

Exploring Student's Attitudes towards Mental Health Problems in Chitwan, Nepal

Samjhana Acharya¹ 

¹Central Department of Rural Development,
Tribhuvan University, Kathmandu, Nepal

Corresponding Author

Samjhana Acharya

Email: samjhoo44@gmail.com

To Cite this article: Acharya, S. (2025). Exploring Student's attitudes towards mental health problems in Chitwan, Nepal. *International Research Journal of MMC*, 6(2), 158–172. <https://doi.org/10.3126/irjmmc.v6i2.80721>

Submitted: 16 June 2025

Accepted: 24 June 2025

Published: 27 June 2025

Abstract

Introduction

I investigated participants' attitudes towards mental health problems (ATMHP), considering demographic variables such as age, gender, ethnicity, religion, study levels, study fields, types of academic institutions, and familiarity with mental health problems. The aim of the study is to examine the relationship of ATMHP with various demographic variables.

Methods

A cross-sectional research design was employed by using opportunity sampling, I sampled 348 participants from private, community and Government Colleges in Chitwan district. I used ATMHP scale, a reliable and valid tool in 2022. I employed descriptive and inferential statistics to examine the relationship between ATMHP and various demographic factors, as well as the differences in ATMHP across different groups.

Results

I observed an overall unfavorable attitude towards mental health problems among the respondents. No significant differences were found between/among gender, ethnicity, religion, study levels, study fields, types of academic institutions, and familiarity with mental health problems in the level of ATMHP.

Conclusion

I observed generally unfavorable ATMHP across the study, with no significant differences between comparison groups. Unfavorable attitudes across all groups highlight the need for inclusive mental health education and stigma-reduction efforts in colleges.

Keywords: attitudes, mental health, stigma, students

1. Introduction

The concept of attitude has become central across various social science disciplines, denoting an individual's relatively stable evaluative stance toward people, objects, or ideas. Originally derived from the language of painting and sculpture—where it described a poised, stable disposition—the term evolved to signify an internal, enduring predisposition (Fleck, 2015). According to Branscombe et al. (2017), attitudes are not formed in isolation; rather, they are shaped through social learning mechanisms such as classical conditioning, instrumental reinforcement, and observational learning. The influence of reference groups—those we belong to or aspire to join—can significantly modify our attitudes toward new or unfamiliar subjects. Attitudes influence how we interpret the world around us, shaping our perceptions, judgments, and behaviors. They may be explicit, consciously held and easily expressed, or implicit, residing outside of conscious awareness yet still shaping our responses.

According to the World Health Organization (2001), health is a complete state of physical, mental, and social well-being—not just the absence of disease. Mental health goes beyond the lack of mental disorders; it includes emotional, cognitive, and behavioral well-being, affecting how individuals think, feel, and act. It involves realizing one's potential, coping with life's stresses, working productively, and contributing to society. Mental health influences daily life and relationships, while life circumstances and physical health can, in turn, impact mental well-being (Felman, 2020). Using this insight, attitude towards mental health problems reflects people's evaluative stance, ranging from negative to positive, shaped by cultural interactions.

Studies found that individuals with mental illness are frequently stigmatized in Asia (Lauber & Rössler, 2007; Poudel et al., 2025). Familial shame, known as "*izzat*," plays a critical role in shaping the experiences of Asian women and is strongly associated with attitudes towards help-seeking (Gilbert et al., 2004; Thake, 2014). Additionally, Asian students are more concerned with external and reflected shame than non-Asian students, making them more susceptible to internal shame (Gilbert et al., 2007). Studies show that people with stronger values tend to have more negative attitudes towards mental health problems (Andrade et al., 2022).

Some studies have found that gender and age are significant indicators of negative attitudes towards mental health problems (Laqua et al., 2018; Younis et al., 2020), while others have found that gender, age, or literacy status are non-significant factors (Poudel et al., 2024; Salve et al., 2013)

Attitudes towards mental health in Nepal show significant variability. Urban adults generally have more favorable attitudes than those in rural areas (Singh et al., 2013). While some studies report generally positive or neutral attitudes (Risal et al., 2013), stigma persists even among the educated (Pokharel & Pokharel, 2017) and overall negative attitudes are noted (Jalan, 2018). Additionally, a negative correlation was found between attitude scores and factors such as grade, gender, and parental education, with no significant associations with ethnicity or family psychiatric history (Nepal et al., 2020).

Studies on ATMHP are increasing globally, but research in Nepal are very limited (Nepal et al., 2020), especially among college students in Chitwan, culturally diverse district in Nepal. Therefore, our aim of the study is to investigate the level of attitudes towards mental health problems in college students across different demographics. This study will provide crucial insights into college students' attitudes towards mental health in Nepal, potentially guiding targeted interventions, improving mental health education, and informing policies to address stigma and enhance support systems for students.

