Depression Anxiety and Stress Among Secondary Level Students of Pokhara Metropolitan City

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A Thesis for the Degree of Master of Philosophy in Health Education

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DECLARATION

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Muna Silwal

July, 2025

RECOMMENDATION LETTER

The undersigned certifies that I have read and recommend to the Faculty of Education, Tribhuvan University, for acceptance, a thesis entitled "**Depression Anxiety and Stress Among Secondary Level Students of Pokhara Metropolitan City"** submitted by Muna Silwal in partial fulfilment of requirements for the degree of MASTERS OF PHILOSOPHY IN EDUCATION WITH SPECIALIZATION IN HEALTH EDUCATION.

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Date: July, 2025

APPROVAL LETTER

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ABSTRACT

Depression, anxiety, and stress are the worldwide-recognized mental health problems affecting adolescents. This research aims to identify the prevalence and factors associated with depression anxiety and stress among Secondary Level Students of Pokhara Metropolitan City. A quantitative analytical cross-sectional research design was adapted in this study. A systematic random sampling technique was used to select 348 students from the five public schools.

For the analysis of data, multivariate logistic regression was carried out to decide statistically significant variables of symptoms of DAS at a p-value <0.05. The overall prevalence of DAS was found to be 43.1%, 47.1%, and 45.6% (95% CI). In multivariate analysis, bad childhood experience and traumatic life experience were found to be significantly associated with depression; similarly, educational stress and traumatic life experience were found to be significantly associated with anxiety, and bad childhood experience, physical illness or injury, involvement in social activities, bullying, traumatic life experience, and exam phobia were found to be significantly associated with stress.

It is concluded that symptoms of depression, anxiety, and stress are more prevalent in the moderate to extremely severe range among the secondary level students. The role of family and school is essential to promote mental health of the secondary level students.

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ABBREVIATIONS

AOR: Adjusted Odds Ratio

APA: American Psychological Association

CNS: Central Nervous System

COPD: Chronic Obstructive Pulmonary Disease

DALYs: Disability-Adjusted Life Years

DASS: Depression Anxiety and Stress Scale

DAS: Depression Anxiety and Stress

GSHS: Global School-Based Student Health Survey

NCHS: National Centre for Health Statistics

NHRC: National Health Research Council

SES: Socio-economic Status

SEAR: South East Asia Region

SPSS: Statistical Package for Social Sciences

WHO: World Health Organization

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CHAPTER I

Introduction

This chapter is divided into seven sections, namely background of the study, statement of the problem, rationale of the study, objectives of the study, research questions, delimitation of the study, and definitions of the key terminologies.

Background of the Study

Adolescence is a critical developmental period marked by rapid physical, emotional, and psychological changes. During this transitional phase, students often face immense academic pressure, social expectations, and future-related uncertainties, making them vulnerable to mental health challenges such as depression, anxiety, and stress (World Health Organization [WHO], 2021). Globally, mental health issues among adolescents have emerged as a major public health concern, with increasing rates of emotional disorders reported among school-going youth (UNICEF, 2023).

Mental health concerns such as depression, anxiety, and stress are becoming increasingly common among school-going students, especially during adolescence a critical period for emotional and psychological development. A growing body of empirical research highlights the widespread nature of these issues and the factors that contribute to them, both globally and within South Asia, including Nepal.

Several international studies have consistently shown that academic pressure, peer conflict, and family-related stress are leading causes of mental health issues among adolescents. For example, a cross-sectional study by Kumaraswamy (2013) found that high levels of academic stress among high school students were strongly associated with symptoms of anxiety and depression. Students often reported

difficulty coping with expectations from teachers and parents, which in turn led to emotional distress and lowered academic performance.

In South Asian contexts, the problem is particularly pronounced due to limited access to mental health resources and persistent social stigma. A study by Deb, Strodl, and Sun (2015) in India revealed that over 60% of high school students reported moderate to severe levels of stress, and nearly 35% showed symptoms of depression. The study also emphasized how cultural factors and rigid educational systems contribute to emotional pressure in students, often without appropriate outlets for support.

In the context of Nepal, while research study in this area is still limited, available studies reflect similar patterns. Poudel et al. (2020) conducted a study among secondary school students in Kathmandu and found that around 40% of participants experienced moderate to severe levels of anxiety, while 30% showed signs of depression. The findings suggested that academic workload, exam stress, and family expectations were significant predictors of poor mental health outcomes. Importantly, the study noted that very few students had access to counselling services, and most were unaware of where or how to seek help.

Similarly, Sharma and Ojha (2021) explored mental health among adolescents in rural Nepal and found that emotional distress was often unrecognized or misinterpreted as behavioral problems. The lack of trained school personnel, cultural stigma, and absence of mental health education contributed to poor mental health literacy among students, teachers, and parents alike.

According to the Nepal Health Research Council (NHRC, 2022), a significant proportion of school, going adolescents report experiencing symptoms of psychological distress, including low mood, restlessness, academic burnout, and peer pressure. Among urban settings like Pokhara Metropolitan city, the rapid pace of modernization, academic competition, and urban stressors may further compound the mental health challenges faced by secondary school students.

Previous research suggests that depression, anxiety, and stress are interrelated constructs that can seriously affect students' academic performance, social relationships, and overall quality of life (Yusoff, 2021). Depression is characterized by persistent feelings of sadness, hopelessness, and a loss of interest in daily activities; anxiety involves excessive worry and fear; and stress refers to the body's response to challenging or demanding circumstances (American Psychological Association [APA], 2023). When these issues remain unrecognized or untreated, they can escalate into severe mental health disorders, substance abuse, and even suicidal ideation (WHO, 2021).

In Kathmandu, a study revealed that 27.5% of school students were dealing with depression, 56.9% with anxiety, and 41.6% with stress. These issues were more common among girls and those facing academic pressure or abuse (Sharma, 2018). A similar study in Birtamod found a 42.8% depression rate, especially among students with low self-esteem, lack of support, or academic dissatisfaction (Giri, 2024).In the Eastern Terai region, almost one-third of adolescents reported having suicidal thoughts, and 12.42% had attempted suicide (Bhattarai, 2020). In Pokhara, depression affected 44.2% of students, particularly those lacking emotional support or someone to talk to (Bhattarai, 2020).

A 13-year-old girl in Rukum died by suicide after being publicly humiliated and physically abused by her principal (Kathmandu Post, 2023). Another student in Chaurjhari, Rukum took his life due to his family's inability to pay school fees (INSEC Online, 2023). A 14-year-old girl in Ratnanagar Municipality-10 Chitwan on February 24, who was isolated and had grown up without parental care, died by suicide in her school hostel (The Kathmandu Post, 2024).

Other previous studies have also highlighted gender differences in mental health. Research generally suggests that female students are more likely to report symptoms of depression and anxiety compared to males, possibly due to societal expectations, safety concerns, and biological factors. For instance, a study by Singh et al. (2019) reported that adolescent girls in South Asia experienced higher psychological distress, often related to both academic and domestic responsibilities.

Overall, empirical evidence points to a clear and concerning trend: school-going students are increasingly vulnerable to mental health challenges, but current school systems, especially in developing countries like Nepal, are not adequately equipped to address them. These findings strongly support the need for school-based mental health interventions, regular screening for mental health issues, and improved access to counselling and psychological support services.

Statement of the Problem

Adolescence is one of the most important and sensitive phases of life. During this time, adolescents begin to develop new ways of thinking, feeling, and making decisions. These changes can shape behaviours, both positive and negative, that often carry into adulthood. It can seriously impact on mental health problems like

depression, anxiety and stress among adolescent students.it causes effects on academic performance, social relationships, behaviour, and even lead to substance abuse or suicidal thoughts (Kumar, 2017).

The conditions of mental health among secondary level students is often under-prioritized, neglected in both policy and practice. In Nepal, some research studies were conducted to examine the prevalence of depression, anxiety and stress and some studies were conducted to find out the risk or associated factors of it. But there is lacking to conduct study extensively to identify the risk factors and its coverage in all over the country, so that intervention to promote the mental health would be easy. In Pokhara, secondary school students are frequently exposed to academic pressures like other part of the country, familial expectations, social comparisons, and the impact of digital media, all of which may contribute to severe psychological distress. Yet, the absence of comprehensive mental health support systems in public schools makes students more vulnerable to these issues. Despite increasing awareness, many students lack access to counselling services and mental health education.

Some recent studies (Karki et al., 2022; Bhattarai et al., 2020; Gautam et al., 2021) revealed that the prevalence of DAS among school going students was 56.5%, 55.6% and 32.9% in Kathmandu, prevalence of depression was 44.2% in Pokhara and in western rural Nepal the prevalence of depression was found to be 27%. It shows the poor mental health status of the school going students. In spite of this result, use of tool and associated factors are not adequately used in each study. Similarly, these study is not guided by any theories. So there was gap in previous study is adequately

coverage of associated factors and use of different related theories. All these things should be addressed in our context.

Similar to the findings (Sandal et al., 2017; Kumar et al., 2017; Yadav et al., 2019; Mishra et al., 2018) study in India, there may be a gap between high prevalence of DAS and lack of adequate associate factors based on study setting, types of schools, age of students and other differences. The incomplete information gives the inadequate answers of a query, which may be the problem for the appropriate interventions. According to the prevalence of DAS, there are various in range more than 80% to less than 20%. More than 80% is the sign of high morbidity of mental health problems. So, holistic factors are responsible to be the problems which are personal factors, family related factors, social factors, academic factors and psychological factors. These are gap of the research study. This gap should be explored further in the Nepalese context.

The increasing prevalence of psychological issues among school going students globally and nationally, it is critical to assess the specific mental health conditions of secondary level students. This study seeks to bridge the gap in the existing literature by examining the levels and different factors related of depression, anxiety, and stress among school going students of public schools in the urban setting.

Rationale of the Study

Adolescence is a critical developmental stage marked by physical, emotional, and social changes. During this period, secondary level students often face various academic pressures, social expectations, and identity issues, which can significantly affect their mental health. In recent years, there has been a growing concern regarding

the increasing prevalence of depression, anxiety, and stress among adolescents worldwide, including in Nepal. However, despite the seriousness of the issue, mental health remains a less prioritized topic in many schools, and students often suffer in silence due to stigma or lack of awareness.

This study is important because it aims to assess the levels of depression, anxiety, and stress among secondary level students and identify the factors contributing to these mental health conditions. By understanding the extent and causes of these issues, educators, parents, and policymakers can take informed actions to support students' mental well-being. The findings of this research will not only help in early identification and intervention but also contribute to the development of mental health programs tailored to the needs of school-going adolescents.

Purpose of the Study

The overarching purpose of this study was to examine factors associated with the depression, anxiety and stress among school going students.

Research Questions

The following research questions address the essential focus of this study and provide parameters for research compiled in the literature review. To accomplish the goals set out above, this study sought to answer the following questions:

What is the demographic status of the respondents?

What is the magnitude of depression, anxiety and stress among secondary level students?

How is the level of depression, anxiety and stress among the respondents?

Is there any relation between demographic variables like; age, sex, ethnicity, religion, monthly income and level of depression, anxiety and stress among the respondents?

What is the psychosocial status of the respondents?

Is there any relation between psycho-social factors and level of depression, anxiety and stress among the respondents?

What extent are there psycho-social factors leading to depression, anxiety and stress among the respondents?

Research Hypothesis

Hypothesis 1:

H1*:*School level students experience different levels of depression, anxiety, and stress.

Hypothesis 2

H2*:* There is a significant association between students' level of depression, anxiety, stress and demographic variables like; age, sex, ethnicity, religion and monthly family income.

Hypothesis 3

H3*:* There is a significant association between students' level of depression, anxiety, stress and psychosocial factors

Hypothesis 4

H4*:* There is a significant association between students' level of depression, anxiety, stress and Psychosocial factors like; Personal factors, family factors, social factors, academic factors

Hypothesis 5

H5*:* Psychosocial factors like; Personal factors, family factors, social factors, academic factors and psychological factors significantly contribute to depression, anxiety, and stress among school students.

Delimitations of the Study

This study is delimited to public secondary schools where grade 1-12 is running at present, and only 48 schools are eligible in this criterion. This study is delimited to secondary level students, specifically those studying in grades 9, 10, 11, and 12. It does not include students from primary (grades 1–8), as the focus is on adolescents typically within the early teenage years. The research is further limited to selected schools within Pokhara Metropolitan city, and the findings may not be generalized to all students in other regions. Only students who were available and willing to participate during the data collection period were included.

The study utilizes the DASS-21 (Depression, Anxiety and Stress Scale) tool to measure mental health status. Other psychological assessment tools and clinical interviews were not used. Additionally, the study was conducted within a specific timeframe, and responses reflect the students' mental state during that period only.

Due to time, resource, and accessibility constraints, the study does not cover private boarding schools outside the chosen area or schools with specialized populations, such as those for differently abled students. These boundaries were created to ensure the research remained focused, manageable, and feasible.

Significance of the Study

This study holds great significance in today's context as it focuses on the mental health status of secondary school students, a group that is often overlooked when it comes to psychological well-being. By identifying the levels of depression, anxiety, and stress among students, this research helps to highlight the growing mental health challenges faced by adolescents during their formative academic years.

Understanding the associated factors, such as childhood experiences, bullying, academic pressure, and traumatic life events provides a deeper insight into the root causes of these issues. This can help teachers, parents, and policymakers to develop targeted interventions and supportive environments within schools.

Furthermore, the findings of this study will contribute to the field of health education and promotion by promoting mental health awareness, encouraging early detection, and advocating for school-based mental health programs. It will also help to reduce stigma related to mental illness among adolescents and encourage open discussions around emotional well-being. Similarly, this research can serve as a foundation for future studies and policy reforms that aim to improve adolescent mental health and academic performance through integrated support systems.

Operational Definition

Anxiety

In the present study, anxiety means real or perceived threats of adolescents and shows the symptoms of fear, tension, worry related to home, school and social environments. Anxiety is measured at different level.

Associated factors of DAS

In this study the following five factors were mentioned; individual factors, family factors, social factors, academic factors and psychological factors; it has a total of 25 sub factors.

DASS-21

Depression, Anxiety and Stress scale, it is standardized scale and it has total 21 items each has seven items used to measure different levels of DAS**.**

Depression

In this study, depression is a common mental health condition that can happen to secondary level students and characterized by loss of interest in activities, changes in behaviour, loss of pleasure in any activities and low mood which affects the everyday routine activities like school performance, daily routine care, work, social relation with family members, friends, school teachers and staffs of the children. Depression is measured at different levels.

Psycho-social factors

In this study psychosocial factor means Personal factors, family factors, social factors, academic factors and psychological factors

Secondary level students

In this study, secondary level students mean students who were studying in public schools of Pokhara, in grade 9, 10, 11 and 12 during the time of data collection.

Stress

In this study stress is the body's reaction to a perceived or real threat or challenge, and it affects physical, mental, or emotional aspects. The symptoms of stress are the lack of attention, concentration, palpitation, sweating, irritation, problems in food habits, sleeping time. It is tension caused by a variety of life events, such as trauma, illness, family problems or new situations.

Organization of the Dissertation

This dissertation has over all six chapters. First chapter includes the introduction unit. It covers the background, statement of the problems, rationale, purpose, research questions, research hypothesis, delimitations, significance of the study and operational definitions. Chapter two contains the review of the related literature in which, policy review, information related to the previous studies is presented thematically; prevalence and levels of DAS, different factors associated of DAS, prevention and recommendation related to problems, in theoretical review psychological theories like psychoanalytic theory, object loss theory, learning theory cognitive theory, theoretical and conceptual framework, research gap and implications of reviewed literature.

The research methodology is described in section three. The chapter comprises a philosophical perspective, research design, population and sample (study setting/participants), sampling procedure, sample size, sampling technique, inclusion and exclusion criteria, research tools, data collection procedure, data analysis techniques and ethical consideration.

Chapter Four encompassed the data analysis and presentation in thematic headings. It comprises the demographic status respondents and different associated factors of DAS in five themes and 20 sub-themes. Chapter five deals with the discussion (exploring meaning) of results obtained from analysing and interpreting the data. At last chapter six sums up the results following conclusions and implications of the results of this study.

Chapter Summary

This chapter highlighted an overview of the study. The background has introduced the research problem and included its rationale and purposes. This part also justified the problem as a statement of the problem. Another hand clarified why mental health status was important and how adolescents' mental health was affected by a different factor. Furthermore, it also outlined the research questions, delimitations of the present study, defined the terms used, and discussed the researcher's reasons for conducting the study. Finally, it outlined the overall organization of this dissertation. In the next chapter, the literature related to the present study has been reviewed.

CHAPTER II

Review of Literature

This literature review chapter deals with the different types of related empirical literature and theoretical literature related to depression, anxiety, and stress theory and conceptual framework; it shows the relation between related theory and its possible outcome (cause -effect relationship between dependent variables and independent variables).

Review of Related Literature

Depression is a mood disorder marked by persistent feelings of sadness, a lack of interest in previously enjoyed activities, difficulties with concentration, and a pervasive sense of hopelessness and worthlessness. It often leads to changes in daily routines, including alterations in sleep and eating patterns. Recognizing depression in adolescents can be challenging, as symptoms may be mistaken for typical developmental changes. Notably, depression is a significant risk factor for suicide among teenagers (Townsend, 2012).

Depression manifests in varying degrees; Mild, moderate, severe and extremely severe. Adolescents may exhibit unique signs of depression, such as inappropriate expressions of anger, aggression, delinquency, social withdrawal, experiences of sexual abuse, substance misuse, low self-esteem, sleep and appetite disturbances. Risk factors encompass traumatic life events, familial relationship issues, stressful environments, low socioeconomic status, physical health problems, family history of depression, substance use, diseases, chronic illnesses, and lack of social support (Sreevani, 2010).

Anxiety is a common experience characterized by emotions like fear, worry, and apprehension, often accompanied by physical symptoms such as palpitations, chest pain, shortness of breath, and tension headaches. While anxiety can serve as a protective mechanism, excessive anxiety may indicate an underlying disorder, potentially stemming from unconscious conflicts or feelings of insecurity (Neeraja, 2008).

Severe anxiety disorders may arise from traumatic experiences, socio-cultural factors (like parenting styles), psychological factors, (interpersonal stress), negative thoughts, medication or substance use, and other health conditions. Symptoms include headaches, palpitations, sleep disturbances, urinary incontinence, pale skin, diarrhea, poor posture, fatigue, panic, nervousness, fear, anger, suspicion, restlessness, social withdrawal, crying, and decreased motivation to study (Sharma, 2016).

Stress is the psycho physiological response to any change requiring adjustment, whether physical, mental, or emotional. It can result from various sources, including work, finances, relationships, parenting, and daily inconveniences. Frequent changes in school or work environments, and relationship issues can contribute to stress. Chronic stress may lead to unhealthy behaviours like alcohol consumption, drug abuse, and other negative activities. Symptoms of stress encompass mood fluctuations, cold or sweaty palms, sleep difficulties, digestive issues, dizziness, diarrhoea, anxiety, feelings of illness, teeth grinding, headaches, fatigue, muscle tension, physical pain, palpitations, and tremors (Nicholas, 1994).

Policy Review

International mental health policy. In recent era, mental health has become a major concern worldwide. Problems like depression, anxiety, and stress are no longer limited to adolescents; they are increasingly affecting school going students. Despite being at a critical stage of emotional and social development, children and adolescents are often supervised in mental health policy concern. This is where international mental health frameworks, particularly World Health Organization (WHO), come into play. But the queries remain: are these policies doing enough for our school going students?

The WHO has focused that mental health is essential to overall well-being. In its Mental Health Action Plan 2013–2020, the organization encouraged countries to integrate mental health into their primary health care systems and focus on four main areas: leadership, community-based care, prevention and promotion, and data systems (World Health Organization, 2013). These goals are well intentioned and provide a strong foundation. However, when it comes to school-aged populations, many countries are falling short in turning these ideas into action.

While the action plan calls for strong leadership and clear national strategies, mental health is still not a priority in many education systems (World Health Organization, 2013). In some cases, schools do not have the authority, resources, or training to properly address students' mental health. As a result, early signs of depression, anxiety, and stress are often ignored or misunderstood, especially in communities where mental health is still stigmatized.

The WHO encourages countries to develop community-based mental health services. This is a step in the right direction but for children and teens, schools *are* the community. Students spend most of their time in school, which makes it one of the most important places to detect and support mental health needs. However, many schools still don't have counsellors or mental health professionals. Without proper school-based support, students struggling with anxiety or depression often have nowhere to turn.

Prevention and promotion are another key part of the WHO's plan. Ideally, this means teaching students about mental health, building coping skills, and creating supportive environments. But in reality, mental health education is rarely included in school curriculums especially in low- and middle-income countries. When these topics are not discussed, students may feel isolated or ashamed of what they're experiencing, which only makes their situation worse.

Finally, without actual data, it's difficult to know how is the magnitude of these problems really are. Many countries don't collect reliable data on youth mental health, which means we can't clearly see how issues like depression or anxiety are affecting students. Without this information, it becomes difficult to plan and design effective policies or programs.

Finally, international policies like the WHO's Mental Health Action Plan provide an important framework, but they often fail to fully address the unique needs of school going students. For real change to happen, countries must focus more on school-based mental health services, train teachers and staff to recognize mental health challenges, and include students in prevention and promotion efforts. Only then

can we hope to reduce the growing rates of depression, anxiety, and stress among school going students.

