CAPITAL UNIVERSITY OF SCIENCE AND TECHNOLOGY, ISLAMABAD

Understanding Help-Seeking Intentions: The Influence of Self-Reliance, MH Literacy, Perceived Social Support and Access to MHS among University Students

by

Erum Hamid

A thesis submitted in partial fulfillment for the degree of Master of Science

in the

Faculty of Management & Social Sciences
Department of Psychology

2026

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Understanding Help-Seeking Intentions: The Influence of Self-Reliance, Mental Health Literacy, Perceived Social Support and Access to Mental Health Services among University Students

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Acknowledgement

I feel proud in dedicating this research project to the youth of Pakistan. Who is the backbone of our nation. I am deeply grateful to my supervisor for her invaluable supervision, constructive feedback, and constant guidance, and to my brother, whose moral support and encouragement have meant more than words can express. This research is dedicated to my beloved parents, whose unwavering support, sacrifices, and precious prayers have been my greatest strength. Their encouragement has guided me through every step of this journey. During my journey I endured the loss of my three beloved family members who are no longer with me today to witness this achievement, but their memories became a source of strength, inspiring me to move forward and complete this work with determination and gratitude.

(Erum Hamid)

Abstract

Mental health concerns are prevalent among university students, however professional help-seeking remains limited. This study aimed to investigate the relation of help-seeking intentions towards formal and informal sources, with self-reliance, perceived social support, and mental health literacy among university students who were recruited from different universities located at districts Buner and Swat (KPK). It further investigated the relationship between access to mental health services (MHS) and its utilization by students in terms of overutilization or underutilization based on the actual need to seek help for mental health. Using a quantitative, correlational research design, data were collected from a sample of 250 university students whose age range was 18-35 including both males and females. This study employed standardized measuresGeneral-Help Seeking Questionnaire, Self-Reliance Scale, Multidimensional Scale of Perceived Social Support, and Mental Health Literacy Scale to assess the accessibility of mental health services within university and outside the university settings. The Cronbach's alpha reliability analysis revealed good internal consistency for the study variables. Spearman's correlation analyses were conducted to examine associations among the study variables. Results indicated a significant negative relationship between self-reliance and help-seeking intentions (rs = -0.364, p = .000), suggesting that higher levels of self-reliance were associated with lower willingness to seek professional help. In contrast, perceived social support and mental health literacy showed significant positive relationships with help-seeking intentions (rs = 0.543, p = .000 & (rs = 0.615, p = .000). The results indicated that access to mental health services is not significantly related to help-seeking intentions among university students. Implications for mental health interventions and campus-based support programs are discussed.

Keywords:Help-seeking intentions, university students, self-reliance, mental health literacy, mental health services (MHS), access to MHS.

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Abbreviations

FS Formal Support
HIS Help-Seeking Intentions
HSB Help-Seeking Behaviors
IS Informal Support
LMICs Low- and Middle - Income Countries
MHL Mental Health Literacy
MHS Mental Health Services
PHSI Professional Help-Seeking Intention
SR Self-Reliance
SR Self-Reliance
TPB Theory of Planned Behavior
WHO World Health Organization

Chapter 1

Introduction

1.1 Background of the Study

The development of help-seeking intentions such as service utilization, degree of willingness for formal and informal sources of help, accessing mental health services, gaining awareness to mental illness increasingly being studied in understanding mental health issues and treatments in the last decade (Abdullah, 2025; Van den Broek et al., 2023; Yamauchi et al., 2023). The help-seeking intention has termed as an adaptive behavior that has a constructive ongoing impact on an individual across the lifespan Lee (1999), termed as an "approach coping style,"; in which a mental health concern is recognized and actively addressed, and those are effective coping strategies (Frydenberg and Lewis, 1993). However, intentions to seek help are grounded in social relationships and interpersonal skills.

Several factors influence help-seeking intentions towards mental health. services (MHS), including mental health literacy, self-reliance, perceived social support, and access to the mental health services in terms of cost and accessibility of mental health centres mental health centers. Self-reliance refers to the essential life skill which is developed in young people when they experience a tendency to cope with stress by themselves, and they trust their abilities rather than reaching out the sources for help (Compas et al., 2001; Ishikawa et al., 2023).

Discussing the potential factors affecting the help-seeking intentions, it has be proposed that students find it difficult to recognize and discriminate between the

normal level of stress and the threshold level of stress, while university students often lack this essential life skill to recognize the mental health issues and need to communicate them to the professionals, termed as mental health literacy (Jorm et al., 1997).

Regarding help-seeking for mental health issues, students are inclined to redefine what is normal and what is beyind normal, hence this modified definition of mental health issues can result in either under-interpretation or over-interpretation of the actual mental health issue (Rickwood et al., 2005). Perceived social support is a belief that support would be available when needed (Day and Livingstone, 2003), further it includes the emnotional as well as instrumental support from the friends, family or others (Trepte and Scharkow, 2016).

Conferring recent assessment of WHO, globally up to 1 billion people of all ages are surviving with mental health issues Organization (2025). However, research has indicated that young people are at a significant risk of mental issues because they have rare help-seeking attitudes (Shi and Dai, 2022; Ibrahim et al., 2019).

During adolescence and youth many critical changes occur specifically with reference to mental health; which may potentially leads to social emotional or cognitive difficulties with significant long term consequences (Haller et al., 2016; Kelly et al., 2007). The untreated mental health issues may disrupt academic or professional achievements. (Kessler et al., 1995).

However, research shows that risk of mental health issues can be reduced, when young people engage in help-seeking behaviors. Thus, they can prevent serious complications and foster optimal performance by actively seeking assistance and addressing concerns early (Wilson et al., 2011; Rickwood et al., 2005).

Furthermore, Rickwood et al. (2005) elaborated that help-seeking behaviors in younger age group are essential to ensure mental well-being. Therefore, they must be encouraged to seek timely and appropriate help. Moreover, it is discovered that 35% of college students during their first year reported a lifetime mental disorder and 31% students reported experiencing at least, one prevalent psychological disorder within the past year (Auerbach et al., 2018). Larger proportion of individuals with mental illness actually do not seek adequate support from psychologists or psychiatrists (Asnakew et al., 2024).

Few pieces of evidences indicated that university students tend not to seek mental health services from appropriate sources, as 13.4% of young people confronted mental or emotional disabilities, but the rate of recovery in this age group is very low; 33% of young people sought mental health services (Polanczyk et al., 2015; Gulliver, 2010). The individual who likes to consult for their mental health issues prioritizes seeking help from their informal support group, including peers and close members, over formal support, including physicians, medical specialists, and other mental health professionals (Rickwood et al., 2007).Thus, it is apparent that low mental health literacy hinders intentions for help seeking .

The above evidence shows that university students tend not to seek assistance for their psychological issues, a rising tendency to manage or cope with stress by themselves, as this is the developmental stage in which people learn to deal with stress by themselves (Compas et al., 2001).
In this regard, another important factor under study is self-reliance that hinders intention to seek help is preference to rely on themselves and trust their abilities (self-reliance) rather than reaching out to mental health services i.e. formal help or a supportive circle like friends, relatives, or spouse i.e. informal help (Ishikawa et al., 2023). Also, they view seeking help from others as a sign of their weakness or incapability to deal effectively with their problems which indicates the lower mental health literacy and higher self-reliance as predictors of lower help-seeking intentions (Rickwood et al., 2007).

Similarly, the lower level of percieved social support is linked with higher self-reliance in young people (Southwick et al., 2016). Social support can be either actual or perceived, and it varies in nature, including emotional, financial, or instrumental support. Social support is essential for mental wellbeing and overall functioning in young people as it helps to cope with stress (Chu et al., 2010)(Cohen and Wills, 1985), however perceived social support significantly influence people's intention to seek help from available sources when they need support(Ryan et al., 2005). This study predicted help-seeking intentions among university students as an outcome variable and the predictors are mental health literacy, self-reliance,

perceived social support and access to professional help.

1.2 Gap Analysis

As we discussed earlier, low levels of knowledge and awareness about mental health and illness; termed as mental health literacy can adversely impact help-seeking intentions, and perceived social support can potentially influence these behaviors. While mental. health issues and intentions to disclose these issues to seek help are extensively studied among younger age groups of students and the general population, but self-reliance and the need to utilize the available mental health sources (under-utilization or over-utilization) of MHS in Pakistani students in terms of help-seeking intentions are not fully explored. Additionally, the association between perceived social support and intentions to seek help from mental health services among Pakistani university students remains unclear.

This study explores the factors influencing university students' intentions to seek help for mental health services in the province of Khyber Pakhtunkhwa (KPK), Pakistan. Specifically, it examined the roles of self-reliance, mental health literacy, perceived social support, and access to mental health services (MHS). The factors mentioned in this study are crucial to examine in Pakistani culture because mental health receives very little attention, even though rising levels of inflation, lower employment status, unstable political conditions, rising levels of academic stress, and other psychosocial factors have heightened the need to timely identify and cope with mental health problems(Kausar et al., 2026; Naz et al., 2024).
The mental health burden and their related risk as well as preventative factors in low- and-middle-income countries (LMIC) like Pakistan may vary from Western nations. In developed countries, societies are typically individualistic where individual interests are prioritized over family or community. In contrast, Asian societies are collectivist where socioeconomic constraints, culturally unique conceptions of mental health issues, family norms and societal expectations significantly influence the mental health issues and seeking help from appropriate sources (Lester, 2011).

Pakistan's low literacy rate, widespread poverty, and lack of resources hinder understanding and access to mental healthcare (Najmi, 2021). A low literacy rate of mental health and illness can make young people either over-utilize the available mental health services for even mild forms of stress or underutilize the available sources, thinking that they can handle the stress, which is beyond their threshold level but they are unable to recognize their threshold level and coping with stress. As discussed earlier, this country has made relatively more progress in addressing children's mental health issues but lacks to work effectively for mental health of young people.

This study aims to explore how perceived social support and self-reliance relate to help-seeking intentions among university students in Pakistan. The connection of self-reliance, perceived social support as predictor with students' tendencies to seek either formal or informal help as outcome variable and, access to mental health services for students in terms of affordability, mode accessing the MHS i.e. may be online or in-person, awareness to the MHS (ease of availability) remains insufficiently understood within the Pakistani context. As discussed earlier, in Pakistan the need for mental health services is increasing while psychosocial factors may influence to seek support from appropriate sources. These factors are not studied in rural areas of Pakistan therefore; this study will target students from rural areas of Pakistan.

1.3 Rationale

Despite significant advancements in understanding mental health issues, the influence of self-reliance and perceived social support towards one's help-seeking intentions remains unclear (Ishikawa et al., 2023). Psychosocial factors that can contribute to the under-utilization of mental health services and the influence of mental health literacy on students' help-seeking intentions are less explored in the culture of Pakistan (Abdullah, 2025). These districts have low mental health facilities and literacy rate than other districts. This study will assess the help-seeking intentions of students in two rural districts of KPK (Mustafa, 2012).

As mentioned in gap analysis, Pakistan is also an LMIC, has a population of

more than 220 million which ranks it as the fifth most populated nation. There is a diverse cultural, religious, ethnic linguistic, economic as well as social groups where people struggle to get a better life through education and employment status. Asad et al. (2024) highlighted that the healthcare system in this country is over-crowded and is inadequate primarily due to difficulties to access the system, low-socioeconomic status, poor governance and low accountability. The limited access to appropriate mental health services rises due to long distances, dearth of mental health professionals corresponding to a crowd of individuals with mental health issues and related awareness.

Additionally, the problem is the utilization of the available mental health systems. There is inappropriate utilization of the system. Some individuals (specifically from urban areas) seek assistance from mental health professionals even for a lower level of stress or problems that can be managed without consulting a professional help on the other hand, there are individuals who actually need help from professionals but they do not seek help (Husain, 2020; Daraz et al., 2025) .

This research aims to investigate how self-reliance, mental health literacy influence. the level of help-seeking. intentions and with a focus on the need and under-utilization or over-utilization of MHS in both male and female university students residing in the districts Buner and Swat (KPK) in Pakistan.

1.4 Theoretical Background

The Theory of help-seeking presented by Rickwood et al. (2005) inform the direction of the current study (Rickwood et al., 2005). According to this theory, help-seeking is a multi-stage process in which an individual's personal needs gradually become interpersonal and action oriented. It explains this process as shown in the figure. The first component, i.e., awareness, refers to an individual's ability to recognize symptoms of the problem. In this study, awareness is closely related to mental health literacy Jorm (2000) because when a person realizes that the problem is beyond the threshold level so there is need to express or communicate the problem to overcome it. Lower levels of mental health literacy can cause normalization or misinterpretation of mental health issue which may delay

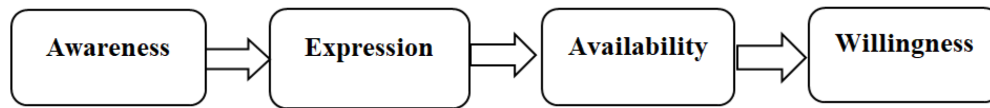

FIGURE 1.1: Theoretical Model

or completely hinders the university students to proceed help-seeking timely and from appropriate source (Gulliver, 2010; Furnham and Swami, 2018). In contrary, the students who are high in mental health literacy are able to timely recognize the mental distress, and proceed to appropriate help-seeking sources (Reavley and Jorm, 2011).

The second component of help-seeking model refers to the expression of the problem (mental health issue), or communicating with others, highlighting an insight for social support. It reflects self-reliance as it involves taking responsibility for a person's well-being (Rickwood et al., 2005). The students who belief more in self-reliance and take proactive steps to manage their mental health issues by their own, are lesser involve in-seeking help from others either formal or informal help. Thus, higher self-reliance may serve a barrier to disclose mental health disturbance with others and lead to inhibit the help-seeking behaviors among university students. In our culture, young adults are encouraged for independence in dealing with personal issues.

The third component refers to the availability of appropriate sources of help for the person, while the source of help can be formal or informal, which is closely in line with the perceived social support (Rickwood et al., 2005). Perceived social support from friends, peers, or family among university students reduce feelings of isolation, and encourage students to engaged in help-seeking behaviors (Eisenberg et al., 2007). The higher levels of perceived social support among university students the higher is the likelihood to disclose mental health issues and higher help-seeking behaviors thus leading to increased utilization of available sources by the students (Rickwood et al., 2007; Hefner and Eisenberg, 2009). The last stage refers to willingness of seeking-help, which is shaped by collective impact of self-reliance, mental. health literacy, and perceived social support (Gulliver,

2010; Sager, 2019). It also includes the factors like accessibility to available mental health facilities, affordability of the services and other contextual factors like beliefs, and prior experiences. Finally, when the person finds the appropriate and accessible source to consult professional assistance, it may affect the person's intention to seek out help from either mental health services or from friends, family members, or others.In summary, this theoretical model demonstrates the social, cognitive and personal factors in understanding the help-seeking intentions. The research questions and hypotheses of the current study are extracted from this theoretical model to understand the relationship of mental health literacy (cognitive factor), self-reliance (personal factor), and perceived social support (social factors) with help-seeking intentions among university students, offering a framework for empirical investigations. In addition to these, access to mental health services is investigated in relation to help-seeking intentions.

1.5 Research Objectives

i. To investigate the relationship between self-reliance, mental health literacy, perceived social support and help-seeking intentions among university students.
ii. To investigate the influence of mental health.services on help-seeking intentions among university students.

1.6 Research Hypotheses

The following hypotheses are formulated:
i. Self-reliance is negatively associated with the help-seeking intentions among university students.
ii. Mental health literacy is positively associated with the help-seeking intentions among university students.
iii. Perceived social support is positively associated with the help-seeking intentions among university students.
iv. Access to mental health services is positively associated with the help-seeking intentions among university students.

Chapter 2

Literature Review

This section provides theoretical and empirical evidence for the hypothesized relationships in the current study a narrative discussion of literature is presented for understanding mental health literacy, self-reliance, perceived social support and accessibility in relation to help-seeking intentions from informal, formal and no one.

2.1 Understanding Help-Seeking Intensions for Mental Health Issues

In health-related research, the term “help-seeking” comes from medical sociology, notably the notion of ”illness behavior” introduced by David Mechanic in 1962, defining the ways people monitor their health, interpret symptoms, take preventative measures, or interact with the healthcare system. It aims to understand the underlying factors why people do not always seek medical help. In 1976, studies revealed that only one in ten individuals sought help from health professionals when they confronted significant symptoms (Mechanic, 1982) .

In the context of mental health,Deva (1999) depicted that in the pre-modern age, mental health care was founded within the community by either family members or religious/traditional healers. This practice was common across the globe, including Asian countries, and is still common in developing countries, mainly because

advanced health services are sometimes not easily accessible to people with mental health issues in many areas of developing countries. Although the WHO recognized the mental health as an essential part of one's overall wellbeing, today, there are relatively good basic medical health services than mental health services including LMICs Meshvara (2002). Which may affect the willingness to seek timely help from mental health professionals.

Mental help-seeking involves actively seeking assistance from others by disclosing personal issues to obtain understanding and advice (Rickwood et al., 2005). Help-seeking intentions refer to individuals' readiness to seek help for mental health issues either formally (health systems, counselors) or informally (relatives, spouse, friends, colleagues). Informal support is often more casual, whereas formal help is provided by skilled professionals.

Moreover, formation of health-related behavior and self-monitoring initiates during adolescence and early adulthood, when students acquire the ability to monitor their health condition and choose healthy activities for themselves, in this way, they copy the role of their parents or guardians. They lack the knowledge that untreated psychological problems can get worse over time, leading to suicidal thoughts or other unhealthy behaviors (Wilson et al., 2011).

2.2 Relationship between Self-Reliance, Perceived Social Support, Mental Health Literacy and Help-Seeking Intentions

This section presents a narrative discussion of the literature indicating the nature of the association between the self-reliance, perceived social support, mental health literacy and help-seeking intentions for mental health issues among university students. These associations are discussed in this study as:

2.2.1 Association of Self-Reliance and Perceived Social Support with Help-Seeking Intentions

Self-reliance is an important milestone but it can be difficult for young people to balance their competing desires for independence and help (Morris et al., 2007; Wilson et al., 2005). Students at the stage of adolescents or young adulthood, who faced unstable family environments, may be especially prone to developing high levels of self-reliance and low levels of help-seeking intentions (Lynch et al., 2024). Young people, who learned to cope independently due to lack of support, might find it difficult to reach out for help when needed. This heightened self-reliance can hinder the tendency to consult MHS timely. (Samuels and Pryce, 2008; Smith et al., 2008).
For instance, Ishikawa et al. (2022) proposed the important role of social support in addressing the negative aspect of self-reliance that can prevent help-seeking intentions among young people. They explored the impact of perceived social support and resilience on the association between self-reliance and help-seeking intentions for mental health issues, as well as self-help sources for mental health problems among Australian students. It was an online survey method, including a sample of 5203 students aged 12-25 years. According to this study, higher levels of self-reliance were associated with reduced intentions to seek informal and professional support, but not with more intentions to rely on self-help (sources of self-help). Perceived social support completely mediated the relation between self-reliance and informal help-seeking intentions. These patterns were consistent across different age and gender groups.

Moreover, social support can be actual support an individual is receiving from a social circle, as well as it can be perceived social support that refers to one's perceived availability of support and is influenced by subjective appraisals and judgments (Lakey and Scoboria, 2005). Perceived social support is considered more effective than actual support (Lenkens et al., 2020). Particularly, how individuals perceive the availability of social support significantly affects the individuals' intention to reach out to their network when needed (Ryan et al., 2005). Young people,

especially those who have grown up in unstable family environments, may be especially inclined to higher self-reliance and low help-seeking tendencies (Samuels and Pryce, 2008).