This study provides important insights into college students' attitudes towards mental health problems (ATMHP) in Nepal. By analyzing responses across diverse demographics using a validated tool, it highlights a generally unfavorable attitude consistent across groups. These findings emphasize the need for inclusive mental health education and stigma-reduction efforts in academic institutions, regardless of student background.

The use of opportunity sampling limits generalizability beyond Chitwan. Self-reported data may be affected by social desirability bias. The cross-sectional design restricts causal interpretations. Some subgroups had small sample sizes, and cultural adaptation of the ATMHP scale may be needed for deeper contextual accuracy.

2. Methods

2.1 Participants

The study involved 348 participants aged 18 to 24 ($M = 20.61$, $SD = 1.67$), including 210 females and 136 males from diverse ethnic backgrounds. Participants comprised 53 high school students and 295 bachelor's degree students, with 200 in their first two years and 85 in their final two years. Data were collected from government ($N = 114$), community ($N = 171$), and private colleges ($N = 63$). Familiarity with individuals with mental health problems varied, with 86 participants reporting acquaintance and 214 not. Detailed demographic information is provided in Table 1.

Table 1: *Demographic Characteristics*

Demographic profile of the participants		Frequency (Percent)
Gender	Female	210 (60.69%)
	Male	136 (39.31%)
Caste/Ethnicity	Brahmin/Kshetri	245 (71.22%)
	Janajaati	37 (10.76%)
	Newar	31 (9.01%)
	Others	31 (9.01%)
Religion	Hindu	314 (90.49%)
	Others	33 (9.51)
Academic Level	Bachelor's Degree	295 (84.77%)
	High School Degree	53 (15.23%)
Year of Study	First Two Years	200 (70.18%)
	Last Two Years	85 (29.83%)
	Government	114 (32.76%)

Demographic profile of the participants		Frequency (Percent)
Types of Academic Institution	Private	63 (18.10%)
	Public	171 (49.14%)
Who knows/does not know PMHP	Participants who do not knows PMHP	214 (71.33%)
	Participants who knows PMHP	86 (28.67%)

Note: PMHP refers to people with mental health problems. The year of study implies to bachelor's degree only.

3. Materials

3.1 Attitudes towards Mental Health Problems (ATMHP)

The instrument used in this study was the Attitudes towards Mental Health Problems (ATMHP) scale, created by Gilbert et al. (2007). This 35-item measure utilizes a 4-point Likert scale to assess attitudes towards mental health issues across five key areas: general attitudes towards mental health problems, external shame (concerns about being judged by others or feeling shame from family/community), internal shame (negative self-evaluations and self-directed shame), reflected shame 1 (shame related to the perceived impact on one's family if mental health issues arise), and reflected shame 2 (shame about the personal impact of having mental health problems) (Gilbert et al., 2007). The scale demonstrated high reliability with a Cronbach's alpha of 0.94 (Cabral Master et al., 2016; Poudel et al., 2024).

3.2 Procedure

A cross-sectional survey design with opportunistic sampling was employed. Approval was taken from college authorities before the consent from all the participants and data collection. Participants were informed about the study's purpose, data protection, and their right to withdraw through consent forms before the data collection.

Data cleaning was conducted in Google Sheets, followed by analysis using descriptive and inferential statistics. The Welch t-test compared variables with unequal sample sizes, while one-way ANOVA was used for demographic comparisons, with Scheffé's HSD for pairwise comparisons. Subgroups with fewer than 30 participants were either merged or excluded from analysis. Data analysis was carried out using JASP, and results were reported according to standard statistical procedures.

4. Results

4.1 Demographics Characteristics

I analyzed the data with JASP version 0.16.0.0, checking for normality and outliers. The skewness was 0.49 (SE = 0.13) and kurtosis was -0.69 (SE = 0.26). Participants had a mean age of 20.61 (SD = 1.67). The details of the demographic data are given in Table 1.

According to the cutoff scores, I observed that scores ranging from 0 to 19 indicated highly favorable attitudes, scores from 20 to 29 indicated favorable attitudes, scores from 30 to 49 indicated unfavorable attitudes, and scores 50 and above indicated highly unfavorable attitudes. The study participants exhibited predominantly unfavourable attitudes towards

mental health problems overall (Table 2, Table 3 & Table 4). In the ATMHP scale, a higher score indicates a higher level of unfavorable attitudes, and vice versa.

Table 2: *Descriptive Statistics*

Categories	Mean (SD) (<i>N</i> = 348)	Minimum to Maximum	25th percentile	50th percentile	75th percentile
ATMHP Factor	8.89 (5.34)	0-24	5	8	12
ES Factor	8.31 (7.04)	0-30	2.75	7	13
IS Factor	3.79 (3.72)	0-15	1	3	5
RS1 Factor	7.9 (5.33)	0-21	4	7	12
RS2 Factor	5.50 (4.61)	0-15	1.75	5	9
ATMHP Total	34.40 (19.79)	0-84	20	30	50

Note: ATMHP refers to attitudes towards mental health problems, ES refers to external shame, IS refers to internal shame, RS1 refers to reflected shame 1 and RS2 refers to reflected shame.