Mental health policy in Nepal. In Nepal, mental health issues such as depression, anxiety, and stress among secondary school students are becoming more visible and concerning. However, the country's policies addressing these challenges remain limited and poorly integrated into the education system. Although Nepal's Mental Health Policy was introduced as early as 1996, its implementation, particularly within schools has been weak. The policy recognizes the importance of mental well-being but does not include specific provisions for adolescents or students, nor does it outline clear strategies for prevention and intervention in school settings.

Similarly, the National Health Policy 2019 aims to integrate mental health into primary healthcare services, but it still falls short in recognizing schools as critical sites for mental health support. This is a significant oversight, considering that schools are environments where students frequently face academic pressure, peer issues, and family expectations factors that can seriously affect their mental health.

Nepal's School Health and Nutrition Policy (2004) does aim to promote the physical and emotional well-being of children, but again, mental health is not given the attention it deserves. While it encourages a "healthy school environment" and includes general health education, the policy lacks specific frameworks or guidelines to identify and respond to mental health concerns such as stress, anxiety and depression. In most schools, mental health is treated as secondary to physical health, and dedicated support systems, like school counsellors or trained psychologists, are either very limited or entirely absent.

The more recent Mental Health Strategy and Action Plan (2020) sets broader goals to improve mental health awareness and community-based services across Nepal. However, its focus remains on general mental health services at the community level and does not specifically address the needs of school-going children. In practice, very few schools in Nepal have professional mental health support, and stigma continues to prevent many students from seeking help. Without proper intervention and care, mental health issues often go unnoticed and untreated, impacting students' academic performance, emotional development, and long-term well-being.

Another key issue is the lack of implementation. Though Nepal has developed several mental health-related policies over the years including the national mental health policy originally launched in 2053 B.S. (1996 A.D.) and revised in 2073 B.S. (2016 A.D.) none have specifically targeted the mental health needs of school children. While some mental health topics have been introduced into the curriculum at the primary and secondary levels, the application is weak and inconsistent. Teachers are often not trained to handle these issues, and schools lack the necessary resources and structures to provide effective support.

In conclusion, although Nepal has made progress in formulating mental health policies, there remains a major gap in addressing the specific mental health needs of secondary school students. Policies exist, but their impact is limited due to poor implementation. Mental health continues to be a shadowed issue in the school system. Moving forward, there is an urgent need for stronger, school focused mental health policies. This includes investing in teacher training, hiring school counsellors, increasing student access to mental health services, and reducing stigma through

awareness. The government must recognize that mental health is a key part of academic success and personal development, and take concrete steps to make support accessible in every school.

Empirical Literature

After the extensive reviewing of empirical literature, it was arranged sequentially in different sub-topic like, prevalence of DAS, factors of DAS and prevention and recommendation aspects of DAS.

Prevalence of DAS. The depression, anxiety and stress among the secondary level students is a major mental health problem. Numerous studies have revealed that there are high levels of DAS among the students, even though there is lacking to include DAS in many studies; it means some study was conducted to assess depression only and some for stress only. It declares increased responsibility to conduct study of DAS together and the below mentioned study showed the prevalence of DAS among the secondary level students.

According to Karki (2022), in Kathmandu, the prevalence of DAS was 56.5%, 55.6% and 32.9% respectively, among the students. An analytical cross-sectional study conducted by Barnawi (2023) found that prevalence of DAS was 30.8%, 35.2%, and 14.7% among secondary level students in Saudi Arabia.Nakie (2022) carried out an institution-based cross-sectional study among high school students in Northwest Ethiopia to assess the prevalence of DAS was 41.4%, 66.7%, and 52.2%. Likewise, A Survey research method was used to collect data from three universities of Sialkot Pakistan by using simple random sampling techniques from 500 university students by Asif (2020). The prevalence of depression was 75%, anxiety 88.4%, and stress was 84.4% respectively.

Similarly, another study was conducted in 2017- 2018 to determine the prevalence of depression, anxiety, and stress by Alenazi (2019) among male secondary school students in Arar city; the capital city of Northern Borders, Saudi Arabia, the prevalence was 56.3 %, 56%, and 41.9% respectively. In another Cross-sectional survey was conducted to assess prevalence of DAS among school going adolescents' students of grade 9^{th} to 12^{th} studying in government schools. Ten government schools in Chandigarh, India by Sandal (2017), the prevalence was 65.53%, 80.85%, and 47.02%, respectively. Overall, co- morbidity between depression and anxiety was 57.65%. Extremely severe depression was 3%, the highest age was 18 years in females.

Kumar (2017), to determine the prevalence of DAS among higher secondary school students of Imphal, undertook a study. Seven schools were randomly selected, and all the students in that school were enrolled in the study. The study tool was DAS scale. The prevalence was 19.5%, 24.4%, and 21.1%, respectively. In total, 81.6% of the respondents had at least one of the studied disorders and 34.7% of the respondents had all the three negative states.

Similar study carried out in Abha, Aseer Region, Saudi Arabia by Al-Gelban (2007) the prevalence of DAS was 38.2%, 48.9% and 35.5%. DAS were strongly, positively, and significantly correlated. Bhasin (2010), cross-sectional study carried out to assess depression, anxiety and stress (DAS) among 242 adolescent of class 9-12 school students. Depression was significantly more among the females (mean rank 132.5) than the males (mean rank 113.2), $p=0.03$. Depression ($p=0.025$), Anxiety (0.005) and Stress ($p<0.001$).

According to Simegn (2021), the prevalence of depression, anxiety, and stress was 46.3%, 52%, and 28.6%, respectively. Another community-based study carried by Gautam (2021) to find out the prevalence of depression, and its correlates among 347 adolescents of rural Nepal. Multistage stratified proportionate random sampling techniques were used to collect information and the prevalence of depression was 27%.

Similarly, another study conducted by Bhattarai (2020), to examine the prevalence and factors associated with depression among 312 students of four randomly selected higher secondary schools in the Pokhara Metropolitan City of Nepal. The results found the prevalence of depression in the students was 44.2%. Furthermore, 18.9% of the students expressed major depression. A study conducted to assess the prevalence of depression and factors associated with psychological health hazard among 311 urban and semi-urban adolescents in Bangladesh by Anjum (2022). A total of 36.6% of the adolescents reported depressive and a higher prevalence among female students (42.9%).

Yadav (2019) Uttar Pradesh, India,the prevalence of stress was 49.3%. Alharbi, (2019).in al-Qassim region to estimate the prevalence of depression and anxiety among high school students, did the next cross-sectional study. Among them 24.6% were moderately depressed, whereas 129 (10.4%) were moderately severely depressed and 62 (5.0%) were severely depressed. Using the GAD-7 questionnaire, it was revealed that out of 1245 students, 243 (19.5%) of them were having moderate anxiety and 122 (9.8%) were having severe anxiety.

Mishra (2018) conducted a study to assess and compare the prevalence of depression and anxiety among children residing in Uttar Pradesh. Among age group

11–18 years, the prevalence of depression was 14.5%, anxiety was 15%. There was no significant difference in the prevalence of depression or anxiety ($P > 0.05$).

These varied results show that while the problem of DAS is global, its intensity and visibility differ across regions. A common thread across all studies is the high prevalence of anxiety, often surpassing that of depression and stress. This could be because anxiety symptoms are often the first to appear during academic challenges or social pressures, especially in adolescence.

From a comparative perspective, it is also worth noting that students in South Asian countries like Nepal, India, and Pakistan tend to report higher levels of DAS. This may be due to stricter academic systems, societal expectations, and limited mental health services. For example, the lack of school-based counselling services and the stigma surrounding mental illness in Nepal could explain why more than half of students report mental health issues without receiving proper support.

In conclusion, while these studies reflect different settings and education systems, they all point to one critical fact: depression, anxiety, and stress among students are not isolated issues but rather widespread and urgent problems. This calls for stronger school-level mental health programs, early identification systems, and culturally sensitive interventions. Particularly in Nepal, the high prevalence of DAS among students—similar to or even higher than global averages indicate that immediate policy attention and resource allocation are needed to protect the mental well-being of adolescents.

Factors related to DASS. Many more factors are responsible to be DAS among the students; these are social, psychological, family, individual and academic

factors. Very few factors are included in most of the studies, so it is difficult to say which factor is most responsible for the depression, anxiety and stress among the students.

Karki (2022) presumed that on the basis of associated factors of depression, anxiety and stress, nuclear family type, students from science or humanities faculty, presence of perceived academic stress, and being electronically bullied were found to be significantly associated with depression. Female sex, having a mother with no formal education, students from science or humanities faculty and presence of perceived academic stress were significantly associated with anxiety. Likewise, female sex, currently living without parents, and presence of perceived academic stress were significantly associated with stress.

These findings reveal that mental health among school students is influenced by a complex web of factors not just academic, but also social, familial, and digital. These findings highlight the urgent need for schools to go beyond academic performance and address the broader context in which students live and learn. Interventions should be holistic, including mental health education, counselling support, parental awareness, and policies to address cyberbullying. Ignoring these factors will only allow mental health problems to worsen silently among our youth.

Barnawi, (2023) showed that females, students who were bullied, who experienced physical assault, had fights, felt unsafe on the way to school, had significantly higher depression, anxiety, and stress. A study result by Nakie (2022) showed the associated factors of DASS were being female (AOR = 1.304, 95% CI = 1.006–1.849), higher risky khat chewers (AOR = 5.595, 95% CI = 2.357–11.132), having social phobia (AOR = 1.416, 95% CI = 1.045–1.919) were associated

with depression. Being higher risky cigarette smokers (AOR = 4.777, 95% CI = 1.407–7304), having a history of chronic medical illness (AOR = 2.099, 95% CI = 1.045–4.218), and having a family history of mental illness (AOR = 1.777, 95% CI = 1.028–3.073) associated with anxiety**.** Stress was associated with high-risk alcohol drinkers (AOR = 1.828, 95% CI = 1.012–3.303), rural residency (AOR = 1.395, 95%CI = 1.010–1.925), and low social support (AOR 1.7391, 95% CI = 1.203–2.515). The study concluded that the burden of DAS among high school students was found to be high. Female sex, chewing khat, and having social phobia are associated with depression. Conversely, smoking cigarettes, having a chronic medical illness, and having a family history of mental illness are all linked to anxiety. Being a highly risky alcoholic drinker, having poor social support, and being a rural resident are positively associated with stress.

Chronic medical illness and a family history of mental illness as predictors of anxiety, suggesting that students with underlying health issues or genetic predispositions are particularly at risk. This supports the need for targeted interventions for vulnerable groups, including routine screening and early psychological support in schools.Finally, the association between rural residency and stress (as found by Nakie) adds an important geographical dimension to the mental health conversation. Students in rural areas often lack access to mental health resources, trained counsellors, or even basic awareness, making them more susceptible to prolonged, untreated stress. This study makes it clear that addressing mental health among students requires a multidimensional approach. Efforts should go beyond academic pressure and include tackling violence in schools**,** promoting gender-sensitive mental health strategies**,** and ensuring access to counselling services for students in rural and underprivileged communities. Moreover, substance abuse

prevention and social support networks must be integral to school health programs. Mental health cannot be separated from the broader context of a student's life, whether it's their home environment, school climate, peer relations, or community resources.

Alenazi (2019) stated that the associated factors of DASS were history of the death of a close family member, family financial difficulties and smoking. Bhasin (2010) reported that Depression and Stress were found to be significantly associated with the number of adverse events in the student's life that occurred in last one year. Result from the Gautam (2021), factors associated with DASS was adolescents who were not satisfied with their academic performance were 2.4 times more likely to have the risk of depression (AOR=2.417, CI: 1.097-5.326). Likewise, tobacco users were almost fourteen times (AOR=13.858, CI: 2.090-91.90), who intended to harm themselves were two times (AOR=2.323, CI: 1.078-5.005), sleep deprivation were fifteen folds (AOR=14.911, CI: 7.376-30.145), often scolded by their parents was almost three times (AOR=2.931, CI: 1.195-7.436), and having poor relationship with friends were 2.4 times more likely (AOR=2.371, CI: 1.078-5.215) of having depression. Sleep deprivation has a long-term negative impact on health leading depression.

These findings make it clear that a mix of emotional trauma, academic stress, lifestyle habits, and social environment shapes adolescent mental health. If schools and communities truly want to support student well-being, they must go beyond academics and consider the whole student, their family background, life experiences, sleep patterns, peer support, and self-esteem. Mental health education, early detection programs, teacher training, and family awareness campaigns are not just helpful—

they are necessary. Without such a comprehensive approach, we risk allowing too many young people to suffer in silence.

In a cross-sectional study conducted in Kaski, Bhattarai (2020) showed the factors of DASS were Students who had low perceived social support (UOR: 3.604; 95% CI 2.088 to 6.220), did not share their problems with anyone (UOR: 1.931; 95% CI 1.228 to 3.038) and had low self-esteem (UOR: 5.282; 95% CI 2.994 to 9.319) were at higher odds of being depressed. A high prevalence of depression was observed among high school students. It was also observed that students' level of perceived social support, self-esteem and help-seeking behaviour are somehow related to their mental well-being. The associated factors showed that socio-demographic factors including being female, residence and grade in school were significantly associated with depression. use of social media (OR 2.06; 95% CI 1.27–3.35), high screen time (>120 min/day; OR 2.35 [95% CI 1.30–4.25]) and sleep disturbance (OR 3.93 [95% CI 2.37–6.50]) were significantly linked with depressive symptoms (Anjum, 2022). Resulted from the study of Yadav (2019) showed the DASS among adolescents, who were living either alone or belonging to nuclear families, children of illiterate parents, belonging to lower socioeconomic class (58.7%) followed by participants from upper socioeconomic class.

Above studies reinforce the idea that adolescent mental health is multi-layered and context-specific. Social support, self-esteem, digital behaviour, family structure, and socioeconomic status all intertwine to influence how adolescents experience depression, anxiety, and stress. To effectively address these issues, interventions must be equally multidimensional. Schools should foster peer support systems and provide mental health education**,** while parents must be educated on the importance of

emotional presence and open communication**.** Moreover, national mental health strategies must begin recognizing the impact of digital overuse and social isolation, especially in the post-pandemic era.

Only through such holistic and youth-centered approaches can we begin to reduce the burden of DASS among school-aged children and help them thrive emotionally, socially, and academically.

A cross-sectional study done in al-Qassim region to estimate the prevalence of depression and anxiety among high school students. The sample size was 1245 students. The tool was the Patient Health Questionnaire (PHQ-9) to assess depression in the students and the GAD7 for anxiety. Study shows that 306 (24.6%) were moderately depressed, whereas 129 (10.4%) were moderately severely depressed and 62 (5.0%) were severely depressed. Using the GAD-7 questionnaire, it was revealed that out of 1245 students, 243 (19.5%) of them were having moderate anxiety and 122 (9.8%) were having severe anxiety. Depression and anxiety, according to gender (*P* value <0.001), show a significant relationship. Health services should make health education for students on how they deal with stress and depression through exercise and good sleep (Alharbi, 2019).

A study was conducted to assess and compare the prevalence of depression and anxiety among children residing in rural and suburban areas of eastern Uttar Pradesh and understand the burden of these problems in our society. Children in the age group 11–18 years, the prevalence of depression was found to be 14.5% while that of anxiety disorder was found to be 15%. There was no significant difference in the prevalence of depression or anxiety in rural and suburban areas ($P > 0.05$).

Depression and anxiety were more prevalent in middle adolescence, in females, and in lower-middle socioeconomic groups. Depression was more prevalent in the students of class 9^{th} –12^{th}, whereas anxiety was more in students of lower classes. Depression was more prevalent in joint families. These differences show some important trends regarding factors affecting these problems (Mishra, 2018).

Mishra's (2018) findings illustrate that adolescent mental health is deeply shaped by age, gender, education level, family structure, and socioeconomic status**,** more than by geography alone. These trends highlight the need for holistic school-based mental health programs that are sensitive to these variables. Teachers, counsellors, and parents must be trained to recognize early signs of distress among middle adolescents, especially girls and students facing academic pressure. Additionally, family counselling and awareness initiatives are crucial to address hidden stressors even in seemingly supportive environments like joint families. Understanding these nuanced trends is key to designing effective mental health interventions for today's youth.

These findings call for urgent policy attention and school-based mental health interventions**.** Simply having mental health topics in the curriculum is not enough implementation, early identification, trained counsellors, and supportive school environments are essential. Mental health services must be more accessible, stigma-free, and inclusive, especially in secondary schools where students are more vulnerable due to developmental changes and life transitions.

In conclusion, DASS among adolescents is a critical public health issue**.** The evidence clearly suggests that without systematic and context-sensitive intervention

strategies, many students will continue to suffer in silence. There is a pressing need for integrated efforts from schools, families, policymakers, and communities to create environments that support psychological resilience, emotional expression, and timely professional help.

Prevention and recommendation of DAS. The mental health status of school-going adolescents should be identified and appropriate timely interventions need to be taken. Family members, teachers and the concerned authorities should give emphasis to the psychological well-being of the adolescents.

Karki (2022) concluded that Prevention and control activities such as school-based counselling services focusing to reduce and manage academic stress and electronic bullying are recommended in considering the findings of this research. Another study Barnawi (2023) highlights the importance of addressing social stressors such as bullying and physical assault and promoting a safe and supportive school environment to prevent mental health disorders in this population. Nakie (2022) concluded that extending mental health services to all high schools, and strengthening the existing counseling services, are recommended. Asif (2020) suggested urgent need of some preventive measures and interventions to improve the mental health of students.

From the result of the study, Alenazi (2019) recommended further in-depth national studies are needed to explore the problem and all possible risk factors. Also, strategies are needed to be developed to early detect these psychological disorders and prevent its progression among adolescents. In a study result, Gelban (2007) concluded that there is an urgent need to pay more attention to the mental health of adolescent secondary school boys in Saudi Arabia. Further studies are needed to explore

knowledge and attitude of students, parents and teachers concerning mental health. Bhatpara (2020) suggested that improving social support and self-esteem may alleviate depression and mental distress among these adolescents.

Evidence shows the alarming prevalence and contributing factors of depression, anxiety, and stress (DASS) among school-going adolescents, as revealed by the reviewed literature, it is clear that preventive measures and targeted interventions are urgently needed particularly within the school environment.School-Based Mental Health Programs play a critical role in shaping the mental health of adolescents. Mental health education should go beyond textbook content. It is important to establish well-structured school mental health programs that include regular screening, awareness sessions, and peer support systems. Trained school counsellors or psychologists must be made available to provide early intervention and support.

Likewise, Teacher Training and Sensitization, teachers are often the first to notice changes in a student’s behaviour. Therefore, regular training workshops should be organized to equip teachers with the skills to recognize signs of emotional distress and refer students to appropriate help. Sensitization of all school staff about adolescent mental health can help reduce stigma and create a more supportive school culture. Similarly, Family Engagement and Parental Education, here many studies, including those by Karki (2022), Nakie (2022), and Gautam (2021), highlight the impact of family environment on students' mental health. Parents should be educated about the signs of stress, depression, and anxiety, and encouraged to maintain open, non-judgmental communication with their children. Family counselling and parental

involvement in mental health programs can significantly strengthen the support system for adolescents.

It is very important to address academic pressure; academic stress was consistently reported as a major contributing factor to adolescent DASS. Schools should reassess the level of academic burden, provide time management and coping skill training, and create a balance between academics and extracurricular activities. The goal should be to support learning without compromising mental well-being. Another most focusing thing is substance use prevention and healthy lifestyle promotion. Substance use like smoking, alcohol, and khat chewing were strongly linked to poor mental health outcomes. Early preventive education on substance use, along with promotion of healthy behaviours like regular sleep, physical activity, and balanced nutrition, should be integrated into school health programs.

Safe and Inclusive School Environment helps to protect children from mental health problems. Bullying, physical violence, and lack of safety were found to be major contributors to psychological distress (Barnawi, 2023). Schools must ensure a zero-tolerance policy on bullying and violence. Creating a safe and inclusive environment where students feel accepted regardless of gender, background, or academic performance is crucial.

For the control and prevention of all psychological issues among school going children are vital and the main role to address the problems is policy makers. Policy Implementation and Monitoring, while Nepal has policies like the Mental Health Strategy and School Health and Nutrition Policy, implementation remains weak. Stronger collaboration between the Ministries of Health and Education is needed to effectively integrate mental health services into the school system. Regular

monitoring, funding, and follow-up are essential to ensure these policies translate into real impact. So, mental health is just as important as physical health, especially during adolescence. The reviewed evidence shows that with the right preventive strategies, community support, and policy action, we can reduce the burden of DASS among students and create an environment where every adolescent can thrive emotionally, socially, and academically.

Theoretical Review

The theoretical framework helps to provide specific concepts to examine the topic. There are many different concepts within psychosocial theory of stress, such as; psychoanalytic theory, object loss theory, learning theory, cognitive theory. These theories may be used to define concepts and explain phenomena.

