

Mental Health Literacy among Mothers of Secondary Level Students: A Cross-Sectional Study in Urban Nepal

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Abstract: Mental health literacy (MHL) among mothers is vital for early detection and management of mental health issues among adolescents but has been inadequately explored in urban Nepal. This study evaluated MHL among mothers of secondary school-going children in Sanepa, Lalitpur. A cross-sectional survey was carried out among 222 mothers of eight schools in Sanepa, Lalitpur, using the standardized Mental Health Literacy Questionnaire (MHLq). Non-parametric tests were used to explore the correlation between MHL and sociodemographic factors. The majority of mothers showed high levels of MHL (87.8%), especially in self-help methods (90.5% had high levels) and knowledge (79.3% had high levels). However, 85.1% of mothers knew that they did not know anyone with mental health issues. There were significant caste-related inequalities ($p=.035$), with lower scores in marginalized castes. There was weak negative correlation between age and MHL ($r=-0.206$) and mild differences related to employment. Despite high literacy levels, there are important experiential gaps in awareness, recognition of serious mental illness, and caste-related disparities. Culturally adapted family-based interventions are urgently required.

Keywords: Mental health literacy, mothers, adolescents, stigma, Nepal, caste, cross-sectional, urban health

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1. Introduction

Mental health literacy (MHL) has been described as the knowledge and beliefs that help people recognize, manage, and prevent mental disorders and is central to early intervention, decreased stigma, and improved help-seeking (Jorm et al., 1997). There is consistent evidence that people with higher MHL have greater understanding of mental health problems, more favorable attitudes toward those with mental illness, and greater intention to seek professional help (Reavley & Jorm, 2011; Masuda et al., 2012; Gulliver et al., 2010). Despite the recognized importance of MHL worldwide, mental health literacy in mothers, especially in urban school settings in low- and middle-income countries, is a critically under-explored area.

Mothers hold a specially significant and influential role in influencing children's perceptions of mental health. As caregivers, their attitudes, reactions, and knowledge have a direct impact on whether children's emotional or behavioral problems are viewed as serious health issues or simply as issues to be addressed through discipline or character building (Hinshaw, 2005). In many cultures, including Nepal, mothers are gatekeepers of healthcare, and their mental health literacy is the key to early detection, intervention, and appropriate responses (Shrestha et al., 2023). Well-informed mothers with good MHL are more likely to identify early signs of stress, anxiety, depression, or behavioral problems in children and address them with empathy and understanding, rather than punishment and scolding. Poor awareness and stigma lead to delayed interventions, internalization of problems by children, and further decline in academic and social performance.

The need for addressing maternal mental health literacy is emphasized by the epidemiological findings that most mental health problems have their onset during childhood and adolescence, but only a few people seek professional help (Kessler et al., 2007). In Nepal, the problem of accessing mental health care is further exacerbated by the presence of socioeconomic inequalities, lack of mental health professionals, stigma, and lack of awareness about mental health care pathways (Mendenhall, 2012). If the mental health literacy of parents is low, they may not be able to identify symptoms and access the healthcare system, which becomes a major hindrance to seeking mental health care.

Schools are increasingly identified as important settings for early identification and mental health interventions. The American School Counselling Association (2009) highlights the importance of collaboration between school counsellors, families, and community members to ensure that parents are made aware of mental health concerns and can access relevant support services. Nevertheless, in the Nepalese urban and semi-urban school context, including Sanepa, Lalitpur, there appears to be a significant absence of localized information on parental views of mental health and participation in school-based mental health programs. The existing body of research in Nepal has primarily been conducted on clinical samples or behavioral outcomes among adolescents, leading to a relative absence of information on the family context, including parental beliefs and attitudes, stigma, and help-seeking.

This research fills this critical gap by exploring mental health literacy among mothers of secondary school-going children in Sanepa, an urbanizing region of Lalitpur, Nepal. Rapid urbanization, growing academic pressures, changing family structures, and sociocultural values define such regions, which may contribute to increased stress levels among adolescents as well as shape the attitudes of parents towards mental health. By exploring the knowledge, attitudes, and resource utilization of mothers, this study hopes to provide context-specific evidence that can help develop effective and sustainable mental health programs. It is critical to understand how cultural values, social norms, and structural factors interact to influence maternal mental health literacy in order to develop effective interventions that are congruent with cultural values while promoting evidence-based mental health practices. Improving maternal mental health literacy is a strategic approach to enhance mental health outcomes among adolescents and develop family-based mental health support systems in urban Nepal.