Correlational research undertaken on the undergraduate students to evaluate the rate of depression, discrepancies in help-seeking behaviors, enablers of help-seeking behaviors and inhibitors to help-seeking behaviors, in light of two important theoretical models: Beck Cognitive. Theory (BCT) and the Theory of Planned Behavior (TPB). The results indicated a high rate. of depression (48.8%) while a lower prevalence of willingness among students to seek help (37.8%) revealing that strong social networks promote help-seeking behaviors negative. attitudes about mental health, and insufficient awareness about access to .available sources are key barriers to help-seeking. behaviors in university students (Nyamwange, 2024).

Similarly, a cross-sectional survey conducted on 2182 medical students at Hainan province (China), aimed to show that lower professional help-seeking intention (PHSI) prevents effective treatment of mental illness, because. PHSI. was still under-recognized. It investigated the rate of PHSI and its risk factors. in Chinese medical students. The results indicated lower levels of professional help-seeking intentions relative to the need to seek help from formal sources. Male students who have higher levels of depression stigma, serious familial issues, and higher mobile phone dependence were significantly less likely to seek help for their mental health issues from mental health professionals (Qiu et al., 2024).

2.2.2 Association of Mental Health Literacy with Help-Seeking Intentions

Highlighting the barriers to lower levels of help-seeking intentions among university students, it has been considered that university students may have difficulty recognizing and discriminating between the normal and threshold level of stress. Young people like university students often lack mental health literacy Jorm et al. (1997), which can be considered as an essential life skill Rickwood et al. (2005)for young people, (including university students), particularly students who encounter numerous challenges in achieving their goals within a set timeframe. They are aware

of their mental health problems but are inclined to redefine what is 'normal' and what is beyond normal, leading to a need to seek help (Rice et al., 2017). It can result in either under-interpretation or over-interpretation of the actual mental health problem.

Contrary to this, Foulkes and Andrews (2023) proposed that labeling a mild level of distress as a mental health issue can worsen the symptoms by influencing individuals' self-perception and behavior. For example, interpreting mild anxiety as an anxiety disorder may lead to avoidance, which further escalate the anxiety level. However discussing underutilization of the professional services for mental health, another study Chandrasekara (2016) demonstrated that public and self-stigmatizing behaviors cause shame, which delay the understanding of the problem and help-seeking intentions.

2.3 Relationship of Access to Mental Health Services and Help-Seeking Intentions

In the context of formal help for mental health issues, globally, universities are experiencing the demand for psychological counseling centers, emphasizing the need for mental health services for students (Meek, 2023). However, the rate of intentions to seek help from mental health professionals and mental health services among university students (adolescents & younger adults) is low. Worldwide, pieces of evidence show a lower prevalence of intentions to seek help for mental health issues among university students, as in the United States, 20-40% of university students Eisenberg et al. (2007), and 28.9% of South African students Bantjes et al. (2020) reported willingness to seek professional help for their mental health. Although mental health services are freely available at a variety of campuses Kosyluk et al. (2026), psychological and social factors continue to contribute to the low rates of help-seeking behavior among students (Dschaak et al., 2021).

Additionally, research has indicated that young people are at a significant risk of mental issues because they have rare help-seeking attitudes, particularly among those with lower levels of education and from low socioeconomic backgrounds

(Shi and Dai, 2022; Ibrahim et al., 2019). Nowadays, mental health problems are widespread in college and university students. Academic concerns, social factors, psychological risk factors, constraints financial factors, lifestyle, and physiological aspects are all risk factors for mental health difficulties in students. In addition to Asian and developing countries, studies conducted in Pakistan Khan et al. (2021) emphasized that help-seeking behavior with respect to mental health is also necessary to be investigated among university students, because this group is more prone to confront a high prevalence of psychological disorders, as 2.66% of students reported symptoms of depression and 36% were struggling with drug addiction, however only a small proportion of this group utilized counselling services available within universities (Aldalaykeh et al., 2019).

2.4 Understanding Help-Seeking Intentions among University Students

Additionally, research has indicated that young people are at a significant risk of mental issues because they have rare help-seeking attitudes, particularly among those with lower levels of education and from low socioeconomic backgrounds (Shi and Dai, 2022; Ibrahim et al., 2019). Nowadays, mental health problems are widespread in college and university students. Academic concerns, social factors, psychological risk factors, constraints financial factors, lifestyle, and physiological aspects are all risk factors for mental. health difficulties in students.
Correlational research undertaken on the undergraduate students to evaluate the rate of depression, discrepancies in help-seeking behaviors, enablers of help-seeking behaviors and inhibitors to help-seeking behaviors, in light of two important theoretical models: Beck Cognitive. Theory (BCT) and the Theory of Planned Behavior (TPB). The results indicated a high rate. of depression (48.8%) while a lower prevalence of willingness among students to seek help (37.8%) revealing that strong social networks promote help-seeking behaviors negative. attitudes about mental health, and insufficient awareness about access to .available sources are key barriers to help-seeking. behaviors in university students (Nyamwange, 2024).

Similarly, a cross-sectional survey conducted on 2182 medical students at Hainan province (China), aimed to show that lower professional help-seeking intention (PHSI) prevents effective treatment of mental illness, because. PHSI. was still under-recognized. It investigated the rate of PHSI and its risk factors. in Chinese medical students. The results indicated lower levels of professional help-seeking intentions relative to the need to seek help from formal sources. Male students who have higher levels of depression stigma, serious familial issues, and higher mobile phone dependence were significantly less likely to seek help for their mental health issues from mental health professionals (Qiu et al., 2024).
Additionally mental health often takes a backseat in countries already struggling with broader healthcare challenges. According to Kermode et al. (2009), the prioritization of other health concerns contributes to financial and resource-related obstacles in advancing mental health policies and practices. These challenges include limited awareness, resource shortages, inefficient service delivery, and rigid allocation systems issues particularly relevant to developing nations like Pakistan. Acknowledging these barriers is a crucial first step in addressing the complex issues surrounding mental health care. services.

2.5 Help-Seeking Intentions among University Students in context of Pakistan

In Pakistan, research proposed the dearth of mental health professionals, mental health literacy, and underutilization of services for mental health issues. Choudhry et al. (2023) identified several barriers/obstacles to help-seeking including economic constraints, interpersonal problems and competing. other priorities, lack of mental health literacy, dissatisfaction from previous treatments and their potential side effects, time and distance limitations, reliance on religious healers, and lack of social (i.e., family and peers) support. While facilitators to access mental health services or providers perceived the effectiveness of mental health services and awareness of the severity of the problem. However. The concept of self-reliance and its role in help-seeking intentions among Pakistani students is not

under-studied.

According to a WHO report, Pakistan has only 400 psychiatrists with few mental health care facilities to serve a population exceeding 180 million (Organization, 2011). The low health literacy is the major facilitating factor to this rising prevalence of mental disorders. Kutcher et al. (2016) define mental. health. literacy as the knowledge and beliefs about mental. health problems that support their recognition, .management, and treatment. Above all, healthcare funding in the country is primarily directed toward medical. colleges and universities, with minimal investment in public awareness or training and development. initiatives (Ahmed et al., 2009).

Although mental health services (MHS) are typically available for those confronting mental health issues, they are often underutilized (Aldalaykeh et al., 2019). Sager (2019) found that 60% people with mental health issues did not have access to MHS in 2012. Similarly, Organization (2011) found the rate of mental health problems in 2011 was approximately 13%, but 75% people with mental illness did not access MHS. Multiple psychosocial factors may account for the under-utilization of MHS, including negative attitudes towards treatment, perceived stigma for seeking psychological help, and an insufficient number of mental health professionals relative to the affected population (Hasan and Musleh, 2017). In LMICs like Pakistan, research has indicated that help seeking behavior is usually influenced by variety of factors including limited mental health literacy (50%), lack of family support (44.6%), high treatment costs (39.6%), and low self-efficacy (16.5%) (Zafar et al., 2024; Choudhry et al., 2023). Zafar et al. (2024) highlighted various factors among Karachi medical students affecting help-seeking intentions for mental health services (MHS), a younger age and a history of self-harm correlated the most with a negative attitude toward mental health care, as well as not revealing their health problems to parents or professionals. These findings suggest that the challenges encountered by students go beyond just awareness and are deeply intertwined with personal and societal barriers.

Discussing the potential facilitators of help-seeking intentions among university students, Downes et al. (2013) maintained that young people claimed inadequate

processing of their distressing experiences because whenever they communicate their internal distressing state to their support group (guardian or other family members), they respond with silence, inadequate conversation, and a feeling of invalidation/ disregard. When young people externalize their inner distressing state, it leads to conversations that help them understand, communicate, and manage their mental health, developing health-related behaviors in young people.

This problem is growing in Pakistani culture as well. There is an interesting debate on mental health literacy among Pakistani young people. Several culturally diverse groups are residing in this low- and middle-income country, varying in their religions, languages, traditions, and beliefs. People living in rural areas of this country are financially weak with low education, which serves as a challenge to mental health literacy and reaching out to mental health services.

Furthermore, Pakistan lacks to provide adequate mental health services to young people, as Aslam and Kingdon (2012) described that this country is providing insufficient mental health facilities to the people, as the field of psychiatry in the country remains underdeveloped, with general psychiatrists handling a wide range of mental disorders. However, there is increasing attention on child psychiatry due to the rising mental health issues in children but in our country mental health services are insufficient for young people including university students.

In order to understand help-seeking behaviors in young Pakistani people, Causier et al. (2024) conducted a study on the Pakistani population residing in the UK. Young people in Pakistan usually have little representation in mental health care. This is significant because 62.5% of all mental health disorders and 75% of serious mental health problems (SMHPs) are identified before the age of 25 years. It is important to recognize and treat mental health issues at this stage to optimize one's functionality. Mental health literacy, stigma, and culturally insufficient services were identified as common barriers faced by Pakistani women, exacerbated by internalized prejudices and fear of damaged reputation, which further contributed to hindering access to care.

There is abundance of research on help-seeking, Gulliver (2010) conducted a systematic review of both qualitative and quantitative studies in which they revealed that multiple social factors including difficulty in recognizing symptoms, and a

preference for self-reliance significantly prevent young people to seek help from mental health services. This systematic review found that facilitators for help-seeking intentions were not extensively studied. Still, it highlighted perceived positive past experiences to seek help for mental health concerns, social support along with encouragement from others facilitates the help-seeking process among young people. The current study involves examining perceived social support and adequate mental health literacy as potential facilitators to help-seeking intentions among university students.

Furthermore, discussing these factors in the context of rural areas of Pakistan, a cross-sectional study conducted by assess level of anxiety among nursing students in Mardan (KPK). They found that 32.3% of nursing students live with mild to moderate anxiety during psychiatric clinical practices. This study detected the prevalence of mental health issues among students but did not account for factors underlying intentions to seek help from different sources of help. Therefore, the current study investigated whether students are willing to seek mental health services.
Another study conducted in KPK by Shah et al. (2014) highlighted the presence of general mental health issues among people from KPK, including depression, anxiety, and adjustment issues. It also studied the quality of available mental health facilities integrated into the health system of this province. But it lacks the assessment of whether people are willing to consult mental health professionals and the access of people to an appropriate source of help.

In summary, there has been an interesting debate on factors influencing the intentions to seek help from formal and informal sources among university students but the association of accessibility to mental health services (online or in-person) in relation to help-seeking among university students is not extensively studied, specifically in rural areas. This study investigated perceived social support and mental health literacy as potential facilitators of willingness to seek help from different sources and further investigated self-reliance as potential barrier to willingness to seek help for mental illness.

2.6 Conceptual Model

Based on the reviewed literature, this study proposes mental health literacy, self-reliance, perceived social support and access to mental health services predicts the help-seeking intentions among university students. Students who have higher rates of mental health literacy, greater perceived social support and greater access to the professional help/ mental health services demonstrates higher rates of help-seeking intentions among university students. Further it predicts that students who are higher on self-reliance demonstrates lower levels of help-seeking intentions.

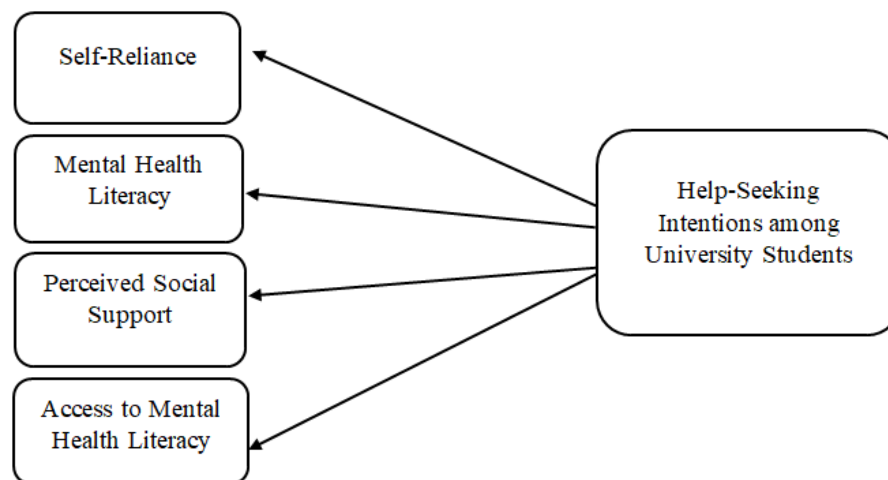

FIGURE 2.1: Theoretical Model

Chapter 3

Research Methodology

3.1 Research Design

The cross-sectional study design was employed to investigate the influence of self-reliance,perceived social support, mental health literacy and access to mental health services on help-seeking intentions among university students.

3.1.1 Sampling Size

The sample consisted of 250 university students including both males and females who were enrolled in their Bachelors' and Masters' Programs. Their age range was 18-35 years.

3.1.2 Study Setting and Data Collection Procedures

Data was collected using convenience-sampling technique from universities of Buner and Swat located in Province, Khyber Pakhtunkhwa (KPK) at Pakistan, regardless of accounting for the counselling centers within the universities to understand the help seeking-intentions with and without easy access to mental health service in universities at zero cost. Data was collected from students who were enrolled in BS or MS degree within 5 universities of Buner and Swat. The study area is selected on the basis of convenience to collect data within the limited time, and

in KPK, there are significant psychosocial factors that have an impact on mental health of young people but relatively little is known about them. As discussed in earlier sections studies conducted to investigate the mental health issues and available services, in other provinces of the country like Punjab and Sindh but there is need to investigate them in KPK.

The Districts Buner and Swat are developing in context of mental health there is limited resources and awareness related to mental health issues. Natural disasters such as floods, and political instabilities triggers challenges for its population to develop/grow. District Buner is semi-rural area within Khyber Pakhtunkhwa Province, with approximately 1 million population in accordance with 2023 national census, with literacy rate 43.75% i.e. 60.61% males and 27.40% females. Its economy depends on agriculture, livestock, marble mining and most of the families depends on remittances sent by their earning members living within abroad. Most of the people speak Pashto while mostly people have religion of Islam with minorities of Sikhism also residing in this district.

District Swat, within Khyber Pakhtunkhwa province has population 2,687,384 as per the 2023 census and is a famous place for tourism. It is a semi-urban area with approximately 30% of population living in urban towns i.e. Mingora and Saidu Sharif, with literacy rate approximately 48.13 % i.e. 61.83% male and 33.95% females. Mostly people speak Pashto and are Muslims while minority is non-Muslim. Relative to Buner, Swat is diversified and its economy is based on tourism, agriculture handicrafts and trade.

3.1.3 Inclusion Criteria

Students who can read and write Urdu, who were enrolled in Bachelors or Masters at the universities located within Districts Buner and Swat (KPK) were recruited to participate in the study.

3.1.4 Exclusion Criteria

The students who were unable to participate in the study due to their physical or mental disability were not included in the research.

3.2 Research Instruments

Current study investigated its variables through Urdu versions of standardized psychological instruments.

3.2.1 Demographic Information

An Urdu version of demographic information sheet was used. It has open- ended questions i.e. name, age, gender, religion, education, marital status, economic status, occupational status, university in which then student is enrolled, residential area, how many years participant has been living at current place any prior experience of mental health issue, prior experience of mental health treatment/service.

3.2.2 Urdu Version of General Help-Seeking Questionnaire

The help-seeking intentions for mental health issues were measured through the General Help-Seeking Questionnaire (GHSQ). This scale measures the help-seeking intentions of people from different sources i.e. formal, informal or relying on one's self (Wilson et al., 2005).Its subscales include three sources of help: formal help (psychologist, psychiatrist, religious healers, and counselor), informal help (friends, parents, family members), and self-help (no help-seeking, internet, or self). It is a 7-point Likert scale from 1 (extremely unlikely) to 7 (extremely likely), a respondent's higher score on this scale indicates higher intentions to seek help. There is no reverse coding of items in this scale.

This scale's test-retest reliability is 0.86 and its internal consistency ranges from 0.67 to 0.90, indicating satisfactory psychometric qualities. Sources of help for the current sample were divided into three subscales: informal help (relative, friend, spouse, colleague,) professional help (mental health professional, physical health professional), and self-help.

Its scoring was done by calculating the average score for each subscale. The higher score indicates the greater intention of students to seek help from the available source. It was translated for this study, translation process is mentioned in detail in this section.

3.2.3 Urdu version of The Self-Reliance Scale

The self-reliance was measured by using an Urdu version of "The Self-reliance Scale", developed and validated by Padhy and her colleagues in 2024. It is a 30 items scale that assess self-reliance by identifying the level of following 4 factors in young people, i.e. self-efficacy, external dependence, autonomy and self-confidenceso there are 4 subscales of the SRS. Items in each subscale: Subscale 1 (Self-efficacy) includes items: 1, 2, 4, 6, 10, 11, 12, 13, 14, 16, 17, 18, 20, 21, 22, 23, 24, 25, 26, 27, 28, Subscale 2 (External dependence) includes items: 3, 8, 9,15, Subscale 3 (Autonomy) includes items 5 and 7, lastly the subscale 4 includes items 19, 29, and 30. This scale included several reverse codded items: 3, 8, 9, 15, 19, 29, 30)

3.2.4 Urdu Version of Mental Health Literacy Scale

Students' mental health literacy was measured through an Urdu version of Mental Health Literacy Scale (MHLS), originally developed by Connor and Casey in 2015, and translated in Urdu by Akhtar and her colleagues in 2020. It is a 35-item univariate scale, with a 4-point scale and 5-point scale, demonstrated good validity, good internal and test-retest reliability (0.8). A total score is produced by summing all items and reverse-scored items are mentioned in the scoring part of this scale. The mental health literacy scale has six subscales: (1) Recognition includes items 1-8, (2) Knowledge of risk factors includes items 9-10, (3) self-treatment includes items 11-12, (4) professional help includes items 13-15, (5) information seeking includes items 16-28, and (6) attitudes includes, items 29-35. This scale included several reverse codded items: 10, 12, 15, 20-28.

3.2.5 Urdu Version of Multidimensional Scale of Perceived Social Support

Perceived social support was measured by using an Urdu version of a scale named the Multidimensional Scale of Perceived Social Support developed originally developed by Zimet, and his colleagues in 1988. It is translated and standardized in

Urdu version by Akhtar and his colleagues in 2010, at women in rural Pakistan. This scale comprises 12 items, rated on a 5-point Likert scale. It has good internal consistency (0.88), test-retest stability (0.75 to 0.88), and strong factorial validity. The MSPSS comprising three subscales: (1) Significant other (So) includes items 1, 2, 5, 10, (2) Family (Fam) included items 3, 4, 8, 11 and (3) Friends (fri) include items 6, 7, 9, 12. There is no reverse coding in this scale. Its scoring is done by adding all the items to get the total score, ranging from 12-84. Higher scores determine a higher level of perceived social support.

3.2.6 Access to Mental Health Services

Access to mental health services was assessed at the end of the assessment process using a few open-ended questions to measure the actual need to seek help. These questions were developed in the Urdu language as a part of the assessment phase. The current study utilizes a 10 items open-ended questions based on a conceptual model "Andersen's Behavioral Model of Health Service Utilization" to explore the access of MHS to the students and their attitude to reach out the available mental health services. This model states following three factors fostering or impeding the help-seeking behavior among university students.
(1) Predisposing factors in relation to our study are awareness about mental illness, comfort in seeking university based MHS, perceived encouragement by the university and past experiences of approaching any mental health facility within or outside the university.
(2) Enabling factors included affordability and accessibility of available MHS, and knowledge of process to consult any mental health facility.
(3) Need factors included perceived need for professional or formal help, and effectiveness of the available mental health facility.