Theoretical Framework

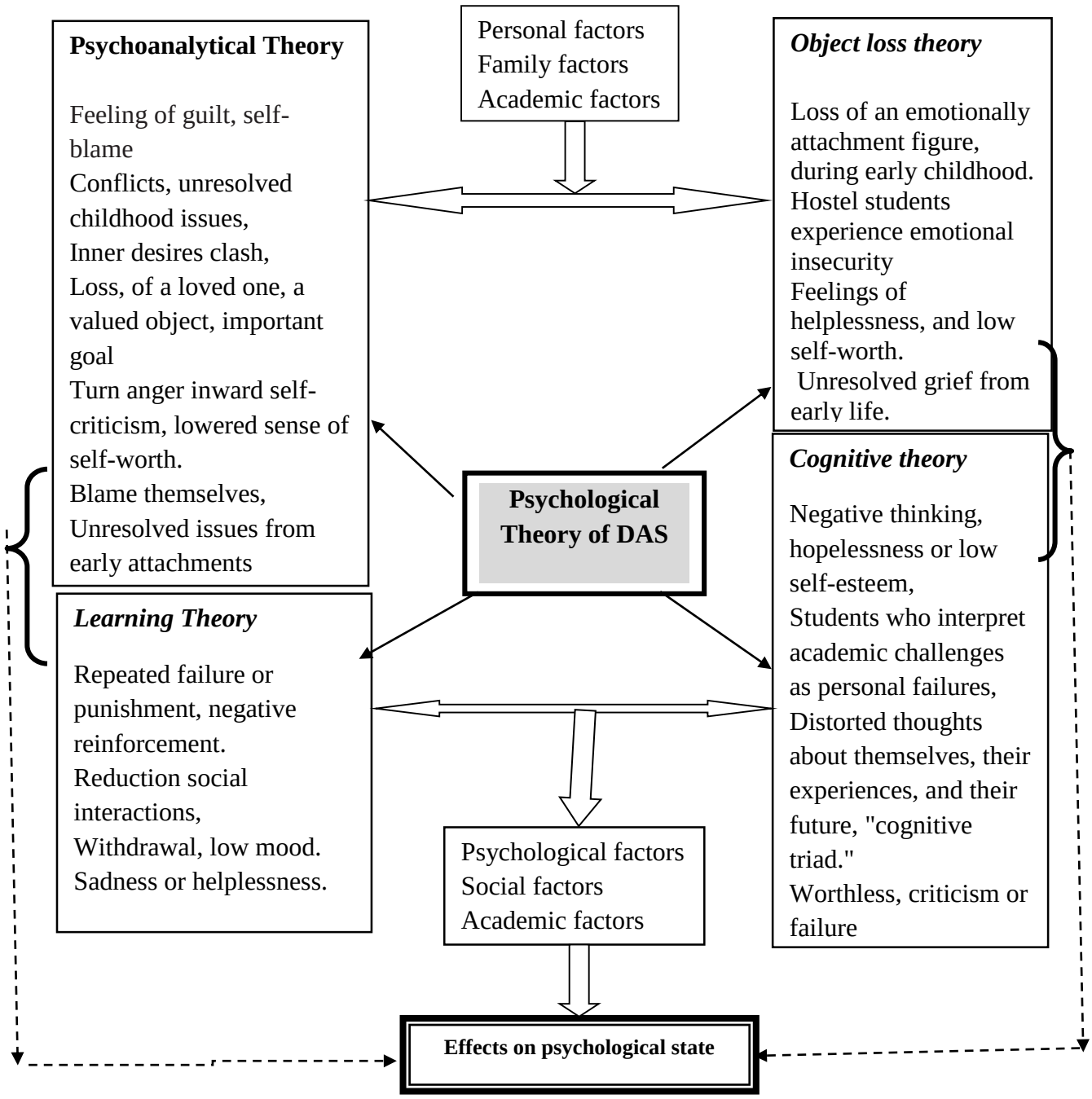

Figure 1. Theoretical Framework

Psychoanalytic Theory. Sigmund Freud (1957), an Austrian neurologist and the founder of psychoanalysis. He was the first to recognize the connection between guilt and depression considering depression to be an exaggerated feeling of guilt and self-blame. He created a new understanding of how the mind works by exploring the

id, superego, and ego. Specifically, Freud looked at the dynamic of these three systems and how they contribute to our mental state. Today, it is a core principle in psychodynamic theory. Freud emphasized unconscious conflicts and unresolved childhood issues. Stress may arise when inner desires clash with social expectations, especially in adolescents struggling with identity or emotional development (Freud, 1923).

This theory of depression suggests that depression results from the internalization of feelings of loss and anger. According to Freud (1917), when individuals experience a significant loss, whether of a loved one, a valued object, or an important goal, they may unconsciously turn their anger inward rather than expressing it outward. This process leads to intense self-criticism, feelings of guilt, and a lowered sense of self-worth. Instead of mourning the loss in a healthy way, individuals blame themselves, which deepens depressive symptoms. Later psychoanalytic thinkers, such as Melanie Klein, expanded on Freud's ideas by emphasizing the role of early childhood relationships in shaping how people manage loss and emotional pain (Klein, 1940). In this view, unresolved issues from early attachments can make individuals more vulnerable to depression later in life when faced with significant losses.

This theory focuses on early childhood experiences, unconscious mind, and internal conflicts. In present study the psychoanalytic theory is used in relation with different associated factors of depression, anxiety and stress. These factors are family related factors, the loss of nearest family member, destructive family relationship, economic hardship, mental illness or injury in family member, suicidal attempt of suicide by family member, broken home, causes the stress and anxiety in early childhood and depression at adolescent period. another factor is personal factors, here,

unconscious conflict during the early childhood, anger cannot express easily and it leads to low self-esteem, self-criticism, self-harm, substance abuse and depression. Last factor is academic factor, in this study excessive academic stress, fear of failure may trigger deeper internal conflict, and it cause the anxiety and depression at adolescent age.

Learning Theory. This theory proposes that stress or anxiety can be learned through conditioning. For example, if a student experiences repeated failure or punishment, they may associate school with anxiety (Skinner, 1953).

The learning theory of depression suggests that depressive behaviours are learned through experiences, particularly through a lack of positive reinforcement and the presence of negative reinforcement. According to Lewinsohn (1974), depression can develop when individuals experience a reduction in rewarding experiences or social interactions, leading to withdrawal and low mood. As individuals engage less with their environment, they receive even fewer positive experiences, creating a cycle that maintains and deepens depressive symptoms. Additionally, behaviours associated with depression, such as sadness or helplessness, may sometimes be unintentionally reinforced by others (for example, through attention or sympathy), making these behaviours more persistent. The theory emphasizes that changing behaviour patterns and increasing engagement in pleasurable activities can help break this depressive cycle, which is the basis for behavioural activation therapy.

In this learning theory, the factors of depression, anxiety and stress is related to educational and social factors. Repeatedly failure in examination or regular punishment, negative reinforcement may cause loss of social connectedness, exam phobia, academic stress, regular absenteeism in school, unsatisfied with academic

performance, low self-esteem. It leads to low mood, sadness, helplessness, stress, anxiety and depression.

Object loss theory. According to Bowlby (1969), this theory, early loss of a caregiver or emotional attachment can lead to vulnerability to depression or stress later in life. Hostel students separated from family might experience emotional insecurity, increasing stress.

The object loss theory of depression, largely influenced by the work of John Bowlby, proposes that depression develops when an individual experiences the loss of an emotionally significant attachment figure, especially during early childhood. According to Bowlby (1969), the early bond between a child and their primary caregiver is crucial for emotional security. When this bond is disrupted by separation, loss, or inconsistent care, the individual may develop feelings of helplessness, insecurity, and low self-worth. These early experiences of loss are believed to set a pattern for how individuals respond to future losses in adulthood, making them more vulnerable to depression. In this view, depression is seen not just as a reaction to a recent loss, but as a reactivation of deep, unresolved grief from early life.

Present study is guided by object loss. In this study different factors are related to DAS among secondary level. These factors are family factors, psychological factors, social factors, academic factors. where, the early bond between a child and their primary caregiver is crucial for emotional security. When this bond is disrupted or disconnected by separation, loss, or inconsistent care, the individual may develop feelings of helplessness, insecurity, and low self-worth. These early experiences of loss are believed to set a pattern for how individuals respond to future losses in adulthood, making them more vulnerable to depression. These factors are, absent of

both parent, bad childhood experience, bad relation with friends, teachers, traumatic life event, low self esteem are the causative factors of DAS among secondary level students.

Cognitive theory. (Beck,1967), This theory suggests that negative thinking patterns, such as hopelessness or low self-esteem, lead to stress and emotional disorders. For example, students who interpret academic challenges as personal failures may experience high levels of stress.

The cognitive theory of depression, developed by Aaron T. Beck, suggests that negative patterns of thinking are central to the development and maintenance of depression. According to Beck (1967), individuals with depression tend to have distorted thoughts about themselves, their experiences, and their future, a pattern he called the "cognitive triad." These individuals often view themselves as worthless, interpret everyday events in a negative way, and believe that the future will be hopeless. Over time, these automatic negative thoughts become habitual, reinforcing feelings of sadness and helplessness. Beck also proposed that early life experiences, such as criticism or failure, can create underlying beliefs or "schemas" that are activated during stressful situations, leading to depressive thinking. Cognitive therapy, based on this theory, aims to help individuals identify and change these distorted thoughts to improve their mood and functioning (Beck,1967).

In cognitive theory, Depression, Anxiety and Stress among secondary level students is directly related to different factors. These are; exam phobia, bullying, educational stress, low-self-esteem, bad relation with family, friends and school teachers, inadequate sleeping pattern, lack of family support, which creates the

negative thinking and feeling regularly, they become sadness, hopelessness and may suffer from DAS.

Research Gap

After reviewing the previous studies researcher had mainly understood what has already been explored in their topic area. By doing this, researcher identified the global situations of DAS among secondary level students. The magnitude of DAS is different in different place; even though it is very high. Gap still exists, very few study is conducted in Pokhara addressing the mental health problems and DAS among the secondary level students. Researcher had felt that it is necessary to conduct study on DAS among the school students.

Reviewing literature also helps researchers build a strong foundation for their work by connecting it to existing knowledge. The process usually involves searching for relevant articles, books, and reports, then carefully analysing, comparing, and organizing the information. Researcher found the different psychosocial factors are associated to be DAS, but in different study, factors were not covered as required. So, in this study researcher had prepared five factors it was individual factors, family factors, social factors, academic factors and psychological factors, it has 25 sub points.

The review of literature indicated a significant gap in the application of psychosocial and cognitive theories in the study of adolescent mental health. To address this, the researchers integrated psychosocial theories to establish a comprehensive theoretical framework for their analysis. The selected theories included psychoanalytical theory, object loss theory, learning theory, and cognitive theory. Within this framework, family and personal factors were found to be

associated with object loss theory, while academic factors were examined through cognitive theory and other psychological perspectives. These theoretical approaches were employed to investigate the associations between these factors and the presence of Depression, Anxiety, and Stress (DAS) among students.

After reviewing the related research articles, further recommendation for prevention of the mental health problems researcher had found that the requirement of social support, counselling and awareness is mentioned but psychological support, role of family, individual and school is not mentioned properly. it is necessary to include all above factors for the prevention of DAS is required.

Implication of Review Literature

The reviewed literature highlights that depression, anxiety, and stress are prevalent among secondary level students globally, with various contributing factors such as academic pressure, family issues, and peer influence. Studies by Sharma (2021) and Lama et al. (2022) show high levels of psychological distress among adolescents in Nepal. However, limited research focuses specifically on the psychosocial status of students living in school and hostels and coverage of different factors of DAS. Moreover, most existing studies use small or urban centred samples. Therefore, this study aims to address these gaps by exploring the mental health status of secondary students in public school's settings.

Various psychological theories provide insight into the development of stress and emotional disorders among adolescents. Beck's Cognitive Theory explains that distorted thinking patterns and self-critical thoughts often result in anxiety and depression in students (Beck, 1976). Similarly, Bowlby's object loss theory emphasizes the impact of early emotional separation, suggesting that students living

away from home in hostels may be more vulnerable to stress. From a behavioural perspective, the Learning Theory indicates that stress-related responses can be acquired through repeated negative experiences in academic settings. Furthermore, Freud's Psychoanalytical Theory links adolescent stress to unresolved unconscious conflicts and emotional repression. These theories collectively offer a foundation for understanding how psychological stress develops in young individuals, particularly in educational contexts.

Conceptual Framework

Conceptual framework shows the relation between the dependent and independent variables. After reviewing the literatures researched has been decided to form the conceptual framework. DAS among School going students as a dependent variable and sociodemographic factors and different five factors are the independent variables. Below figures shows the correlations between these concepts.

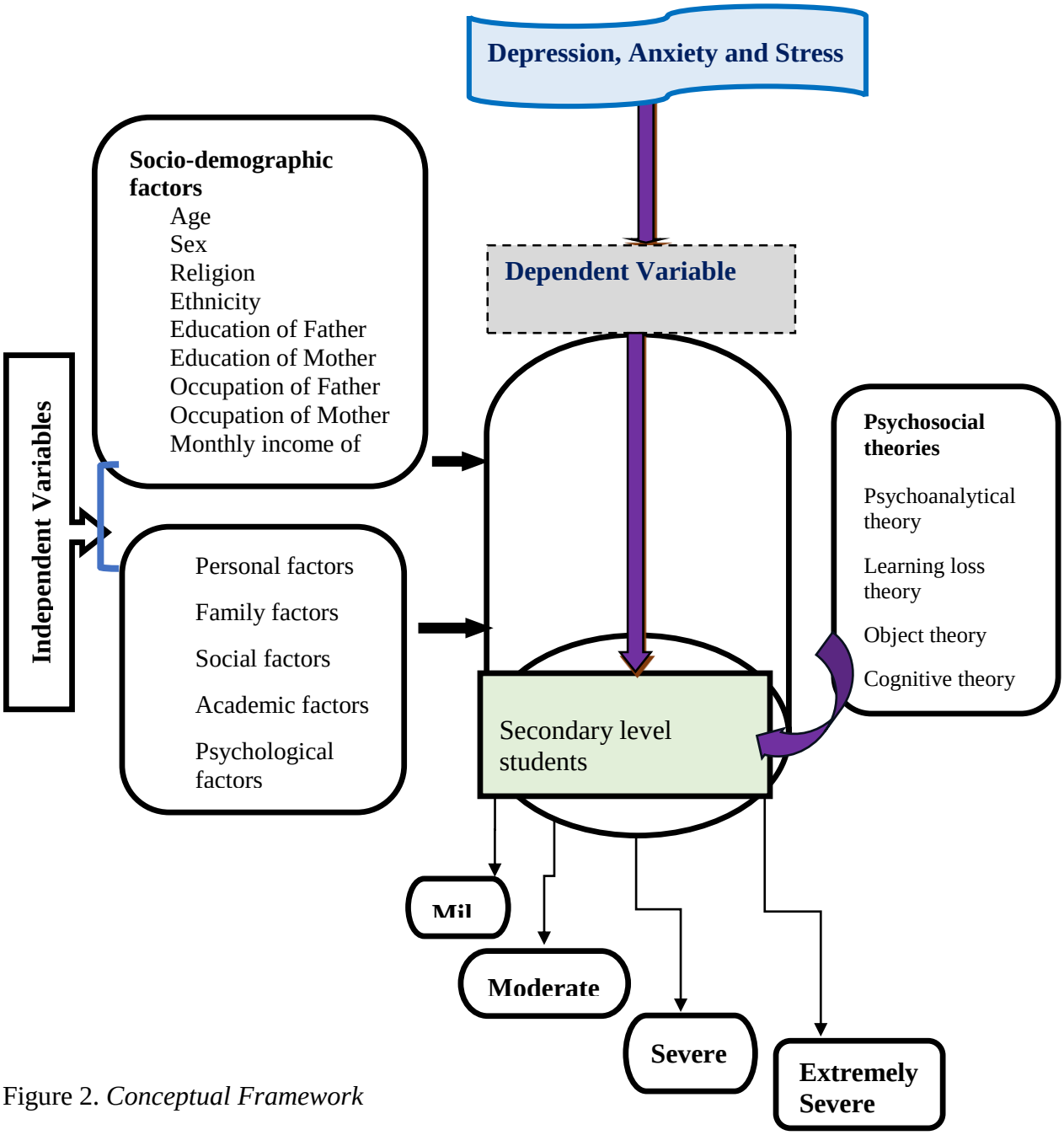

Figure 2. *Conceptual Framework*

This conceptual framework was developed to show the cause and effect relation between the dependent and independent variables. Depression, anxiety and stress among the school students as the dependent variable and socio-demographic variables and different five factors are mention as the independent variables.

The demographical variables are; respondent's age, sex, religion, ethnicity, type of family, place of residence, place of recent stay, current grade, education of

father, education of mother, occupation of father, occupation of mother, and monthly income of family are the independent variables of this framework. Factors leading to depression, anxiety and stress among the students are related to the psychosocial theory through the personal factors, family factors, academic factors psychological factors and social factors. From these factors researcher was able to assess the different levels of DAS and its associated factors.

Students demographic characteristics are basic components as a independent variables, of DAS, likewise different factors used in this study are also the independent variables or both are the causative factors of DAS. Similarly, it is followed by psychosocial theories of depression, these are; psychoanalytical theory, object loss theory, learning theory, and cognitive theory which guides the all associated factors of DAS. Here, secondary level students is the dependent variable as the effect of the study.

Chapter Summary

This chapter described the literature related to study areas of depression, anxiety and stress. It included thematic review and empirical review of literature. It also encompassed related concepts with depression, anxiety, stress, and their symptoms. Based on the literature, the research gap was determined and implication of present study was mentioned. This study has followed the theory by Freud (1957), it is directly related to DAS among the school going students.

CHAPTER III

Research Methodology

Research methodology refers to the steps or methods used to locate, select out, organize, and analyse information on a subject. This section incorporates quantitative research method as philosophical stance, research design, study population and sample, sample size, sampling techniques, study site/participants, inclusion and exclusion criteria, research tools, data collection procedure, data analysis procedure and ethical consideration.

Philosophical Stance

This research is grounded in the post-positivist framework. To understand the philosophical foundations of quantitative research, it's essential to examine where it fits in the overall research process, recognizing its significance as a research component, and figuring out how to effectively integrate it into a study. Post-positivist researchers acknowledge that complete objectivity is unattainable, recognizing the influence of the researcher's personal values, beliefs, and assumptions on the study. They emphasize the need for transparency, reflexivity, and critical self-awareness throughout the research process (Khatri, 2020). This study is closely aligned with the deductive research approach. Post-positivism is based on the belief in a single, objective reality (Denzin & Lincoln, 2018; Leavy, 2017).

This philosophical position is adopted because this research aims to explore how participants perceive and understand objective realities in relation to the factors influencing DAS among public school students. The participants' social, cultural, and

historical backgrounds play a significant role in shaping their understanding of this objective reality.

Ontology. Ontology deals with philosophical assumptions about the nature of reality or existence. It is simply called theory of reality. It concerned with the assumptions we make in order to believe that something makes sense or is real, or the very nature or essence of the social phenomenon we are investigating (Scotland, 2012).

Researcher believes participants come from diverse contexts and will provide responses based on their understanding of the given realities regarding different associated factors of depression, anxiety, and stress among them. With the assumption of a single reality and objectivity among the participants regarding mental health problems, responses will be categorized as either "yes" or "no," and a single response from multiple options will be scored as a correct response.

Epistemology. Pertains to the source of knowledge, or how we acquire knowledge and attribute it. It is concerned with providing a philosophical basis for determining the types of knowledge that are possible and how we can ensure their adequacy and limitations (Crotty, 1998). Crotty emphasizes that epistemology seeks to delineate the scope and limitations of knowledge acquisition and attainment. Similarly, according to Cline (2006), epistemology serves as a means for acquiring knowledge, shedding light on its sources. Drawing from this literature, epistemology is a branch of philosophy that strives to illuminate the sources of knowledge while avoiding deficiencies.

In this study, researcher embraces the objective philosophical assumption and recognizes the value of empirical evidence, while acknowledging that all observations

are influenced by theory and the researcher's perspective. It underscores the importance of interpretation, multiple perspectives, and reflexivity in knowledge generation. Research participants produce the findings, and the knowledge of a phenomenon (associated factors of depression, anxiety, and stress) emerges from the interpretations and scoring of their responses. Research participants objectively select the correct answer from the given context, contributing to the trustworthiness of the study. This research relies on participants' responses as evidence.

Methodological. Assumptions dictate adherence to deductive processes, theory verification, emphasis on discrete, specific concepts, and a focus on the objective and quantifiable aspects of research. They entail evidence of the researcher's predictions, utilization of outsider knowledge, a fixed, pre-specified design, and control over the research context. Additionally, methodological assumptions call for the inclusion of large, representative samples, measured quantitative information, statistical analysis, the pursuit of generalizations, and a focus on the final product (Polit & Beck, 2012).

In this study, the research methodology will align with the objectives of the research. A quantitative analytical cross-sectional research design will be employed among secondary level students of Pokhara Metropolitan. The sample size will be determined using the appropriate formula. Reliability and validity will be ensured, ethical approval will be obtained from GMC-IRC, the standardized tool DASS will be utilized for data collection, and analysis and interpretation will be conducted in accordance with the research objectives.

Axiology. Pertains to the values inherent in entities within the universe. These values can vary with time, place, and individual perspective, rendering them

contextual. Values are interconnected with the purpose of human life (Sharma, 2005) and may exhibit subjectivity, objectivity, or contextuality (Julian, 1967). In this study, the researcher will uphold ethics and aesthetics by prioritizing the privacy, rights, and dignity of the participants. Informed written consent will be obtained before commencing the data collection procedure. The study aims to remain value-free and objective, with participants relying on provided objective responses.