2. Materials and methods

2.1. Study Design and setting

The research design used in this study was cross-sectional descriptive research, which was carried out using a quantitative approach to evaluate mental health literacy among mothers of secondary school students. The study was carried out in Sanepa, an urban part of Lalitpur District, Nepal, for a period of three months. The reason why the cross-sectional descriptive research design was used in this study is that it allows the collection of data at a single point in time, giving a glimpse of the situation regarding mental health literacy and stigma among the target group.

2.2. Study Population and sampling

The universe of the study included mothers of students enrolled in grades 9 and 10 in eight schools of Sanepa, including both private and community-based educational institutions. The total population included 426 eligible participants. A proportionate stratified sampling technique was used to ensure adequate representation of participants based on their characteristics such as age, education, income, and occupation. Strata were defined by school type (private vs. community/government) and grade level, with proportional allocation to reduce bias and increase external validity. Stratification by maternal sociodemographic characteristics was applied only during descriptive analysis to examine subgroup differences, not during the sampling frame construction.

The sample size was calculated using the finite population formula: $n = (N \times Z^2 \times p \times (1-p)) / ((N-1) \times E^2 + Z^2 \times p \times (1-p))$. Assuming a 95% confidence level ($Z = 1.96$), a 5% margin of error ($E = 0.05$), and maximum variability ($p = 0.5$), the required sample size was determined to be approximately 227 respondents. After the collection and cleaning of data, five outlier responses were detected using boxplot techniques and eliminated to avoid any distortions in the analysis, leaving a final sample of 222 respondents for analysis.

Inclusion Criteria: Mothers or caregivers of secondary level students enrolled in the sample schools who gave their consent and willingness to participate in the study.

2.3 Data Collection Tool

The research employed the 29-item Mental Health Literacy Questionnaire (MHLQ), which was originally developed by Dias et al. (2018). This instrument was specifically designed for young adults and is suitable for parental evaluation. The instrument used a 5-point Likert scale, ranging from 1 (strongly disagree) to 5 (strongly agree). The total score for mental health literacy was determined by adding all the items after reverse scoring, ranging from 29 to 145.

2.4 Cultural Adaptation and Validation

The questionnaire was translated into Nepali using the forward and backward translation technique by bilingual professionals. The translated questionnaire was pre-tested on 20 mothers to evaluate the clarity, understandability, and

cultural relevance. Some modifications were made based on the pre-test results to improve cultural relevance. The reliability analysis showed a Cronbach alpha value of 0.84, which indicated good internal consistency. Face validity was established through expert validation by mental health professionals and academic supervisors, and construct validity was established through the theoretical basis of the MHL framework.

2.5 Data collection Procedure

The data was collected using systematic distribution of structured questionnaires during parent-teacher meetings and parent events organized by the schools over a period of three months. The school administrations acted as facilitating agencies in the study by organizing the schedules of the meetings and ensuring conducive environments for the administration of the surveys. Before the administration of the survey, all respondents were given adequate information regarding the purpose of the study, the nature of the questions, the confidentiality of the responses, and their rights as participants. Written informed consent was sought from all respondents. The respondents were also assured that their participation was voluntary, that the information would be used for academic purposes only, and that they could withdraw from the study at any time without any consequences. Anonymity was ensured by using identification codes instead of personal identifiers.

2.6. Data Analysis

The data was assessed for completeness, organized, coded, and imported into Microsoft Excel, then further analyzed using Jeffrey's Amazing Statistics Program (JASP). The outliers were detected using the box plot method, and five outliers were deleted after a thorough examination to avoid any potential impact on statistical analysis.

