations. Studies like Kaur et al. (2024) recommend hybrid models combining digital with community outreach.

5.4 Recommendations for Future Research

- Include more diverse samples (rural, less educated, elderly) to improve generalizability.
- Employ mixed-methods designs to capture qualitative insights into stigma, family influence, and secrecy.
- Study the effectiveness of digital vs. in-person awareness campaigns.
- Explore longitudinal impacts of mental health education interventions in educational institutions.

Chapter 6: CONCLUSION

In conclusion, this study provides valuable insights into the current state of mental health awareness in India, particularly among urban, educated, and younger demographics. While high awareness levels are encouraging, persistent gaps in understanding, stigma reduction, and access to care suggest that awareness alone is insufficient. The nuanced influence of age, place of residence, and living arrangements underscores the need for multifaceted and demographically tailored interventions. Digital platforms offer promising avenues for outreach, but disparities in technological confidence must be addressed to ensure equitable impact. Furthermore, family dynamics and social networks play a significant role in shaping perceptions and behaviors related to mental health, suggesting that awareness campaigns must be community-inclusive. As India advances its national mental health programs and digital initiatives, integrating localized, culturally sensitive, and age-appropriate strategies will be critical to bridging the gap between knowledge and behavior. This study not only contributes empirical evidence to the evolving landscape of mental health literacy in India but also calls for sustained, inclusive efforts that move beyond awareness to foster lasting behavioral and attitudinal change.

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