Research Design

The study was adopted a quantitative analytical cross-sectional research design to examine the levels of depression, anxiety, stress (DAS), and to identify the association between the different factors like personal, family, social, academic, psychological, level of DAS among secondary level students in public schools within Pokhara. Self-administered structured questionnaires (SAQs) used as the primary tool of research. Globally many studies were conducted in this title, also conducted in different city of Nepal but in Kaski only one study was conducted to assess the prevalence of depression among the higher secondary level adolescent students. The prevalence of DAS in almost all studies were high so researcher was interested to conduct this study in the public schools of Pokhara Metropolitan city. The result of this study will provide the key information for further researcher.

Research Setting

This study was conducted in various schools within Pokhara Metropolitan City, spanning wards 1 to 33 of Kaski District. The setting refers to the location where the research is conducted, which can range from natural to highly controlled environments (Sharma, 2012). Initially, the researcher has visited the District Education Office in Kaski to gather detailed information from the relevant authorities.

This was enabling the researcher to compile a list of public schools in Kaski Metropolitan City and select a random sample representing at least 10 percent of the eligible schools. The numbers of total public schools were 205 within the ward number 1-33 of Pokhara metropolitan city. Researcher had set a criteria of schools that was the schools who is presently running grade 1 to 12. Only 48 schools were met these criteria and from these, total of five schools (more than 10%) were selected randomly.

The researcher was initiated to contact with the selected schools' authorities via mobile communication to seek permission for data collection. Subsequently, the researcher had arranged face-to-face meetings with school authorities to gather detailed information and confirm the schedule for data collection.

Selected schools were offering a diverse representation across different wards of Pokhara Metropolitan City in Kaski District, ranging from various distances from the city centre. Their establishment dates indicate their long-standing presence in the community, suggesting they may have a significant impact on the local education landscape. The list of selected schools given the pseudonyms. It was School A (pseudo name) secondary school ward no. 26, a reputed school established in 2011 BS and about 10 Km far from the centre of Kaski. Second is School B (Pseudo name) secondary school, established in 2067 BS, it is in ward no 26 and about 14 Km far from the centre of the Kaski, third school is school C (pseudo name) secondary school it was established in 2025BS, it is in ward no. 27 and about 18 Km far from the centre of Kaski, fourth school is School D (Pseudo name) secondary school, established in 2015 BS, it is in ward no.29 and is about 21Km far from the centre of Kaski and last fifth school is School E(Pseudo name) secondary school, established in 2015 BS. It is

in ward no. 30, and about 25Km far from the centre of Kaski. These all schools are the old and reputed schools of Metropolitan city in Kaski.

Research Population, Sample and Sampling Procedure

Study populations consist of students of different selected secondary schools. A population is the entire aggregation of cases that meet the sample criteria for inclusion in a study or in which a researcher is interested (Sharma, 2012).

Research population for the study was secondary school students currently studying in grade 9, 10, 11 and 12.The concern school authority had provided the name list of the students of grade 9, 10, 11 and 12. To determine the sample size the common formula of a famous statistician Cochran was used $n=Z^2pq/e^2$Where, n= required sample size, p=prevalence of the DAS among adolescents (56.5%), q= 1-p, z= the standard normal variate, value of Z at 95% confidence interval=1.96, e= permissible error, value of d=5%=0.05. sample size is 348 and total population in selected schools are 1912.

Sample Size

Sample size refers the number of subjects, events, behaviours or situations that are examined in a study (Sharma, 2012). Quantitative researchers need to pay attention to the number of participants needed to achieve statistical conclusion validity. Total 348-sample size is calculated by using standard formula and considering the following data. According to the study conducted in urban Municipality of Kathmandu, prevalence of the Depression, anxiety and stress among high school students was 56.5%, 55.6% and 32.9% (Karki, 2022). Based on this

prevalence rate, with 95% confidence interval and 5% allowable error, sample size estimation can be calculated as:

Sample size (n_0) = $\frac{z^2pq}{e^2}$ (Cochran's formula)

n= required sample size

p=prevalence of the DAS among adolescents (56.5%)

q= 1-p

z= the standard normal variate, value of Z at 95% confidence interval=1.96

e= permissible error, value of d=5%=0.05

Then estimated sample size n_0=$\frac{z^2pq}{e^2}$

$$=\frac{1.96^2\times0.565\times0.435}{0.05^2}$$

=377.6 =378

Then, estimated sample size (n_0) =378

For finite population (N = 1912)

Again, n = $\frac{n_0}{1+\frac{n_0}{N}}$

$$n = \frac{378}{1+\frac{378}{1912}}$$

n =315.60

n=316

Now, adding 10% of non-response rate 316+32=348

Total sample size (n) =348

Sampling Technique

Pokhara metropolitan was selected purposively. At least 10 percent public schools were selected randomly from the total eligible schools. A systematic random sampling technique was used to obtain the desired sample size. Based on the total number of students in total selected schools, the proportion of students were selected from each school, was calculated as:

Total number of students in 5 schools= 1912

Required sample size of 348

Numbers of students ‘were selected for the study from School A Secondary school.

= 348/1912 ×71 = 12.92/4=3.23=3 from each class

Numbers of students were selected for the study from School B secondary school

= 348/1912×379 =68.98/4 =17.24 =17 from each class

Numbers of students ‘were selected for the study from School CSecondarySchool

= 348/1912×459 = 83.54/4 =20.88=21 from each class

Numbers of students ‘were selected for the study from School D Secondary school

= 348/1912×409 = 74.44/4 =18.61=19 from each class

Numbers of students ‘were selected for the study from School ESecondarySchool

= 348/1912×594 =108.11/4 =27.02=27 from each class

Finally, the participants of the study were selected by using simple random sampling (lottery method) from each grade through school attendance register.

Flow chart of sampling techniques

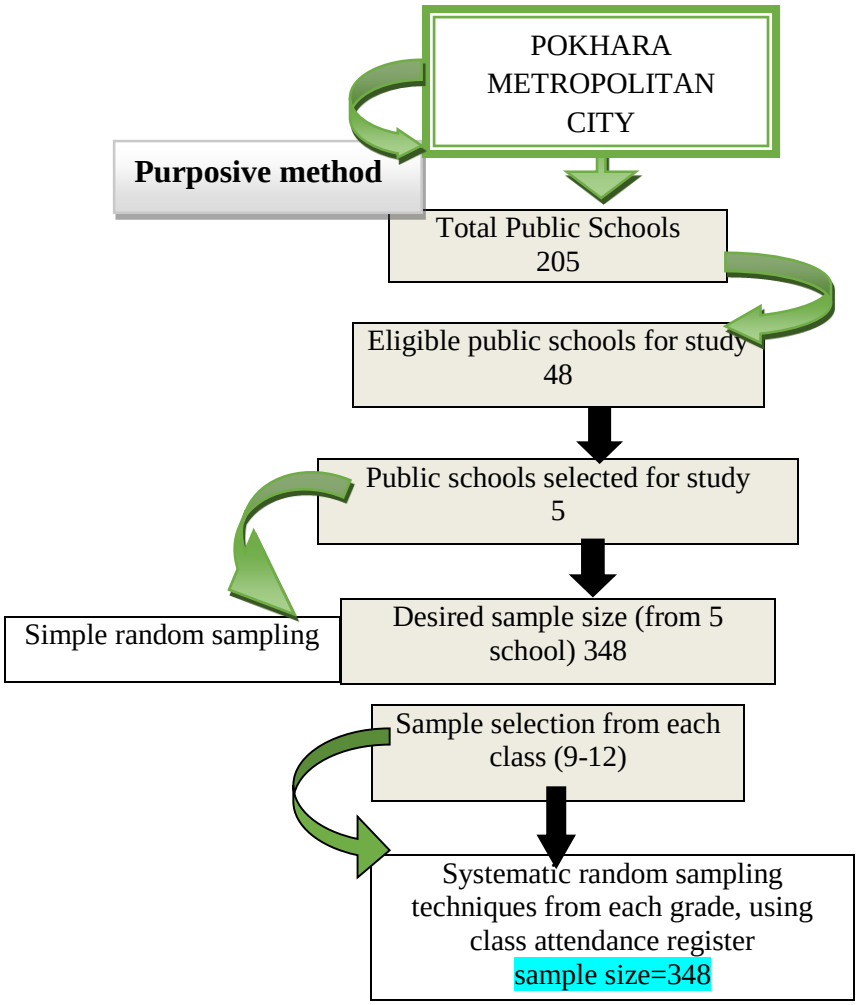

Figure 3. *Flow chart of sampling techniques*

Inclusion and Exclusion Criteria

All public schools present in Pokhara Metropolitan city, ward number 1 to 33, and the students studying in grade 9th, 10th, 11th, and 12th of both genders (male and female) were included in this study.

Exclusion criteria indeed help to maintain the integrity of the study by ensuring that only not willing to participate and not available during the time of data collection were excluded.

Research Tools

The study included the primary data. A self-administered structured questionnaire was used for data collection. Standardized tool depression, anxiety and stress scale (DASS-21) was used to identify the level of DAS. This tool is publically available and no need to take permission to use. The instrument is divided into three parts:

Part I: comprises of questions related to socio demographic information included 20 questions. It included participants age, sex, religion, ethnicity, types of family, place of residence, current living status, achievement in last examination, current grade, faculty of the respondents, reason for selecting current subjects, education of father, education of mother, occupation of father, occupation of mother and monthly income of family.

Part II: comprises of questionnaire related to psychosocial factors of DAS included 5 factors; individual related factors, family related factors, social factors, academic related factors and psychological factors.

Part III**:** comprise of Depression, Anxiety and Stress scale-21 (DASS-21), Standardized tool it consists of 21 statements rating scale (rated as 0, 1, 2, 3), and grading are mild, moderate, severe and extremely severe. This standardizes tool is in public access and can use without any permission. The statements in this tool are categorized as: D (Depression) Q3, 5, 10, 13, 16, 17, 21, A (Anxiety) Q2, 4, 7, 9, 15, 19, 20 and S (Stress) Q1, 6, 8, 11, 12, 14, 18. The level of depression, anxiety and stress were measured according to following range:

Depression; Normal─ 0-4, Mild─ 5-6, Moderate 7-10, Severe ─ 11-13 and Extremely Severe─ 14+.

Anxiety; Normal─ 0-3, Mild ─ 4-5, Moderate ─ 6-7, Severe─8-9 and Extremely Severe─ 10+.

Stress; Normal─0-7, Mild─ 8-9, Moderate─ 10-12, Severe ─ 13-16 and Extremely Severe─17+.

Lovibond, S.H & Lovibond, P.F (1995)

Pretesting, Validity and Reliability

The validity of the instrument was established by intense review of related literature and consulting with research advisor and subject experts. It refers extent to which an instrument accurately reflects the abstract construct (or concept) being examined.

Pretesting of the instrument was done in 10% of the population for its understanding and clarity and Instrument. Pre-testing was done in an X Secondary School, in pre-testing, respondents felt difficulty in technical words so it was revised (translated into Nepali Language) and finalized based on pre-test and feedback from the research expert.

Reliability of the tool was maintained by its stability, and consistency of the tool. DASS- 21 is a valid standard scale frequently used by nurses, psychologists, and psychiatrists of Nepal. The DASS-21 is a validated tool and has been used in different groups of Nepalese population to identify symptoms of Depression, Anxiety and Stress (Kunwor, 2016; Tonsing, 2014). Cronbach's alpha coefficient for DASS 21 has been found to be ranging from r = 0.77*, 0.70*, and o.70*, it is acceptable to use in study.

Data Collection Procedures

Before the collection of information from the participants' researcher had taken the permission from the related authorities of different institutions. First, the researcher was taken an authorized letter from the research committee of Graduate School, T.U. Kirtipur, Kathmandu. Then, researcher had prepared the list of the randomly selected public schools and communicated with the authority of schools through the telephone contact. After taking primary permission researcher met physically to authority of all selected schools and took written and verbal permission from the principal and related class teachers for the data collection. Students list was granted from the school attendance register and students were selected using systematic random sampling techniques. Selected participants were prepared for the data collection.

Similarly, date and time for data collection was decided as their convenient day and time (10 am to 4 pm). Prior to data collection researcher had met the class teacher of (each school) grade 9, 10, 11 and 12 for verbal permission. Then, consent form was distributed to all participants who were the age group of 17 years and above and ascent form was distributed to the class teachers to take permission, for the students who were the age of below 17 years. Researcher had introduced herself and briefing about the objectives and tool to the participants. Students were taken in a hall and the seating arrangement was one student per bench. One respective class teacher was taken during the periods of data collection. Data was collected separately in each class.

After that the questionnaire were distributed to all selected students to collect information. Total time to fill up information was taken approximately 25-30 minutes.

Doubts regarding the questionnaire and queries were clarified on the spot. Participants were filled the questionnaire in the presence of the researcher to prevent data contamination. Researcher had spent two days per school, one day for conformation the time, planning of venue for data collection and prepares students list and next day for data collection. First data was collected in School A secondary school, second was School B secondary school, third was school C secondary school fourth was school D secondary school and last was school E Secondary School. Total time duration of data collection was almost two weeks.

Data Analysis Procedures

Analysis and interpretation of data is the most important phase of the research process, which involves the computation of the certain measures along with searching for patterns of relationship that exists among data groups. Data collection is followed by the analysis and interpretation, in accordance with study objectives. The purpose of analysing the data is, to describe the data in meaningful terms. The collected data or raw data does not answer the research questions or test research hypothesis. The data used is to be systematically analysed so that trends and patterns of relationship can be detected (Sharma, 2012).

All the collected data was reviewed and checked immediately for completeness, consistency and accuracy. Data was edited and coded on the same day of data collection and entered, analysed on Statistical Package for Social Science (SPSS) Version 16. Data analysis was done using univariate (frequency, percentage, mean, standard deviation), bivariate for to measure association (Chi-square) between demographic variables and level of DAS and psychosocial factors and level of

DASand multivariate analysis (regression analysis), and interpreted based on the objectives of the study. The findings are presented in different tables and figures.

Ethical Considerations

At first, the permission was taken from the Graduate School of Education and research supervisor. Ethical approval was taken from the Gandaki Medical College, Institutional Review Committee (GMC-IRC).

Verbal and written permission was taken from the authority of related school. Verbal permission obtained from respective class teachers before the data collection. Informed written assent was obtained from the teachers of respondents who were the age of below 17years. For the respondents of 17 years and above aged Informed written consent was taken from each after explaining the purpose of study.

Self-administered structured questionnaire was used to collect the data. The researcher ensures to collect the data without disrupting the respondents 'class schedule.

Approximately, 20-25 minutes was given to each class to fill up the questionnaires.

None of the respondents was forced to participate in the study.
Respondents' dignity was maintained by giving right to reject or discontinue their participation from the study at any time without any penalty.
Confidentiality was maintained by not disclosing the name and other information of the respondent except its use in the study.
Anonymity was considered by coding the tool.

Chapter Summary

This study was conducted under a post-positivist philosophical paradigm achieved by ontology, epistemology, and methodology to the secondary level students Depression, anxiety and stress level and its associated factors. Survey data were collected from public school students from the Pokhara Metropolitan city at Kaski district. Systematic random-sampling technique was adopted to select the required sample. In this study, the sample size was determined by Cochran's formula. A total of 348students were randomly selected. The study used a self-administered structured questionnaire that was grouped into three specific sections with 66 items. It included demographical information; psychosocial factors associated with DASS and standardized tool to assess the DASS. The collected data was analysed using the IBM Statistical Package for Social Sciences (SPSS) Version 16 and applied descriptive and inferential statistics. Ethical approval was taken from the Gandaki Medical College Institutional Review Committee (GMC-IRC) (Ref. no. 15 /080/081-F).

CHAPTER IV

Analysis and Interpretations of the Results

This chapter mainly concerns the analysis and interpretation of the collected detail information from secondary school students. It deals according to the objectives of the study including socio-demographic characteristics of the secondary level students, level and magnitudes of DAS and factors related to Depression Anxiety and stress. SPSS version 16 software was used for data analysis.

This chapter ends with concluding remarks of the chapter. The researcher has analysed the collected data in three types of their nature as descriptive, bivariate and multivariate. Over all questions of this research are as follows;

Socio-demographic Characteristics of the Respondents

In socio-demographic characteristics, it includes distribution of the population by gender, age, ethnicity, religion, types of family, place of residence, current living status, achievement in last exam, educational status, occupation of parents and monthly family income.

Descriptive statistics were applied to analyse the demographic appearances of the study population. Data have been presented in tables and figures in terms of frequencies and percentages in the following sub-section.

Table 1. *Distribution of the Respondents by Socio-demographic Characteristics (n=348)*

Characteristics	Number	Percent
Age in completed years		
<17	204	58.6
≥17	144	41.4
Mean ±SD16.21 ±1.480, min=14, max=24		
Sex		
Male	150	43.1
Female	198	56.9
Religion		
Hinduism	310	89.1
Buddhism	18	5.2
Christianity& others	20	5.8
Ethnicity		
Dalit	93	26.7
Janajatis	128	36.8
Brahman/chhetri	127	36.5
Type of Family		
Nuclear	220	63.2
Joint	116	33.3
Extended	12	3.4
Place of Residence		
Urban	51	14.7
Rural	297	85.3
Current living status		
With parents	273	78.4
Without parents	75	21.6
Current Grade		
Nine	87	25.0
Ten	87	25.0
Eleven	87	25.0
Twelve	87	25.0
Faculty of the respondent, grade11,12(174)		
Education	22	12.6
Management	146	84.0
Others	6	3.4
Reason for selecting the current studying faculty (174)		
Own decision	167	96.0
Others	7	4.0

Above table 1 shows the total population of the study was 348. The age group was categorized based on mean value into two, <17, ≥17 (Mean ±SD17.21 ±1.480, min=14, max=24), the first group was below the 17 years and next was 17 years and

above. The total number of below 17 years were 289 (83.0%) and the 17 years and above were 59 (17.0%).

Similarly, the male respondents were 150 (43.1%) and the total numbers of female respondents were 198(56.9%). Likewise, according to religion of respondents, majority of the respondents were following Hinduism that was 310 (89.1%), 18(5.2%) from Buddhism, 18(4.6%) were from Christianity, 1(0.3%) from Muslim and 3(0.9%) were from other religion. The highest numbers of respondents were Janajatis that was 128 (36.8%). Then Brahmin and Chhetri were127 (36.5%). Similarly, dalit were93 (26.7%). janajatis were in the highest number because they are in the majority in public schools of Nepal. Based on types of family of the respondents 220(63.3 %) were from nuclear family, 116 (33.3%) were from joint family and only 12(3.4%) were from extended family.

The data showed that the number of participants below 17 years was higher than those above 17 years, and females outnumbered males, which was consistent with the 2021 Nepal Census. (male female ratio 9.6:10.1) and among them most of the students were following the Hindu religion this data was consistence national data which is 81.19% (census Nepal 2021)

According to above data most of the students were below 17 years and females were more than male. Likewise, most of them were following Hindu religion and majority were related to Janajatis group, in our context most of the students who are belongs to low socio-economic status were studying to public schools.

Similarly, place of residence of the respondent's majority was from rural area that was 297(85.3%) and from urban 51(14.7%). Likewise, in current living status of respondents, majority of the respondents were living with their parents that is 273 (78.4%) and 75(21.6%) were living without parents. Current grade of the respondents

was equal hence it is proportionate sampling from each class that was 87 (25%) from each grade 9, 10, 11 and 12.

According to different faculty of grade 11 and 12(total of 174) respondents 146 (42,0%) were from management faculty, 22 (6.3%) were from education faculty and from others faculty were 6 (1.7%), similarly reason for selecting these respective faculty of the respondents were from own decision 176 (48.0%) and only 7 (4%) were from others decision. In last exam 324 (90.2%) were passed and 34 (9.8%), respondents were failed, this result shows that majority of the respondents were success in their exam.

Majority of the students who were studying in public schools were from the rural residence and almost 10% students were failing in their last examination. It shows the quality of public schools is not quite good than private schools. Respondents were from the grade 9, 10, 11 and 12, they were studying in different faculties like management, education and others (law). Their reason for selecting these different subjects.

Furthermore, in the academic status of the respondents, the number of respondents taken from all grade was equal, it was 25%. Majority of the respondents (84.0%) were studying the management subject, 12.6% of the respondents were studying education subject and about 2% of the respondents' subject was law. all most all of the respondents (96.0%) were selected above subjects by their own decision and only 4% of the respondents' subjects were selected by others.

Academic Status of Respondents Parents

Parents are the first teacher of the child. Education of the parents is very important milestone for the child. In our context, educational opportunity is not equal

to male and female, and accessibility of the school/college is the difficult in rural and remote area. Below table shows the parents educational status.