The aim is to understand the collective impact of institutional efforts, service accessibility and students' perceptions for effectiveness as well as access to MHS, shape mental health services utilization among university students.
In order to analyze this scale, the items were transformed into numeric, response

categories were generated and then results were computed for each of the item in relation to the subscales of GHSQ to meet the last assumption of this study.

3.2.7 Translation of General Help-Seeking Questionnaire and The Self-Reliance Scale

In order to assess two variables of this study i.e. help-seeking intentions and self-reliance the mentioned instruments were not translated in Urdu version. So, these scales were translated according to the Brislin's translation guidelines (Chavez & Canino, 2005; Ozoline, 2009). This translation procedure include 5 steps:
Step 1: Forward Translation Eight professionals i.e. 2 of them were clinical psychologists, 2 were lecturer in English, 2 were research assistants and two were nurse, were contacted to translate the scales. They were fluent in both the languages. They were informed about the rationale of this study and instructed to focus on the conceptual meaning. In this step, two versions of the forward translation i.e. English to Urdu were formed and forwarded to the committee evaluation. It was done by 4 independent persons/professionals, two of them were lecturers in English, one was a clinical psychologist and one was a research assistant.

Step 2: Committee Evaluation A committee evaluation was formed containing following members: the researcher herself, the Supervisor, researcher assistants from the Capital University of Science and Technology, Islamabad. The committee reviewed each item of both the scales with the aim to get translated versions which have culturally appropriate words and have content that accurately reflected the original scales.
Step 3: Back Translation Once the translated versions (Urdu versions) were finalized through committee evaluation, we moved forward for the third step in which back translation was done from Urdu to English language. This step was completed by requesting to 4 independent person/professionals i.e. 2 nurses, a clinical psychologist, and a research assistant. These people have no access to original scales as there was no title of the scale added during translation phase, and they were fluent in both the languages. They were instructed to translate the

scales into English language according to their knowledge and understanding and avoiding the use of any helping tool etc.

3.2.7.1 Committee Evaluation

A committee evaluation was formed to review the given 4 versions of the back translations for two scales. This committee was comprised of the researcher, the supervisor, and research assistants and the supervisor was the head of this committee.

The expert panel committee discussed the two back-translated versions and there was no item for modification. Similarities between these back translated versions were noted. The panel determined that, the translated versions reflected true meaning of the original version.

3.2.8 Ethical Considerations and Inform Consent

The approval for the current study was obtained from Research Ethics Committee of faculty of Management and Social Sciences. An Urdu version of a detailed Informed consent sheet was used to obtain the consent from the participant.

The important components of this study were clearly mentioned in the consent form, including the information that during their participation when the respondents want to quit this study at any time, they have the right to quit/withdraw their participation from this study.

3.2.9 Ensuring Confidentiality Issue

Confidentiality was ensured for all the participants of this study. They were informed that all their information will be used for the research purpose only and the data will be anonymized. The participants were also informed about the criteria to breach confidentiality.

It was mentioned that if the researcher recognized any severe issue for example suicidal thoughts, or thoughts to harm others, then confidentiality will be breached and will be referred to corresponding mental health care to ensure their safety.

Chapter 4

Results

This chapter presents the empirical results of the association between help-seeking intentions, self-reliance, mental health literacy, perceived social support, and access to the means of professional mental health services among university students. A cross-sectional correlational study design was employed. Data were collected from total of 250 university students through a convenient sampling method, from different universities including private and public sectors, located within districts Buner and Swat within Province KPK. Data were analyzed using Statistical Package for the Social Sciences (SPSS) version 21.

This chapter is further divided into several sections. First, this chapter shows the demographic characteristics of the sample. Second, the reliabilities and descriptives of the scales used to test assumptions of this study,

(a) General Help-seeking Questionnaire (GHSQ),
(b) Mental Health Literacy Scale (MHLS),
(c) The Multidimensional Scale of Perceived Social Support (MSPSS), and
(d) The Self-reliance Scale (SRS).

The third part highlighted the nature and strength of the associations between the study variables to test the assumptions/hypotheses of the current study. For the purpose to assess the assumptions of this study, standardized measures were utilized (discussed in chapter 3), but last assumption of the study was assessed

through a self-made questionnaire. Therefore, the last section of this chapter, represents the results of descriptives of access to mental health services and its association with help-seeking intentions among university students.

4.1 Demographic Characteristics of the Sample

Table 4.1 represents the demographical characteristic of the total number of participants, (N=250), in which male has higher representation compared to females (M= 166, 66.4% & F=84, 33.6%). Discussing their educational background, students from BS were more (209, 83.6 %) as compared to MS students (41, 16.4%). Mostly students were Muslims (98%) while only (2%) belongs to Sikhism and higher proportion of the sample 84.4% resides in rural areas than urban areas (15.6 %). This table further represents that only 2% of the total population sought help for their prior mental health issues in their lifetime while the percentage of prior mental health issue was 4.8%.
Larger group of the total sample belonged to middle socio-economic status (80.8%) compared to higher socioeconomic status 8.4% and lower socioeconomic status (10.8%). Further it tells that 80% of the students were unemployed, while small proportion of these students were employed (18.8%) and only (1.2%) of the total sample were doing internship during their degree.

The figure 4.1 shows the frequency distribution of ages for the total number of samples, 250 (N= 250) enrolled in final analysis. This figure visualized the normal distribution of age, as indicated by a symmetrical bell-shaped curve, pointing that majority of the observations cluster around the central value. Further, its descriptive statistics represents a mean age of 22.92, median 22, mode 20, and standard deviation of 3.081, which clearly demonstrates the minimal variability within the sample of this study.

The values of skewness and kurtosis were found to be 0.98 and 1.4 respectively. The highest proportion of age falls between 20-25 years of age, in line with the computed central tendency.

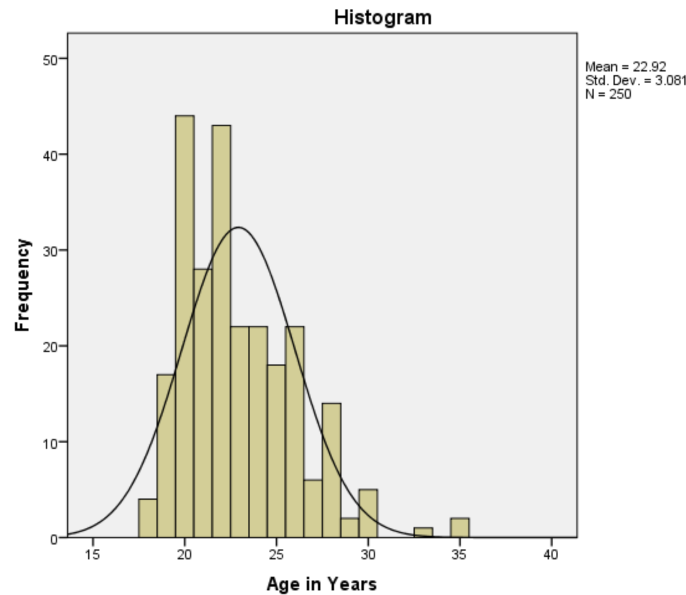

FIGURE 4.1: Distribution of Participants' Ages (N=250)

TABLE 4.2: Difference in Help-seeking Intentions across Religion among University Students ($N = 250$)

Subscales	**Group**	**Mean Rank**	**U**	**Z**	**p-value**
Informal Help Sources	Muslim vs Non-Muslim	126.97 / 53.30	251.50	-2.25	.02*
Formal Help Sources	Muslim vs Non-Muslim	126.35 / 83.80	404.00	-1.30	.19
No Help-seeking / Self-Help Sources	Muslim vs Non-Muslim	126.19 / 91.90	444.50	-1.06	.29

Note. $*p < .05$, $**p < .01$.

A Mann-Whitney U Test was conducted to determine if there are significant differences in help-seeking intentions between Muslim (N=245) and Non-Muslim (N=5) students. A statistically significant difference was found for Informal Help Source, (p = .02), where Muslim participants showed higher mean ranks. However, no statistically significant differences were observed for Formal Help Source (p = .19) and No help-seeking/ Self-Help Sources (p = .29).

Table 4.1: Demographic Characteristics of Sample (N = 250)

Demographic Variable	Category	f	%
Gender	Male	166	66.4
	Female	84	33.6
Age	Early Adults	158	63.2
	Middle Adults	89	35.6
	Older Adults	3	1.2
Education	BS	209	83.6
	MS	41	16.4
Marital Status	Single	221	88.4
	Married	24	9.6
	Engaged	5	2.0
Employment Status	Employed	47	18.8
	Unemployed	200	80.0
	Intern	3	1.2
Socio-Economic Status	Low	27	10.8
	Middle	202	80.8
	High	21	8.4
Religion	Muslim	245	98.0
	Non-Muslim (Sikhism)	5	2.0
Residential Area	Rural	211	84.4
	Urban	39	15.6
Prior Mental Health Issue	Yes	12	4.8
	No	238	95.2
Prior Mental Health Treatment	Yes	5	2.0
	No	245	98.0

Note. f = frequency; % = percentage.

Table 4.3: Difference in Help-seeking Intentions across Residence Area among University Students (N = 250)

Subscales	Group	Mean Rank	U	Z	p-value
Informal Help Source	Rural vs Urban	119.95/155.54	2943.00	-2.82	.005**
Formal Help Source	Rural vs Urban	120.56/152.23	3072.00	-2.51	.012*
No Help-seeking Self-Help Sources	Rural vs Urban	120.87/150.53	3138.50	-2.38	.017*

Note. $^{*}p < .05$, $^{**}p < .01$.

A Mann-Whitney U Test was conducted to examine differences between Rural (n=211) and Urban (n=39) participants. Statistically significant differences were found for Informal Help Source (p = .00), Formal Help Source (p = .01), and No Help-seeking / Self- Help Sources (p = .01). In all cases, Urban participants had higher mean ranks, indicating higher help-seeking intentions.

TABLE 4.4: Difference in Help-seeking Intentions across Economic Status among University Students ($N = 250$)

Subscales	**Group**	**Mean Rank**	**U**	**Z**	**p-value**
Informal Help Sources	Low vs Middle	126.39/ 113.48	2419.50	-0.95	.34
Formal Help Source	Low vs Middle	124.00/ 113.80	2484.00	-0.75	.45
No Help-seeking Self-Help Sources	Low vs Middle	118.67/114.51	2628.00	-0.31	.76

Note. *$p < .05$, **$p < .01$.

A Mann-Whitney U Test was conducted to compare Low (n=27) and Middle (n=202) economic status groups. No statistically significant differences were observed for Informal Help Sources (p = .34), Formal Help Source (p = .46), and No Help-Seeking / Self- Help Sources (p = .76), indicating that economic status did not significantly influence help-seeking intentions.

TABLE 4.5: Difference in Help-seeking Intentions across Prior Mental Health Issue among University Students ($N = 250$)

Subscales	**Group**	**Mean Rank**	**U**	**Z**	**p-value**
Informal Help Sources	Yes vs No	93.96/127.09	1049.50	-1.55	.12
Formal Help Source	Yes vs No	102.42/126.66	1151.00	-1.13	.26
No Help-seeking Self-Help Sources	Yes vs No	142.79/124.63	1220.50	-0.86	.39

Note. *$p < .05$, **$p < .01$.

A Mann-Whitney U Test was conducted to compare participants with prior mental health issues (n=12) and those without (n=24). No statistically significant differences were found for Informal Help Sources (p = 0.12), Formal Help Sources (p = 0.26), and No Help-Seeking or Self-Help Sources (p = 0.39), indicating that prior mental health history did not significantly affect help-seeking intentions.

4.2 Reliabilities of Scales in Terms of Cronbach's Alpha Reliability

This section represents the results of reliability test computed by using the Cronbach's Alpha reliability for all the scales and subscale used in this study. The reliability analysis was computed to evaluate/determine the internal consistency of the items within each scale and its subscales to assess the degree at which the items of each scale measured the same construct. The Cronbach's alpha coefficient value is equal to or higher than 0.7 ($\alpha \geq 0.7$) represents the good internal consistency between the items of each scale. The variables measured through standardized tools showed good reliability while the last scale, which was a self-generated questions related to access to mental health services showed acceptable reliability (discussed in detail in the last section of this chapter).

The table 4.3 indicates the Cronbach's alpha (α) reliabilities of the scales used in this study to compute the empirical association between the study variables. All of these scales were used in Urdu versions. The results represent the higher Cronbach's alpha when computed for MSPSS (α = 0.97), GHSQ (α= 0.94), MHLS (α = 0.95), and SRS (α = 0.97) which indicated the good internal consistency between items of each of the scales in this study. This table further represented the reliabilities of the three subscales of MSPSS; MSPSS-SoS indicated perceived social support from Significant Other, MSPSS-FamS which assess perceived social support from family members and finally MSPSS-Frnds, indicating perceived social support from friends. The reliability analysis indicated the good internal consistency (α=0.94, α=0.93 & α=0.86) respectively.

This table further indicated the descriptives of the three subscales of GHSQ;

TABLE 4.6: Cronbach's Alpha Reliability (α) of Scales and Subscales of GHSQ, MSPSS, and MHLS (N = 250)

Scales	N	M	SD	α	Range		Skew	Kurtosis
					Potential	Actual		
MSPSS	12	41.38	13.22	0.97	12-60	12-60	−0.79	−0.40
MSPSS-SoS	4	14.19	4.77	0.94	4-20	4-20	−0.86	−0.37
MSPSS-FamS	4	14.17	4.70	0.93	4-20	4-20	−0.78	−0.45
MSPSS-FrndS	4	13.00	4.50	0.86	4-20	4-20	−0.45	−0.92
GHSQ	10	34.18	16.30	0.94	10-70	9-70	0.42	−0.77
IS-GHSQ	4	14.74	7.15	0.86	4-28	4-28	0.17	−1.08
FS-GHSQ	4	13.29	7.44	0.90	4-28	4-28	0.41	−0.99
SR-GHSQ	1	3.67	2.16	—	1-7	1-7	0.17	−1.40
MHLS-T	35	102.06	27.78	0.95	35-160	35-156	−0.97	0.55
MHLS-1	8	23.21	7.10	0.91	8-32	8-32	−0.76	−0.40
MHLS-2	2	5.59	1.94	0.56	2-8	2-8	−0.49	−0.82
MHLS-3	2	5.59	1.85	0.70	2-8	2-8	−0.37	−0.89
MHLS-4	3	8.95	2.84	0.81	3-12	3-12	−0.82	−0.42
MHLS-5	4	13.05	4.47	0.84	4-20	4-20	−0.53	−0.57
MHLS-6	16	31.93	9.94	0.88	16-80	16-80	−0.45	−0.32
SRS-T	30	86.45	24.41	0.97	30–120	30-119	−1.19	0.17
SRS-1	21	62.89	18.59	0.97	21-84	21-84	−1.16	0.103
SRS-2	4	10.34	3.40	0.75	4-16	4-16	−.38	−.54
SRS-3	2	5.40	2.11	0.63	2-8	2-8	−.32	−1.21
SRS-4	3	7.82	2.21	0.61	3-12	3-12	−.28	−.69

Note. N = number of items; M = mean; SD = standard deviation; α = Cronbach's alpha reliability; MSPSS = Multidimensional Scale of Perceived Social Support; GHSQ = General Help-Seeking Questionnaire; MHLS = Mental Health Literacy Scale; SRS = Self-Reliance Scale. Cronbach's alpha was not computed for single-item scales;skew=skewness.

GHSQ-IS, GHSQ-FS and GHSQ-SR which indicated general help-seeking intentions among university students for informal sources, formal sources and self-reliance (no help-seeking intention) respectively. The Cronbach's alpha values for GHSQ-IS was α=0.86 and for GHSQ-FS was α=0.90, revealed to be good internal consistencies. The last subscale was the single item therefore its reliability was not calculated in this study. Lastly, the above table represents the results of Cronbach's reliability coefficient computed for six subscales of mental health literacy scale (MHLS) mentioned as MHLS-1: recognition of disorder, MHLS-2 knowledge of risk factors, MHLS-3 self-treatment, MHLS-4-knowledge of professional help, MHLS-5- information-seeking knowledge and MHLS-6- attitutde promoting recognition/help-seeking, all of these measure perceptions or literacy level for different domains of general mental health and illness among university students. There was no missing value on these subscales. The reliability analysis indicated the good internal consistencies between the items of each subscale (MHLS-1- recognition of disorders, α=0.9, MHLS-2-knowledge of risk factors, α=.0.6, MHLS-3-self-treatment knowledge, α=0.7, MHLS-4-knowledge of professional help, α=0.8, MHLS-5-information seeking knowledge, α=0.8, MHLS-6-attitude promoting recognition/help-seeking, α=0.8).
The subscale MHLS-1 assess the recognition of disorders, MHLS-2 assess knowledge of risk factors and causes, MHLS-3 assess self-treatment knowledge, MHLS-4 assess knowledge of professional help available, MHLS-5 assess knowledge of how to seek mental health information, and the last subscale MHLS-6 assess attitudes that promote recognition and appropriate help-seeking.

4.3 Descriptive Statistics of the Scales and Subscales

This section presents the descriptives of all the scales used for the analysis of the study assumptions. The variables in this study were treated as non-normal distributed based on the normality testing, symmetrical shape of the distribution curve, values of skewness and kurtosis, to compute the correlational analysis for

the total number of participants enrolled in this study (N=250). The results are given in table.

In order to assess the intentions to seek help from formal sources, informal sources, and no-help seeking intentions, the three subscales of general help-seeking questionnaire were used. The frequencies and percentages of each item are shown in Table.

The above table represents frequency and percentages between Extremely Un-

TABLE 4.7: Frequency and Percentage of the General Help-Seeking Questionnaire (N = 250)

GHSQ Items	**Extremely Unlikely**		**Extremely Likely**	
	f	**%**	**f**	**%**
a. Intimate partner	96	38.4	27	10.8
b. Friend	33	13.2	42	16.8
c. Parent	46	18.4	54	21.6
d. Other relative/family member	68	27.2	22	8.8
e. Mental health professional	84	33.6	27	10.8
f. Phone helpline	88	35.2	18	7.2
g. Doctor/GP	81	32.4	24	9.6
h. Minister or religious leader	57	22.8	40	16.0
i. I would not seek help from anyone	58	23.2	36	14.4
j. I would seek help from another person	49	19.6	31	12.4

Note. f = frequency; % = percentage, GHSQ: General Help-seeking Questionnaire

likely to Extremely Likely calculated for each item of GHSQ. It was calculated for total number of participants (n=250) with zero missing values. The larger proportion of the sample indicated unwillingness to seek help from both professional and non-professional support. The category of Parent has the highest percentage 21.6% representing students' willingness to seek help for their mental health issues.

On the other hand, the lowest proportion representing willingness to seek help is found under the categories; Phone Helpline (7.2%), Doctor (9.6%), Relative or family members (8.8%), and Intimate Partner 10.8%. This table further represents that there is a proportion of students who rely on themselves (14.4%) for dealing

with their mental health issues, while not seeking help from all of these mentioned categories of the available support system. Out of total 250 participants only 168 rated their scores on the last item (j) "I would seek help from another person" while 88 cases were missing.

The table 4.4 demonstrates the normality test of all the study variables. The result indicates that all the study variables significantly deviated from normal distribution ($p < 0.05$), based on the Kolmogorov-Smirnov normality test. K-S test was computed for normality testing because the sample size is larger than 50. The results clearly indicated the violation of the normality model therefore the non-parametric statistical tests were employed for the correlation analysis to test the assumptions of this study.