4.2 Relationship between ATMHP and Demographic Variables

In this study, both males and females exhibited unfavorable attitudes towards mental health problems; however, a non-significant difference between these two genders was found in the level of ATMHP, including its dimensions (Table 3).

Table 3: *Descriptive and Inferential Statistics (Welch's *t*- test) for different demographic variables*

Categories	Group	Mean	SD	<i>t</i>	<i>df</i>	<i>p</i>
Genders [female (<i>N</i> = 210), Male (<i>N</i> = 136)]						
ATMHP Factor	Female	8.81	5.06	-0.28	274.12	0.78
	Male	8.98	5.41			
ES Factor	Female	8.29	6.63	0.00	269.16	1.00
	Male	8.29	7.27			
IS Factor	Female	3.72	3.60	-0.29	275.27	0.77
	Male	3.84	3.83			
RS1 Factor	Female	7.88	5.27	-0.04	284.17	0.97
	Male	7.90	5.37			
RS2 Factor	Female	5.73	4.50	1.24	281.93	0.22
	Male	5.11	4.64			
ATMHP Total	Female	34.43	18.89	0.14	271.55	0.89
	Male	34.12	20.48			
Religion [Hindu (<i>N</i> = 314), Others (<i>N</i> = 33)]						
ATMHP Factor	Hindu	8.86	5.11	-0.44	37.15	0.661
	Others	9.33	5.94			
ES Factor	Hindu	8.28	6.89	-0.41	39.41	0.683
	Others	8.79	6.72			

Categories	Group	Mean	SD	<i>t</i>	<i>df</i>	<i>p</i>
IS Factor	Hindu	3.74	3.69	-0.72	38.40	0.479
	Others	4.24	3.87			
RS1 Factor	Hindu	7.91	5.35	0.03	40.43	0.975
	Others	7.88	4.90			
RS2 Factor	Hindu	5.55	4.60	0.38	40.01	0.706
	Others	5.24	4.32			
ATMHP Total	Hindu	34.33	19.48	-0.31	38.44	0.757
	Others	35.49	20.33			
Academic Levels [Bachelor's Degree (<i>N</i> = 295), High School Degree (<i>N</i> = 53)]						
ATMHP Factor	Bachelor's Degree	9.08	5.17	1.57	71.99	0.122
	High School Degree	7.87	5.17			
ES Factor	Bachelor's Degree	8.42	6.80	0.67	69.46	0.502
	High School Degree	7.70	7.25			
IS Factor	Bachelor's Degree	3.90	3.74	1.40	75.65	0.167
	High School Degree	3.17	3.45			
RS1 Factor	Bachelor's Degree	7.97	5.29	0.60	71.36	0.548
	High School Degree	7.49	5.36			
RS2 Factor	Bachelor's Degree	5.52	4.52	0.09	69.02	0.927
	High School Degree	5.45	4.87			
ATMHP Total	Bachelor's Degree	34.89	19.23	1.03	68.45	0.305
	High School Degree	31.68	21.07			
Year of Education in Bachelor's Degree [First Two Years (<i>N</i> = 227), Last Two Years (<i>N</i> = 92)]						
ATMHP Factor	First Two Years	8.82	5.00	-1.49	155.73	0.138
	Last Two Years	9.80	5.48			
ES Factor	First Two Years	8.50	6.82	-0.14	163.10	0.888
	Last Two Years	8.62	7.08			
IS Factor	First Two Years	3.59	3.77	-1.82	183.54	0.071
	Last Two Years	4.38	3.44			
RS1 Factor	First Two Years	8.05	5.41	0.20	182.22	0.838
	Last Two Years	7.92	4.98			
RS2 Factor	First Two Years	5.56	4.57	-0.07	170.06	0.946
	Last Two Years	5.60	4.53			

Categories	Group	Mean	SD	<i>t</i>	<i>df</i>	<i>p</i>
ATMHP Total	First Two Years	34.52	19.64	-0.76	173.19	0.447
	Last Two Years	36.33	19.07			
PNKPMHP and PKPMHP [PNKPMHP (<i>N</i> = 214), PKPMHP (<i>N</i> = 86)]						
ATMHP Factor	Participants who do not know PMHP	8.97	5.10	-0.21	149.96	0.831
	Participants who know PMHP	9.12	5.37			
ES Factor	Participants who do not know PMHP	8.11	6.83	-0.99	150.72	0.324
	Participants who know PMHP	9.00	7.15			
IS Factor	Participants who do not know PMHP	3.94	3.88	1.06	173.60	0.293
	Participants who know PMHP	3.45	3.49			
RS1 Factor	Participants who do not know PMHP	7.82	5.35	-0.36	156.08	0.719
	Participants who know PMHP	8.07	5.38			
RS2 Factor	Participants who do not know PMHP	5.81	4.55	1.42	155.71	0.157
	Participants who know PMHP	4.98	4.59			
ATMHP Total	Participants who do not know PMHP	34.65	19.65	0.01	153.84	0.99
	Participants who know PMHP	34.62	20.09			

Note: ATMHP: attitudes towards mental health problems; ES: external shame; IS: internal shame, Reflected Shame 1: shame about how it affects family; Reflected Shame 2: shame about how it affects oneself.