Table 2. *Distribution of the Respondents by Parents' informations (*n=348)

Characteristics	Number	Percent (%)
Education of Father		
Illiterate	56	16.0
Basic education	170	48.9
Secondary level	102	29.3
Bachelor Level	9	2.6
Master and above	11	3.2
Education of Mother		
Illiterate	99	28.4
Basic education	160	46.0
Secondary level	74	21.3
Bachelor level	8	2.3
Master and above	7	2.0
Occupation of father		
Unemployed	10	3.0
Government service	28	8.0
Non-Government service	8	2.3
Self-employed/business	40	11.5
Farmer	78	22.4
Daily labour	34	9.4
House maker	9	2.6
Foreign employ	144	33.0
Other (specify)….	27	7.8
Occupation of Mother		
Unemployed	21	6.0
Government service	14	4.0
Non-Government service	3	0.9
Self-employed/business	12	3.4
Farmer	94	27.0
Daily labour	13	3.7
House maker	172	49.4
Foreign employ	14	4.2
Other (specify)….	5	1.4
Monthly income of Family		
less than 10,000	74	21.3
10,000 to 36,000	178	51.1
36,000 to 1,11,000	85	24.4
Above 1,11,000	11	3.2

Above table 2 showed the education level of respondent's father, where 56(16.1%) were literate, about half of the (48.9%) respondent's fathers had basic

level, less than one third (29.3%) had secondary level education, least number (3.2%) had master level and bachelor level (2.6%) education. Similarly, the education level of respondent's mother, more than one-fourth (28.4%) were illiterate, 160 (46.0%) respondent's mothers had basic level of education, 74 (21.3%) had secondary level, 9 (2.6%) had bachelor level and only 7 (2.0%) had master level of education. In this study, most of the parents had equal basic level of education; here 84% of the father and 72% mothers were literate. This level of education is consistence with the literacy rate of male 83.6% and female 69.4% according to National census 2021.

Parents' education and awareness level shows the social status, awareness on mental health and impact on their children's holistic growth and development. People from the rural areas mostly depend on traditional agriculture. Occupation of the parents and their income shows the overall status of the family. Presently peoples are involving is much income generating activities. Below table shows the different occupations where the parents are involving for their earning.

Among the respondents, 3.0% of fathers were unemployed, while employed fathers worked mainly in foreign employment (33.0%), farming (22.4%), self-employment/business (11.5%), daily labour (9.4%), government service (8.0%), other occupations (7.8%), non-governmental service (2.3%), and homemaking (2. 6%).Likewise, among the respondents, 6.0% of mothers were unemployed, while employed mothers involved mainly in home maker (94.4%), farming (27%), government service (4.0%), daily labour (3.7%), non-governmental service (3.4%), foreign employment (1.4%), and non-governmental service (0.9%)

Briefly, it denotes that majority of fathers were involved in agriculture and abroad income likewise mother involved in house making and agriculture, which is

the main sources of family income. Socio-economic status shows the choice of their daily living, and schools for children.

Prevalence of DAS among the Respondents

In previous study, the prevalence of DAS among the school going students' is found high. Similarly, in present study depression, anxiety and stress if found very high. Below figure shows the present study scenario of the problem.

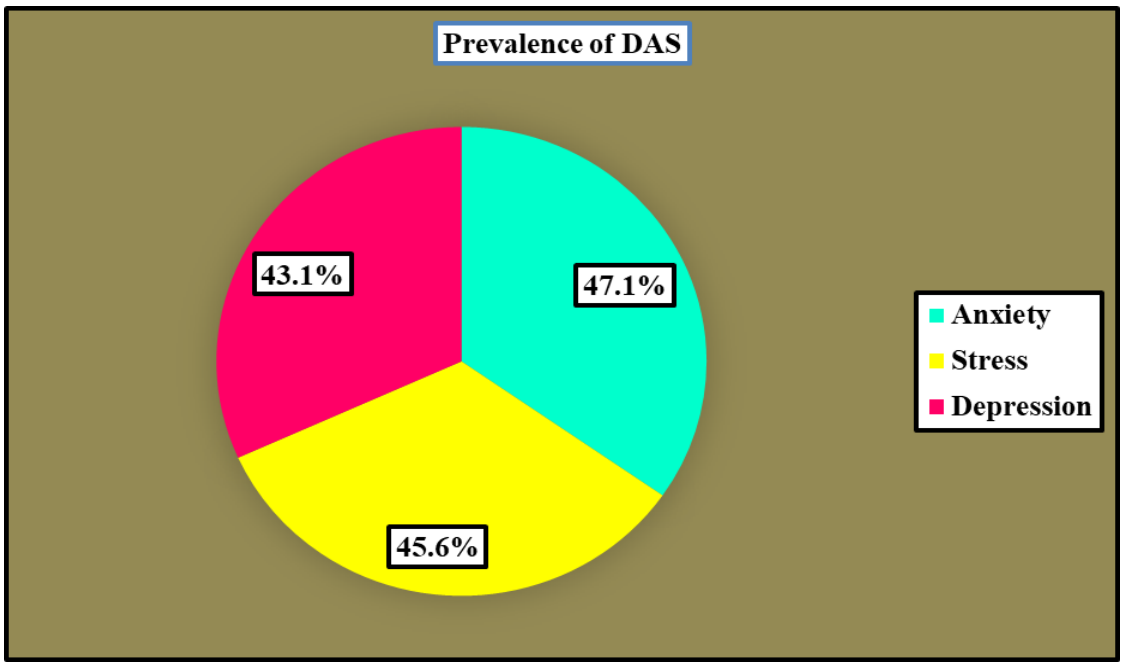

Figure 4. *Prevalence of DAS Among the Respondents*

Above pie chart 4 reveals, the prevalence of symptoms of DAS and it was found to be 43.1%, 47.1% and 45.6% respectively. This figure shows that DAS status is very high in school students, which indicates the risk of mental health problems. Early screening and intervention are required to prevent the mental health problems among them. The symptoms of depression, anxiety and stress are more prevalent with moderate to extremely severe range in the current sample. These findings suggest

urgent need of some preventive measures and interventions to improve the mental health of students.

Level of Depression, Anxiety and Stress

Level of Depression, Anxiety and Stress of the respondents were measured by using standardized tool (DASS-21), the level of each DAS is categorized in normal, mild, moderate, severe and extremely severe. Analysis was done separately and shown in below table.

Table 3. *Level of Symptoms of Depression Among the Respondents (n = 348)*

Level	Depression	
	n	%
Normal (0-4)	198	56.9
Mild (5-6)	49	14.1
Moderate (7-10)	62	17.8
Severe (11-13)	21	6.0
Extremely severe (14+)	18	5.2
Overall	150	43.1

Above table 3 shows the level of Depression among the respondents. The prevalence of depression was 43.1%. More than fifty percent of the respondents were in normal condition; likewise, 14.1% respondents showed the mild level of depression, 17.8% moderate, 6%, severe and 5.2% of the respondents showed the extremely severe level of depression.

This prevalence and different level of depression is the indicator of mental health problems. Here severe (6.0%) and extremely severe (5.2%) level of depression urges the early requirements of interventions to prevent from the suicidal attempt.

Table 4. *Level of Symptoms of Anxiety Among the Respondents (n = 348)*

Level	Anxiety	
	n	%
Normal (0-3)	184	52.9
Mild (4-5)	36	10.3
Moderate (6-7)	77	22.1
Severe (8-9)	24	6.9
Extremely severe (10+)	27	7.8
overall	164	47.1

Above table 4 reveals that 47.1% of the respondents had anxiety symptoms. More than fifty percent of the respondents were in normal level of anxiety. Similarly, about 10.3% of the respondents showed the mild level of anxiety symptoms, 22.1% showed moderate, 6.9% showed the severe level and 7.8% of the respondents showed the extremely severe level of anxiety.

This prevalence and different level of anxiety is very high so for severe (6.9%) and extremely severe (7.8%) anxiety required extensive interventions.

Table 5. *Level of Symptoms of Stress Among the Respondents (n = 348)*

Level	Stress	
	n	%
Normal (0-7)	189	54.3
Mild (8-9)	89	25.6
Moderate (10-12)	48	13.8
Severe (13-16)	21	6.0
Extremely severe (17+)	1	0.3
overall	159	45.6

Above table 5 reveals the prevalence of stress and different level of stress symptoms among the participants. The prevalence of stress is 45.6% and more than fifty percent had normal level of stress symptoms. About one fourth of the

respondents had mild stress. Similarly, 13.8% had moderate level, 6.0% had severe level and less than one percent had extremely severe level of depression.

From this result, severe level of stress (6.0%) and extremely severe level of stress (0.3%) require urgently intervention.

The data shows the situation of depression, anxiety and stress among secondary level students. It indicates the poor mental health condition and secondary level students are at the risky zone of mental illness.

Association between Level of Depression, Anxiety and Stress and Socio-Demographic Variables

The symptoms of different levels of depression, anxiety and stress are associated with demographic variables like age, sex, religion, ethnicity and monthly family income. In previous studies, there are different in association between level of DAS and socio-demographic variables.

Similarly, in present study association is not similar with DAS and socio-demographic variables.

Association between Level of Depression and Socio-demographic Variables

The depressive symptoms of the respondents were related to the socio-demographic characteristics like; age, sex, religions, ethnicity and monthly income of the family. In this study, there is no statistical significant between the depressive symptoms and socio-demographic characteristics of the respondents.

Table 6. *Association between Depression level of Respondents and Selected Socio-demographic Variables*

Variables		Symptoms of Depression			
		No N(%)	Yes N(%)	χ^2	*p*-value
Age					
	<17	164(56.7)	125(43.3)	0.015	0.901
	≥17	34(57.6)	25(42.4)		
Sex					
	Male	91(60.7)	59(39.3)	1.528	0.216
	Female	107(54.0)	91(46.0)		
Religion					
	Hinduism	178(57.4)	132(42.5)	0.316	0.574
	Others#	20(52.6)	18(47.4)		
Ethnicity					
	Dalit	48(51.6)	45(48.4)	2.624	0.269
	Janajatis	71(55.5)	57(44.5)		
	Brahman/Chhetri	79(62.2)	48(37.8)		
Monthly income					
	Less than 10000	37(50.0)	37(50.0)	4.186	0.242
	10000-36000	108(60.7)	70(39.3)		
	36000-111000	45(52.9)	40(47.1)		
	Above 111000	8(72.7)	3(27.3)		

**p* value significant at < .05 χ^2 =Chi-square CI= Confidence Interval
#Buddhism, Christianity, Islam

The above table 6 shows, the depression status of respondents were not significantly associated with the age, sex, religion, ethnicity and monthly income of the respondents.

Association between Level of Anxiety and Socio-demographic Variables

Below table showed the relation between anxiety symptoms of the respondents and socio-demographic characteristics like; age, sex, religions, ethnicity and monthly income of the family.

Table 7. *Association between Anxiety of Respondents and Selected Socio-demographic Variables*

Variables	Symptoms of Anxiety			
	No N (%)	Yes N (%)	χ^2	*p*-value
Age				
<17	151(52.2)	138(47.8)	0.267	0.606
≥17	33(55.9)	25(42.4)		
Sex				
Male	86(57.3)	64(42.7)	2.104	**0.014***
Female	98(49.5)	100(50.5)		
Religion				
Hindu	163(52.6)	147(47.4)	0.098	0.755
Others#	21(55.3)	17(44.7)		
Ethnicity				
Dalit	44(47.3)	49(52.7)	1.763	**0.041***
Janajatis	72(56.2)	56(43.8)		
Brahman/Chhetri	68(53.5)	59(46.5)		
Monthly income				
Less than 10000	41(55.4)	33(44.6)	4.186	0.242
10000-36000	98(55.1)	80(44.9)		
36000-111000	43(50.6)	42(49.4)		
Above 111000	2(18.2)	9(81.8)		

**p* value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

#Buddhism, Christianity, Islam

Above table 7 reveals that the anxiety status was significantly associated with sex (*p*= 0.014) and ethnicity (*p*= 0.041). The anxiety status was not significantly associated with other demographic variables like, age, religion and monthly income.

Association between Level of Stress and Socio-demographic Variables

Below table showed the relation between stress symptoms of the respondents and socio-demographic characteristics like; age, sex, religions, ethnicity and monthly income of the family.

Table 8. *Association between Stress of Respondents and Selected Socio-demographic Variables*

Variables		Symptoms of Stress			
		No N (%)	Yes N(%)	χ^2	*p*-value
Age					
	<17	158(54.7)	131(45.3)	0.089	0.765
	≥17	31(52.5)	28(47.5)		
Sex					
	Male	89(59.3)	61(40.5)	2.681	**0.012***
	Female	100(50.5)	98(49.5)		
Religion					
	Hindu	169(54.5)	141(45.5)	0.048	0.826
	Others#	20(52.6)	18(47.4)		
Ethnicity					
	Dalit	50(53.8)	43(46.2)	0.019	0.991
	Janajatis	70(54.7)	58(45.3)		
	Brahman/Chhetri	69(54.3)	58(45.7)		
Monthly income					
	Less than 10000	35(47.3)	39(52.7)	2.111	0.550
	10000-36000	102(57.3)	76(42.7)		
	36000-111000	46(54.1)	39(45.9)		
	Above 111000	6(54.5)	5(45.5)		

**p* value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Buddhism, Christianity, Islam

The above table 8 depicts that respondents' stress status was statistically associated with sex (*p*=0.012). There was not statistically significant association between the stress status and age, religion, ethnicity and monthly income of respondents.

Frequency of psychosocial factors associated with depression, anxiety and stress

In the present study associated factors of depression, anxiety and stress were categorized into five types, which directly and indirectly affected the secondary level students.

These factors are at first individual factors: it includes five items, second is family factors, it includes seven items, third is social factor, it has six items, fourth is academic factor and it has three items and last is psychological factors and it has four items. The frequency was calculated based on sex of the students and total number.

Individual Factors Status of the Respondents

In this table individual factors that means personality behaviour, attitude, childhood effects on family behaviour, social status and its effects. it indicates the habit and behaviours of respondents like; tobacco smoking and alcohol consumption, use of illicit drugs, way of sleeping habit, bad childhood experience and physical illness injury.

These individual factors are directly related to the mental illness of the respondents.

Table 9. *Individual Factors Status of the Respondents*

		Total	
Item Description		%	N
Tobacco smoking and alcohol consumption	No	96.3	335
	Yes	3.7	13
Drug use	No	98.8	343
	Yes	1.2	4
Inadequate sleep	No	69.5	242
	Yes	30.5	106
Bad childhood experience	No	79.3	275
	Yes	20.7	72
Physical illness injury	No	62.1	216
	Yes	37.6	132
Total		100.0	348

Above table 9 shows the individual factors of students where the total number of students who used to consume alcohol and tobacco were 13 (3.7 %). Whereas total number of illicit drug users was 1.2%. Based on sleep pattern total 106 (30.5%) inadequate sleep pattern. 72 (20.7%) had bad childhood experiences, and based on their physical injury 132 (37.6%) of respondents had effects of it.

Individual factors measure the behaviour factors and other factors faced by the students, which leads to mental health problems.

Family factors Status of the Respondents

The family factors indicate the support system and health habit of family members of respondents. Which effects the mental health of their children, like; Living with both parents, absence of both parents, relation with family, family history of mental illness, tobacco smoking, alcohol, consumption, drugs abuse, economic support from family and suicidal attempt by family member.

Table 10. *Status of the Respondents in Relation to Family Factors*

Item Description		Total	
		%	N
Living with both parents	No	18.4	64
	Yes	81.6	284
Absence of both parents	No	87.1	303
	Yes	12.6	44
Good relation with family	No	8.0	28
	Yes	92.0	320
Family history of mental illness	No	85.6	298
	Yes	14.1	49
Tobacco smoking, alcohol, consumption, drugs abuse by family	No	61.5	214
	Yes	38.5	134
Economic support from family	No	12.6	44
	yes	87.4	304
Suicidal attempt by family member	No	88.2	307
	Yes	11.8	41
Total		100.0	348

Above table 10, shows the status of family factors (associated factors of DAS), among the total students 64(18.4%) students were living without both parents, 44 (12.6%) students had absence of both parents. Based on good family relations almost all (92%) students had good relations with their family. Among the 348 students,49 (14.1%) had a family history of mental illness, 134 (38.5%) students had a family history of tobacco smoking, alcohol consumption and drug abuse 44 (12.6%) students had lack of economic support from their family. About 41 (11.8%) students' family members had attempted suicide.

Love and belongingness of parents, healthy family relationship and bonding, normal behaviour pattern, and economic support helps to foster the growing children. Problems in these factors may create mental health problems in children.

Social Factors Status of the Respondents

The social factors indicate the social relationship, communication, involvement, support system and effects of religious and social status on within the community. Which effects the mental health of the respondents and their family.

Table 11. *Social Factors Status of the Respondents*

Item Description		Total	
		%	N
Adequate social support	No	31.0	108
	Yes	69.0	240
Good relation with friends	No	4.9	17
	Yes	95.1	331
Good relation with teacher, staffs	No	11.5	40
	Yes	88.5	308
Involvement in social activities	No	30.7	107
	Yes	69.3	241
Belongs to religious minorities	No	74.7	260
	Yes	25.3	88
Internet addiction social media usage	No	45.7	159
	Yes	54.3	189
Total		100.0	348

The above table 11 indicates that more than two third (69.0%) of respondents had adequate social support and about one third of the respondents had no social support. Similarly, all most all of the respondents had good relation with their friends. Among them majority (88.5%) of the respondents had good relation and least (11.5%) of the respondents had not good relation with teachers and other staffs. More than two third (69.0%) of respondents were involved in social activities and less than one-third (30.7%) of respondents were not involved in social activities.

One-fourth (25.3%) of the respondents belongs to religious minorities, likewise more than half (54.3%) of the respondents were internet addicted, among them males are about two third (64%) and females were less than half (47%).

Social relationship, social support and acceptance of social values, to give and take social respect is crucial to be the mentally healthy in society. The response in above items is very important aspects for the social adaptation.

Academic Factors Status of the Respondents

The academic factors are the key to be mentally ill among the school going children. The relationship with school family, academic performance, stress and bullying are used as academic factors of the respondents.

Table 12. *Academic Factors Status of the Respondents*

Item Description		Total	
		%	N
Satisfied with academic performance	No	22.4	78
	Yes	77.6	270
Educational stress	No	65.8	229
	Yes	34.2	119
Bullying	No	74.1	258
	Yes	25.9	90
Total		100.0	348

Above table 12 shows more than three forth (77.6%) of the respondents were satisfied with their academic performance. More than one third (34.2%) of the respondents had educational stress and about one fourth (25.9%) of the respondents had faced the bullying from their seniors.

Academic environment should be stress free for the students, academic pressure, negative achievements and bullying by school students, teachers and staffs are the negative parameter for the student's wellbeing.

Psychological Factors Status of the Respondents

The psychological factors are pattern of thinking, feeling and behaviour of the respondents toward oneself. These are traumatic life experiences, low self-esteem, tried to hurt yourself /suicidal attempt and Exam phobia. If psychological factors are not appropriate or healthy it cause the mental health problems.

Table 13. *Psychological Factors Status of the Respondents*

Item Description		Total	
		%	N
Traumatic life experiences	No	64.4	224
	yes	35.6	124
Low self-esteem	No	84.5	294
	Yes	15.5	54
Tried to hurt yourself/ suicidal	No	81.9	285
attempt	Yes	18.1	63
Exam phobia	No	36.2	126
	Yes	63.2	220
Total		100.0	348

Table 13 reveals the respondents on status of psychological factors. More than one third (35.6%) of the respondents had traumatic life experiences, where as 15.5% (54) respondents had felt low self-esteem, 18.1% of the respondents were tried to hurt themselves and suicidal attempt. Less than two third (63.2%) of the respondents were suffered from the exam phobia.

Association between level of Depression, Anxiety, Stress and Psychosocial Factors

The symptoms of depression, anxiety and stress are associated with different psychosocial factors five, like; individual factors, family factors, social factors, academic factors and psychological factors. In previous studies, there are varies in association between DAS and different psychosocial factors as well as socio-

demographic variables. Similarly, in present study association is found between psychosocial factors and level of depression, anxiety and stress.

Mental illness is prevalent among school going students. Many different psychosocial factors are associated to be mentally ill. In present study, the association was calculated between level of DAS and the five different factors with 25 sub themes. These factors were individual, family, social, academic and psychological. The below table shows the association between level of depression and associated factors (Individual factors and Family factors)

Table 14. *Association between Level Depression of Respondents and Psychosocial Factors (Individual/Family factor)*

Characteristics	Level of Depression		χ^2	*p*-value
	No N(%)	Yes N(%)		
Tobacco smoking and alcohol consumption				
No	191(54.9)	144(41.4)	0.051	0.821
Yes	7(2.0)	6(1.7)		
Drug abuse				
No	196(56.3)	148(42.5)	0.078	0.779
Yes	2(0.6)	2(0.6)		
Inadequate sleep				
No	152(43.7)	90(25.9)	11.328	0.001*
Yes	46(13.2)	60(17.2)		
Bad Childhood experience				
No	175(50.3)	101(29.0)	23.047	0.000*
Yes	23(6.6)	4914.1)		
Physical illness injury				
No	134(38.5)	82(23.6)	6.136	0.013*
Yes	64(18.4)	68(19.5)		
Living with both parents				
No	38(10.9)	26(7.5)	0.196	0.658
Yes	160(46.0)	124(35.6)		
Absence of both parents				
No	173(49.7)	131(37.6)	0.000	0.991
Yes	25(7.2)	19(5.5)		
Good relationship with family				
No	15(4.3)	13(3.7)	0.137	0.711
Yes	183(52.6)	137(39.4)		
Family history of mental illness				
No	175(50.3)	123(35.3)	2.827	0.093
Yes	23(6.6)	27(7.8)		
Tobacco smoking, alcohol consumption and drug abuse by family				
No	131(37.6)	83(23.9)	4.226	0.040*
Yes	67(19.3)	67(19.3)		
Lack of economic support from family				
No	22(6.3)	22(6.3)	0.977	0.323
Yes	176(50.6)	128(36.8)		
Life time suicidal attempt by family member				
No	183(52.6)	124(35.6)	7.818	0.005*
Yes	15(4.3)	26(7.5)		

**p* value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Above table 14 reveals that the depression status was significantly associated with Inadequate sleep(*p*= 0.001) Bad Childhood experience (*p*= 0.000), Physical illness injury (*p*= 0.013), Tobacco smoking, alcohol consumption and drug abuse by family(*p*= 0.040) and Life time suicidal attempt by family member(*p*= 0.013). The depression status was not significantly associated with other factors like, Tobacco smoking and alcohol consumption, Drug abuse, Living with both parents, Absence of both parents, Good relationship with family, Family history of mental illness and Lack of economic support from family (p=< .05).