Further this table highlighted the results of descriptive statistics of each of the study scale and a subscale. The mean score of Multidimensional Scale of Perceived Social Support (MSPSS) was 41.38, the median was 45.5, and mode was 47. The calculated score of standard deviation was 13.22, skewness was 0-.794, and kurtosis was 0-.40, calculated for total number of participants (N=250).

The descriptive statistics when computed for the subscale of General Help-Seeking Questionnaire, the result indicated that its means score was 34.18, median score was 33.50, and mode score was 34. The values of standard deviation, skewness and kurtosis were 16.30, 0.419, and 0.767 respectively, calculated for total number of participants (N=250).

The descriptive statistics when calculated for Mental Health Literacy Scale indicated that its mean score was 102.0, median score was 107.5, and mode score was 101. When scores for standard deviation, skewness, and kurtosis calculated the findings were 27.78, 0-.96, and 0.547 respectively, calculated for total number of participants (N=250).
The descriptive statistics of the fourth scale, Self-Reliance Scale indicated that its mean score was 86.45, median score was 95.0, and mode score was 96. The values

Table 4.8: Descriptive Statistics & Normality Tests of the Variables(N = 250)

Scales	**M**	**Mdn**	**Mode**	**SD**	**Skew**	**Kurt**	**K–S**	
							Statistic	**p**
MSPSS	41.3	45.5	47.0	13.22	−0.79	−0.40	0.14	<.001
MSPSS-1	14.1	16.0	16.0	4.77	−0.86	−0.37	0.20	<.001
MSPSS-2	14.1	16.0	16.0	4.70	−0.78	−0.45	0.17	<.001
MSPSS-3	13.0	14.0	16.0	4.50	−0.45	−0.92	0.13	<.001
GHSQ	34.9	33.5	34.0	16.30	0.42	0.77	0.076	.001
IS-GHSQ	14.7	14.5	4.0	7.15	0.17	−1.08	0.08	<.001
FS-GHSQ	13.3	12.0	4.0	7.44	0.41	−0.99	0.11	<.001
SR-GHSQ	3.7	3.5	1.0	2.16	0.17	−1.40	0.17	<.001
MHLS	102	107	101	27.78	−0.96	0.55	0.25	<.001
MHLS-1	23.2	25.0	32.0	7.10	−0.76	−0.40	0.12	<.001
MHLS-2	5.59	6.00	5.0	1.94	−0.49	−0.82	0.15	<.001
MHLS-3	5.59	10.0	8.0	1.85	−0.37	−0.89	0.13	<.001
MHLS-4	8.95	10.0	12.0	2.85	−0.82	−0.42	0.17	<.001
MHLS-5	13.0	14.0	15.0	4.47	−0.53	−0.57	0.12	<.001
MHLS-6	31.9	33.0	11.0	9.95	−0.45	−0.32	0.08	<.001
SRS	86.5	95.0	96.0	24.41	−1.18	0.17	0.21	<.001
SRS-1	62.89	70.	21	18.59	−1.17	0.10	0.21	.00
SRS-2	10.34	11	12	34.41	−.39	−.55	0.12	.00
SRS-3	5.40	6	8	2.11	−0.32	−1.22	1.75	.00
SRS-4	7.82	8	8	22.22	−.29	0.69	0.120	.00

Note. M = mean; Mdn = median; SD = standard deviation; K–S = Kolmogorov–Smirnov test with Lilliefors significance correction; p < .05 indicates significant deviation from normality. MSPSS = Multidimensional Scale of Perceived Social Support; GHSQ = General Help-Seeking Questionnaire; MHLS = Mental Health Literacy Scale; SRS = Self-Reliance Scale;skew=skewness;Kurt= Kurtosis.

of standard deviation, skewness, and kurtosis found to be 24.41, -1.18, and 0.174 respectively, for total number of participants (N=250).

4.4 Distribution of the Scales and subscales of GHSQ, MSPSS, MHLS and SRS with super imposed normal curve

The following figures show distribution of GHSQ, MSPSS, MHLS, SRS scales and subscales in the form of histograms with superimposed normal curves. These figures indicate non-normal distribution of the data.

4.5 Hypothesis Testing

This section presents the empirical results of the assumptions of this study. It predicts help-seeking intentions among university students for both formal as well as informal support based on the students' mental health literacy (MHLS), perceived social support (MSPSS) and self-reliance scale. This section is further divided in two parts, first part tests the study hypotheses by using correlation analysis and second part test the assumptions using multiple linear regression.
As discussed in the above section, the study variables were not normally distributed therefore the relationship between the general help-seeking intentions, self-reliance, perceived social support and mental health literacy were examined by using the Spearman's correlation. Correlation matrix indicated results of the association of each sub-scale of the GHSQ with the other three study variables. The results are given in the Tables 4.5, 4.6 and 4.7.

Multiple linear regression was employed to assess linear variance within help-seeking intentions due to multiple predictors; the self-reliance, mental health literacy and perceived social support because a real-life outcome cannot be predicted solely based on a single factor. This model account for multiple variables at the

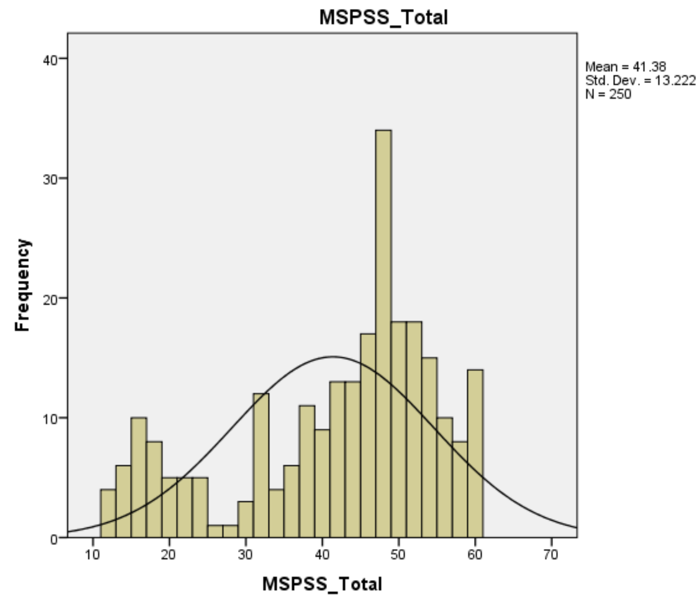

FIGURE 4.2: Distribution of scores across Multidimensional Scale of Perceived Social Support

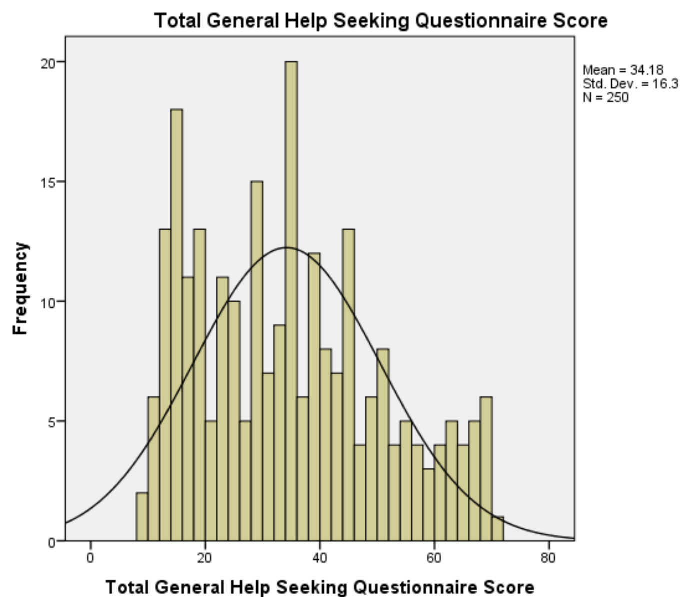

FIGURE 4.3: Distribution of scores across General Help-Seeking Questionnaire

same time and thus, offers a more reliable analysis by keeping constant the confounding variables. This analysis was computed for each subscale of the GHSQ against the other three study predictors. The results are indicated in the Tables 4.9, 4.10, and 4.11.

H1: Hypothesis 1: Association of Self- reliance with Help Seeking intentions of university students.

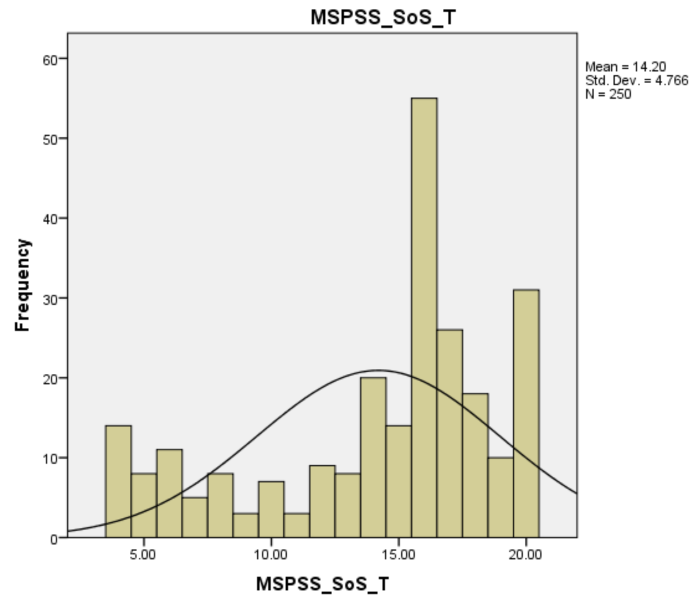

FIGURE 4.4: Distribution of subscale "Significant Other" of MSPSS

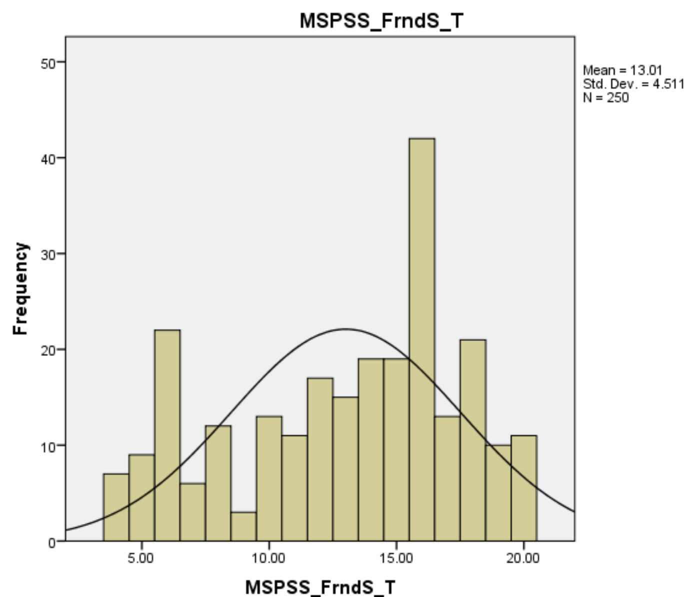

FIGURE 4.5: Distribution of scores across the subscale "Friends" of MSPSS

The following table represents the association of self-reliance and help-seeking intentions of university students.

The above table reports the correlation matrix of study variables used in hypothesis 1. The dependent variable in our study is willingness to seek help from formal as well as informal sources, was measured through the subscales of GHSQ;

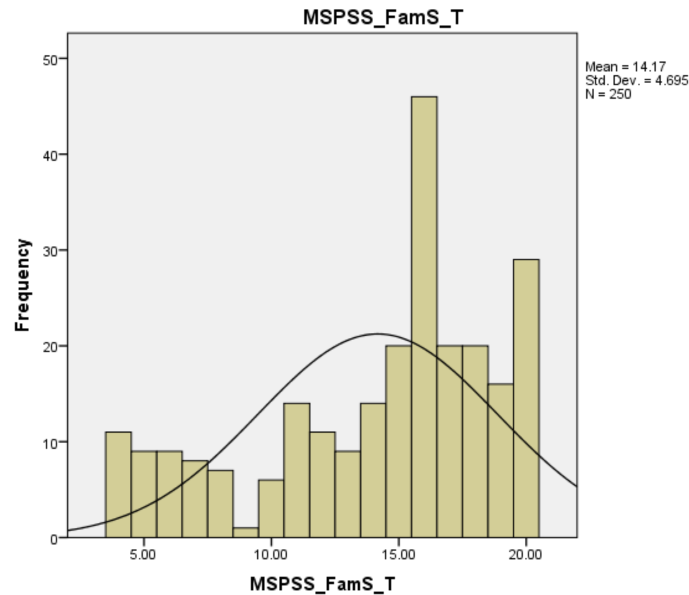

FIGURE 4.6: Distribution of subscale "Family Support" of MSPSS

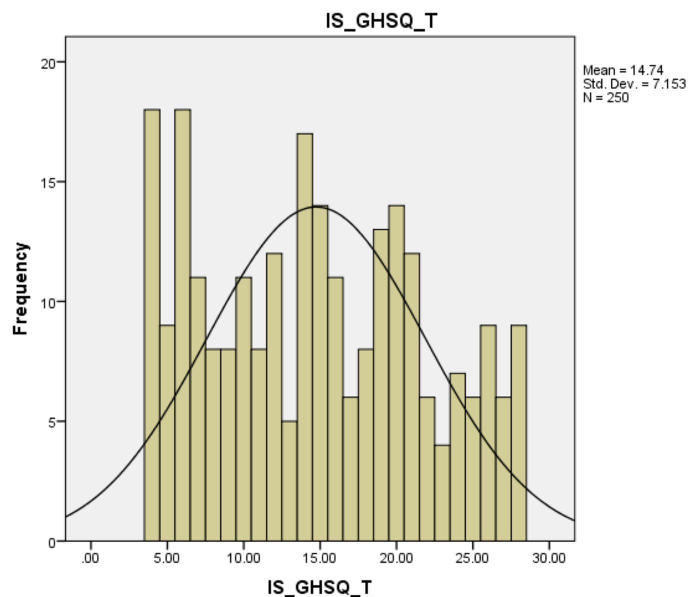

FIGURE 4.7: Distribution of scores across the subscale "Informal Support" of GHSQ

General Help-Seeking Questionnaire- Informal Support (IS-GHSQ), General Help-Seeking Questionnaire- Formal Support (FS-GHSQ), and General Help-Seeking Questionnaire-Self-reliance or no help-seeking intentions (SR-GHSQ). The independent variable used in this study is the self-reliance scale (SRS). The correlation matrix (Table 4.5) shows a significant negative correlation between IS-GHSQ, FS-GHSQ, SR-GHSQ, and SRS. For instance, the SRS relationship with IS-GHSQ

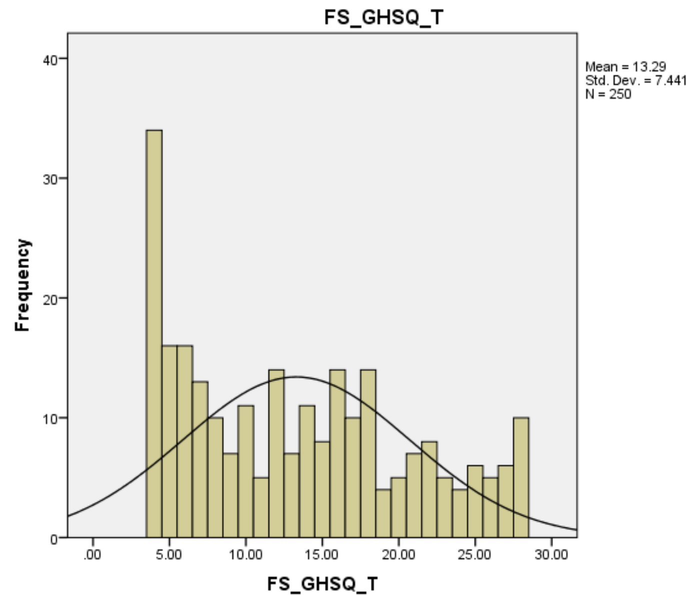

FIGURE 4.8: Distribution of scores across the sub-scale "Formal Support" of GHSQ

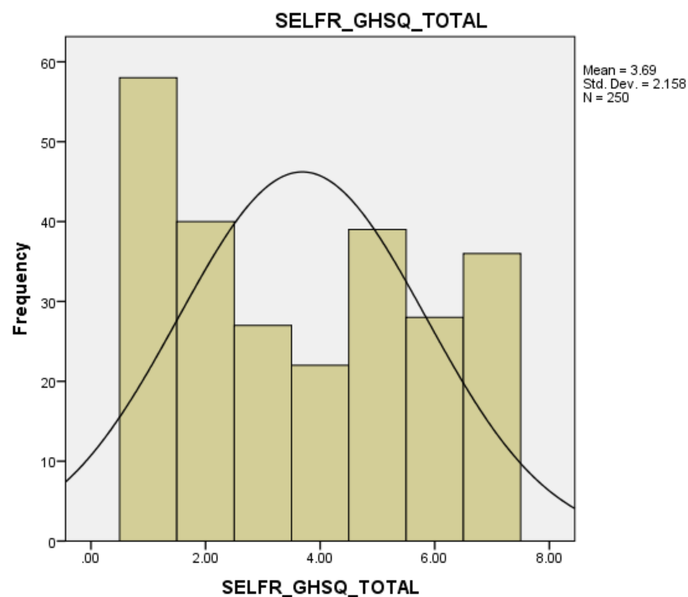

FIGURE 4.9: Distribution of scores across the sub-scale "Self-Reliance" of GHSQ

was calculated as (rs = -0.483, p = .000); this means that self-reliance (SRS) in students negatively contributes to seek help from informal source (IS-GHSQ), thus supporting our hypothesis one. Similarly, this study also finds a significant negative correlation between SRS and FS-GHSQ. The relationship between SRS and FS-GHSQ was computed as (rs = -0.503, p = .000); this means that higher

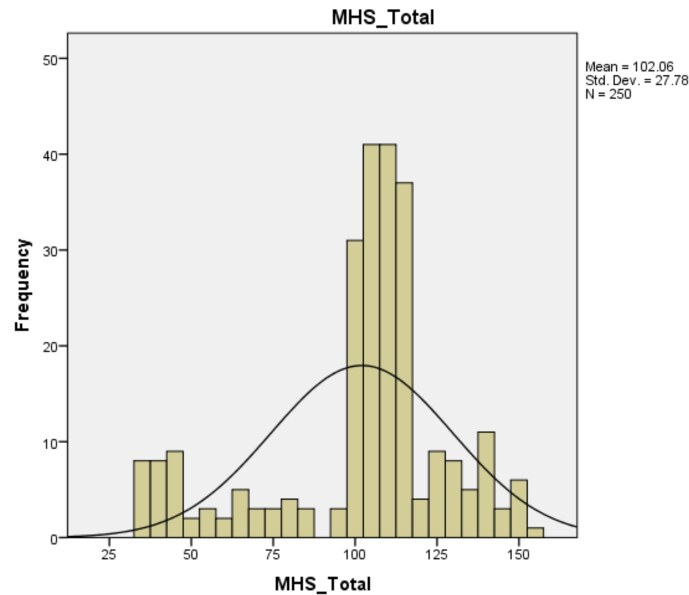

FIGURE 4.10: Distribution of scores across Mental Health Literacy Scale

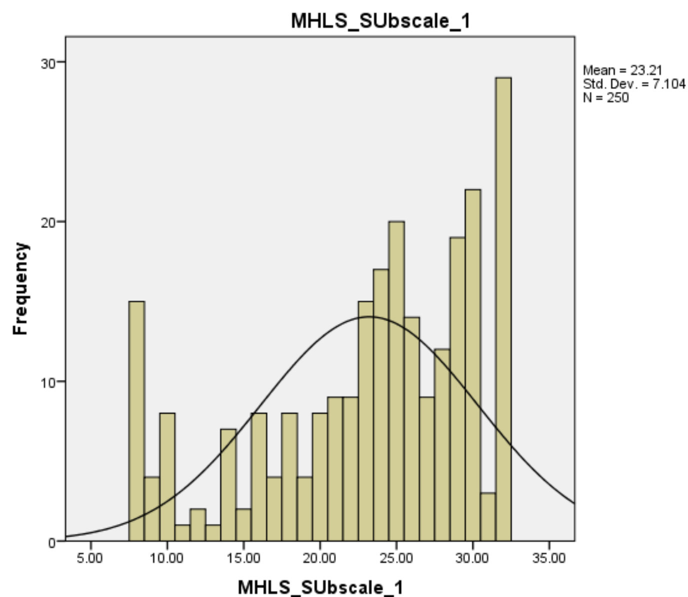

FIGURE 4.11: Distribution of scores across Mental Health Literacy Sub-Scale-1

self-reliance (SRS) decreases willingness to seek formal help (FS-GHSQ), thus supporting our Hypothesis 1.