Descriptive and inferential statistical analysis was conducted while maintaining a 95% confidence level, 5% margin of error, and significance level of $p = 0.05$. The descriptive statistics included frequency, percentage, mean, standard deviation, percentile distribution, and interquartile range. Normality tests were conducted using skewness, kurtosis, and the Shapiro-Wilk test, which showed that all variables in the study were significantly non-normal ($p < 0.001$). Therefore, non-parametric tests were used in the study. These tests included the Mann-Whitney U test for two-group comparisons, the Kruskal-Wallis test for comparisons involving more than two groups, and Spearman's rank-order correlation test for correlation analysis between two continuous variables.

2.7. Ethical Considerations

Strict ethical procedures were followed throughout the research process. The study was formally granted ethical clearance by the Nepal Health Research Council (NHRC) on February 27, 2025, and was carried out in accordance with the ethical norms of Tribhuvan University. Informed consent was obtained from all participants before embarking on data collection. Privacy and confidentiality were maintained strictly, with all data kept in password-protected files that were accessible only to the researcher. The dignity, emotional well-being, and autonomy of the participants were maintained throughout the research process. This is especially important in the context of Nepalese society, where mental health issues are stigmatized.

3. Results

3.1. Sociodemographic Characteristics of Respondents

A total of 222 mothers of secondary school students from eight schools in Sanepa, Lalitpur, participated in this study. Table 1 presents the key sociodemographic characteristics of the sample.

Table 1: Sociodemographic Characteristics of Respondents (N=222)

Characteristic	Category	Frequency (n)	Percentage (%)
Educational Attainment	Undergraduate	29	13.1
	Pre-Secondary	49	22.1
	University	4	1.8
	Higher Secondary	42	18.9
	Secondary	98	44.1
School Type (Child)	Community	20	9.0
	Government	84	37.8
	Private	114	51.4

Awareness of Someone with Mental Health Problems	Others	4	1.8
Mental Health Problems Known (n=27)	I don't know	189	85.1
	I know	27	12.2
	I'm confused	6	2.7
	Anxiety	9	33.3
Relationship to Affected Person (n=29)	Depression	16	59.3
	Schizophrenia	2	7.4
	Relative	19	65.5
	Friend	3	10.3
	Self	2	6.9
	Other	5	17.2

Source: Field Survey, 2025

The educational background of the mothers showed a fair degree of diversity, with the majority having completed secondary education (44.1%, n=98), followed by pre-secondary education (22.1%, n=49). Very few had completed university education (1.8%, n=4). In terms of institutional enrollment, more than half of the respondents' children were enrolled in private institutions (51.4%, n=114), which is in line with the mothers' preference for better infrastructure and support services like counseling.

One of the most significant findings of this study is that the vast majority of mothers (85.1%, n=189) reported that they did not know anyone with mental health problems. Only 12.2% (n=27) of the mothers reported that they knew someone with mental health problems. This huge gap between the literacy levels and awareness levels is one of the most significant findings of this study. The very low awareness level indicates that mental health problems are still a hidden, unrecognized, and unnamed reality in families and communities, possibly due to stigma, taboo, and fear of labeling.

Of the few who claimed to be aware, the most common condition identified was depression (n=16), followed by anxiety (n=9), and then schizophrenia (n=2). The near-absence of schizophrenia in the awareness repertoire of the respondents is a significant knowledge gap, as the delay in awareness of psychotic disorders has been shown to significantly impair the outcome of early intervention efforts. The association between the respondents and the aware individuals was mainly familial (65.5%, n=19), as has been observed in previous studies that when mental health issues are acknowledged, they are usually identified within the family circle. Siblings, uncles, parents, and children were the most commonly reported.

3.2 Levels and Distribution of Mental Health Literacy

The total mental health literacy level among mothers showed a mean of 114.7 (SD = 16.83) on a scale of 29 to 145, which is moderate to high with considerable variation among the participants (range: 35.0-146.0). The negative skewness of -1.472 revealed that most of the participants tended to score above the mean.

Categorization of Mental Health Literacy Levels: The majority of the participants (87.8%, n=195) showed high levels of mental health literacy. Only 9.0% (n=20) showed moderate levels, and 2.3% (n=5) showed low levels of mental health literacy.