Association between Level of Depression of Respondents and Psychosocial Factors (Social Factors, Academic Factors and Psychological Factors)

Different psychosocial factors like; social, academic and psychological and sub-factors of These three factors were calculated to conform the association between the level of depression and It. Social status relation, involvement, and support are the social factors likewise, academic performance, academic stress, relationship with school family, bullying, exam phobia, suicidal attempts are the other factors.

Table 15. *Association between level of Depression of Respondents and Social, Academic, Psychological Factor*

Characteristics	Level of Depression		χ^2	*p*-value
	No N(%)	Yes N(%)		
Adequate social support				
No	57(16.4)	51(14.7)	1.083	0.298
Yes	141(40.5)	99(28.4)		
Good relation with friends				
No	10(2.9)	7(2.0)	0.027	0.869
Yes	188(54.0)	143(41.1)		
Good relation with teacher and other staffs				
No	24(6.9)	16(4.6)	0.177	0.674
Yes	174(50.0)	134(38.5)		
Involvement in social activities				
No	60(17.2)	47(13.5)	0.043	0.837
Yes	138(39.7)	103(29.6)		
Belongs to religious minorities group				
No	152(43.7)	108(31.0)	1.027	0.311
Yes	46(13.2)	42(12.1)		
Internet addiction and excessive social media uses				
No	99(28.4)	60(17.2)	3.439	0.064
Yes	9928.4)	90(25.9)		
Satisfied with academic performance				
No	35(10.1)	43(12.4)	5.927	0.015*
Yes	163(46.8)	107(30.7)		
Educational stress				
No	147(42.2)	82(23.6)	14.534	0.000*
Yes	51(14.7)	68(19.5)		
Bullying				
No	161(46.3)	97(27.9)	12.334	0.000*
yes	37(10.6)	53(15.2)		
Traumatic life events				
No	141(40.5)	83(23.9)	9.382	0.002*
yes	57(16.4)	67(19.3)		
Low self steem				
No	174(50.0)	120(34.5)	4.041	0.044*
Yes	24(6.9)	30(8.6)		
Try to hurt yourself				
No	181(52.0)	104(29.9)	28.066	0.000*
Yes	17(4.9)	46(13.2)		
Exam phobia				
No	96(27.6)	30(8.6)	29.981	0.000*
Yes	102(29.3)	120(34.5)		

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Table 15 demonstrates that depression status was significantly associated with satisfaction regarding academic performance (p = 0.015),educational stress (p=< 0.001), experiences of bullying (p=< 0.001), exposure to traumatic life events (p = 0.002), low self-esteem (p = 0.044), self-harm behaviours (p= < 0.001), and exam-related phobia (p=< 0.001).The depression status was not significantly associated with other factors like, Adequate social support, Good relation with friends, Good relation with teacher and other staffs, Involvement in social activities, Belongs to religious minorities group and Internet addiction and excessive social media uses (p=< .05).

Association between Level of Anxiety and Associated Factors (Individual Factors and Family Factors)

Different psychosocial factors like; individual and family and sub-factors of these factors were calculated to conform the association between the level of anxiety and It. Family behaviour, relationship, involvement, suicidal history in family, absent or present of mental illness and support are the family factors and individual habit and behaviour, sleeping pattern, bad childhood experiences are the individual factors

Table 16. *Association between Level of Anxiety of Respondents and Individual, Family factor*

Characteristics	Level of Anxiety		χ^2	*p*-value
	No N(%)	Yes N(%)		
Tobacco smoking and alcohol consumption				
No	178(51.1)	157(45.1)	0.245	0.621
Yes	6(1.7)	7(2.0)		
Drug abuse				
No	182(52.3)	162(46.6)	0.013	0.908
Yes	2(0.6)	2(0.6)		
Inadequate sleep				
No	136(39.1)	106(30.5)	3.525	0.060
Yes	48(13.8)	58(16.7)		
Bad Childhood experience				
No	158(45.4)	118(33.9)	10.237	0.001*
Yes	26(7.5)	46(13.2)		
Physical illness injury				
No	127(36.5)	89(25.6)	8.017	0.005*
Yes	57(16.4)	75(21.6)		
Living with both parents				
No	31(8.9)	33(9.5)	0.619	0.431
Yes	153(44.0)	131(37.6)		
Absence of both parents				
No	163(46.8)	141(40.5)	0.535	0.464
Yes	21(6.0)	23(6.6)		
Good relationship with family				
No	16(4.6)	12(3.4)	0.223	0.637
Yes	168(48.3)	152(43.7)		
Family history of mental illness				
No	162(46.6)	136(39.1)	1.845	0.174
Yes	22(6.3)	28(8.0)		
Tobacco smoking, alcohol consumption and drug abuse by family				
No	117(33.6)	97(27.9)	0.722	0.395
Yes	67(19.3)	67(19.3)		
Lack of economic support from family				
No	24(6.9)	20(5.7)	0.057	0.812
Yes	160(46.0)	144(41.4)		
Life time suicidal attempt by family member				
No	164(47.1)	143(41.1)	0.312	0.576
Yes	20(5.7)	21(6.0)		

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Above table 16 reveals that the anxiety status was significantly associated with Bad Childhood experience (*p*= 0.001), and Physical illness injury (*p*= 0.005).

The anxiety status was not significantly associated with other factors like, Tobacco smoking and alcohol consumption, Drug abuse, Inadequate sleep, Living with both parents, Absence of both parents, Good relationship with family, Family history of mental illness, Tobacco smoking, alcohol consumption and drug abuse by family, Lack of economic support from family and Life time suicidal attempt by family member (p=< .05).

Association between Level of Anxiety of Respondents and Associated Factors (Social Factors, Academic Factors and Psychological Factors)

Different psychosocial factors like; social, academic and psychological and sub-factors of These factors were calculated to conform the association between the level of anxiety and It. Social status relation, involvement, and support are the social factors likewise, academic performance, academic stress, relationship with school family, bullying, exam phobia, suicidal attempts are the other factors.

Table 17. *Association between Level of Anxiety of Respondents and Social, Academic, and Psychological Factor*

Characteristics	Level of Anxiety		χ^2	*p*-value
	No N(%)	Yes N(%)		
Adequate social support				
No	54(15.5)	54(15.5)	0.519	0.471
Yes	130(37.4)	110(31.6)		
Good relation with friends				
No	9(2.6)	8(2.3)	0.000	0.995
Yes	175(50.3)	156(44.8)		
Good relation with teacher and other staffs				
No	23((6.6)	17(4.9)	0.388	0.533
Yes	161(46.3)	14742.2)		
Involvement in social activities				
No	51(14.7)	56(16.1)	1.683	0.195
Yes	133(38.2)	108(31.0)		
Belongs to religious minorities group				
No	137(39.4)	123(35.3)	0.014	0.907
Yes	47(13.5)	41(11.8)		
Internet addiction and excessive social media uses				
No	88(25.3)	71(20.4)	0.718	0.397
Yes	96(27.6)	93(26.7)		
Satisfied with academic performance				
No	35(10.1)	43(12.4)	2.583	0.108
Yes	149(42.8)	121(34.8)		
Educational stress				
No	141(40.5)	88(25.3)	20.335	0.000*
Yes	43(12.4)	76(21.8)		
Bullying				
No	146(42.0)	112(32.2)	5.527	0.019*
yes	3810.9)	52(14.9)		
Traumatic life events				
No	135(38.8)	89(25.6)	13.794	0.000*
yes	49(14.1)	75(21.6)		
Low self steem				
No	165(47.4)	129(37.1)	8.026	0.005*
Yes	19(5.5)	35(10.1)		
Try to hurt yourself				
No	163(46.8)	122(354.1)	11.788	0.001*
Yes	21(6.0)	4212.1)		
Exam phobia				
No	81(23.3)	45(12.9)	10.324	0.001*
Yes	103(29.6)	119(34.2)		

**p* value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Above table 17 reveals that the anxiety status was significantly associated with Educational stress (*p*= 0.000),Bullying (*p*= 0.019), Traumatic life events(*p*= 0.000), Low self-steam (*p*= 0.005), Try to hurt yourself (*p*= 0.001), and Exam phobia (*p*= 0.001).The anxiety status was not significantly associated with other factors like, Adequate social support, Good relation with friends, Good relation with teacher and other staffs, Involvement in social activities, Satisfied with academic performance, Belongs to religious minorities group and Internet addiction and excessive social media uses (p=< .05).

Association between Level of Stress and Psychosocial Factors

Association between Level of Stress and Psychosocial Factors (Individual and Family Factors)

The psychosocial factors like; individual and family and sub-factors of These factors were calculated to conform the association between the level of stress and it. Family behaviour, relationship, involvement, suicidal history in family, absent or present of mental illness and support are the family factors and individual habit and behaviour, sleeping pattern, bad childhood experience are the individual factors

Table 18. *Association between Level of Stress of Respondents and Individual, Family factor*

Characteristics	Level of stress		χ^2	*p*-value
	No N(%)	Yes N(%)		
Tobacco smoking and alcohol consumption				
No	236(67.8)	99(28.4)	1.637	0.201
Yes	7(2.0)	6(1.7)		
Drug abuse				
No	240(69.0)	104(29.9)	0.051	0.821
Yes	3(0.9)	1(0.3)		
Inadequate sleep				
No	179(51.4)	63(18.1)	6.461	0.011*
Yes	64(18.4)	42(12.1)		
Bad Childhood experience				
No	207(59.5)	69(19.8)	16.940	0.000*
Yes	36(10.3)	36(10.3)		
Physical illness injury				
No	166(47.7)	50(14.4)	13.336	0.000*
Yes	77(22.1)	55(15.8)		
Living with both parents				
No	42(12.1)	22(6.3)	0.657	0.417
Yes	201(57.8)	83(23.9)		
Absence of both parents				
No	216(62.1)	88(25.3)	1.713	0.191
Yes	27(7.8)	17(4.9)		
Good relationship with family				
No	20(5.7)	8(2.3)	0.037	0.847
Yes	223(64.1)	97(27.9)		
Family history of mental illness				
No	213(61.2)	85(24.4)	2.677	0.102
Yes	30(8.6)	20(5.7)		
Tobacco smoking, alcohol consumption and drug abuse by family				
No	157(45.1)	57(16.4)	3.300	0.069
Yes	86(24.7)	48(13.8)		
Lack of economic support from family				
No	29(8.3)	15(4.3)	0.367	0.545
Yes	214(61.5)	90(25.9)		
Life time suicidal attempt by family member				
No	219(62.9)	88(25.3)	2.812	0.094
yes	24(6.9)	17(4.9)		

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Above table 18 reveals that the stress status was significantly associated with Inadequate sleep (p= 0.011) Bad Childhood experience (p= 0.000), Physical illness injury (p= 0.000). The stress status was not significantly associated with other factors like Tobacco smoking, alcohol consumption, drug abuse by family, Life time suicidal attempt by family member, Tobacco smoking and alcohol consumption, Drug abuse, Living with both parents, Absence of both parents, Good relationship with family, Family history of mental illness and Lack of economic support from family (p=< .05).

Association between Level of Stress of Respondents and Associated Factors (Social Factors, Academic Factors and Psychological Factors)

The below table shows the psychosocial factors like; social, academic and psychological and sub-factors of These factors were calculated to conform the association between the level of stress and It. Social status relation, involvement, and support are the social factors likewise, academic performance, academic stress, relationship with school family, bullying, exam phobia, suicidal attempt are the other factors.

Table 19. *Association between Level Stress of Respondents and Social, Academic, Psychological Factor*

Characteristics	Level of stress		χ^2	*p*-value
	No N(%)	Yes N(%)		
Adequate social support				
No	74(21.3)	34(9.8)	0.127	0.721
Yes	169(48.6)	71(20.4)		
Good relation with friends				
No	10(2.9)	7(2.0)	1.027	0.311
Yes	233(67.0)	98(28.2)		
Good relation with teachers and other staffs				
No	28(8.0)	12(3.4)	0.001	0.980
Yes	215(61.8)	93(26.7)		
Involvement in social activities				
No	76(21.8)	31(8.9)	0.106	0.745
Yes	167(48.0)	74(21.3)		
Belongs to a religious minorities group				
No	185(53.2)	75(21.6)	0.858	0.354
Yes	58(16.7)	30(8.6)		
Internet addiction and excessive social media uses				
No	113(32.5)	46(13.2)	0.214	0.643
Yes	130(37.4)	59(17.0)		
Satisfied with academic performance				
No	52(14.9)	26(7.5)	0.477	0.490
Yes	191(54.9)	79(22.7)		
Educational stress				
No	180(51.7)	49(14.1)	24.475	0.000*
Yes	63(18.1)	56(16.1)		
Bullying				
No	197(56.6)	61(17.5)	20.184	0.000*
Yes	46(13.2)	44(12.6)		
Traumatic life events				
No	173(49.7)	51(14.7)	16.359	0.000*
Yes	70(20.1)	54(15.5)		
Low self steem				
No	213(61.2)	81(23.3)	6.180	0.013*
Yes	30(8.6)	24(6.9)		
Try to hurt yourself				
No	212(60.9)	73(21.0)	15.526	0.000*
Yes	31(8.9)	32(9.2)		
Exam phobia				
No	105(30.2)	21(6.0)	17.100	0.000*
Yes	138(39.7)	84(24.1)		

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

Above table 19, reveals that the stress status was significantly associated with Educational stress (*p*= 0.000), Bullying (*p*= 0.000), Traumatic life events (*p*= 0.000), Low self-esteem (*p*= 0.013), Try to hurt yourself (*p*= 0.000), and Exam phobia (*p*= 0.000). The stress status was not significantly associated with other factors like, satisfied with academic performance, Adequate social support, Good relation with friends, Good relation with teacher and other staffs, Involvement in social activities, belongs to religious minorities group and Internet addiction and excessive social media uses (p=< .05).

Psychosocial Factors Leading to Depression, Anxiety and Stress Among School-Going Students

In this study, associated factors are divided into five different subtypes and twenty items and these factors are directly and indirectly related to depression, anxiety and stress among the respondents. These five subtypes' factors are individual related, family related, social related, academic related and psychological related factors.

Psychosocial Factors of Depression among the Respondents

The magnitude of association between the psychosocial factors and different sub-factors and level of depression was determined in below table.

Table 20. *Psychological Factors Associated with Symptoms of Depression among the Respondents (n=348)*

Characteristics	Symptoms of Depression		COR (95%CI)	AOR (95%CI)
	No	Yes		
Bad Childhood experience				
No	175(50.3)	101(29.0)	1	1
Yes	23(6.6)	49(14.1)	3.691(2.12-6.41)	2.89(1.60-5.2) *
Physical illness injury				
No	134(38.5)	82(23.6)	1	1
Yes	64(18.4)	68(19.5)	1.74(1.12-2.69)	1.29(0.79-2.13)
Family history of mental illness				
No	175(50.3)	123(35.3)	1	1
Yes	23(6.6)	27(7.8)	1.67(0.91-3.05)	1.26(0.64-2.46)
Family history of substance abuse				
No	131(37.6)	83(23.9)	1	1
Yes	67(19.3)	67(19.3)	1.58(1.02-2.44)	1.36(0.77-1.96)
Internet addiction				
No	99(28.4)	60(17.2)	1	1
Yes	99(28.4)	90(25.9)	1.50(0.98-2.30)	1.22(0.77-1.96)
Satisfied with academic performance				
No	35(10.1)	43(12.4)	1	1
Yes	163(46.8)	107(30.7)	0.53(0.32-0.89)	0.68(0.39-1.20)
Educational Stress				
No	147(42.2)	82(23.6)	1	1
Yes	51(14.7)	68(19.5)	2.39(1.52-3.76))	1.64(0.98-2.77)
Bullying				
No	161(46.3)	97(27.9)	1	1
Yes	37(10.6)	53(15.2)	2.38(1.46-3.88)	1.70(0.99-2.95)*
Traumatic life experience				
No	141(40.5)	83(23.9)	1	1
Yes	57(16.4)	67(19.3)	1.20(1.28-3.12)	1.47(0.89-2.41)
Low self-esteem				
No	174(50.0)	120(34.5)	1	1
Yes	24(6.9)	30(8.6)	1.81(1.01-3.25)	1.10(0.57-2.13)

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

The results from the multivariable logistic regression analysis for correlates of depression symptoms are shown in Table 20. The variables that remained in the final model were bad childhood experience, physical illness or injury, family history of mental illness, family history of substance abuse, internet addiction, satisfaction with

academic performance, educational stress, bullying, traumatic life experience, and low self-esteem. These variables were included in the final model because they had p-values <0.15 in the univariate model.

In the final model, bad childhood experience (AOR: 2.89, 95% CI: 1.60–5.20) and Bullying (AOR: 1.70, 95% CI: 0.99–2.95) were significantly associated with the presence of depression symptoms. This suggests that adverse early life experiences and traumatic events are key contributors to the development of depression in the respondents.

Psychosocial factors of Anxiety among the Respondents

The magnitude of association between the level of anxiety and subs factors of psychosocial factors were determined in below table.

Table 21. *Psychosocial Factors Associated with Symptoms of Anxiety Among Respondents* (n=348)

Characteristics	Symptoms of Anxiety			
	No	Yes	COR (95%CI)	AOR (95%CI)
Sex				
Male	86(24.7)	64(18.4)	1	1
Female	98(28.2)	100(28.7)	1.37(0.90-2.10)	1.29(0.80-2.09)
Inadequate sleep				
No	136(39.1)	106(30.5)	1	1
Yes	48(13.8)	58(16.7)	1.55(0.98-2.45)	1.05(0.63-1.77)
Bad Childhood experience				
No	158(45.4)	118(33.9)	1	1
Yes	26(7.5)	46(13.2)	2.37(1.38-4.05)	1.66(0.92-2.98)
Physical illness injury				
No	127(36.5)	89(25.6)	1	1
Yes	57(16.4)	75(21.6)	1.88(1.21-2.91)	1.49(0.91-2.44)
Satisfied with academic performance				
No	35(10.1)	43(12.4)	1	1
Yes	149(42.8)	121(34.8)	0.66(0.40-1.10)	0.83(0.47-1.46)
Educational Stress				
No	141(40.5)	88(25.3)	1	1
Yes	43(12.4)	76(21.8)	2.83(1.79-4.48)	1.94(1.15-3.36) *
Bullying				
No	146(42.0)	112(32.2)	1	1
Yes	38(10.9)	52(14.9)	1.78(1.20-2.90)	1.11(0.64-1.93)
Traumatic life experience				
No	135(38.8)	89(25.6)	1	1
Yes	49(14.1)	75(21.6)	2.32(1.48-3.64)	1.88(1.15-3.10) *
Low self-esteem				
No	165(47.4)	129(37.1)	1	1
Yes	19(5.5)	35(10.1)	2.356(1.29-4.31)	1.52(0.79-2.93)
Exam Phobia				
No	81(23.3)	45(12.9)	1	1
Yes	103(29.6)	119(34.2)	2.08(1.33-3.26)	1.51(0.92-2.49)

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

The results from the multivariable logistic regression analysis for factors associated with symptoms of anxiety are presented in Table21. The variables that remained in the final model included sex**,** inadequate sleep**,** bad childhood experience**,** physical illness or injury**,** satisfaction with academic performance**,** educational stress**,**

bullying**,** traumatic life experience**,** low self-esteem**,** and exam phobia (p->0.15 in the univariate analysis).

In the final model, educational stress (AOR: 1.94, 95% CI: 1.15–3.36) and traumatic life experience (AOR: 1.88, 95% CI: 1.15–3.10) were found to be significantly associated with anxiety symptoms. This indicates that stress related to education and past traumatic experiences are important factors contributing to anxiety in the respondents.

Psychosocial Factors of Stress among the Respondents

The magnitude of association between the level of stress and subs factors of psychosocial factors were determined in below table.