Finally, we find a negative correlation between SRS and SR-GHSQ. For instance, the SRS nexus with SR-GHSQ was (rs = -0.328, p = .000), indicating that self-reliance (SRS) mitigates no help-seeking (SR-GHSQ) component among university students. The results are consistent with Hypothesis 1. Hence, overall, the results

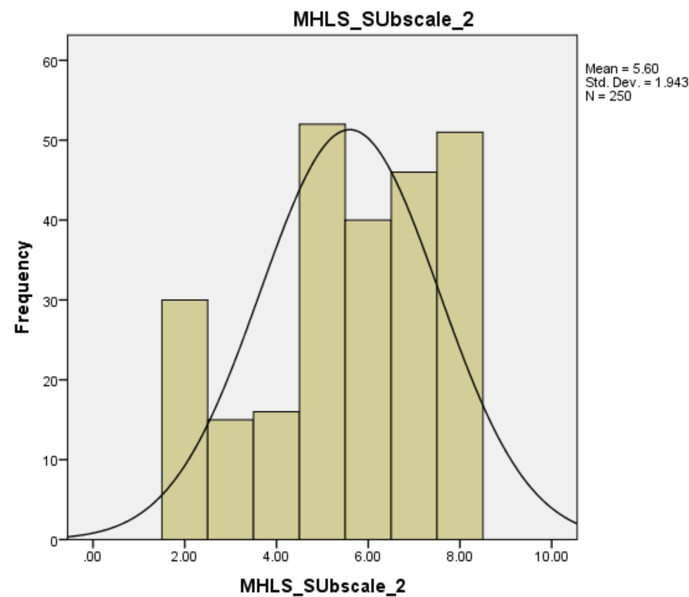

FIGURE 4.12: Distribution of scores across Mental Health Literacy Sub-Scale-2

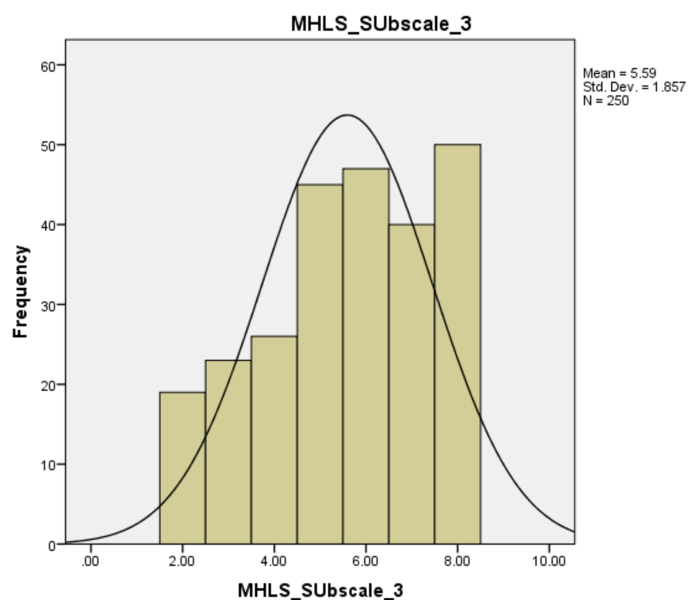

FIGURE 4.13: Distribution of scores across Mental Health Literacy Sub-Scale-3

conclude that self-reliance is negatively associated with the help-seeking intentions among university students.

H2: Hypothesis 2: Mental health literacy and help-seeking intention among university students.

The following table represents the association of mental health literacy with the help-seeking intentions among university students.

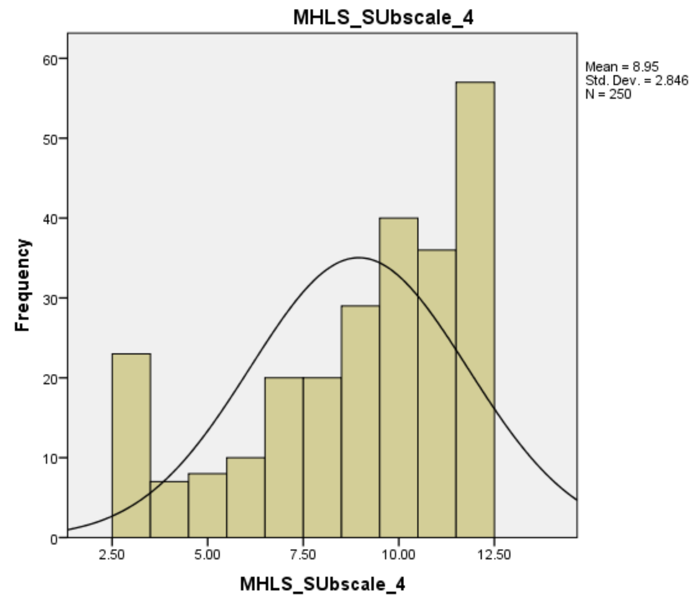

Figure 4.14: Distribution of scores across Mental Health Literacy Sub-Scale-4

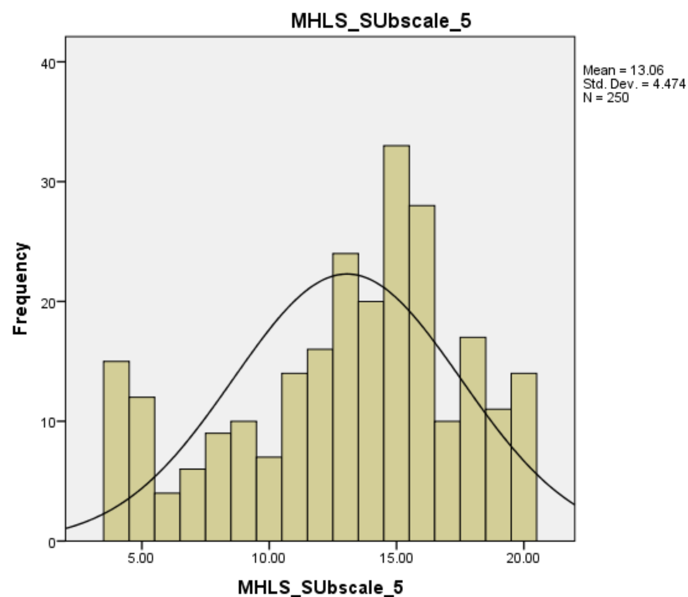

Figure 4.15: Distribution of scores across Mental Health Literacy Sub-Scale-5

Table 4.6 reports the correlation matrix of our variables used in hypothesis 2. The dependent variable is in our study willingness to seek formal as well as inf-ormal help, which are measured through subscales of GHSQ; General Help-Seeking Questionnaire-Informal Support (IS-GHSQ), General Help-Seeking Questionnaire Formal Support (FS-GHSQ), and General Help-Seeking Questionnaire Self-reliance or no help-seeking intentions (SR-GHSQ). The second independent

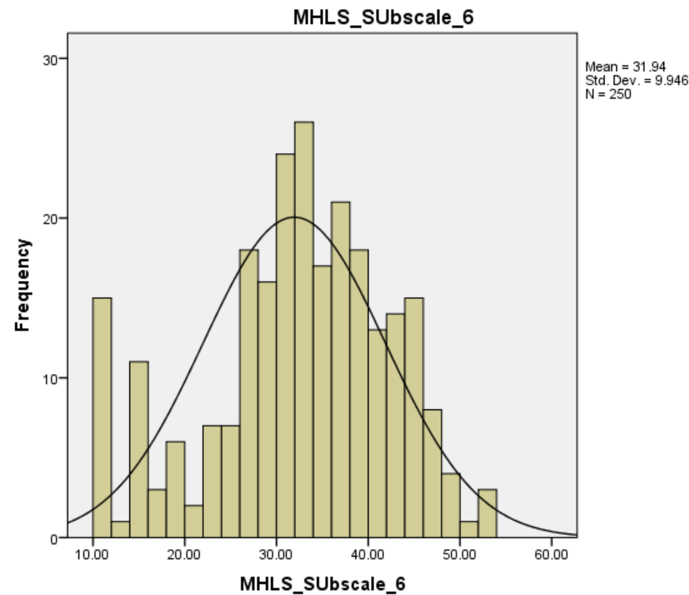

FIGURE 4.16: Distribution of scores across Mental Health Literacy Sub-Scale-6

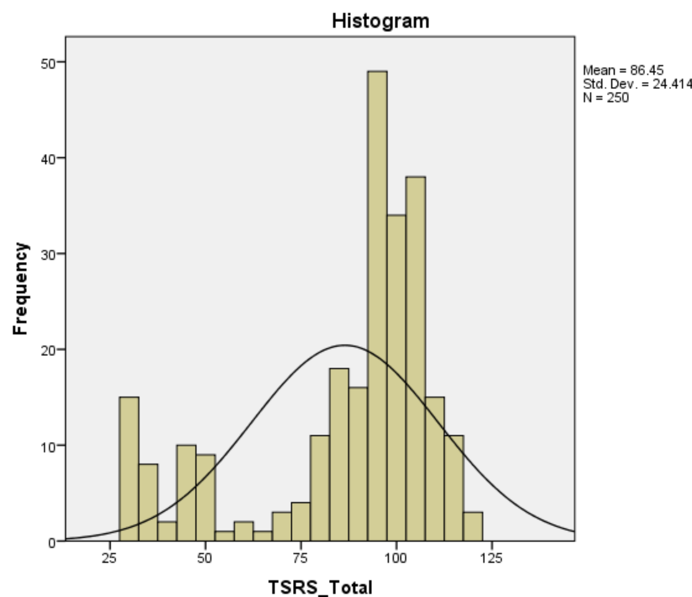

FIGURE 4.17: Distribution of scores across Self-Reliance Scale

variable used in this study is the Mental Health Literacy Scale (MHLS).

The correlation matrix (Table 4.6) presents a significant positive correlation between IS-GHSQ, FS-GHSQ, SR-GHSQ, and MHLS. For instance, the relationship of mental health literacy (MHLS) with informal help (IS-GHSQ) was (rs = 0.604, p = .000); this means that, mental health literacy (MHLS) significantly positively contributes to informal source of help (IS-GHSQ), thus supporting our hypothesis

Table 4.9: Relationship Between Help-Seeking Intentions and Self-Reliance Among University Students (N = 250)

Variable	1	2	3	4
1. IS-GHSQ	1			
2. FS-GHSQ	0.801**	1		
3. SR_GHSQ	0.450**	0.449**	1	
4. SRS	−0.483**	−0.503**	−0.328**	1

Note. Values represent Pearson correlation coefficients. IS_GHSQ = Informal Sources of the General Help-Seeking Questionnaire; FS_GHSQ = Formal Sources of the General Help-Seeking Questionnaire; SR_GHSQ = Self-Reliance subscale of the General Help-Seeking Questionnaire; SRS = Self-Reliance Scale. $^{*}p < .05$. $^{**}p < .01$. No missing values were observed.

Table 4.10: Relationship Between Help-Seeking Intentions and Mental Health Literacy Among University Students (N = 250)

Variable	1	2	3	4
1. IS_GHSQ	1			
2. FS_GHSQ	0.801**	1		
3. SR_GHSQ	0.450**	0.449**	1	
4. MHLS	0.604**	0.523**	0.490**	1

Note. Values represent Pearson correlation coefficients. IS_GHSQ = Informal Sources of the General Help-Seeking Questionnaire; FS_GHSQ = Formal Sources of the General Help-Seeking Questionnaire; SR_GHSQ = Self-Reliance subscale of the General Help-Seeking Questionnaire; MHLS = Mental Health Literacy Scale. $^{*}p < .05$. $^{**}p < .01$. No missing values were observed.

2. Similarly, this study also finds a significant positive correlation between MHLS and FS-GHSQ. The relationship between MHLS and FS-GHSQ was (rs = 0.523, p = .000); this means that mental health literacy (MHLS) significantly ameliorates formal source of help (FS-GHSQ) among university students, thus supporting our Hypothesis 2. Finally, we find a positive correlation between MHLS and SR-GHSQ. For instance, the MHLS nexus with SR-GHSQ was (rs = 0.490, p = .000), indicating that mental health literacy significantly improves (SR-GHSQ). These results are consistent with Hypothesis 2. Overall, results in light of this correlation matrix conclude that mental health literacy is positively associated with the help-seeking intentions among university students.

H3: Hypothesis 3: Perceived social support and help-seeking intention among university students The following table represents the association of perceived social support with the help-seeking intentions among university students.

Table 4.11: Relationship Between Help-Seeking Intentions and Perceived Social Support Among University Students (N = 250)

Variable	1	2	3	4
1. IS_GHSQ	1			
2. FS_GHSQ	0.801**	1		
3. SR_GHSQ	0.450**	0.449**	1	
4. MSPSS	0.562**	0.469**	0.317**	1

Note. Values represent Pearson correlation coefficients. IS_GHSQ = Informal Sources of the General Help-Seeking Questionnaire; FS_GHSQ = Formal Sources of the General Help-Seeking Questionnaire; SR_GHSQ = Self-Reliance subscale of the General Help-Seeking Questionnaire; MSPSS = Multidimensional Scale of Perceived Social Support. $^{*}p < .05$. $^{**}p < .01$.

Table 4.12: Relationship Between Help-Seeking Intentions and Perceived Social Support Among University Students (N = 250)

Variable	1	2	3	4
1. IS_GHSQ	1			
2. FS_GHSQ	0.801**	1		
3. SR_GHSQ	0.450**	0.449**	1	
4. MSPSS	0.562**	0.469**	0.317**	1

Note. Values represent Pearson correlation coefficients. IS_GHSQ = Informal Sources of the General Help-Seeking Questionnaire; FS_GHSQ = Formal Sources of the General Help-Seeking Questionnaire; SR_GHSQ = Self-Reliance subscale of the General Help-Seeking Questionnaire; MSPSS = Multidimensional Scale of Perceived Social Support. $^{*}p < .05$. $^{**}p < .01$.

Table 4.7 reports the correlation matrix of our variables used in hypothesis 3. The dependent variable in our study is general help-seeking intentions towards different sources of support/help, measured through General Help-Seeking Questionnaire-Informal Support (IS-GHSQ), General Help-Seeking Questionnaire Formal Support (FS-GHSQ), and General Help-Seeking Questionnaire Self-reliance or no help-seeking intentions (SR-GHSQ). The third independent variable used in this study is the perceived social support comprising support from friends, family and significant others, was assessed by using Multidimensional Scale of Perceived Social Support (MSPSS).

The correlation matrix (Table 4.7) reports a significant positive correlation between IS-GHSQ, FS-GHSQ, SR-GHSQ, and MSPSS. For instance, the relationship of perceived social support (MSPSS) with students' intentions for informal help (IS-GHSQ) was calculated as (rs = 0.562, p = .000); this means that perceived social support positively contributes to consult informal source of help (IS-GHSQ),

thus supporting our hypothesis three. Similarly, this study also finds a significant positive correlation between perceived social support (MSPSS) and willingness for formal help (FS-GHSQ).

The relationship between these variables (MSPSS and FS-GHSQ) was found as (rs = 0.469, p = .000); this means that perceived social support significantly ameliorates intentions in students to seek formal help, thus supporting our Hypothesis 3. Finally, we find a positive correlation between MSPSS and SR-GHSQ. For instance, the MSPSS nexus with SR-GHSQ was computed as (rs = 0.317, p = .000); indicating that MSPSS improves SR-GHSQ. The results are consistent with Hypothesis 3. The results conclude that perceived social support is positively associated with the help-seeking intentions among university students.

Table 4.13: Relationship of Perceived Social Support, Mental Health Literacy, and Self-Reliance with General Help-Seeking Intentions Among University Students (N = 250)

Variable	**1**	**2**	**3**	**4**
1. MSPSS	1			
2. GHSQ	0.543**	1		
3. MHS	0.650**	0.615**	1	
4. SRS	−0.364**	−0.523**	−0.383**	1

Note. Values represent Pearson correlation coefficients. MSPSS = Multidimensional Scale of Perceived Social Support; GHSQ = General Help-Seeking Questionnaire; MHS = Mental Health Literacy Scale; SRS = Self-Reliance Scale. $^{*}p < .05$, $^{**}p < .01$.

Table 4.8 reports the correlation matrix of all the study variables. The dependent variable is willingness of students to get help from both formal and informal sources. It was assessed by using GHSQ and its subscales; General Help-Seeking Questionnaire Informal Support (IS-GHSQ), General Help-Seeking Questionnaire Formal Support (FS-GHSQ), and General Help-Seeking Questionnaire Self-reliance or no help-seeking intentions (SR-GHSQ).

The independent variables employed in the current study are perceived social support (mainly from family members, friends and significant others), the mental health literacy (comprising both mental health & illness), students' ability to rely on their own abilities to cope with their mental health issues. These were assessed through the Multidimensional Scale of Perceived Social Support (MSPSS), mental

health literacy scale (MHLS), and the self-reliance scale (SRS), (The last independent variable is given in next section).
The given table indicated the results for the first three assumptions of this study, when computed by using the total scores and not the scores of subscales. This matrix revealed significant positive association of MSPSS with GHSQ (rs = 0.543, p = .000) and MHS with GHSQ (rs = 0.615, p = .000); revealing that willingness to get help is positively associated with perceived social support and mental health literacy among university students, supporting hypotheses 2 and 3 of the study. Further this matrix represented a significant negative relationship between GHSQ and SRS (rs = -0.364, p = .000); revealing that priority of students to rely on their own abilities negatively impacts sense of getting help from available sources, supporting hypothesis 1 of the study.
Hence, finally the overall scores proved that, the students who are high on mental health literacy and perceive high social support have higher intentions for getting formal as well as informal help. Contrary to this, results demonstrated that higher self-reliance among students hinders their intentions to seek help from their support group and mental health services.

4.6 Multiple Linear Regression

In order to assess the linear relationship between the study variables; help-seeking intentions, self-reliance, perceived social support, and mental health literacy, a multiple linear regression analysis was computed by using SPSS Ver 21. Following tables show the final results of the relationship of self-reliance, perceived social support and mental health literacy with help-seeking intentions among university students.

Table 4.9 represents the impact of mental health literacy, self-reliance, and perceived social support on help-seeking intentions towards informal support, including parents, spouse, friends, The final score was computed by using multiple linear regression. The results indicated that the model explained a significant proportion of variance in help-seeking intentions, R2 = 0.58, F (3, 246) = 114.339, p = .000. The dependent variable; help-seeking intentions towards informal sources, of this

TABLE 4.14: Multiple Regression Analysis of Self-Reliance, Mental Health Literacy, and Perceived Social Support on Help-Seeking Intentions (Informal Support) Among Students (N = 250)

Variables	B	Std. Error	Beta	t	p	LL	UL
MHLS	0.098	0.021	0.379	4.58	0.000	0.056	0.140
SRS	-0.099	0.015	-0.339	6.84	0.000	-0.128	-0.071
MSPSS	0.091	0.041	0.167	2.19	0.025	0.009	0.172
Constant	9.622	2.270		4.24	0.000		

Note. B = Unstandardized coefficient; SE = Standard error; Beta = Standardized coefficient; t = t-value; p = significance level; LL = Lower limit of 95% confidence interval; UL = Upper limit of 95% confidence interval.

study is measured through IS-GHSQ. The independent variables; mental health literacy, self-reliance and perceived social support, are measured through the scales MHLS, SRS, and MSPSS. The coefficient on MHLS is positive and significant (coefficient 0.098, $p = 0.000$), indicating a positive relationship between mental health literacy and seeking help from informal sources. This means that mental health literacy improves the help-seeking. The coefficient on MHLS suggests that a one standard deviation increase in MHLS will increase the help-seeking by approximately 18.47%.
In addition, the coefficient on SRS is negative and significant (coefficient -0.099, $p = 0.000$), showing a negative nexus between self-reliance and the intentions to seek help from informal sources among university students. This means that SRS decreases students' intentions to seek informal help. The coefficient on SRS posits that a one standard deviation increase in SRS will increase the dependent variable by approximately 4.99%.