The study discovered unfavorable attitudes towards mental health problems across all ethnic categories. I also found the difference was non-significant in the ATMHP total among all ethnic groups participated in the study. The difference was non-significant in all the dimensions (Table 4).

Table 4: Descriptive and Inferential Statistics (one-way ANOVA) for different demographic variables

Variables	Mean	SD	F	df Between Group	Within Group	P
Ethnicity [Brahmin/Kshetri (N = 245), Janajaati (N = 37), Newar (N = 31), Others (N = 31)]						
ATMHP Factor						
Brahmin/Kshetri	8.98	5.39	2.22	3	340	0.085
Janajaati	10.43	4.92				
Newar	8.00	4.49				
Others	7.45	4.23				
ES Factor						
Brahmin/Kshetri	8.14	7.10	0.50	3	340	0.681
Janajaati	9.43	6.11				
Newar	8.94	6.74				
Others	7.87	6.08				
IS Factor						
Brahmin/Kshetri	3.65	3.78	1.42	3	340	0.237
Janajaati	4.95	3.93				
Newar	3.81	3.09				
Others	3.45	3.25				
RS1 Factor						
Brahmin/Kshetri	7.89	5.46	0.33	3	340	0.803
Janajaati	8.60	4.30				
Newar	7.32	4.72				
Others	7.90	5.77				
RS2 Factor						
Brahmin/Kshetri	5.49	4.73	0.40	3	340	0.754
Janajaati	6.24	4.02				
Newar	5.29	3.91				
Others	5.16	4.69				
ATMHP Total						
Brahmin/Kshetri	34.15	20.11	1.11	3	340	0.344
Janajaati	39.65	18.05				
Newar	33.36	17.13				
Others	31.84	18.53				
Types of Institutions [Government (N = 122), Private (N = 84), Public (N = 179)]						
ATMHP Factor						
Government	8.83	5.33	0.12	2	345	0.888
Private	8.67	5.50				
Public	9.02	4.98				
ES Factor						

Variables	Mean	<i>SD</i>	<i>F</i>	<i>df</i> Between Group	Within Group	<i>P</i>
Government	9.19	7.56	2.29	2	345	0.103
Private	8.86	7.88				
Public	7.52	5.85				
IS Factor						
Government	3.40	3.59	3.41	2	345	0.034*
Private	4.86	4.38				
Public	3.65	3.44				
RS1 Factor						
Government	8.25	5.80	0.47	2	345	0.626
Private	7.97	5.78				
Public	7.64	4.75				
RS2 Factor						
Government	5.59	4.99	0.32	2	345	0.73
Private	5.10	4.78				
Public	5.61	4.19				
ATMHP Total						
Government	35.26	20.48	0.41	2	345	0.664
Private	35.44	23.23				
Public	33.43	17.33				

* $p < .05$. *Note:* P-value and confidence intervals adjusted for comparing a family of 3 estimates (confidence intervals corrected using the Tukey method). ATMHP: attitudes towards mental health problems; ES: external shame; IS: internal shame, Reflected Shame 1: shame about how it affects family; Reflected Shame 2: shame about how it affects oneself.

I found unfavorable attitudes towards mental health problems within both religious groups with non-significant difference between Hindu and others in the level of ATMHP. The difference the religious groups was non-significant in all the dimensions in ATMHP (Table 3).

Participants with both a bachelor's degree and a high school degree demonstrated unfavourable attitudes towards mental health problems. I found that the difference was non-significant between the participants from bachelor's degree and high school degree in the level of ATMHP. The difference was non-significant between these two variables in all the factors in ATMHP (Table 3).

I observed unfavourable attitudes towards mental health problems in participants from the first two years and the last two years, with non-significant difference between these two groups. I also observed non-significant difference between the first two years and the last two years in all the factors (Table 3).

I found unfavourable attitudes towards mental health problems among participants from government, private and public academic institutions with non-significant difference in the level of global ATMHP. The difference among the groups was non-significant in all the factors in ATMHP except IS factor. In IS factor, the difference was significant among government, private and public (see table 5). Scheffé's HSD found significant difference between the

participants from government institution ($N = 114$) and private institution ($N = 63$), $p = 0.043^*$, 95% CI [- 2.81, - 0.095].