Table 22. *Factors Associated with Symptoms of Stress Among the Respondents* (n=348)

Characteristics	Symptoms of Anxiety			
	No	Yes	COR (95%CI)	AOR (95%CI)
Sex				
Male	89(25.6)	61(17.5)	1	1
Female	100(28.7)	98(28.2)	1.43(0.93-2.19)	1.45(0.88-2.40)
Inadequate sleep				
No	140(40.2)	102(29.3)	1	1
Yes	49(14.1)	57(16.4)	1.59(1.01-2.53)	1.06(0.62-1.81)
Bad Childhood experience				
No	162(46.6)	114(32.8)	1	1
Yes	27(7.8)	45(12.9)	2.37(1.39-4.04)	1.87(1.01-3.46)*
Physical illness injury				
No	134(38.5)	82(23.6)	1	1
Yes	55(15.8)	77(22.1)	2.29(1.47-3.55)	1.64(0.99-2.72)*
Family history of substance use				
No	128(36.8)	86(24.7)	1	1
Yes	61(17.5)	73(21.0)	1.78(1.15-2.75)	1.78(0.60-2.33)
Involvement in social activities				
No	66(19.0)	41(11.8)	1	
Yes	123(35.3)	118(33.9)	1.54(0.97-2.46)	1.89(1.11-3.23)*
Internet addiction social media usages				
No	94(27.0)	65(18.7)	1	
Yes	95(27.3)	94(27.0)	1.43(0.93-2.19)	1.22(0.75-1.99)
Educational Stress				
No	140(40.2)	89(25.6)	1	1
Yes	49(14.1)	70(20.1)	2.25(1.43-3.53)	1.26(0.73-2.17)
Bullying				
No	159(45.7)	99(28.4)	1	1
Yes	30(8.6)	60(17.2)	3.21(1.94-5.32)	2.38(1.35-4.21)*
Traumatic life experience				
No	142(40.8)	82(23.6)	1	1
Yes	47(13.5)	77(22.1)	2.84(1.80-4.46)	2.27(1.36-3.76)*
Exam Phobia				
No	85(24.4)	41(11.8)	1	1
Yes	104(29.9)	118(33.9)	2.35(1.49-3.71)	1.95(1.15-3.30)*

*p value significant at < .05 χ^2 =Chi-square CI= Confidence Interval

The results from the multivariable logistic regression analysis examining the factors associated with stress are presented in Table 22. The variables that remained in

the final model included sex**,** inadequate sleep**,** bad childhood experience**,** physical illness or injury**,** family history of substance abuse**,** internet addiction**,** involvement in social activities**,** internet addiction and social media usage**,** educational stress**,** bullying**,** traumatic life experience**,** and exam phobia **(**p-values < 0.15 in the univariate analysis).

In the final model, several factors were found to be significantly associated with the presence of stress symptoms, including bad childhood experience (AOR: 1.87, 95% CI: 1.01–3.46**),** physical illness or injury (AOR: 1.64, 95% CI: 0.99–2.72), involvement in social activities (AOR: 1.89, 95% CI: 1.11–3.23), bullying(AOR: 2.38, 95% CI: 1.35–4.21), traumatic life experience (AOR: 2.27, 95% CI: 1.36–3.76), and exam phobia (AOR: 1.95, 95% CI: 1.15–3.30). These findings suggest that early life experiences, physical health issues, social involvement, and certain stressors, such as bullying, trauma and exam phobia are key predictors of stress symptoms.

Chapter Summary

This was the main part of the research study and it helps to fulfil the research objectives. It has included measurement of all the variables. This chapter produced the prevalence and level of DASS symptoms in respondents. It also found the relation between socio-demographic characters of the respondents and level of depression, anxiety and stress. Likewise, it found the association between the level of DAS and associated factors of DAS.

CHAPTER V

Discussion of Findings

This chapter organizes a discussion of the major findings of the study. Themes or subtopics are developed based on the research purpose and research questions. Under each topic, major findings and discussions are made by these study findings with the help of relevant literature or findings from similar studies and theories. Based on the objectives, analysed data, discussions on key findings are drawn as mentioned below.

Socio-demographic Characteristics of the Respondents

In this study, the results indicated the demographic characteristic was the majority of the respondents were in the age group of below 18 years. More than fifty percent were female, most of the respondents were from Hinduism, more than one third of the respondents were from janajatis, less than two third belonged to nuclear families. Most of the respondents were residing from rural areas, the majority of the respondents were living with their parents. Almost all of the respondents passed their last exam. About half of the respondent's fathers and mother's educational status was basic level. About two third of the father's occupation was foreign employees and about half of the mothers were house makers. The study finding is similar with the study done in the school of Kathmandu rural municipality (Karki et al., 2022) it was the mean age, sex status, types of family, current living status and achievement in the last examination of the respondents.

Prevalence of Depression Anxiety and Stress Among the Respondents

This study reveals that more than half respondents were in a normal state and less than half were in different levels of depression, anxiety and stress. The

prevalence of symptoms of depression, anxiety and stress was 43.1%, 47.1 and 45.6% respectively. The level of DAS was similar to findings from previous studies (Girum et al., 2022; Karki et al.,2022; Sahril et al., 2019; Sharma et al.,2022; Bhattarai et al., 2020) which was conducted in Africa, depression and anxiety 41.4%, 52.2%, another study was conducted in an urban municipality of Kathmandu, Nepal DAS was 56.5%, 55.6%, 32.9% and next similar finding was study conducted from Kathmandu Nepal it was anxiety 56% and stress 41%. As well as it is contrast to the study conducted in Pakistan Depression 75%, anxiety 88.4% and stress 84.4% (Asif et al., 2010), Malaysia the depression was 33.2%, in Africa Anxiety was 66.7%, in Kathmandu Depression was 27% and conducted in Pokhara depression was 44.2%. It seems that adolescents 'responses to available DAS might differ between geographic areas with unique social contexts.

Level of Depression, Anxiety and Stress

In this study the depression levels show 14.1% mild, 17.8% moderate, 6.0% severe, and 5.2% extremely severe. It suggests that nearly half of the students are struggling with symptoms that may interfere with their academic performance and social functioning. These findings are consistent with previous research by Kumar and Akoijam (2017), which reported high levels of depressive symptoms among school students in India. Moreover, Patel et al. (2007) emphasized the vulnerability of adolescents to mood disorders due to rapid emotional, social, and cognitive changes.

Regarding anxiety level, this study found that 10.3% of students experienced mild anxiety, 22.1% moderate, 6.9% severe, and 7.8% extremely severe. These results align with the work of Deb et al. (2015), who found academic stress and performance pressure to be major contributors to anxiety among adolescents. The observed anxiety

levels could be attributed to academic demands, family expectations, and fear of failure, which are commonly reported stressors among secondary students.

The stress levels in the current study shows 25.6% mild, 13.8% moderate, 6.0% severe, and 0.3% extremely severe, this study support finding from previous studies that link high levels of perceived stress in adolescents to both school and social pressures (Verma & Gupta, 2020). It is notable that stress co-occurs with other mental health problems, which is supported by Lovibond & Lovibond (1995), the developers of the DASS scale, who explained how stress often overlaps with anxiety and depression in adolescents.

The study also identified key risk factors, such as adverse childhood experiences, bullying, educational stress, traumatic life events, physical illness, and exam phobia, which are in line with cognitive and behavioural theories of emotional disorders (Beck, 1967; Bandura, 1977). These psychological stressors may distort students' perceptions of themselves and the world, leading to maladaptive emotional and behavioural responses.

Overall, this study emphasizes the pressing need for school-based mental health programs focused on early identification, prevention, and intervention. Schools must adopt comprehensive mental health strategies that include counselling, life skills education, stress management workshops, and parent-teacher collaboration.

Social Factors Associated with Depression, Anxiety and Stress

In present study depression status of respondents were not significantly associated with their age, sex, religion, ethnicity and monthly income.

This finding is in contrast with the findings of another study (Sharma et al., 2022; Bhattarai et al., 2020) which reported that there is statistically significant association between the level of depression and sex, academic stress and types of family (p=0.006) in P-value of <0.05 of the respondents.

Similarly, in this study findings anxiety status was significantly associated with sex (*p*= 0.014) and ethnicity (*p*= 0.041) of the respondents, this study finding is in contrast with the finding of a similar study that there is statistically significant association between anxiety and academic stress of the respondents. In the present study, stress status was statistically associated with their sex (*p*=0.012) inP-value of <0.05, and in another similar study finding are similar in sex and in contrast with academic stress, there is statistically significant association between the stress status with sex and academic stress.

The depression status was significantly associated with Inadequate sleep (*p*= 0.001) Bad Childhood experience (*p*= 0.000), Physical illness injury (*p*= 0.013), Tobacco smoking, alcohol consumption and drug abuse by family (*p*= 0.040) and Life time suicidal attempt by family member (*p*= 0.013). Satisfied with academic performance (*p*= 0.015), Educational stress (*p*= 0.000), Bullying (*p*= 0.000), Traumatic life events (*p*= 0.002), Low self-esteem (*p*= 0.044), Try to hurt yourself (*p*= 0.000), and Exam phobia (*p*= 0.000). (p=< .05).

The anxiety status was significantly associated with Bad Childhood experience (*p*= 0.001), and Physical illness injury (*p*= 0.005), Educational stress (*p*= 0.000), Bullying (*p*= 0.019), Traumatic life events (*p*= 0.000), Low self-esteem (*p*= 0.005), Try to hurt yourself (*p*= 0.001), and Exam phobia (*p*= 0.001). (p=< .05).

The stress status was significantly associated with Inadequate sleep (*p*= 0.011) Bad Childhood experience (*p*= 0.000), Physical illness injury (*p*= 0.000), Educational stress (*p*= 0.000), Bullying (*p*= 0.000), Traumatic life events (*p*= 0.000), Low self steem (*p*= 0.013), Try to hurt yourself (*p*= 0.000), and Exam phobia (*p*= 0.000). (p=< .05).

Psychosocial Factors Associated with Symptoms of Depression Among Respondents

This study reveals that respondents who had bad childhood experience had two times higher odds of experiencing depression symptoms than the respondents had not such a bad experience (AOR: 2.89, 95% CI: 1.60–5.20), and the respondents who had bullying were more likely to exhibit 1.7 times more depressive symptoms compare to respondents from without Bullying (AOR: 1.70, 95% CI: 0.99–2.95).This study is similar to a study conducted in Kathmandu(Sharma et al.,2020)the finding was bullied (AOR: 2.84, 95% CI: 1.34–5.99) were significantly associated with symptoms of depression.

The result showed the linkage of psychoanalytic theory on bad childhood experience in home like broken family, bad family relationship, economic hardship, absent of parent physical punishment and learning theory on bullying in school by seniors and classmates.it indicate the suitable home and school environment is necessary to prevent the depression among the secondary level students.

This finding is in contrast with the findings of another study conducted in Kathmandu which reported that female respondents had (AOR:1.46, 95%CI:0.97-2.22) 1.4 times more depressive symptoms than male, the respondents who had high academic pressure had 1.6 times more likely to have depression when compared with

those of low academic pressure. This finding is in contrast with the finding of another study which reported in Africa that being female (AOR=1.304, 95% CI=1.006–1.849), higher risky khat chewers (AOR=5.595, 95% CI=2.357–11.132), having social phobia (AOR=1.416, 95% CI=1.045–1.919) were associated with depression (Nakie, et al., 2022). Another contrast study finding from Kathmandu, shows nuclear family type (AOR: 1.64, 95% CI: 1.06–2.52), students from science/humanities faculty (AOR: 1.58, 95% CI: 1.05–2.40), presence of perceived academic stress (AOR: 1.62, 95% CI: 1.08–2.44) and bullied electronically in past 12 months (AOR: 2.84, 95% CI: 1.34–5.99) were significantly associated with symptoms of depression (Karki, 2022).

Psychosocial Factors Associated with Symptoms of Anxiety Among Respondents

This study reveals that respondents with educational stress had more anxiety symptoms than the respondents had no academic stress symptoms (AOR: 1.94, 95% CI: 1.15–3.36). This finding is similar to a study conducted by Karki, et al., (2022) in Nepal, which showed that academic stress was significantly associated with the anxiety symptoms (AOR: 1.93, 95% CI: 1.30–2.87). Another similar study conducted by Sharma, (2020), that showed that academic pressure was significantly associated with the symptoms of anxiety. Respondents who had traumatic life experience were experiencing more anxiety symptoms compared to no traumatic life experiences (AOR: 1.88, 95% CI: 1.15–3.10). This indicates that stress related to education and past traumatic experiences are important factors contributing to anxiety in this population.

This finding is in contrast with the finding of another study which reported in Africa that being higher risky cigarette smokers (AOR=4.777, 95% CI=1.407–7304), having a history of chronic medical illness (AOR=2.099, 95% CI=1.045–4.218), and having a family history of mental illness (AOR=1.777, 95% CI=1.028–3.073) associated with anxiety (Nakie, et al., 2022).

The result showed the linkage of psychoanalytic theory, social theory and object loss theory on Traumatic life experience in home and in school and in community or society. It is like physical or mental abuse, loss of loved one may be parents of family members, loss of property, broken family, bad family relationship, economic hardship. According to learning theory, educational stress, because of failure in exam, punishment by family or school teachers, expectation of family and teachers, bad relation with friends, teachers and school teachers, belongs to religious minorities, not satisfied with academic performance and bullying. These factors show the appropriate home and school environment is very important to prevent the anxiety among the secondary level students.

Psychosocial Factors Associated with Symptoms of Stress among Respondents

This study reveals that respondents who had bad childhood experience had more stress symptoms than who had no bad childhood experience (AOR: 1.87, 95% CI: 1.01–3.46), likewise, who had physical illness or injury were more prone to have stress symptoms than who had no physical illness or injury (AOR: 1.64, 95% CI: 0.99–2.72), similarly respondents who involved in social activities more likely to show the stress symptoms than who were not involved (AOR: 1.89, 95% CI: 1.11–3.23). Respondents who were bullying by others were suffering from stress symptoms

compared to who were not bullied (AOR: 2.38, 95% CI: 1.35–4.21), the respondents who reported traumatic life experience were at greater risk to showing symptoms of stress than who were not reported traumatic life experience (AOR: 2.27, 95% CI: 1.36–3.76). Moreover, this study also found out that risk of stress symptoms was higher among respondents who were facing exam phobia compared to not facing exam phobia (AOR: 1.95, 95% CI: 1.15–3.30).

Above result shows the relation of psychosocial theory and the association between associated factors and stress among the secondary level students. The traumatic life experience, exam phobia and bullying are related to different theories. Traumatic life experience is related to psychoanalytic theory, learning theory, object loss theory and cognitive theory, likewise bullying is related to learning theory, cognitive theory and exam phobia is related to learning theory, psychoanalytic theory and cognitive theory. Relation and expectation of teacher, family and friends, satisfaction from the exam, punishment system in school, sleeping pattern, personal behaviour pattern, physical illness and injuries, social support, school environment are the factors to enhance anxiety among the school students.

Contrary to this finding, a study from Kathmandu found (Sharma et al.,2020) that having the female students had 1.7 times higher odds in having stress in comparison with male students. The adolescent students who had high academic pressure had two times more chance of having stress than of low academic pressure. Another finding also is in contrast with the finding of another study which reported in Africa Stress was associated with high-risk alcohol drinkers (AOR=1.828, 95% CI=1.012–3.303), rural residency (AOR=1.395, 95%CI=1.010–1.925), and low social support (AOR 1.7391, 95% CI=1.203–2.515).Another contrast finding from

Kathmandu shows, female sex (AOR: 1.54, 95% CI: 1.01–2.34), currently living without parents, (AOR: 1.70, 95% CI: 1.11–2.61), and presence of perceived academic stress (AOR: 2.11, 95% CI: 1.36–3.26) were significantly associated with stress symptoms (Karki, 2022).

This study is guided by various psychological theories, among which psychoanalytic theory suggests that unresolved unconscious conflicts, often rooted in childhood or early adolescence, may manifest as symptoms of depression, anxiety, and stress in students. Negative childhood experiences, physical illness, poor social relationships, and traumatic life events are key factors associated with depression, anxiety, and stress, as explained by psychoanalytic theory and object loss theory. Similarly, factors such as bullying, exam phobia, and educational stress are linked to depression and stress, aligning with learning theory and cognitive theory.

The study investigated the levels and associated factors of depression, anxiety, and stress (DAS) among secondary level students in Pokhara, Nepal. The socio-demographic characteristics of the respondents provided important context for interpreting the findings. This study revealed notable prevalence rates of depression, anxiety, and stress among the secondary level students surveyed. The rates observed in this study align with previous research indicating that adolescents, particularly those in urban settings facing academic and social pressures, are susceptible to mental health challenges. Comparing these rates with findings from other regions and countries allows for a broader understanding of the issue and its global context. Variations in prevalence rates may be attributed to differing cultural, socio-economic, and educational environments. Beyond prevalence, examining the levels of DAS (mild, moderate, severe, and extremely severe) provides a more nuanced

understanding of the mental health status of the students. The distribution of these levels indicates the severity of the issues, highlighting that a significant portion of students may be experiencing clinically relevant levels of DAS. These levels directly relate to the potential impact on students' daily lives, academic performance, and overall well-being. Findings of moderate to extremely severe levels should be of particular concern, as they may necessitate more immediate and intensive intervention.

Analysing the association between DAS levels and demographic variables such as age, sex, and ethnicity revealed patterns that offer valuable insights. Statistically significant associations indicate how certain groups within the student population may be disproportionately affected by DAS. For instance, if sex was found to be associated with anxiety, with one gender reporting higher anxiety levels, this would suggest the influence of gender-related factors such as societal expectations or biological differences. Similarly, if ethnicity showed an association, it could point to unique stressors faced by certain ethnic groups.

The examination of associated factors such as individual, family, social, academic, and psychological factors showed significant relationships with the levels of DAS. These factors provide insight into the root causes and contributing elements to mental health difficulties. Factors such as inadequate sleep, bad childhood experiences, bullying, and academic stress were all shown to be significantly related to varying levels of DAS. These findings align with existing literature that emphasize the role of environmental stressors and personal experiences in shaping adolescent mental health.

The study identified specific factors significantly associated with symptoms of depression. Bad childhood experiences, traumatic life events, inadequate sleep, and academic stress were among the key factors identified. These findings corroborate existing theories and research on the development of depression, particularly in adolescents. Identifying such specific factors allows for focused interventions and targeted support for students who may be experiencing depression. In the case of anxiety, factors such as educational stress, traumatic life events, bad childhood experiences, and exam phobia were found to be significantly associated. These factors speak to the role of academic pressure and personal history in fostering anxiety among students.

Stress was significantly associated with factors such as inadequate sleep, bad childhood experiences, physical illness or injury, bullying, traumatic life events, and exam phobia. These associations demonstrate how various life stressors and challenges can contribute to high stress levels. Stress, as a physiological response, is closely tied to many life events, and understanding these associations is critical for developing stress management strategies. This study effectively highlights the prevalence and associated factors of depression, anxiety, and stress among school going students in Pokhara. The findings underscore the need for comprehensive mental health support systems within schools, as well as targeted interventions that address the specific factors contributing to mental health difficulties in adolescents.

CHAPTER VI

Conclusions and Implications

This chapter is divided into three sections that specifically summarise the whole dissertation, conclude the study, and implications of the research findings for policymakers, school administrations, and further researchers.

Conclusions

The findings of this study indicate that the mental health status of school-going students is generally poor. Various factors contribute to the prevalence and levels of depression, anxiety, and stress among them. Significant associations were identified between DAS and various demographic and psychosocial factors. Anxiety and stress were notably associated with sex, while anxiety also showed a significant relationship with ethnicity. Inadequate sleep, adverse childhood experiences, physical illness or injury, substance use within the family, family history of suicidal behaviour, academic dissatisfaction, educational stress, bullying, traumatic life events, low self-esteem, self-harm tendencies, and exam phobia appear as key factors associated with depression.

Overall findings of the study concluded that, the mental health situation of the school going students was poor. Many more factors are responsible for the depression, anxiety and stress among them.

Through the examination of collected data and information, literature and the findings of present study, a number of explanations for the increasing of mental health problems like depression, anxiety and stress of students is articulated. in findings, sex, and ethnicity are responsible for the anxiety and stress, similarly different

psychosocial factors like, bad childhood experience, bullying, educational stress, traumatic life experience, physical illness and injury, social activities and exam phobia are the significant for students' mental health problems. Results of the present study clarifies that, role of family for healthy childhood, role of school for appropriate school environment, role of society for healthy social relationship, personal behaviour and national, international mental health policy, strategy and proper implication, plays a significant role for the mental wellbeing.

The findings of this study align with established psychological theories. According to psychoanalytic theory and object loss theory, unresolved childhood trauma and loss, such as bullying and adverse childhood experiences that can lead to internalized distress manifesting as depression. Learning theory explains how stressful environments and repeated negative experiences (e.g., exam phobia, trauma) can reinforce anxiety and stress responses. Meanwhile, cognitive theory supports that students' negative thinking patterns, shaped by past and present experiences (like academic pressure or social isolation), contribute to the development and maintenance of depression, anxiety, and stress. These results affirm that multiple psychological mechanisms interplay to influence adolescent mental health.

School-level students are living an increasingly complicated and complex life. They have many more interests and demands to make their lives successful. Home and family are the first school and teachers to foster their mental health. Broken home, bad family relationships, economic hardship, unhealthy behaviour of parents, love and affection among family members, rearing and caring environment of the children are the primary and pivotal elements for health and wellbeing.

These findings underscore the urgent need for targeted mental health interventions within educational settings. Implementing school-based guidance and counselling programs, addressing academic stress, preventing bullying, and promoting open communication between students, families, and school personnel are crucial steps.