Analysis of the four component factors revealed:

- Knowledge of Mental Health Problems (Factor 1): Mean = 40.98 (SD = 6.282) out of 55; 79.3% (n=176) high, 19.4% (n=43) moderate.
- Erroneous Beliefs/Stereotypes (Factor 2): Mean = 29.47 (SD = 3.689) out of 40; 80.2% (n=178) high (indicating low stigma endorsement).
- First Aid Skills/Help-Seeking (Factor 3): Mean = 23.88 (SD = 3.800) out of 30; 80.2% (n=178) high.
- Self-Help Strategies (Factor 4): Mean = 15.45 (SD = 2.059) out of 20; 90.5% (n=201) high.

Although these results indicate positive knowledge, attitudes, and perceptions of competencies, the gap between theoretical knowledge and the remarkably low rate of personal awareness of mental health issues (85.1% reporting no known affected individuals) is of paramount importance. This suggests that the ability to identify and acknowledge mental health issues may not be easily achieved by knowledge, a distinction between knowledge and the ability to apply it in practical life.

Normality tests using the Shapiro-Wilk test showed significant departures from normality for all variables ($p < .001$), with negative skewness for all variables (-0.395 to -1.472). These properties of the data distribution required the application of non-parametric tests for all inferential analyses.

3.3 Mental Health Literacy and Caste

One of the most significant findings of this study was the identification of statistically significant differences in mental health literacy across caste groups. Table 2 presents the descriptive statistics and Kruskal-Wallis test results.

Table 2: Mental Health Literacy Scores by Caste with Kruskal-Wallis Test Results

Caste Group	N	Mean	SD	SE	H	df	p
Newar	50	119.74	13.26	1.875	12.01	5	.035
Janjati	49	114.41	13.96	1.995			
Chettri	68	113.50	18.02	2.185			
Madhesi	46	111.72	23.23	3.425			
Dalit	5	103.80	14.34	6.414			
Other	2	72.50	40.31	28.500			

Source: Field Survey, 2025

The Newar group had the highest mean value for mental health literacy (Mean = 119.74, SD = 13.26), followed by the Janjati group (Mean = 114.41, SD = 13.96) and the Chettri group (Mean = 113.50, SD = 18.02). The Madhesi group had a slightly lower mean value (Mean = 111.72, SD = 23.23) with much larger variability. The Dalit group had a lower mean value (Mean = 103.80, SD = 14.34), although the small sample size should be kept in mind when interpreting this result.

The Kruskal-Wallis test confirmed that these differences were statistically significant ($H = 12.01$, $df = 5$, $p = .035$). This result offers empirical support for the notion that mental health literacy is not equally distributed across social groups in urban Nepal. The result, which shows that groups with historically marginalized caste systems (Dalit, Madhesi) have lower mean scores than groups who have had more historical access to social and educational resources (Newar, Chettri, Janjati), suggests that structural inequalities and information disparities are still influencing mental health literacy.

This has utterly fundamental implications: universal, one-size-fits-all awareness campaigns are unlikely to adequately address the needs of communities experiencing systematic disadvantage. Culturally adapted, socially inclusive interventions co-designed with marginalized communities are critical to ensure that mental health promotion campaigns do not inadvertently perpetuate existing inequities.

3.4. Mental Health Literacy, Employment Status and Age

Employment Status: Descriptive comparisons between employed and unemployed mothers showed small differences favoring the employed group on all aspects. Employed mothers ($n=146$) scored slightly higher on the total mental health literacy (Mean = 114.58, SD = 18.33) than unemployed mothers ($n=74$; Mean = 113.31, SD = 17.96). This was true for knowledge (employed: 41.23; unemployed: 40.47), help-seeking (employed: 24.02; unemployed: 23.59), and self-help strategies (employed: 15.62; unemployed: 15.09). The only exception was the section on erroneous beliefs/stereotypes, where unemployed mothers scored marginally better (Mean = 29.66) than employed mothers (Mean = 29.37).

Although these differences were always in favor of employed mothers, they were not large in magnitude. Employment status may have some advantages in terms of information exposure, social networks, and health discussions, but it does not seem to be a major factor in mental health literacy.

Age: Spearman's rank correlation test showed weak negative correlations between age and all measures of mental health literacy.