Participants who knew people with mental health problems and participants who did not know people with mental health problems showed unfavourable attitudes towards mental health problems; however, the difference was non-significant between the groups in the global ATMHP including its dimensions (Table 3).

5. Discussion

5.1 Sociodemographic Factors

I had 348 participants aged 18-24 ($M = 20.61$, $SD = 1.67$). Among them, 60.69% were female, 39.31% male; most were Brahmin/Kshetri (71.22%), followed by Janajaati, Newar, and others. Most identified as Hindu (90.49%). Regarding education, 84.77% had a bachelor's degree, and 15.23% had a high school degree. Bachelor's students were mostly in their first two years. Fields of study included business, hotel management, science, and others. Most attended public institutions, with 94.55% being students and 5.45% employed. 28.67% knew people with mental health issues, while 71.33% did not (Table 1).

5.2 Attitudes in Study Participants

I found unfavourable attitudes in our study participants in each demographic group. Consistently, a study displayed an overall negative attitude towards individuals with mental illness in students (Risal et al., 2013). Jha & Mandal (2021) found negative attitudes towards mental illness in their study. Jalan (2018), also found a prevailing unfavourable attitude within the study population towards individuals with mental illness. A study consistently found an unfavorable attitude in 59.7% of participants and a favorable attitude in 40.3% of participants (Nepal et al., 2021). Furthermore, aggregate prevalence of self-stigma (self-stigma among psychiatric individuals refers to the process wherein individuals who have mental health conditions internalize societal prejudices and negative perceptions related to mental illness) was 54.44% among psychiatric patients in Nepal (Maharjan & Panthee, 2019).

I found no relationship between the level of ATMHP and age. This result is consistent with the finding that age had no relationship with attitude towards MWMI (Al-Adawi et al., 2002; Poudel et al., 2024). Similarly, age was non-significantly related to *izzat* (a major factor in ATMHP) in Nepalese people living in United Kingdom (Thake, 2014). However, a study in Singapore found a significant relationship between advancing age and increasingly negative attitudes towards individuals with mental illness (Yuan et al., 2016). Another study found that older age was linked to a negative attitude toward mental health in women (Lee et al., 2020).

Both female and male genders demonstrated unfavourable attitudes towards mental health problems. The difference between females and males was non-significant in the level of attitudes in all dimensions. This is consistent with another study (Poudel et al., 2024). Gilbert et al. (2004) found that the concept of familial shame (*izzat*) played a significant role in Asian women's experiences. Salve et al. (2013) found non-significant gender differences in the level of attitude towards mental illness. Similarly, another study found non-significant relationship between genders in the level of stigma in Nepal (Pokharel & Pokharel, 2017). However, another study found that males had significantly higher levels of unfavourable attitudes towards

mental health problems than females (Nepal et al., 2020; Yuan et al., 2016). Contrarily, Neupane et al. (2016) discovered a significant association between the sex of the caregiver and the sex of the patients, wherein females exhibited notably lower attitude scores compared to males.

I observed unfavourable attitudes towards mental health problems in all ethnic groups with non-significant differences in each dimension. Similar to this finding, Nepal et al., (2020) reported that ethnicity had no effect in attitude. Similarly, my study found unfavourable attitudes towards mental health problems in Hindus and others with non-significant differences in each dimension. Nepal et al., (2020) consistently found non-significant differences between Hindus and others.

I found unfavourable attitudes towards mental health problems in bachelor's and high school degrees. The difference was non-significant in all dimensions of attitudes towards mental health problems. Similarly, Salve et al. (2013) reported that difference in attitudes towards mental illness across literacy status was found statistically non-significant. In line with this finding, another study found that the Izzat related to mental health problems (A major construct in ATMHP) is non-significantly correlated with the level of education, ($r = 0.20$) (Thake, 2014). Pokharel & Pokharel (2017) reported that stigma against mental illness exists even among the country's educated population. In contrast, Doumit et al. (2019).found that a high level of education was associated with less stigmatizing attitudes. Another study found a significant negative correlation between attitude scores and the grade enrolled where the respondents' attitudes improved with their increasing grades (Nepal et al., 2020). However, Lopez et al. (2018) reported that higher education was associated with greater stigma about antidepressant use.

Attitude scores varied significantly based on caregivers' educational status, with higher education linked to more positive attitudes. This may be due to educated caregivers' increased exposure to mass media and greater awareness of misconceptions about mental illness (Neupane et al., 2016). Baziga et al. (2019) found people with lower levels of education and less experience as community health workers displayed higher negative attitudes towards individuals with mental illness compared to those with higher education and more experience. Sahile et al. (2019) found that nurses with a diploma and less work experience were more likely to have negative attitudes towards individuals with mental illness than those with an educational level of MSc. They further reported that lack of mental health training contributes to negative attitudes among nurses. In consistent with the findings, Shahif et al. (2019) showed that nurses with higher education level demonstrated higher authoritarianism attitude – authoritarianism [*sic*] expresses a view of the mentally ill as a second-class citizen who requires coercion (Taylor & Dear, 1981).