Furthermore, the coefficient on MSPSS is positive and significant (coefficient 0.091, $p = 0.025$), showing a positive link between MSPSS and the IS-GHSQ. This means that MSPSS ameliorates the help-seeking intentions towards informal sources of help including parents, spouse, friends and relatives. The coefficient on MSPSS indicates that a one standard deviation increase in MSPSS will increase the intentions to seek help in students by approximately 1.33%.

All the regression assumptions were found satisfactory, standardized residuals were

distributed normally. There were no outliers as indicated by cook's distance (max = 0.23, mean = 0.004). The error terms expressed constant variance (-2.3 to 3.3). Independence of values was calculated through Durbin Watson test (1.61). The relationship of all predictors with outcome were linear as examined through scatter dot. There was no multicollinearity as indicated by tolerance for MHS (0.25), SRS (0.69), MSPSS (0.29) and VIF computed for MHS (4.04), SRS (1.45), and MSPSS (3.41).

TABLE 4.15: Multiple Regression Analysis of Self-Reliance, Mental Health Literacy, and Perceived Social Support on Help-Seeking Intentions (Formal Support) Among Students (N = 250)

Variables	B	Std. Error	Beta	t	p	LL	UL
MHLS	0.068	0.023	0.255	2.980	0.003	0.023	0.114
SRS	-0.150	0.016	-0.491	-9.562	0.000	-0.181	-0.119
MSPSS	0.063	0.044	0.157	1.418	0.000	-0.024	0.150
Constant	16.643	2.450		6.806	0.000	11.827	21.245

Note. B = Unstandardized coefficient; SE = Standard error; Beta = Standardized coefficient; t = t-value; p = significance level; LL = Lower limit of 95% confidence interval; UL = Upper limit of 95% confidence interval.

Table 4.10 represents the impact of mental health literacy (MHLS), self-reliance (SRS), and perceived social support (MSPSS) on help-seeking intentions towards formal support (FS-GHSQ), which included doctors, physician, mental health professionals and religious healers. The final score was computed by using multiple linear regression. The results indicated that the model explained a significant proportion of variance in help-seeking intentions, R2 = 0.55, F (3, 246) =100.897, p = 0.000.

The coefficient on MHLS is positive and significant (coefficient 0.068, p = 0.003), indicating a positive relationship between mental health literacy and seeking help from formal sources. This means that mental health literacy improves the help-seeking. The coefficient on MHLS suggests that a one standard deviation increase in MLSH will increase the willingness to seek formal help by approximately 14.21%. In addition, the coefficient on SRS is negative and significant (coefficient = -0.150, p = 0.000), showing a negative nexus between self-reliance and the intentions to seek help from formal sources among university students. This means that SRS decreases students' intentions to seek formal help. The coefficient on SRS posits

that a one standard deviation increase in SRS will decrease the willingness to seek formal help by approximately 8.39%.

Furthermore, the coefficient on MSPSS is positive and significant (coefficient = .063, p = 0.000), showing a positive link between MSPSS and the FS-GHSQ. This means that MSPSS ameliorates the help-seeking intentions towards formal sources of help including general physician, psychologist, psychiatrist, counselor and religious healer. The coefficient on MSPSS indicates that a one standard deviation increase in MSPSS will increase the intentions to seek help from formal source by approximately 1.33%.

All the regression assumptions were found satisfactory, standardized residuals were distributed normally. There were no outliers as indicated by cook's distance (max= 0.159, mean = 004). The error terms expressed constant variance (-2.7 to 3.3). Independence of values was calculated through Durbin Watson test (1.45). The relationship of all predictors with outcome were linear as examined through scatter dot. There was no multicollinearity as indicated by tolerance for MHS (0.25), SRS (0.69), MSPSS (0.29), and the values of VIF for MHS (4.03), SRS (1.48), and MSPSS (3.41).

Table 4.16: Multiple Regression Analysis of Self-Reliance, Mental Health Literacy, and Perceived Social Support on Help-Seeking Intentions (No-Help-Seeking Intentions) Among Students (N = 250)

Variables	**B**	**Std. Error**	**Beta**	**t**	**p**	**LL**	**UL**
MHLS	0.048	0.008	0.379	5.832	0.000	0.032	0.064
SRS	-0.013	0.006	-0.339	-2.390	0.018	-0.024	-0.002
MSPSS	-0.030	0.016	0.167	-1.904	0.048	-0.061	0.001
Constant	1.216	0.872		1.395	0.164	-0.501	2.932

Note. B = Unstandardized coefficient; SE = Standard error; Beta = Standardized coefficient; t = t-value; p = significance level; LL = Lower limit of 95% confidence interval; UL = Upper limit of 95% confidence interval.

Table 4.11. represents the impact of mental health literacy (MHLS), self-reliance (SRS), and perceived social support (MSPSS) based on no-help-seeking intentions (SR-GHSQ). The final score was computed by using multiple linear regression. The results indicated that the model explained a significant proportion of variance in help-seeking intentions, R2 = 0.323, F (3, 246) =100.897, p = .000.

The coefficient on MHLS is positive and significant (coefficient 0.048, p = 0.032), indicating a positive relationship between mental health literacy and intentions of no help-seeking among university students. This means that mental health literacy improves the help-seeking. The coefficient on MHLS suggests that a one standard deviation increase in MLSH will increase no-help-seeking intentions by approximately 36.33% among university students.

In addition, the coefficient on SRS is negative and significant (coefficient = -0.013, p = 0.018), showing a negative nexus between self-reliance and the intentions not-seek help from formal and informal sources of help among university students. The coefficient on SRS posits that a one standard deviation increase in SRS will decrease the no-help seeking intentions by approximately 2.63% among university students.

Furthermore, the coefficient on MSPSS is positive and significant (coefficient = -0.30, p = 0.48), showing a positive link between MSPSS and the IS-GHSQ. This means that MSPSS ameliorates the help-seeking intentions towards no help-seeking intention among university students. The coefficient on MSPSS indicates that a one standard deviation increase in MSPSS will increase the dependent variable by approximately 3.67%.

All the regression assumptions were found satisfactory. Standardized residuals were distributed normally. There were no outliers, as indicated by Cooks distance (max = 0.57, mean = 0.004). The error terms expressed constant variance (-2.73 to 2.19). Independence of values was calculated through the Durbin-Watson test (1.73). The relationship of all predictors with the outcome was linear, as examined through scatter plots. There was no multicollinearity, as indicated by tolerance values of MHS (0.25), SRS (0.69), and MSPSS (3.41) and VIF values of MHS (4.03), SRS (1.45), and MSPSS (3.41).

H4: Hypothesis 4: Accessibility of MHS and help-seeking intentions among university students. The following tables represent the association of accessibility to mental health services with the help-seeking intentions among university students. The variable accessibility to mental health services was assessed by a self-develop 10-items open-ended questionnaire named “Access to Mental Health Services”, which was converted to numeric. In order to test the last assumption of this study

correlational analysis was computed, the results are presented in Tables.

Table 4.17: Relationship Between Help-Seeking Intentions and Access to Mental Health Services Among University Students ($N = 250$)

Variables	1	2	3	4	5	6	7	8	9	10	11
1. FS_GHSQ	1										
2. IS_GHSQ	.80**	1									
3. SR_GHSQ	.45**	.45**	1								
4. MHS Responsiveness Within University	.00	-.01	.07	1							
5. Encouragement Efforts of University to Seek Mental Help	-.01	.07	.02	.08	1						
6. Cost of Available MHS	.05	.06	.05	-.07	.21**	1					
7. Professional Help-Seeking Perceptions	-.04	-.02	.04	.16**	.09	.04	1				
8. Steps to Access MHS	-.05	-.00	.01	.11	.12*	.13*	.25**	1			
9. Determinants of Mental Help-Seeking	-.01	-.01	.01	.26**	.14*	.06	.29**	.05	1		
10. Awareness Efforts of University to Seek Help	.07	.09	.01	.37**	.22**	.05	.27**	.18**	.21**	1	
11. Prior Help-Seeking Experience	-.03	-.00	-.07	.30**	.00	.06	.04	-.02	.17**	.28**	1

Note. Values represent Spearman's rho correlations among study variables. Sample size ranged from 217 to 250 due to missing values.
* $p < .05$. ** $p < .01$.

Table 4.18: Relationship between Help-Seeking Intentions and Access to the Mental Health Services Among University Students (N = 250)

max width=

Variables	1	2	3	4	5	6	7	8	9	10	11
1. FS_GHSQ	1										
2. IS_GHSQ	0.80**	1									
3. SR_GHSQ	0.45**	0.45**	1								
4. MHS Responsiveness within Uni	0.00	-0.01	0.07	1							
5. Encouragement efforts of Uni	-0.01	0.07	0.02	0.08	1						
6. Cost of available MHS	0.05	0.06	0.05	-0.07	0.21**	1					
7. Professional help-seeking perceptions	-0.04	-0.02	0.04	0.16**	0.09	0.04	1				
8. Steps to access MHS	-0.05	-0.00	0.01	0.11	0.12*	0.13*	0.25**	1			
9. Determinants of mental-help seeking	-0.01	-0.01	0.01	0.26**	0.14*	0.06	0.29**	0.05	1		
10. Awareness efforts to seek help of Uni	0.07	0.09	0.01	0.37**	0.22**	0.05	0.27**	0.18**	0.21**	1	
11. Prior help-seeking experience	-0.03	-0.00	-0.07	0.30**	0.00	0.06	0.04	-0.02	0.17**	0.28**	1

Note. * $p < .05$, ** $p < .01$. Values represent Spearman's rho correlations between three subscales of GHSQ and items of a self-made questionnaire. Sample size ranged from 217 to 250 due to missing values.

The Table 4.12 represents the results of help-seeking intentions from formal, informal sources and no-help seeking with the item-1 to item-2c of the self-developed questionnaire. The Table 4.13 represents the results of help-seeking intentions from formal, informal sources and no-help seeking with the item-3 to item-10 of the self-developed questionnaire. as well as outside the university including both online or in-person services.

Table 4.12. reports the correlation matrix of the study variables used in hypothesis 4. The last independent variable used in this study is the access to the mental health services (MHS) which is a 10-items, self-generated questionnaire which assess the MHS within the university as well as outside the university including both online or in-person services (hospital settings, private clinics etc.). The correlation matrix (Table 4.12) represents the correlation between each subscale of GHSQ and each item of Access to mental health services (Access-1 to Access-2C), among university students. The overall result demonstrated that there is no significant relationship between help-seeking intensions and access to mental health services among university students.

Table 4.13. reports the correlation matrix of the study variables used in hypothesis 4. The last independent variable used in this study is the access to the mental health services (MHS) The correlation matrix (Table 4.13) represents the correlation between each subscale of GHSQ and items of access to mental health services (Access-3 to Access-10), among university students. The overall result demonstrated that there is no significant relationship between help-seeking intensions and access to mental health services among university students.

Chapter 5

Discussion and Conclusion

This chapter discusses the empirical findings of this study with respect to the study objectives and assumptions; which were deduced from the analysis used in this study. Further this chapter highlights the contribution of the current study to the existing body of knowledge and identifies further areas of study for the future research. The results were interpreted in light of the existing literature and theoretical framework.

This study was conducted to quantitatively assess the relationship of psychological/mental help-seeking intentions towards formal as well as informal sources with perceived social support (PSS), mental health literacy (MHS), self-reliance (SR) and access to the mental health services including affordability in terms of cost and distance to the MHS, mode of the available services which may be online or in-person, and perceptions about these mental health services to consult when needed among the university students. The aim of the last component of the study was to explore the available means of professional MHS within the university setting and other settings including online platforms, private sectors and public sectors. Further it was aimed to assess the degree of willingness to seek help for the mental issues among university students in terms of over-utilization and under-utilization of these services.

This study was a cross-sectional study in which sample (N=250) was collected from different universities located in the Districts Buner and Swat within the province Khyber Pakhtunkhwa (KPK), in Pakistan. This study employed the convenient

sampling technique to approach the university students and to meet the study objectives, standardized quantitative scales were used in Urdu version for the first three assumptions of the study. However, to assess the last assumption of this study a self-made open-ended questionnaire was used in Urdu version which was then converted to numeric during the final analysis through using the Statistical Package of Social Sciences.

These areas of the study had been the origin of natural disasters and political instabilities which contributed to lower quality of mental health services and increased role of welfare organizations including Al Khidmat Foundation, Khpal Kor Foundation, Minhaj Welfare Foundation, and affect awareness about mental health issues and treatments.

5.1 Demographics

The analysis of the sample demographics in this study represents that the number of female students is lower than males. In this regard, a study conducted by Rasheed and Mar'iyah (2024) depicted that under-developed educational infrastructure, low-income resources and multiple cultural values including concept of premature marital practices and concept of male dominance are potential contributors for lower literacy rate in females within this study setting. The current study found that the mean age of the university students was 21-23 years which is consistent with a finding of a cross-sectional study carried out with nursing students enrolled in their undergraduate program within Swat. They found that near 89% of the students' reported their age between 20-24 years (Ali et al., 2024). Further the findings revealed that majority of the students were Muslims, unemployed and belonged to middle class family who were residing in these areas from their birth. Moreover, larger group of the sample reported their marital status as single and Master's (MS) students were lower in number as compared to the (Bachelor's) BS students. There are multiple factors addressing this educational gap. For instance, in higher educational settings commonly the BS students are observed to be larger compared with MS students, because usually undergraduate programs inherently enroll more students as they serve the entire outgoing cohort from intermediate

(12th grade) studies.

On the other hand, only a smaller proportion of BS graduates qualify to pursue postgraduate MS education due to additional academic requirements, financial constraints, and limited availability of postgraduate seats in local institutions. National data from Pakistan stated that from a small proportion of students who enrolled in bachelor's program, a smaller fraction of the students qualify for post-graduate program pointing to a significant drop-off as students transition from undergraduate to graduate studies.

The limited research resources and poor availability of local educational infrastructure within rural districts like Buner and Swat, discourages the BS holders to continue their education and they have to travel long distances to other areas for getting enrolment in MS programs. For instance, as per report of a campus within rural district stated the enrollment of 184 students as compared to 24 MS students which reflects the limited access to further studies within local settings.

5.2 Reliabilities of the Scales

In this study the Cronbach's alpha (α) reliability for the Urdu translated version of Mental Health Literacy Scale (MHLS) was found to be .94 which is consistent with another study conducted by Akhtar et al. (2010), who translated and validated this scale in Pakistani culture. In the original validation study conducted by O' Connor and Casey (2015), reported good internal consistency (0.9) for 35-items scale.

In this study the value of Cronbach's alpha (α) reliability for the Urdu translated version of Multidimensional Scale of Perceived Social Support was 0.97 which stated good internal consistency between the items of this scale when used with students. This result is consistent with the result of reliability reported by Akhtar et al. (2010)) who administered this scale to antenatal women, with the aim to translate and validate this scale in context of Pakistan. According to this study the Cronbach's alpha reliability of MSPSS Urdu version is 0.97, indicating good internal consistency and stated good construct validity as well.

The final analysis revealed that the Cronbach's alpha reliability of the General

Help-Seeking Questionnaire (GHSQ) is .94, termed as good internal consistency between the items of this scale when computed for the overall score. This finding is in line with the finding of Wilson et al. (2005), in their research to assess the psychometric properties of GHSQ, which was reported as .92. This scale was administered in a study conducted by Rice and his colleagues to address the issue of suicidality in students. This study reported the good internal consistency between the items for each of the subscale i.e. formal and informal support. Similarly current study found good internal consistency between the items of each subscale of GHSQ.

The Self-Reliance scale was recently developed and validated by Padhy et al. (2024), demonstrated good internal consistency of this scale when used with a large sample size (N=2210) which supported the reliability of this scale to use for research purpose. When the Cronbach's alpha reliability was computed for this scale in the present study, the results yield good internal consistency (α=.94).

5.3 Association of self-reliance with help-seeking intentions among university students

This study revealed a significant negative correlation of self-reliance with help-seeking intentions for informal sources available to the university students. This finding is consistent with findings of another study that targeted the mentally ill people to investigate the moderating relationship of self-reliance with help-seeking attitudes. It confirmed that self-reliance significantly affect the intentions to seek assistance (Fabry et al., 2024). The informal sources of help were included mental health professionals, hotline, doctors and religious healers. Further investigation of self-reliance and help-seeking intentions for the formal sources available to the students, revealed a significant negative correlation which proved the assumptions of this study to be true and supports the prior literature who find the negative relationship between these two variables. These finding clearly suggests that the students who have greater level of the tendency to handle their issues by their own will be lower to seek help for mental health issues.

This study further revealed an interesting finding which states that the students who has high scores in the last subscale of GHSQ i.e. GHSQ-SR had also high scores on the self-reliance scale so students who tend to not seek any of the available sources of help possess higher level of the self-reliance. In order to assess this assumption of the study, the three subscales of GHSQ were correlated with the total scores of self-reliance scale and then total score of GHSQ was also correlated with the total score of GHSQ.

Additionally, the current study suggested that the willingness to reach out for help towards formal help has higher scores in comparison with informal sources which confirms that students with higher sense of handling their issues by themselves have higher intentions to not consult professional help including mental health services, religious healers and mental health professionals as compared to their parents, spouse and friends.The multiple linear regression was used to test the association and strength of the relationship between these study variables, consistent finding were concluded for these study variables.

5.4 Association of mental health literacy with help-seeking intentions among university students

This study hypothesized that there exists a positively relationship between mental health literacy and help-seeking intentions for both the sources of help i.e. informal and formal sources. Numerous studies have outlined the association between mental health literacy and psychological issues and treatment in addressing the mental health disorders and delay in treatments (Tay et al., 2018; Kutcher et al., 2016; Kelly et al., 2007).

However, as far as the literature is being studied the association of help-seeking with the mental health literacy is not extensively studied in context of university students specifically in areas rural areas where the educational infrastructure is under-developed. Therefore, this study was aimed to assess the relationship of with the degree of willingness to seek both professional as well as unprofessional

help. In order to assess this assumption, a correlation was computed for each of the subscale of GHSQ with the mental health literacy scale. And then final analysis was calculated with the total scores of GHSQ and the MHLS.
The results demonstrated a moderate significant positive correlation between these variables, supporting the second assumption of the study. This finding is in line with the first component of the theory proposed by Rickwood et al. (2005), who explained that awareness of the psychological issue is the first component which helps in recognizing the symptoms of disturbance. Therefore, higher awareness to psychological disturbances lead to increased level of willingness to seek out help from different sources. The multiple linear regression was used to test the association and strength of the relationship between these study variables, consistent finding were concluded for these study variables.

5.5 Association of perceived social support with help-seeking intentions among university students

The concept of perceived social support (PSS) has been studied in context of rural Pakistan but is studied with the people with depression, to find the association of perceived social support with mental health disorders and other sever issues like suicide specifically within women (Sikander et al., 2019; Collins et al., 2025).
There is a gap to study the association of this factor with help-seeking intentions among university students from rural districts. Further this study attempt to study PSS in relation to formal sources for help, informal sources for help and no help seeking intentions among students who may have or may not mental disturbance. In order to test this assumptions, correlational analysis was computed for each of the three subscales of GHSQ with the Multidimensional Scale of Perceived Social Support (MSPSS) and then the analysis was done for the total score of GHSQ with total score of MSPSS. The multiple linear regression was used to test the association and strength of the relationship between these study variables, consistent finding were concluded for these study variables. The result confirms a

significant positive relationship of perceived social support with willingness to get formal as well as informal help among university students.