Table 3: Spearman's Correlations between Age and Mental Health Literacy Components

Variable	Age	Overall Score	Knowledge	Help-Seeking	Self-Help	Stereotypes
Age	—	-0.206	-0.085	-0.104	-0.055	-0.166
Overall Score		—	0.755	0.746	0.414	0.060
Knowledge			—	0.633	0.500	-0.006
Help-Seeking				—	0.419	0.011
Self-Help					—	0.001
Stereotypes						—

Source: Field Survey, 2025

The correlation coefficient between age and total mental health literacy was $r = -0.206$, suggesting that as age rises, the total mental health literacy modestly declines. Likewise, very weak negative correlations were found between age and the component factors (ranging from -0.055 to -0.166). These results imply that younger mothers have marginally higher mental health literacy, possibly due to increased exposure to mental health education through various media and campaigns. Nevertheless, the very weak strength of the correlation coefficients suggests that age is not a strong predictor of mental health literacy, which is an encouraging result indicating that mental health literacy can be improved at any age.

3.5 Interrelationships among Mental Health Literacy Components

The correlation matrix (Table 3) reveals several important patterns regarding the internal structure of mental health literacy:

Strong positive correlations were observed between:

- Overall score and knowledge ($r = 0.755$)
- Overall score and help-seeking ($r = 0.746$)
- Knowledge and help-seeking ($r = 0.633$)

These indicate that knowledge and help-seeking capabilities are central, tightly integrated components of overall mental health literacy.

Moderate positive correlations were observed between:

- Knowledge and self-help strategies ($r = 0.500$)
- Overall score and self-help ($r = 0.414$)
- Help-seeking and self-help ($r = 0.419$)

These suggest that self-help strategies, while positively associated with other domains, represent a somewhat distinct competency.

Critically, the stereotypes score (erroneous beliefs) showed very weak or negligible correlations with other components, namely knowledge ($r = -0.006$), general literacy ($r = 0.060$), and help-seeking ($r = 0.011$). This is highly significant, as the absence of stigmatizing beliefs is independent of the presence of positive knowledge and skills. In other words, improving knowledge and help-seeking skills does not necessarily lead to the reduction of stigmatizing attitudes; rather, direct intervention is required.

The high intercorrelations among knowledge, help-seeking, and self-help components have positive implications for interventions. The fact that these components are interrelated implies that improving one component is likely to have a positive impact on other components. Interventions aimed at improving practical knowledge, especially regarding the timing and manner of seeking professional help, may lead to improvements in overall literacy skills in various aspects.

4. Discussion

The present study examined mental health literacy (MHL) among mothers of secondary school students and revealed the following significant trends in relation to the sociodemographic variables, levels of literacy, and the psychosocial variables. Overall, the findings indicate that most mothers reported moderate to high levels of mental health literacy in relation to mental health issues related to knowledge, self-help practices, and help-seeking. In developed thought, the findings are in line with the initial definition of mental health literacy, which emphasizes mental health recognition, management, and prevention-related knowledge and beliefs (Jorm et al., 1997). However, despite the fact that the scores of standardized instruments are relatively high, a close look reveals that there are significant discrepancies in the levels of awareness, experience-based knowledge, and equal distribution of mental health literacy among the social groups.

The level of educational attainment was found to be an important contextual issue that influences the mental health literacy. Nearly 50% of the participants have completed secondary-level education, and a considerable number of participants have pre-secondary-level education. The educational attainment level of the participants is consistent with the previous studies conducted in Nepal, which have shown that parental education is the best predictor of mental health awareness and positive attitudes towards help-seeking (Shrestha et al., 2025). The same has been reflected in the international literature, which further reveals that parents with a higher level of educational attainment are better equipped to possess accurate information about mental health problems and demonstrate supportive responses to their victims (Kusaka et al., 2024). Direct quantitative comparison with previous Nepalese studies is instructive: Shrestha et al. (2023) reported a mean MHL score of 108.4 ($SD = 18.2$) among a mixed sample of adolescents and parents in Kathmandu using the same MHLQ instrument, while the present study found a higher mean score of 114.7 ($SD = 16.83$) among mothers only. Similarly, Shrestha et al. (2025) observed that 72.3% of parents in their sample demonstrated high MHL, compared with 87.8% in this study. The higher literacy levels in Sanepa may reflect increasing mental health awareness in urban settings over time, differences in sampling (mothers-only versus mixed parents), or the relatively higher educational attainment and private school enrollment in the present sample. The diversity of the participants in this study suggests that the mental health literacy program should be designed to address the disparities in the educational attainment level of the participants by using simple language and culturally relevant examples to address the literacy gap (Johnson et al., 2023).