I found statistically non-significant unfavourable attitudes towards mental health problems in both first two years and the last two years. Consistently, Pokharel and Pokharel (2017) also found non-significant relationship between the year of bachelor's study and the level of stigma in college students.

In a study with medical students, the authors found conflicting results in first-semester students and nine-semester students. They reported that first-semester students held more favorable attitudes towards excluding individuals with mental illness from responsible jobs and believing in a purely genetic origin of mental illnesses. In contrast, ninth-semester students

expressed more favorable attitudes towards the idea that psychiatric hospitals resembled prisons and that psychiatrists were not equal to other doctors (Risal et al., 2013).

Prasai et al. (2018) reported that medical students had a neutral attitude towards social restriction of mental illness and interpersonal relationships as a reason of mental illness – social restrictiveness means viewing the mentally ill as a menace to society (Taylor & Dear, 1981). Medical students and interns at the medical school generally had positive or neutral attitudes toward mental disease and psychiatry (Risal et al., 2013). Jyothi et al. (2015) found that medical students had unfavorable attitudes towards the mentally ill, where 90% of students believed that a mentally ill person was more likely to harm others. Similarly, another study also found that student nurses possessed predominantly unfavorable views towards mental illness, perceiving individuals with mental health conditions as potentially harmful or threatening (Bennett & Stennett, 2015).

The authors found the highest unfavourable attitude in students from private colleges. However, the difference among the groups was non-significant. We found students from private school had significantly higher level of internal shame than students from Government College.

It was also observed that people who know people with mental health problems had higher level of unfavorable attitudes than people who do not know such people. However, the difference was non-significant. A study found non-significant results with people who had previous experience people who had a mental illness (Abolfotouh et al., 2019). Another study found that the general population and specialists revealed a negative attitude towards psychiatric patients; however, family practitioners revealed a positive attitude (Al-Atram, 2018).

This study is inconsistent with the result that is familiar with close people with mental illness, less stigmatizing attitudes and higher knowledge of mental illness were associated with higher favourable behaviours, whereas knowing a non-close person with a mental illness was associated with lower favourable behaviours (Doumit et al., 2019). In Nigeria, it was found that having a family member with mental illness lessened the social distance towards the mentally ill amongst the doctors (Adewuya & Oguntade, 2007)

6. Conclusion

This study revealed generally unfavorable attitudes toward mental health problems among college students, with no significant differences across most demographic variables. However, students from private colleges reported significantly higher levels of internal shame than those from government institutions. These findings underscore the need for targeted awareness and intervention programs within academic settings to reduce stigma and promote mental health literacy.

7. Future direction

Future research should include more diverse and representative samples, covering broader age groups, gender minorities, and individuals from rural and remote regions. Comparative studies across geographic and socio-educational contexts, along with larger sample sizes, will help deepen understanding and guide culturally appropriate interventions.