5.6 Association between access to mental health services and students' help-seeking intentions

Spearman's correlation analysis was computed to assess the relationship between access to professional help (mental health services) and willingness to seek help among university students. This study find that there is no significant relationship between these two study variables. This finding is consistent with previous studies, who claimed that awareness and educational interventions are crucial in improving the help-seeking intentions among university students but access to MHS is insignificant as evident by the fact that MHS are available free of cost within the universities but still students reported under-utilization of these services (Pinho et al., 2025; Sheldon et al., 2024; Shim et al., 2022)

5.7 Conclusion

A cross-sectional, correlational quantitative study was conducted to investigate the predictors of help-seeking intentions among university students recruited from different universities located within districts Buner and Swat. These areas are semi-rural areas where the educational infrastructure and health systems are developing, and are the places prone to natural disasters. The predictors used in this study were self-reliance, perceived social support, mental health literacy and access to mental health services. Standardized measures were used to assess the link between the study variables. The study found significant negative relationship with intentions to seek help from formal (including doctors or general practitioner, religious leader, psychologist/psychiatrist, and counselor), and informal sources of help (including spouse, friend, relative, parents and siblings). Which

clearly demonstrated that the students who highly depend on their abilities and tend to solve their issues by their own, are prone to not consult for their mental health issues. Further it reported significant positive relationship of help-seeking intentions in students with perceived social support and mental health literacy. Which explains the fact that students who have high sense of support from their peer group or family and have awareness about their mental illness and health express greater intentions to seek help from formal and informal sources.

5.8 Limitations and Suggestions

Following are the limitations and suggestions of the current study:
i. There were numerous practical issues to employed this research study. The small sample size drawn from different universities within rural districts of Buner and Swat, limits the study's generalizability. Moreover, due to the restricted time and lack of resources to reach out the students within specified time, the small number of participants were approached by using convenient sampling technique limits the equal number of recruitments of participants in terms of BS MS program as well as gender differences, to make the sample more representable. Thus the results can be more valid and reliable by replicating the study with a larger sample size covering other cities and provinces and in a more systematic way of data collection.
ii. Future studies can use a sample from different ethnic groups within this country to better study these variables because cultural and ethnic factors influence mental health-seeking behaviors, which were not studied in the current study.
iii. The help-seeking can be qualitatively studied to understand well the mechanism by which the study variables are affecting the willingness to reach out the sources for help when needed. Due to limited time and resources, the current study could not qualitatively assess the underlying factors so a mixed-method approach can better answer the question of the study.
iv. Future studies may focus on introducing interventions to enhance the knowledge of psychological issues and treatment and encouraging students to seek help from mental health services based on the need to address mental health issues.

v. This study focuses on only educational settings and middle age range it would contribute more to the existing knowledge of the research body when these factors are studied with elderlies as and teenagers to understand well the development of the study variables in relation to age.
vi. One of the limitations of this study is that it used convenient sampling technique which may compromise the true representativeness of the population it can be replicated with other sampling techniques to recruit equal participants on the basis of gender as well as qualification level to better understand the relationship between the study variables.
vii. These variables can be studied after the flood due to cloud bursts 2025, in Buner and Swat, to investigate the difference in these variables after traumatic event.

5.9 Proposed Implications

Following are the implications of this study:
i. In Pakistan, these variables were less explored specifically under the dynamics of KPK, so its results can be applied to different educational sectors to optimize better performance and future achievements, through good mental health of the students.
ii. The study results can be applied to educational settings to recognize and address the mental health issues like the need to increase access to skilled professionals and pay attention to not only the academic requirements but also ensuring the student's better mental health for their optimal performance and achievements.
iii. Understanding the relationships between self-reliance, mental health literacy and perceived social supports can guide the guardians of young people to recognize their threshold level and encourage young people to seek help from appropriate sources, such as formal or informal sources.
iv. The study results can help understand the disease burden and inform future interventions to address the issues of accessibility of mental health services, unhealthy level of self-reliance and inadequate awareness about mental health and illness.

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Appendix A: Protocol of the Study

معلوماتی فارم

میں ارم حمید، کیپٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی میں نفسیات کی طالبہ ہوں، اور میں آپ کو اِس تحقیق میں حصہ لینے کی دعوت دینا چاہتی ہوں۔ برائے مہربانی مندرجہ ذیل معلومات کو احتیاط سے پڑھیں۔

تحقیق کا مقصد: اس تحقیق کا مقصد یونیورسٹی کے طلبہ میں ذہنی صحت کے مسائل کے لئے صحت کی سہولیات یا دوسرے لوگوں سے مدد حاصل کرنے کا رحجان جاننا ہے۔ ہم اس بارے میں جاننے کی کوشش کریں گے کہ طلبہ کے اندر ذہنی صحت کے مسائل پر دوسروں سے بات کرنا اور مدد لینا کس حد تک پایا جاتا ہے۔

مجھے تحقیق میں حصہ لے کر کیا کرنا ہوگا؟

اس تحقیق میں حصہ لینے کے لیے آپ کی رضامندی ضروری ہے۔ اس کے بعد کچھ بنیادی معلومات کا فارم بھرنا ہوگا۔ اور آپکو چند سوالنامے دیے جائیں گے جس پہ آپ اپنی رائے کا اظہار کر سکتے ہیں۔ یہ سوالنامے سادہ اور آسان الفاظ میں بنائے گئے ہیں لیکن اگر سوالنامے یا اس تحقیق سے متعلق آپ کچھ بھی پوچھنا چاہتے ہیں تو براہمہربانی آپ بلا جھجھک پوچھ سکتے ہیں۔ اس مقصد کے لئے آپکے 30-40 منٹ درکار ہوں گے۔ اس تحقیق میں حصہ لینے کو بعد اگر آپ چاہیں تو کسی بھی وقت اپنی رضامندی واپس لے سکتے ہیں۔

اس تحقیق کی معلومات کس طرح کام آئیں گی؟

آپ سے حاصل کردہ تمام معلومات دونوں شکلوں (کاغذ اور کمپیوٹر) میں خفیہ اور محفوظ رہے گی۔ اور ان معلومات کو صرف تحقیق کے مقصد کے لئے استعمال کیا جائے گا۔ اس کے علاوہ نتائج کے شائع ہونے پر آپ کی شناخت کو کسی بھی شکل میں ظاہر نہیں کیا جائے گا۔ آپکی دی گئی معلومات سے، طلبہ کے لئے ذہنی صحت کی سہولیات کو بہتر بنانے میں مدد ملے گی۔

اس تحقیق میں حصہ لینے سے کیا ہوگا؟

اس تحقیق سے اس بارے میں آگاہی حاصل ہوگی کہ طلبہ کے اندر ذہنی صحت کے مسائل سے نمٹنے کے لئے دوسروں سے مدد یا ذہنی صحت کی سہولیات حاصل کرنے کا رحجان کیا ہے۔ اس بات کی آگاہی نظام کو بہتر بنانے میں مدد کرے گی۔

سوالات یا مزید معلومات کے لئے مجھے کس سے رابطہ کرنا چاہیے؟

کسی بھی سوال یا مسئلے کی صورت میں آپ یہاں رابطہ کر سکتے ہیں:

051-111-555-666Ext: 178

یا

msp233003@cust.pk

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شعبہ نفسیات، کیپٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی، کہوٹہ روڈ، اسلام آباد

مددگار اداروں کا پتہ

اس تحقیق کے دوران یا بعد اگر آپ کو کسی قسم کے ذہنی تناؤ یا دباؤ کا سامنا کرنا پڑے تو نیچے موجود پتہ پر رابطہ کریں۔

Well Being Center

051-111-555-666 Ext: 296

یا

wbc@cust.edu.pk

یہاں پر آپ صبح 9 سے 5 بجے تک جا سکتے ہیں : کیپٹل یونیورسٹی آف سائنس اینڈ ٹیکنالوجی، کہوٹہ روڈ، اسلام آباد

تسکین ہیلپ لائن نمبر 0316 82753360

یہاں پر آپ صبح ۱۱ بجے سے رات ۱۱ بجے تک مفت کال کر سکتے ہیں اور ماہر نفسیات سے مدد لے سکتے ہیں۔

اجازت نامہ

		ہاں	نہیں
.1	میں اس بات کی تصدیق کرتا/کرتی ہوں کہ مجھے اس تحقیق کے بارے میں اور اس میں ہونے والی سرگرمیوں اور طریقہ کار کے بارے میں معلومات فراہم کی گئی ہیں۔	ہاں	نہیں
.2	میں جانتا/جانتی ہوں کے میری شرکت مکمل طور پر رضاکارانہ ہے اور میں کسی بھی وقت بغیر کسی فائدے یا نقصان کے اپنی شرکت ختم کرنے کا حق رکھتا/رکھتی ہوں۔	ہاں	نہیں
.3	میں سمجھتا/سمجھتی ہوں کہ میری معلومات ظاہر نہیں کی جائیں گی اور صرف تحقیقی مقاصد کے لئے استعمال کی جائیں گی۔	ہاں	نہیں

نام________ دستخط________ تاریخ________

ذاتی معلومات کا فارم

نمبر شمار	سوالات	جوابات
1.	آپ کا نام کیا ہے؟	
2.	آپ کی جنس کیا ہے؟	
3.	آپ کی عمر کیا ہے؟	
4.	آپکی تعلیم کتنی ہے؟	
5.	آپ کس یونیورسٹی میں پڑھتے ہیں؟	
6.	آپکی ازدواجی حیثیت کیا ہے؟	
7.	آپ کس مذہب سے تعلق رکھتے ہیں؟	
8.	کیا آپ ملازمت کرتے ہیں؟ اگر ہاں، تو کس قسم کی؟	
9.	آپ کس علاقے میں رہتے ہیں؟	
10.	آپ اس علاقے/گاوں میں کتنے عرصے سے رہ رہے ہیں؟	
11.	آپکی معاشی حیثیت کیا ہے؟	
12.	کیا آپ کو کبھی کسی قسم کی ذہنی/نفسیاتی بیماری کی تشخیص کی گئی ہے؟	
13.	کیا آپ نے کوئی نفسیاتی مدد حاصل کی ہے؟ اگر ہاں تو کونسی؟	

س1:۔ اگر آپ کسی ذاتی یا جذباتی مسئلے کا شکار ہوں، تو آپکے درج ذیل افراد سے مدد لینے کا کتنا امکان ہے؟

براہِ کرم اپنے جواب کی نشاندہی دئے گئے مدد کے ذرائع کی فہرست پر، اُس نمبر کے گرد دائرہ لگا کر کریں جو آپکی مدد حاصل کرنے کی نیت کو سب سے بہتر بتاتا ہو۔

ذیل میں چند بیانات دیے گئے ہیں۔ براہ کرم انہیں غور سے پڑھیں۔ آپ کو ہر بیان کو پڑھ کر چار دی گئی آپشنز میں سے ایک کو منتخب کرتے ہوئے ✔ کا نشان لگانا ہے۔ مثال کے طور پر، ہر بیان کے لیے صرف ایک خانے پر ✔ کا نشان لگائیں جو آپ کی شخصیت یا رائے کی بہترین عکاسی کرتا ہو۔ براہ کرم ہر جملہ غور سے پڑھیں اور دیانت داری سے جواب دیں۔

(۳) ایسا نہیں ہے	(۲) کسی حد تک ایسا نہیں ہے	(۱) بالکل بھی ایسا نہیں ہے
(٦) کسی حد تک ایسا ہی ہے	(۵) ایسا ہی ہے	(۴) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے
		(۷) بالکل ایسا ہی ہے

۷	٦	۵	۴	۳	۲	۱	
۷	٦	۵	۴	۳	۲	۱	موجودہ جیون ساتھی یا قریبی ساتھی (مثلاً، گرل فرنڈ، بوائے فرنڈ، شوہر، بیوی)
۷	٦	۵	۴	۳	۲	۱	دوست (جو آپکا رشتہ دار نہ ہو)
۷	٦	۵	۴	۳	۲	۱	والدین
۷	٦	۵	۴	۳	۲	۱	کوئی اور رشتہ دار یا خاندان کا فرد
۷	٦	۵	۴	۳	۲	۱	ذہنی صحت کے ماہر (ماہر نفسیات، کاونسلر، سماجی کارکن)
۷	٦	۵	۴	۳	۲	۱	فون ہیلپ لائن نمبر
۷	٦	۵	۴	۳	۲	۱	ڈاکٹر یا جنرل فزیشن
۷	٦	۵	۴	۳	۲	۱	مذہبی رہنما (امام، پادری یا راہب)
۷	٦	۵	۴	۳	۲	۱	میں کسی اور سے مدد نہیں لوں گا / لوں گی
۷	٦	۵	۴	۳	۲	۱	میں کسی اور سے مدد لینا چاہوں گا جو اوپر دی گئی فہرست میں نہیں ہے۔ (براہ کرم دی گئی جگہ پر اسکے بارے میں لکھیں جیسے کام کا ساتھی۔ اگر نہیں، ____ تو خالی چھوڑ دیں۔

ذیل میں چند بیانات دیے گئے ہیں۔ براہ کرم انہیں غور سے پڑھیں. آپ کو ہر بیان کو پڑھ کر چار دی گئی آپشنز میں سے ایک کو منتخب کرتے ہوئے ✓ کا نشان لگانا ہے۔ مثال کے طور پر، ہر بیان کے لیے صرف ایک خانے پر ✓ کا نشان لگائیں جو آپ کی شخصیت یا رائے کی بہترین عکاسی کرتا ہو۔ براہ کرم ہر جملہ غور سے پڑھیں اور دیانت داری سے جواب دیں۔

(د) بالکل اتفاق ہے	(ج) کسی حد تک اتفاق ہے	(ب) کسی حد تک اتفاق نہیں	(ا) بالکل اتفاق نہیں

(د)	(ج)	(ب)	(ا)	1. میں اپنے مسائل حل کرنے کے قابل ہوں۔
(د)	(ج)	(ب)	(ا)	2. میں اپنی قابلیت پر اعتماد کرتا ہوں۔
(د)	(ج)	(ب)	(ا)	3. جب مجھ سے کوئی کام کرنے کا کہا جاتا ہے تو مجھے کسی کی مدد کی ضرورت ہوتی ہے۔
(د)	(ج)	(ب)	(ا)	4. میں اپنے فیصلے خود کرتا ہوں۔
(د)	(ج)	(ب)	(ا)	5. میں دوسروں پر انحصار نہیں کرتا۔
(د)	(ج)	(ب)	(ا)	6. میں اکیلا ہی حالات کا سامنا کر سکتا ہوں۔
(د)	(ج)	(ب)	(ا)	7. اگر کوئی مدد کے لیے موجود نہ ہو، تب بھی مجھے کبھی کوئی مسئلہ نہیں ہوتا۔
(د)	(ج)	(ب)	(ا)	8. میں کوئی فیصلہ کرنے سے پہلے اپنے بڑوں سے مشورہ کرتا / کرتی ہوں۔
(د)	(ج)	(ب)	(ا)	9. میں اپنی مشکلات کا اظہار دوسروں سے کرتا ہوں / کرتی ہوں، تاکہ میں غلطی نہ کروں۔
(د)	(ج)	(ب)	(ا)	10. میں مشکلات کا سامنا کرنے کے لئے تیار ہوں۔
(د)	(ج)	(ب)	(ا)	11. میں مشکل حالات پر قابو پا سکتا / سکتی ہوں۔
(د)	(ج)	(ب)	(ا)	12. میں اپنے وعدے وقت پر پورے کرتا / کرتی ہوں۔

13. میرے خیال میں ترقی کرنے کے لیے انسان کو اپنی صلاحیتوں پر بھروسہ کرنا چاہیے۔	(ا)	(ب)	(ج)	(د)
14. میں کسی پر انحصار کرنے والا نہیں ہوں۔	(ا)	(ب)	(ج)	(د)
15. مجھے دوسروں سے زیادہ سے زیادہ مدد لینا پسند ہے۔	(ا)	(ب)	(ج)	(د)
16. میں نئے خیالات کے لیے مختلف منصوبے (پلان) آزماتا / آزماتی ہوں۔	(ا)	(ب)	(ج)	(د)
17. میں خود مختاری سے کام کرنے کے لئے نئی چیزیں سیکھتا / سیکھتی ہوں۔	(ا)	(ب)	(ج)	(د)
18. میں اپنے کاموں کو ترتیب دیتا / دیتی ہوں تاکہ وقت پر مکمل ہو جائیں۔	(ا)	(ب)	(ج)	(د)
19. میں کوئی نئی سرگرمی شروع کرنے میں گھبراہٹ محسوس کرتا / کرتی ہے۔	(ا)	(ب)	(ج)	(د)
20. میرے اندر نئی سرگرمیاں شروع کرنے کی قوت ارادی (مضبوط ارادہ موجود) ہے۔	(ا)	(ب)	(ج)	(د)
21. مجھے معمولی چیزوں کے لیے لوگوں سے مشورہ کرنا پسند نہیں۔	(ا)	(ب)	(ج)	(د)
22. میں یقین رکھتا / رکھتی ہوں کہ خود مختاری انسان کو بہادر بناتی ہے۔	(ا)	(ب)	(ج)	(د)
23. میں ہمیشہ اپنے مقاصد حاصل کرنے کی کوشش کرتا / کرتی ہوں۔	(ا)	(ب)	(ج)	(د)
24. مجھے خوشی محسوس ہوتی ہے جب میں اپنا کام اکیلا ختم کرتا / کرتی ہوں۔	(ا)	(ب)	(ج)	(د)
25. میں کبھی بھی آسانی سے ہار نہیں مانتا / مانتی۔	(ا)	(ب)	(ج)	(د)
26. میں اپنے جذبات سنبھال لیتا / لیتی ہوں۔	(ا)	(ب)	(ج)	(د)
27. میں یقین رکھتا ہوں کہ میں اپنا کام مکمل کر سکتا / سکتی ہوں۔	(ا)	(ب)	(ج)	(د)
28. میں مسائل کا پہلے سے اندازہ لگا سکتا / سکتی ہوں۔	(ا)	(ب)	(ج)	(د)
29. جیسے ہی کوئی مسئلہ پیش آئے تو میں فوری طور پر اسکا حل تلاش نہیں کر سکتا / سکتی۔	(ا)	(ب)	(ج)	(د)
30. میں دوسروں کو قائل نہیں کر سکتا / سکتی۔	(ا)	(ب)	(ج)	(د)

ان سوالات کا مقصد ذہنی صحت کے بارے میں آپ کو کتنا علم ہے، کے بارے میں جاننا ہے آپ جب ان سوالات کے جوابات دیں تو آپ کے علم کی درجہ بندی کی جائے گی لہذا آپ جواب منتخب کرتے ہوئے۔

مندرجہ ذیل نکات کو مد نظر رکھیں۔

(الف) بالکل ایسا نہیں　　(ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(د) مجھے پورا یقین ہے کہ ایسا ہی ہے　　(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے

س 1:۔ اگر کوئی شخص ایک یا ایک سے زیادہ حالات میں دوسرے لوگوں کی موجودگی میں بے حد پریشان اور بے چین ہو جہاں اُسے ڈر یا خوف ہو کہ اُسکا تجزیہ کیا جائے گا۔ مثال کے طور پر کسی میٹنگ میں یا کوئی پریزنٹیشن دیتے ہوئے کوئی اس کا مذاق اُڑائے گا اور شرمندگی کا باعث بنے گا تو آپ کے خیال میں کس حد کا سماجی خوف (Social Phobia) ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے)　　(ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے　　(د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س 2:۔ اگر کوئی انسان بہت سے معاملات اور سرگرمیوں میں بہت زیادہ پریشان ہو جاتا ہے جہاں پریشانی متوقع نہ ہو اور اُسے پریشانی کو کنٹرول کرنے میں بہت مشکل پیش آرہی ہوتی ہے اور بہت جسمانی علامات جیسے اعصابی تناؤ اور تھکان محسوس ہو تو آپ کے مطابق کس حد تک سمجھیں گے کہ اُن کو عمومی تشویش کا مرض (Generalised Anxiety Disorder) ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے)　　(ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے　　(د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س 3:۔ اگر کسی کو دو یا دو سے زیادہ ہفتے افسردگی یا خوشی میں کمی، عدم دلچسپی بھوک اور نیند میں خرابی محسوس ہو تو آپ کے خیال میں کس حد

تک اس کو شدید ذہنی دباؤ ڈپریشن(Major Depressive Disorder) ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س4:۔ آپ کے خیال میں کس حد تک شخصیاتی بگاڑ (Personality Disorder) ذہنی بیماری کے زمرے میں آتا ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س5:۔ آپ کے خیال میں کسی حد تک مسلسل ذہنی افسردگی (Dysthymia) ایک بیماری ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س6:۔ آپ کے خیال میں کس حد تک ہجوم اور تنگ جگہوں کے خوف کی بیماری (Agora Phobia) کا تعلق ان حالات میں بے چینی (Anxiety) سے ہے جن سے نکلنا مشکل ہو یا باعث شرمندگی ہو۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س7:۔ آپ کو کس حد تک لگتا ہے کہ بائی پولر (Bipolar Disorder) کی تشخیص میں مزاج کے اُتار چڑھاؤ کا سامنا ہوتا ہے۔(مثال کے طور پر بے وجہ بھی بہت زیادہ خوش ہو جانا اور کبھی بہت زیادہ اُداس ہو جانا بغیر کسی وجہ کے)

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س8:۔ کسی درجے تک آپ کے خیال میں منشیات پر انحصار کی تشخیص (Drug Dependence)) منشیات کے عادی میں جسمانی اور ذہنی اثرات حاصل کرنے کیلئے اُس نشے کی مقدار کی برداشت بڑھ جاتی ہے۔(مثال کے طور پر جتنی دوا یا نشہ پہلے لیا جاتا تھا اس کی مقدار بڑھانی پڑتی ہے پہلے والا اثر حاصل کرنے کیلئے)

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س9:۔ آپ کے خیال میں کس حد تک عورتیں مردوں کی نسبت کسی بھی قسم کی ذہنی بیماری (Mental Illness) کا زیادہ شکار ہو سکتی ہیں۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتاا/ سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س10:۔ آپ کے خیال میں کس حد تک عموماً مرد عورتیں کی نسبت تشویشی بیماریوں (Anxity Disorder) کا زیادہ شکار ہوتے ہیں۔(مثال کے طور پر بے وجہ وہم اور بے چینی ہونا)

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا اسکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

مندرجہ ذیل نکات کا خیال رکھتے ہوئے اپنے جواب کا انتخاب کریں۔

(الف) بالکل مددگار نہیں (مجھے یقین نہیں ہے کہ مددگار ہے)

(ب) مددگار نہیں (میرا خیال ہے کہ یہ مددگار نہیں ہے لیکن میں یقین سے نہیں کہ سکتا / سکتی

(ج) مددگار ہے (کچھ حد تک مددگار ہے مگر یقین نہیں ہے)

(د) بہت مددگار ہے (مجھے یقین ہے کہ یہ بہت مددگار ہے)

س11:۔ آپ کے خیال میں اگر کسی کو اپنے جذبات کو قابو رکھنے میں مشکلات کا سامنا ہو تو کس حد تک نیند کے معیار(Quality of Sleep) کو بہتر کرنا اس کے لئے مدد گار ثابت ہوگا۔

(الف) بالکل مدد گار نہیں (مجھے یقین نہیں ہے کہ مدد گار ہے)

(ب) مدد گار نہیں (میرا خیال ہے کہ یہ مدد گار نہیں ہے لیکن میں یقین سے نہیں کہ سکتا / سکتی

(ج) مدد گار ہے (کچھ حد تک مدد گار ہے مگر یقین نہیں ہے)

(د) بہت مدد گار ہے (مجھے یقین ہے کہ یہ بہت مدد گار ہے)

س12:۔ آپ کے خیال میں کس حد تک کسی کے لئے مدد گار ثابت ہو سکتا ہے کہ وہ ان تمام سرگرمیوں اور حالات سے بچیں جو ان کو تشویش(Anxiety) میں مبتلا کر دیں۔ اگر اُن کو اپنے جذبات پر قابو رکھنے میں مشکلات کا سامنا ہو تو۔

(الف) بالکل مدد گار نہیں (مجھے یقین نہیں ہے کہ مدد گار ہے)

(ب) مدد گار نہیں (میرا خیال ہے کہ بیدد گار نہیں ہے لیکن میں یقین سے نہیں کہ سکتا / سکتی

(ج) مدد گار ہے (کچھ حد تک مدد گار ہے مگر یقین نہیں ہے)

(د) بہت مدد گار ہے (مجھے یقین ہے کہ یہ بہت مدد گار ہے)

س13:۔ آپ کے خیال میں کس حد تک ذہنی سوچ کی تبدیلی(Cognative Behaviour Therapy) ایک ایسا علاج ہے جو منفی سوچوں کو چیلنج کرتی اور مدد گار برتاؤ کو بڑھاتا ہے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / سکتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے۔ (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س14:۔ ذہنی معالج (علاج میں) رازداری کے پابند ہوتے ہیں مگر کچھ ایسے حالات ہوتے ہیں جن کے تحت رازداری لاگو نہیں ہوتی آپ کے خیال میں کس حد تک مندرجہ ذیل حالات میں ذہنی معالج راازداری (ختم) توڑ سکتا ہے مثلاً جب آپ کو فوری اپنے یا دوسرے کے نقصان کا خطرہ ہو تو۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / کتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

س15:۔ ذہنی معالج (علاج میں) رازداری کے پابند ہوتے ہیں مگر کچھ ایسے حالات ہوتے ہیں جن کے تحت رازداری لاگو نہیں ہوتی آپ کے خیال میں کس حد تک مندرجہ ذیل حالات میں ذہنی معالج رازداری توڑ (ختم) کر سکتا ہے مثلاً اگر آپ کا مسئلہ جان لیوا نہیں ہے اور وہ (معالج) دوسروں کی مدد کرتا ہے آپ کی بہتر سپورٹ کے لئے۔

(الف) بالکل ایسا نہیں (مجھے یقین ہے کہ ایسا نہیں ہے) (ب) میں یقین سے نہیں کہ سکتا / کتی کہ ایسا ہے

(ج) شاید ایسا ہی ہے لیکن مجھے پورا یقین نہیں ہے (د) مجھے پورا یقین ہے کہ ایسا ہی ہے

آپ واضح نشاندہی کریں کہ مندرجہ ذیل عبارات میں سے کس عبارت سے آپ متفق ہیں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س16:۔ میں پر اعتماد ہوں کہ میں جانتی / اجانتا ہوں کہ ذہنی بیماری کے متعلق معلومات کہاں سے لینی ہیں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س17:۔ میں پر اعتماد طریقے سے کمپیور اور ٹیلی فون کے ذریعے ذہنی بیماریوں(Mental Illness) کے متعلق معلومات حاصل کر سکتی / سکتا ہوں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س18:۔ میں پراعتماد طریقے سے آمنے سامنے بیٹھ کر بھی ذہنی بیماری کے متعلق معلومات حاصل کر سکتا/سکتی ہوں(مثال کے طور پر طبی معالج کے پاس جانا)۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س19:۔ میں پراعتماد ہوں مجھے ان ذرائع (مثال کے طور پر طبی معالج، دوست) تک رسائی حاصل ہے جن کے ذریعے ذہنی بیماریوں کے متعلق معلومات حاصل کر سکتا/سکتی ہوں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س20:۔ ذہنی مرض میں مبتلا شخص اگر خود چاہے تو ذہنی بیماری (Mental Illness) سے نکل سکتا ہے۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س21:۔ ذہنی بیماری (Mental Illness) ذاتی کمزوری کی علامت ہے۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س25:۔ اگر مجھے ذہنی بیماری (Mental Illnes) ہو تو میں کسی کو نہیں بتاتا/بتاتی۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س22:۔ ذہنی بیماری دراصل طبی بیماری (Medical Illness) نہیں ہوتی۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س23:۔ ذہنی بیماری میں مبتلا لوگ خطرناک ہوتے ہیں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س24:۔ یہ سب سے بہتر ہے کہ ذہنی مریض سے بچا جائے تاکہ آپ میں وہ مسئلہ پیدا نہ ہو جائے۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س:26: کسی ذہنی معالج (Mental Health Professional) کو ملنے کا مطلب یہ ہے کہ آپ اتنے مضبوط نہیں ہیں کہ اپنے مسائل خود حل کر سکیں۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س:27: اگر مجھے ذہنی بیماری ہوئی تو میں ذہنی معالج (Mental Health Professional) سے مدد حاصل نہیں کروں گا/گی۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

س28:۔ میرا یقین ہے کہ جو علاج ذہنی معالج (Mental Health Professional) کرتے ہیں وہ زیادہ موثر نہیں ہے۔

(الف) بالکل متفق نہیں ہوں (ب) متفق نہیں ہوں (ج) معلوم نہیں متفق ہوں یا نہیں

(د) متفق ہوں (ہ) بالکل متفق ہوں

نشاندہی کریں کہ کس حد تک آپ مندرجہ ذیل باتوں سے متفق ہیں۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:29: آپ کتنے رضامند ہوں گے کہ آپ کسی قریب رہنے والے ذہنی مریض کے پڑوس / ہمائے میں رہیں۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:30:۔ آپ کسی ذہنی مریض کے ساتھ شام گزارنے اور بات چیت کرنے پر کتنے رضامند ہوں گے۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلومر رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:31۔ آپ کسی ذہنی مریض کو دوست بنانے پر کتنے رضامند ہوں گے۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:32:۔ اگر کوئی ذہنی مریض آپ کے ساتھ کام کرنا شروع کر دے تو آپ کس حد تک اس کے ساتھ کام کرنے پر رضامند ہوں گے۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:33:۔ آپ کس حد تک کسی ذہنی مریض کی اپنے خاندان میں شادی کیلئے رضامند ہوں گے۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:34:- آپ کسی حد تک کسی ایسے سیاست دان کو ووٹ دینا پسند کریں گے جو خود ذہنی مریض رہا ہو۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

س:35:۔ آپ کس حد تک ذہنی مریض کو ملازمت دینا پسند کریں گے۔

(الف) بالکل رضامند نہیں ہوں (ب) شاید رضامند نہیں ہوں (ج) نہیں معلوم رضامند ہوں یا نہیں

(د) شاید رضامند ہوں (ہ) بالکل رضامند ہوں

<table dir="rtl">
<tr><td colspan="2">اب میں آپ سے کچھ سوالات پوچھوں گی۔ جن کے بارے میں ہم یہ جاننا چاہتے ہیں کہ آپ کیسا محسوس کرتی ہیں۔ آپ اس کے مطابق جواب دیں۔</td></tr>
<tr><td>مکمل طور پر غیر متفق .1</td><td>1. ضرورت کے وقت کوئی ایسا بھروسے والا شخص ہے جو آپ کو سہارا دے سکتا ہے.</td></tr>
</table>

<table>
<tr><td></td><td>2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>2. کوئی ایسا بھروسے والا شخص ہے جس کے ساتھ آپ اپنا دکھ سکھ کر سکتی ہیں.</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5.مکمل طور پر متفق</td></tr>
<tr><td>3. کوئی ایسا بھروسے والا شخص ہے جس سے بات کرکے آپ کوتسلی ہوجاتی ہے.</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>4. آپ کی زندگی میں ایسا بھروسے والا شخص ہے جو آپ کی طبیعت سمجھ سکتا ہے.(جو آپکے احساسات / جذبات کاخیال کرتا ہے / پرواہ کرتا ہے)</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>5. آپ کے گھر والے آپ کی مدد کرنے کی پوری کوشش کرتے ہیں</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>6. آپ کے گھر والے آپ کو سہارا دینے کے لئے موجود ہوتے ہیں۔ 6.</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>7. آپ اپنے گھر والوں سے اپنی مشکلوں اور مسائل کے بارے میں بات کر سکتی ہیں۔</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق
3. نہ متفق نہ غیر متفق
4. متفق
5. مکمل طور پر متفق</td></tr>
<tr><td>8. اگر آپ کو کوئی فیصلہ کرنا ہو تو آپ کے گھر والے آپ کو مشورہ دینے کے لئے موجود ہوتے ہیں۔</td><td>1. مکمل طور پر غیر متفق
2. غیر متفق</td></tr>
</table>

	3. نہ متفق نہ غیر متفق 4. متفق 5. مکمل طور پر متفق
9. آپ کی سہیلیاں آپ کی مدد کرنے کی پوری کوشش کرتی ہیں۔	1. مکمل طور پر غیر متفق 2. غیر متفق 3. نہ متفق نہ غیر متفق 4. متفق 5. مکمل طور پر متفق
10. اگر آپ کو کوئی مشکل ہو تو آپ کی سہیلیاں آپ کی مدد کے لئے موجود ہونگی۔	1. مکمل طور پر غیر متفق 2. غیر متفق 3. نہ متفق نہ غیر متفق 4. متفق 5. مکمل طور پر متفق
11. آپ اپنی سہیلیوں / دوستوں کے ساتھ اپنا دکھ سکھ کر سکتی / سکتے ہیں۔	1. مکمل طور پر غیر متفق 2. غیر متفق 3. نہ متفق نہ غیر متفق 4. متفق 5. مکمل طور پر متفق
12. اگر کوئی مسئلہ ہو تو آپ اپنی سہیلی / دوست سے اس بارے میں بات کر سکتی / سکتے ہیں۔	1. مکمل طور پر غیر متفق 2. غیر متفق 3. نہ متفق نہ غیر متفق 4. متفق 5. مکمل طور پر متفق

1. کیا آپکی یونیورسٹی میں ذہنی صحت کی سہولیات موجود ہیں؟ (اگر ہاں)

A. آپکے خیال میں، آپکی یونیورسٹی میں موجود ذہنی صحت کی سہولیات کا معیار کیسا ہے؟

B. اگر آپ کو کبھی ذہنی دباؤ یا مسئلہ ہو تو کیا آپ یونیورسٹی کی ذہنی صحت کی سہولیات سے مدد لینا چاہیں گے؟ وجہ بھی بتائیں۔

2. یونیورسٹی کے علاوہ کیا آپ کو ذہنی صحت کی سہولیات کے بارے میں معلوم ہے؟ (اگر ہاں)

A. کیا ذھنی صحت کی یہ سہولیات آپ آسانی سے حاصل کر سکتے ہیں؟

B. .اگر آپ کو کبھی ذہنی دباؤ یا مسئلہ ہو تو کیا آپ کی ذہنی صحت کی ان سہولیات سے مدد لینا چاہیں گے؟ وجہ بھی بتاءیں۔

C. یونیورسٹی کے علاوہ آپ کو کون سی ذہنی صحت کی سہولتوں کا علم ہے، اور آپ نے ان کے بارے میں کیسے جانا؟

3. آپ یونیورسٹی میں موجود ذہنی صحت کے ماہرین کی دستیابی اور ان کے ردِ عمل کے بارے میں کیسے خیالات رکھتے ہیں؟

4. آپ کے خیال میں آپکی یونیورسٹی طلبہ کو ذہنی صحت کے ذرائع (مثال کے طور پر ذہنی صحت کے ماہرین، ادارے وغیرہ) سے مدد حاصل کرنے کی حوصلہ افزائی کرتی ہے؟(اگر ہاں) تو کیسے؟

5. (یونیورسٹی کے اندر اور باہر) ذہنی صحت کی سہولتوں کے اخراجات کے بارے میں آپ کی کیا رائے ہے؟ کیا طلبہ آسانی سے یہ سہولیات حاصل کر سکتے ہیں؟

6. یونیورسٹی سے باہر ذہنی صحت کے ماہرین یا اداروں سے مدد لینے کے بارے میں آپ کے کیا خیالات (راۓ) ہیں؟

7. اگر آپ کو کبھی ذہنی صحت کی سہولتوں کی ضرورت ہو تو آپ انہیں حاصل کرنے کا کیا طریقہ اپنائیں گے؟ یا کیسے حاصل کر سکتے ہیں؟

8. جب آپ ذہنی دباو یا پریشانی محسوس کرتے ہیں تو کون سی باتیں آپ کو یہ فیصلہ کرنے میں مدد دیتی ہیں کہ آپ کو ماہر ذہنی صحت یا ذہنی صحت کے ادارے سے مدد لینی چاہیۓ؟

9. آپ طلبہ کو دستیاب ذہنی صحت کی سہولیات کے بارے میں آگاہ کرنے کے لیے یونیورسٹی کی کوششوں کا کس طرح جائزہ لیں گے؟

10. کیا آپ ان ذہنی صحت کے ماہرین کی پیشہ ورانہ صلاحیت یا معیار کے بارے میں کوئی تاثر یا تجربہ شیئر کر سکتے ہیں جن سے آپ نے مدد لی ہو؟

Appendix B: Ethical Approval form

Capital University of Science & Technology
Your Journey Awaits

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Kahuta Road Zone V,
Islamabad Pakistan

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W www.cust.edu.pk

Ref. CUST/IBD/PSY/Thesis-1608
May 29, 2025

SUBJECT: REQUEST FOR DATA COLLECTION

Capital University of Science and Technology (CUST) is a federally chartered university. The university is authorized by the Federal Government to award degrees at Bachelor's, Master's and Doctorate level for a wide variety of programs.

Ms. Erum Hamid registration number **MSP233003** is a bona fide student in MS Psychology program at this University from Fall-2023 till date. In partial fulfillment of the degree, she is conducting research on ***"Understanding Help-Seeking Intentions: The Influence of Self-Reliance, Mental Health Literacy, and Social Support among University Students in Pakistan".*** In this continuation, the student is required to collect data from your institute.

Considering the forgoing, kindly allow the student to collect the requisite data from your institute. Your cooperation in this regard will be highly appreciated.

Please feel free to contact undersigned if you have any query in this regard.

Best Wishes,

Dr. Sabahat Haqqani
Head, Department of Psychology
Ph No. 111-555-666 Ext: 178
sabahat.haqqani@cust.edu.pk

CamScanner

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Ref: CUST/FMSS/REC/2025-51

May 29, 2025

RESEARCH ETHICS COMMITTEE CERTIFICATE OF REVIEW AND SUPPORT

This is to certify that Project titled: ***" Understanding Help-Seeking Intentions: The Influence of Self-Reliance, Mental Health Literacy, and Social Support among University Students in Pakistan"*** submitted by Scholar: **Erum Hamid MSP233003** and supervised by: **Dr. Sabahat Haqqani** reviewed by the Research Ethics Committee of Faculty of Management and Social Science, meets the requirements of the American Psychological Association's Ethical guidelines for Human Research and is **REVIEWED** and **APPROVED** by Research Ethics Committee of Faculty of Management and Social Sciences.

It is the Scholar's responsibility to ensure that all researchers associated with this project are aware of the conditions of approval and which documents have been approved.

The Scholar is required to notify the Research Ethics Committee in case of any amendment in the project, specifically:

- Any significant change to the project and the reason for that change, including an indication of ethical implications (if any)
- Serious adverse effects on participants and the actions taken to address those effects
- Any other unforeseen events or unexpected developments that merit notification
- The inability of the Principal Investigator to continue in that role, or any other change in research personnel involved in the project
- A delay of more than 12 months in the commencement of the project; and,
- Termination or closure of the project.

Dr. Sabahat Haqqani

Convener, Research Ethics Committee
Faculty of Management and Social Sciences
Capital University of Science and Technology
Islamabad

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