The type of school that the students of respondents attend also provides an important interpretive differentiation. The children also had a greater proportion who were enrolled in both government schools and community schools, with more than half of the children attending the schools that were privately owned. The Nepal context generally perceives the advantage of the private schools in offering better infrastructures, teachers, and other activities such as psychosocial support and counseling services. This institutional experience may have an indirect influence on the awareness of parents about mental health through school-parent communication and experiences gained by children (Gurung et al., 2022). On the contrary, the challenges faced by government and community schools are generally linked with the absence of resources

and necessary psychosocial support that may hamper the future of mental health promotion. This institutional inequality highlights the significance of school setting as a potential avenue through which parental mental health literacy may be enhanced in the entire education system.

Though the literacy rates were relatively high, the awareness of mental health problems was drastically low. The large number of respondents reported that they had no acquaintances with mental health problems. This finding is in line with the findings reported elsewhere, including Nepal, that mental illness remains hidden because of stigma, fear of social labeling, and less mental health vocabulary in families and communities (Renwick et al., 2024). Among the few respondents who reported awareness, depression and anxiety were most common, but severe mental illness such as schizophrenia was rarely reported. This finding is a part of global trends, where common mental health problems are relatively easier to identify, and severe mental illnesses are relatively understudied and stigmatized on a massive scale (Jorm, 2000; Kusaka et al., 2022). The findings indicate the presence of a serious gap in the mental health literacy, that is, the lack of knowledge about severe and chronic mental illness, which may lead to a delay in early diagnosis and treatment.

The awareness issue regarding mental health problems is dependent on the family relationship. Most of the respondents who identified a person with a mental health problem identified close family members, specifically siblings, parents, or extended family members. The finding is in support of the assumption that mental problems are often identified in the family setting, especially in collectivist societies, like Nepal, where the family is the central source of care and decision-making process. It has been previously researched that family support and communication play a significant role in the reduction of stigma and treatment each time (Johnson et al., 2023). However, the number of respondents who have affected members is also relatively small and thus this also indicates that many cases may be unidentified or unreported in the family setting. It is worth mentioning the importance of family-based mental health education that equips the parents with knowledge of early symptom recognition, communication, and access to the provided services.

The skewness of mental health literacy and its four factors or variables was found to be negative with several respondents scoring above the mean. This indicates that there is a tendency to have a positive attitude towards mental health in general, although the high values of the Shapiro-wilk test indicate that there is no normality, and this further indicates that the responses may be biased due to social desirability or biased responding. These findings are common in self-reported measures of mental health literacy, particularly in settings where the respondent may be able to motivate himself to view himself as being helpful and knowledgeable (Campos et al., 2022). Therefore, high scores should be considered as the reflection of positive attitudes and perceived knowledge but not necessarily as the definitive measure of the ability to apply it in real life.

The most prominent findings of this study were the presence of differences in mental health literacy based on the castes. The scores of mental health literacy were significantly different based on the caste groups, and the Kruskal-Wallis test has proved the presence of statistically significant differences. The presence of more people in some caste groups scoring higher than others may be an indication of their social and structural inequality over the years in terms of education, information, and cultural beliefs about mental illness outcomes. Taking into consideration the fact that factors such as culture, belief systems, and social orders play a very important role in the perception and treatment of mental illnesses, it is important to note that previous studies have shown that they played a significant part (Shawon et al., 2024). The findings of this study suggest that mental health literacy interventions should be culturally integrated to cater to the needs and barriers of the marginalized groups in order not to support the inequality in place. While this study identified significant caste-based disparities in MHL, we did not formally examine whether caste interacts with education or employment status to moderate literacy levels. Future research should employ moderated regression or multi-group structural equation modeling to investigate whether the relationship between caste and MHL is conditional upon educational attainment or employment status, and whether these interactions differ across marginalized versus privileged caste groups.