References

1. Abolfotouh, M. A., Almutairi, A. F., Almutairi, Z., Salam, M., Alhashem, A., Adlan, A. A., & Modayfer, O. (2019). Attitudes toward mental illness, mentally ill persons, and help-seeking among the Saudi public and sociodemographic correlates. *Psychology Research and Behavior Management*, 12, 45–54. <https://doi.org/10.2147/PRBM.S191676>
2. Adewuya, A. O., & Oguntade, A. A. (2007). Doctors' attitude towards people with mental illness in Western Nigeria. *Soc Psychiatry Psychiatr Epidemiol*, 42(11), 931–936. <https://doi.org/10.1007/s00127-007-0246-4>
3. Al-Adawi, S., Dorvlo, A. S. S., Al-Ismaïly, S. S., Alghafry, D. A., Al-Noobi, B. Z., Al-Salmi, A., Burke, D. T., Shah, M. K., Ghassany, H., & Chand, S. P. (2002). Perception of and attitude towards mental illness in Oman. *International Journal of Social Psychiatry*, 48(4), 305–317. <https://doi.org/10.1177/002076402128783334>
4. Al-Atram, A. A. (2018). Physicians' Knowledge and Attitude towards Mental Health in Saudi Arabia. *Ethiopian Journal of Health Sciences*, 28, 771–778. <https://doi.org/10.4314/ejhs.v28i6.12>
5. Andrade, G., Bedewy, D., Elamin, A. B. A., Abdelmonem, K. Y. A., Teir, H. J., & Alqaderi, N. (2022). Attitudes towards mental health problems in a sample of United Arab Emirates' residents. *Middle East Current Psychiatry*, 29(1), 2–6. <https://doi.org/10.1186/s43045-022-00255-4>
6. Baziga, V., Gasovya, A., & Uwingabire, F. (2019). Community health workers' attitude towards people with mental illness: potential challenge of maternal mental health services in a selected health centre, Ruhengeri Hospital in Rwanda. *Rwanda J Med Health Sci*, 2(3), 220–229. <https://doi.org/10.4314/rjmh.v2i3.3>
7. Bennett, J., & Stennett, R. (2015). Attitudes towards mental illness of nursing students in a Baccalaureate programme in Jamaica: A questionnaire survey. *Journal of Psychiatric and Mental Health Nursing*, 22(8), 599–605. <https://doi.org/10.1111/jpm.12234>
8. Branscombe, Nyla R.; Baron, R. A. (2017). *Social Psychology* (First Impr). Pearson India Education Services Pvt.Ltd.
9. Cabral Master, J. M., Barreto Carvalho, C. M. de O., Motta, C. D., Sousa, M. C., & Gilbert, P. (2016). Attitudes towards mental health problems scale: Confirmatory factor analysis and validation in the Portuguese population. *American Journal of Psychiatric Rehabilitation*, 19(3), 206–222. <https://doi.org/10.1080/15487768.2016.1197860>
10. Doumit, C. A., Haddad, C., Sacre, H., Salameh, P., Akel, M., Obeid, S., Akiki, M., Mattar, E., Hilal, N., Hallit, S., & Soufia, M. (2019). Knowledge, attitude and behaviors towards patients with mental illness: Results from a national Lebanese study. *PLoS ONE*. <https://doi.org/10.1371/journal.pone.0222172>
11. Felman, A. (2020). *Mental health: Definition, common disorders, early signs, and more*. <https://www.medicalnewstoday.com/articles/154543>
12. Fleck, C. (2015). Attitude: History of Concept. *International Encyclopedia of the Social & Behavioral Sciences: Second Edition*, November, 175–177. <https://doi.org/10.1016/B978-0-08-097086-8.03146-9>
13. Gilbert, P., Bhundia, R., Mitra, R., McEwan, K., Irons, C., & Sanghera, J. (2007). Cultural

- differences in shame-focused attitudes towards mental health problems in Asian and non-Asian student women. *Mental Health, Religion and Culture*, 10(2), 127–141. <https://doi.org/10.1080/13694670500415124>
14. Gilbert, P., Gilbert, J., & Sanghera, J. (2004). A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby. *Mental Health, Religion and Culture*, 7(2), 109–130. <https://doi.org/10.1080/13674670310001602418>
 15. Jalan, R. (2018). Attitudes of Undergraduate Medical Students towards the Persons with Mental Illness in a Medical College of Western Region of Nepal. *Journal of Nepalgunj Medical College*, 16(1), 48–53. <https://doi.org/10.3126/jngmc.v16i1.24230>
 16. Jha, P., & Mandal, P. K. (2021). Knowledge And Attitude On Mental Illness Among People Of A Selected Community Of Biratnagar. *Journal of Psychiatrists' Association of Nepal*, 10(1), 43–49. <https://doi.org/10.3126/jpan.v10i1.40347>
 17. Jyothi, N. U., Bollu, M., Ali, S. F., Chaitanya, D. S., & Mounika, S. (2015). A questionnaire survey on student's attitudes towards individuals with mental illness. *Journal of Pharmaceutical Sciences and Research*, 7(7), 393–396.
 18. Laqua, C., Hahn, E., Böge, K., Martensen, L. K., Nguyen, T. D., Schomerus, G., Cao, T. D., Dettling, M., von Poser, A., Lanca, J. C., Diefenbacher, A., Angermeyer, M. C., & Ta, T. M. T. (2018). Public attitude towards restrictions on persons with mental illness in greater Hanoi area, Vietnam. *International Journal of Social Psychiatry*, 64(4), 335–343. <https://doi.org/10.1177/0020764018763685>
 19. Lauber, C., & Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International Review of Psychiatry*, 19(2), 157–178. <https://doi.org/10.1080/09540260701278903>
 20. Lee, H. Y., Hwang, J., Ball, J. G., Lee, J., Yu, Y., & Albright, D. L. (2020). Mental health literacy affects mental health attitude: Is there a gender difference? *American Journal of Health Behavior*, 44(3), 283–291. <https://doi.org/10.5993/AJHB.44.3.1>
 21. Lopez, V., Sanchez, K., Killian, M. O., & Eghaneyan, B. H. (2018). Depression screening and education: An examination of mental health literacy and stigma in a sample of Hispanic women. *BMC Public Health*, 18(1), 1–8. <https://doi.org/10.1186/s12889-018-5516-4>
 22. Maharjan, S., & Panthee, B. (2019). Prevalence of self-stigma and its association with self-esteem among psychiatric patients in a Nepalese teaching hospital: A cross-sectional study. *BMC Psychiatry*, 19(1), 1–8. <https://doi.org/10.1186/s12888-019-2344-8>
 23. Nepal, S., Rayamajhi, A., Shrestha, M., & Aryal, N. (2020). Attitude of Senior Secondary Level Students towards Mental Illness. *Journal of Psychiatrists' Association of Nepal*, 9(1), 47–52. <https://doi.org/10.3126/jpan.v9i1.31337>
 24. Neupane, D., Dhakal, S., Thapa, S., Bhandari, P. M., & Mishra, S. R. (2016). Caregivers' attitude towards people with mental illness and perceived stigma: A cross-sectional study in a tertiary hospital in Nepal. *PLoS ONE*, 11(6), 1–12. <https://doi.org/10.1371/journal.pone.0158113>
 25. Pokharel, B., & Pokharel, A. (2017). Perceived stigma towards mental illness among college students of western Nepal. *Birat Journal of Health Sciences*, 2(3), 292–295. <https://www.nepjol.info/index.php/bjhs/article/view/18946/15487>