Portent descriptive differences existed with regard to employment status, where employed mothers had a slightly higher score with regard to knowledge, help-seeking behaviour, and self-help strategy. The employment status may provide greater access to social networks, source of information, and health-related discussions that can be harnessed to develop awareness (Shrestha et al., 2023). However, the differences that were observed were very small, and it should not be considered in terms of causation. Similarly, the correlation analysis revealed weak negative correlations of age and mental health literacy, where younger mothers may be slightly more enlightened or slightly open-minded to the ideas of mental health. This could be attributed to the exposure to new education, online media, and campaigns. However, age was not a strong predictor, which implies that social and contextual factors have a greater influence on mental health literacy than age. Notably, strong positive correlations were observed between the factors of mental health literacy, particularly the overall literacy, knowledge, and help-seeking behaviour. This result confirms the multidimensionality of mental health literacy and points to the possibility that the positive effect of literacy improvement in one area can be made in others (Jorm, 2000). In intervention terms, it means that the benefits of programs centered on practical knowledge, such as where and how to seek help, could be more extended to the program of the general literacy and attitudes.

Several limitations should be considered when interpreting these findings. First, the use of self-reported MHL measures introduces the risk of social desirability bias, whereby mothers may have overestimated their knowledge and attitudes due to societal expectations of being knowledgeable caregivers. The negative skewness observed in all variables supports this possibility. Second, the study was conducted exclusively in Sanepa, an urban area of Lalitpur, which limits the generalizability of findings to rural Nepal, where cultural beliefs, educational access, and mental health resources differ substantially. Third, the cross-sectional design precludes any causal inferences about the direction of relationships between

sociodemographic factors and MHL. Fourth, certain caste groups, particularly Dalit (n=5) and "Other" (n=2), had very small sample sizes, meaning that comparisons involving these groups should be interpreted with caution and require replication with larger samples. Fifth, non-response bias may be present, as mothers who agreed to participate during parent-teacher meetings may differ systematically from those who did not, potentially overrepresenting those with higher educational attainment or greater engagement with school activities. Despite these limitations, the study provides valuable baseline data for urban Nepal and identifies clear directions for future research and intervention.

5. Conclusion

This research offers a thorough insight into mental health literacy (MHL) among mothers of secondary school-going children in urban Nepal. The results indicate a paradoxical situation, where most mothers show high levels of MHL on standardized scales, especially in self-help methods, knowledge, and help-seeking intentions, but a deep chasm exists in experiential knowledge and its equitable distribution among social groups.

The most striking result is the gap between literacy levels and actual recognition, where 85.1% of mothers reported not knowing anyone with mental health issues. This indicates that despite the availability of adequate knowledge, mental health problems remain invisible, unrecognized, or unnamed in families and communities because of the stigma associated with mental illness and the lack of mental health terminology. When recognition did happen, it happened mostly in the context of family systems, which reaffirms the importance of family systems in Nepalese culture. However, recognition was mostly limited to common mental health problems such as depression and anxiety, while serious problems like schizophrenia remained largely unrecognized, which is a serious deficiency in early intervention.

The most important contribution of this study is the establishment of the existence of statistically significant disparities in MHL ($p=.035$) based on caste, with lower scores from marginalized sections of society. This helps to establish that structural inequalities continue to influence mental health literacy in urban Nepal, and that culturally specific, socially inclusive interventions are required to address the needs of the community.

Employment status and age were found to have only weak correlations with MHL, suggesting that more pervasive sociocultural factors, such as caste, education, and family exposure, have more significant effects. The high levels of intercorrelation between knowledge, help-seeking, and self-help, and the relative independence of stigmatizing beliefs, suggest that comprehensive interventions must target literacy improvement and stigma reduction through complementary approaches.

Improving maternal mental health literacy is a key strategic focus for improving mental health outcomes for adolescents in Nepal. Interventions need to go beyond awareness and include disorder-specific knowledge, stigma reduction, family-centered communication skills, and equitable access for marginalized groups. By empowering mothers to become informed advocates for mental health, a sustainable and culturally responsive mental health support system can be developed in urban Nepalese communities.

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