26. Poudel, D. B., Dhakal, S., & Khatri, B. B. (2025). Review Articles Attitudes Towards Mental Health Problems : A Scoping Review. *Birat Journal of Helath Sciences*, 9(2), 3–13. <https://bjhs.com.np/bjhs/index.php/bjhs/article/view/523/533>
27. Poudel, D. B., Sharif, L. S., Acharya, S., Mahsoon, A., Sharif, K., & Wright, R. (2024). Mental health literacy and attitudes towards mental health problems among college students, Nepal. *Behavioral Sciences*, 14(12), 1–18. <https://doi.org/10.3390/bs14121189>
28. Prasai, A., Sharma, S. C., Rijal, R., & Shreeyanta, K. C. (2018). Attitude towards mental illness among medical students and interns of a medical college. *Journal of the Nepal Medical Association*, 56(213), 837–841. <https://doi.org/10.31729/jnma.3716>
29. Risal, A., Sharma, P. P., & Sanjel, S. (2013). Attitude toward mental illness and psychiatry among the medical students and interns in a medical college. *Journal of the Nepal Medical Association*, 52(6), 322–331. <https://doi.org/10.31729/jnma.703>
30. Sahile, Y., Yitayih, S., Yeshanew, B., Ayelegne, D., & Mihiretu, A. (2019). Primary health care nurses attitude towards people with severe mental disorders in Addis Ababa, Ethiopia: A cross sectional study. *Int J Ment Health Syst*, 13(1), 1–8. <https://doi.org/10.1186/s13033-019-0283-x>
31. Salve, H., Goswami, K., Sagar, R., Nongkynrih, B., & Sreenivas, V. (2013). Perception and attitude towards mental illness in an urban community in South Delhi - A community based study. *Indian Journal of Psychological Medicine*, 35(2), 154–158. <https://doi.org/10.4103/0253-7176.116244>
32. Shahif, S., Idris, D. R., Lupat, A., & Abdul Rahman, H. (2019). Knowledge and attitude towards mental illness among primary healthcare nurses in Brunei: A cross-sectional study. *Asian Journal of Psychiatry*, 45(April), 33–37. <https://doi.org/10.1016/j.ajp.2019.08.013>
33. Singh, B., Singh, R., & Singh, K. K. (2013). Knowledge and Attitude towards Mental Health and Mental Illness: An Issue among Rural and Urban Community of Jhapa District of Nepal. *International Journal of Health Sciences and Research*, 3(9), 29–34. <https://www.researchgate.net/publication/336263360>
34. Taylor, S. M., & Dear, M. J. (1981). Scaling community attitudes toward the mentally ill. *Schizophrenia Bulletin*, 7(2), 225–240. <https://doi.org/10.1093/schbul/7.2.225>
35. Thake, A. (2014). *Factors influencing beliefs about mental health difficulties and attitudes towards seeking help amongst Nepalese people in the United Kingdom*. 1(October).
36. World Health Organization. (2001). *The World health report : 2001 : Mental health : new understanding, new hope*. <https://apps.who.int/iris/handle/10665/42390>
37. Younis, M. S., Anwer, A. H., & Hussain, H. Y. (2020). Stigmatising attitude and reflections towards mental illness at community setting, population-based approach, Baghdad City 2020. *International Journal of Social Psychiatry*, 67(5), 461–466. <https://doi.org/10.1177/0020764020961797>
38. Yuan, Q., Abdin, E., Picco, L., Vaingankar, J. A., Shahwan, S., Jeyagurunathan, A., Sagayadevan, V., Shafie, S., Tay, J., Chong, S. A., & Subramaniam, M. (2016). Attitudes to mental illness and its demographic correlates among general population in Singapore. *PLoS ONE*, 11(11), 1–13. <https://doi.org/10.1371/journal.pone.0167297>