Healthy school environment helps to enhance the personality of the students. Every student has a unique personality so they need to behave differently. Academic stress, severe types of punishment, excessive academic loads, bullying by seniors, teachers and friends, and behaviour patterns of students like alcohol abuse, drugs abuse are the main factors of depression, anxiety and stress. To address these problems, a triad relationship among school, parents and students is essential. Regular meetings, and emergency meetings in case of any doubt in students' behaviour and reward for best behaviour are the preventive remedies of mental health problems.

The messages have been designed based on the psychosocial theory of stress. The role of family, especially parents, it means family attachment, love and affection during childhood is very important to be mentally healthy. An appropriate school environment, positive reinforcement to avoid educational stress, exam phobia and bullying among the students is necessary to foster the mental health of the students.

Triad relationship between family, school and students, with open communication, co-operation and co-ordination is very important to prevent mental health problems among the secondary school students.

Implications

This study result may be a useful resource for implications for health education and promotion, implications for school policy and administration,

implications for mental health professionals and implications for future research and especially those working in mental health. Based on the findings of the study, the following implications are suggested.

Implications for Health Education and Promotion

In school level curriculum the contents of mental health and illness are included but it should be focused on to raise awareness and reduce stigma rather than knowledge focused content. While developing the curriculum, most important areas to promote mental health like; stress management, emotional regulation, and coping strategies should be included and delivered at the secondary level. Not only these factors, different harmful behaviours like bullying, fighting and risk factors like exam pressure and educational trauma should be avoided from the school level.

Implications for School Policy and Administration

Schools should implement anti- ragging policy and campaign to avoid bullying to create a safe and supportive learning environment. Likewise, should establish of counselling services and referral systems for students showing signs of psychological distress. For the mentally healthy school environment regular mental health screenings and well-being assessments should be introduced as part of school health programs.

Implications for Mental Health Professionals

The study findings highlight the need for school-based mental health professionals to provide timely intervention and psycho-education. Mental health

practitioners can use these insights to design adolescent-friendly therapy models based on cognitive behavioural and trauma-informed approaches.

Implications for Future Research

Although the adolescent students are more vulnerable to be mentally disturb, there are very less studies are conducted and only limited factors are explored, so this study finding will help for further extended studies. It can be effective to reduce prevalence of depression, anxiety and stress. In other hand longitudinal research could assess how early interventions affect mental health outcomes over time. Similarly, comparative studies across regions or age, sex, educational status groups could broaden understanding of influencing factors.

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Appendices

Appendix I

Information Sheet for Participants

"Depression Anxiety and Stress Among Secondary School Going Students in Pokhara "

I am Muna Silwal, an M. Phil Scholar at Tribhuvan University, and Faculty of education. I am researching the title **"Depression Anxiety and Stress Among Secondary School Students in Pokhara Metropolitan City"** as a part of my course.

The purpose of this quantitative analytical study is to explore the different factors which induced the DAS among the public-school students of secondary level at Kaski.

I will distribute the questionnaire and it takes about 20-25 minutes to fill the form.

Participation is voluntary and you have the right to withdraw at any stage without penalty. If you withdraw, I will remove information relating to you. However, it will be impossible to withdraw the information, when it is published in the thesis.

The results of the project may be published, but you may be assured of the complete confidentiality of data gathered in this investigation: your identity will not be made public without your prior consent. To ensure anonymity and confidentiality, no personal information which identifies you and your organization will be published. To ensure the data is protected, the raw data will be stored in my password-locked computer and secured. A thesis is a public document and will be available through the Faculty of Education, central Library, Kirtipur.

The proposal is being carried out as a requirement for M. Phil in Health Education Degree by Muna Silwal under the supervision of Prof. Dr. Surendra Giri, who can be contactedat*Surendra.giri2010@gmail*

This proposal has been reviewed and ethically approved by the Gandaki Medical College-Institutional review Committee and participants should address any complaints to The Chair, Ethics Committee, Gandaki Medical College, Kaski, Pokhara (gmcirc2019@gmail.com) .

If you agree to participate in the study, you are asked to complete the consent form and return it.

Muna Silwal
Faculty of Education
Telephone: +977 9856070590
Email: *munasilwal@gmail.com*
Date: …….

Appendix II

Consent Form for Participants

"Depression, Anxiety and Stress Among Students in School Going Students"

I have been given a full explanation of this proposal and have had the opportunity to ask questions.

I understand what is required of me if I agree to take part in the research.

I understand that participation is voluntary, and I may withdraw at any time without penalty. When I withdraw my participation, all the information I provided should be practically achieved.

I understand that any information or opinions I provide will be kept confidential to the researcher and the authorized person of the university and that any published or reported results will not identify the participants and their institutions. I understand that a thesis is a public document and will be available through the Faculty of Education, Central Library.

I understand that the data collected for the research will be securely kept in locked facilities such as password-locked computers and university digital repositories and will be destroyed after five years.

I understand the risks associated with taking part and how they will be managed.

I understand that I can receive a copy of the results of the study by contacting the researcher after completion of the entire work.
I understand that I can contact the researcher Muna Silwal or supervisor Prof. Dr. Surendra Giri who can be reached at *Surendra.giri2010@gmail.com* or Faculty of Education, Tribhuvan University for further information. If I have any complaints, I can contact the Chair of the Ethics Committee, Gandaki Medical College, Kaski, Pokhara (gmcirc2019@gmail.com) .

By signing below, I agree to participate in this research.

Name of the participant:
Signature:
Date:
Note: Please return this consent form before filling up the research questionnaire form.

Muna Silwal, Faculty of Education
Telephone: +977 9856070590
Email: *munasilwal@gmail.com*

Appendix III

Assent Form

Study title: : "Depression, Anxiety and Stress among secondary level students in Pokhara"

Namaskar!

I am Muna Silwal, M. Phil student from Tribhuvan University, Faculty of Education. is conducting this research as partial fulfilment of the requirement of the M. Phil programme. The purpose of this study is to assess DAS among the public-school students of Kaski.

I would like to request you to participate in the study and assure you that your answer will be kept confidential, the name of the respondent will not be attached to the answer and the study will be used for research purposes only. Your participation in this study is voluntary and you have the right to withdraw any time or to refuse to answer any particular question if you feel uncomfortable. Your cooperation will be very much helpful to give the final structure of this study. I am looking forward to your valuable response.

I (the participant) have read this assent form and voluntarily I am willing to participate in this study.
Thank you!!!

Would you like to participate as a respondent in this study?

Yes ☐ No ☐

If yes, please do signature…….

Date.....

Appendix IV

Research Instrument

Research Title: "Depression, Anxiety and Stress among secondary level students in Pokhara"

Instruction: The participants are requested to read the questions carefully and please tick (√) the appropriate answers or write the response in the space provided.

Code No…… **Date: …...…….**

PART – I

Questions related to socio-demographics information

SN	Question	Responses	Skip…….
1.1	Age (in completed years)	……	
1.2	Sex	Male...1 Female...2	
1.3	Religion	Hinduism…1 Buddhism…2 Christianity…3 Islam…4 Other Specify……	
1.4	Ethnicity	Dalit…1 Jana Jati…2 Brahman/Chhetri …3	
1.5	Type of Family	Nuclear…1 Joint…2 Extended…3	
1.6	Place of residence	Urban area…1 Rural area…2	
1.7	Current living status	With parents…1 Without parents…2	
1.8	Current Grade	Grade……	
1.9	Faculty of the respondent (For grade 11 & 12)	Education …1 Management...2	
1.10	Reason for selecting the currently studying faculty	Own decision …1 Others ...2	
1.11	Achievement in last exam	Passed …1 fail ...2	

1.12	Education of Father	Literate…1 Illiterate…2	
1.13	If literate,	Basic education (up to 8) ...1 Secondary level (9-12) ...2 Bachelor level…3 Master and above…4	
1.14	Education of Mother	Literate…1 Illiterate…2	
1.15	If literate,	Basic education (up to 8) ...1 Secondary level (9-12) ...2 Bachelor level…3 Master and above…4	
1.16	Occupation of Father	Unemployed…1 Employed…2	
1.17	If employed, nature of employment	Governmental Service…1 Non-Governmental Service…2 Self-employed/Business…3 Farmer…4 Daily labor…5 House maker…6 Foreign employment which country…7 Others (specify……)8	
1.18	Occupation of Mother	Unemployed…1 Employed…2	
1.19	If employed, nature of employment	Governmental Service…1 Non-Governmental Service…2 Self-employed/Business…3 Farmer…4 Daily labor…5 House maker…6 Foreign employment Which country…7 Others (specify……) …8	
1.20	Monthly income of Family	Less than 10,000 (Low Income) …1 10, 000- 36,000 (Medium Income) …2 36,000- 1,11,000 (Upper Medium Income) …3 Above 1,11,000 (High Income) …4	

Part II

Psychosocial factors Associated with Depression, Anxiety and Stress

Associated Factors	Variables	Yes	No
Individual factors	Tobacco/ smoking, Alcohol consumption		
	Drug abuse		
	Inadequate sleep		
	Bad childhood experiences		
	Physical illness/injury		
Family factors	Living with Both parents		
	Absence of both parents		
	Good relationship with family		
	Family history of mental illness		
	Tobacco smoking, alcohol consumption, and drug abuse by family		
	Lack of economic support from family		
	Life time suicidal attempt by family member		
Social factors	Adequate social support		
	Good relationship with friends		
	Good relationship with teachers and other staffs		
	Involvement in social activities		
	Belongs to religious minority group		
	Internet addiction and excessive social media usage		
Academic factors	Satisfied with academic performance		
	Educational stress (fear of poor grades workload)		
	Bullying		
Psychological factors	Traumatic life event		
	Low self-esteem		
	Tried to hurt yourself		
	Exam phobia		

Part III

DEPRESSION ANXIETY AND STRESS SCALE-21(DASS-21)

This section asks for your views about your feeling. For each of the following items, indicate how you have been feeling in the **LAST WEEK**. There is no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 - Did not apply to me at all

1 - Applied to me to some degree, or some of the time

2 - Applied to me to a considerable degree, or a good part of time

3 - Applied to me very much, or most of the time

SN	Statements	0	1	2	3
1	I found it hard to wind down				
2	I was aware of dryness of my mouth				
3	I couldn't seem to experience any positive feeling at all				
4	I found it difficult to work up the initiative to do things				
5	It was hard for me to have the initiatives to do things				
6	I tended to over-react to situations				
7	I experienced trembling (eg, in the hands)				
8	I felt that I was using a lot of nervous energy				
9	I was worried about situations in which I might panic and make a fool of myself				
10	I felt that I had nothing to look forward to				
11	I found myself getting agitated				
12	I found it difficult to relax				
13	I felt down-hearted and blue				
14	I was intolerant of the things that kept me from continuing to do what I had been doing				
15	I felt like I was going to panic				
16	I didn't feel enthusiastic about anything				
17	I felt like I was worthless as a person				
18	I felt like I was being a little too emotional/sensitive				
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20	I felt scared without any good reason.				
21	I felt that life was meaningless				

Scoring Grade

DASS-21 Scoring	**Depression**	**Anxiety**	**Stress**
Normal	0-4	0-3	0-7
Mild	5-6	4-5	8-9
Moderate	7-10	6-7	10-12
Severe	11-13	8-9	13-16
Extremely Severe	14+	10+	17+

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21
S	A	D	A	D	S	A	S	A	D	S	S	D	S	A	D	D	S	A	A	D

(Lovibond & Lovibond, 1995; Western District Health Services [WDHS], 2009)

तथ्याङ्क संकलनको लागि प्रश्नावली

शिर्षक "पोखरामा अवस्थित माध्यामिक स्कुलका विद्यार्थीहरुमा उदासिनता, चिन्ता र तनाव गराउने तत्वहरु"सन्बन्धिअध्ययन ।

निर्देशन सहभागिहरुल ेतल दिइएका प्रश्नहरु ध्यानपूर्बक पढेर उपयुक्त उत्तर भएको संख्यामा चिन्ह लगाउन/सहिउत्तर लेख्न अनुरोध गर्दछु ।कृपया सबै प्रश्नहरुको उत्तर दिनुहोला ।

कोड नं. **मिति**

भाग–१

सामाजिक जनसाख्यिकिय सम्वन्धित जानकारी

क. स.	प्रश्न	जवाफ	
१.१	बर्ष (पुरा भएको उमेर) ?	..... बर्ष	
१.२	तपाईको लिङ्ग के हो ?	पुरुषः.....१ महिला.....२ अन्य.....३	
१.३	तपाईको धर्मके हो ?	हिन्दु.....१ बुद्ध.....२ क्रिश्चियन.....३ ईस्लाम.....४ अन्य.....५	
१.४	तपाईको जातिके हो ?	दलित.....१ जनजाति.....२ ब्राम्हण/क्षेत्री.....३	
१.५	तपाईको परिवारको प्रकार कुनहो ?	सानो.....१ संयुक्त.....२ फैलिएको...३	
१.६	तपाईकोहालको बसार्ईरबासस्थानकहाहो ?	ग्रामिण क्षेत्र.....१ सहरी क्षेत्र.....२	
१.७	तपाईकोअहिलेको बसाइस्थितिके छ ?	आमाबुबा संग.....१ आमाबुबा संग नबसेको.....२	
१.८	तपाईअहिलेकुनकक्षामा पढनु हुन्छ ?	कक्षा.....	
१.९	तपाईकोविषयकुनहो (कक्षा ११र १२ को लागिमात्र) ?	शिक्षा संकाय.....१ ब्यबस्थापन संकाय.....२ अन्य.....३	
१.१०	तपाईले यो विषयछान्नुको कारण के हो ?	आफ्नै निर्णय.....१ अरुकोनिर्णय.....२	
१.११	तपाईको अन्तिम परीक्षाको नतिजाके छ ?	पास....१ फेल....२	

१.१२	तपाईको बाबुको शिक्षास्थिति कस्तो छ ?	निरक्षर....१ आधारभूत शिक्षा (८ सम्म).....२ माध्यामिक तह (९–१२).....३ स्नातक तह.....४ स्नातकोत्तर तह र सो भन्दा माथि.....५	
१.१३	तपाईको आमाको शिक्षास्थिति कस्तो छ ?	निरक्षर....१ आधारभूत शिक्षा (८ सम्म).....२ माध्यामिक तह (९–१२).....३ स्नातक तह.....४ स्नातकोत्तर तह र सो भन्दा माथि.....५	
१.१४	तपाईको बाबुको पेशा के हो ?	बेरोजगार.....१ सरकारी सेवा.....२ गैर सरकारी सेवा.....३ स्वरोजगार व्यबसाय.....४ कृषि.....५ दैनिकज्यालादारी.....६ घरको.....७ वैदेशिक रोजगार र देश.....८ अन्य.....९	
१.१५	तपाईको आमाको पेशा के हो ?	बेरोजगार.....१ सरकारी सेवा.....२ गैर सरकारी सेवा.....३ स्वरोजगार व्यबसाय.....४ कृषि.....५ दैनिकज्यालादारी.....६ घरको काम.....७ वैदेशिक रोजगार र देश.....८ अन्य.....९	
१.१६	परीवारको मासिक आम्दानि ?	रु. १०,०००। भन्दाकम (निम्नआय).....१ रु १०,०००। – रु. ३६,०००। सम्म (मध्यमआय).....२ रु.३६,०००।–रु. १,११,०००। सम्म(उच्चमध्यमआय)..३ रु. १,११,०००। भन्दामाथि (उच्चआय).....४	

भाग–२

तलदिइएकाप्रश्नहरुध्यानपूर्बक पढनु होस र ठिक भएछ र बेठिक भएछैनमाचिन्हलगाउन अनुरोधगर्दछु ।कृपया सबै प्रश्नहरुको उत्तर दिनुहोला ।

२. उदासिन, चिन्ता, र तनाव संग सम्बन्धिततत्वहरु

सम्बन्धिततत्वहरु	परिवर्तनियतत्वहरु	छ	छैन
तपाईको व्यत्तिगततत्वहरु	के तपाईले सुर्तिजन्य, चुरोट, रक्सि प्रयोग गर्नु भएको छ ?		
	के तपाई लागु पदार्थ दुर्ब्यसनीहुनु भएको छ ?		
	के तपाई अपर्याप्त सुत्नु भएको छ ?		
	के तपाईले वच्चाबेलामा नराम्रो अनुभव गर्नु भएको छ ?		
	के तपाइलाईसारीरीक विरामिवा चोटपटकलागेको छ ?		
तपाईको परीवारीक तत्वहरु	के तपाई बाबु आमादुबै संगबस्नु भएको छ ?		
	के तपाई बाबु आमादुबै जनानभएको स्थितिछ ?		
	के तपाईको परीवार संगकोसम्बन्धराम्रो छ ?		
	के तपाईको परीवारमामानसिक रोगिहुन हुन्छ ?		
	के तपाईको परीवारमा सुर्तिजन्य बस्तु चुरोट, रक्सि तथालागु पदार्थको प्रयोगगर्नुहुन्छ ?		
	के तपाईलाई परीवारबाट आर्थिक सहयोग छ ?		
	के तपाईको परीवारका सदस्यहरुले जीवनमाआत्माहत्याप्रयास गरेको छ ?		
तपाईको सामाजीक तत्वहरु	के तपाईलाई पर्याप्त सामाजीक समर्थन छ ?		
	के तपाईको साथिहरु संगसम्बन्धराम्रो छ ?		
	के तपाईको शिक्षक र अन्यकर्मचारी संगको सम्बन्धराम्रो छ ?		
	के तपाई सामाजीकगतिविधिमा संलग्नहुनुन्छ ?		
	के तपाई धार्मिकरुपले अल्पसंख्यक समुदायमा पर्नु हुन्छ ?		
	के तपाई ईन्टरनेटका अतिरिक्त सामाजीक संजालको बढि प्रयोग गर्नु हुन्छ ?		
तपाईको शैक्षिक तत्वहरु	के तपाई शैक्षिककार्यमा सन्तुष्टहुनुन्छ ?		
	के तपाईलाई शैक्षिकतनाव(कक्षाको कमजोर कार्यबोझ) को डर छ ?		
	के तपाई भयभितहुनु भएको छ ?		
तपाईको मानसिक तत्वहरु	के तपाईको जीवनमा चोटयुक्त घटनाघटेको छ ?		
	के तपाईआफ्नो स्वभिमानमाकमिभएको छ ?		
	के तपाईले आफुलाई दुखदिने कोशीस गर्नु भएको छ ?		
	के तपाईलाई जाचको डर छ ?		

भाग-३

उदासिन, मानसिकचिन्ता, तनावमापन स्केल सम्वन्धि प्रश्नावली

नाम: मिति:

कृपया तलदिएका बयान ध्यानपूर्वक पढ्नु होला । पछिल्लो एक हप्तामायी कुराहरु तपाइको जीबनमा कुनै हद सम्म लागु हुन्छ भने तलदिएका खालि स्थान मध्ये जुनचाहि बढि उपयुक्त हुन्छ, त्यसमा चिन्ह लगाउनु होला । यो प्रश्नको कुनै पनि सहिवा गलत उत्तर छैन । यो केवल तपाइको पछिल्लो अनुभव जनाउनको लागि मात्र हो ।

कृपया यसको उत्तर दिनमा धेरै समय नलगाउनु होला ।

०–कहिल्यै पनिभएको छैन ।

१–कुनै हद सम्मभएको छैन ।

२–अलि बढि भएको छ ।

३–एकदम बढि भएको छ ।

कृपया प्रत्यक बयानको उत्तर दिनुहोला:

क्र. स.	कथनहरू	०	१	२	३
१	आफूले आफैलाई सहजतामहशुस गर्न गाह्रो भएको थियो ।				
२	मलाई मेरो मुख सुख्खाभएको अवगतहुन्थ्यो ।				
३	मैले केहि सकारात्मकभावअनुभवगर्न सकेको थिइन ।				
४	मलाइश्वास फेर्न गाह्रो महशुस हुन्थ्यो, जस्तै छिटो छिटो फेर्न, कुनै शारिरिक परिश्रम विनाश्वस फुल्ने ।				
५	मलाइकुनै पनिकाम सुरुवातगर्न गाह्रो भएको थियो ।				
६	मैले चाहिने भन्दा बढि प्रतिक्रियादिन्थे ।				
७	मैले मेरो शरिरमाकम्पनमहशुस गरेको थिए (जस्तै हातकाप्ने) ।				
८	मैले यस्तो महशुस गरेकि, म कुनैबेलाकेहि बढि नै डराए ।				
९	म यो परिस्थितिको बारेमा बढि नै चिन्तितहुन्थे, जसले गर्दा म धेरै डराएर आफुले आफैलाई मुर्ख बनाउनेत हैनभन्ने हुन्थ्यो ।				
१०	मलाई अघि बढने आधार नै छैनभन्ने अनुभवहुन्थ्यो ।				
११	म आफै सानो कुराहरुमाचिन्तितभएको पाए ।				
१२	मलाई आरामगर्न गाह्रो भएको थियो ।				
१३	मैले आफु उदाशिन र दुखिमहशुस गरेको थिए ।				
१४	मैले गरेको काममा कसैले कुनै तरिकाबाट बाधादिएमा, मलाई सहननसक्ने हुन्थ्यो ।				
१५	मैले म आतंकितभएको महशुस गरेको थिए ।				
१६	म कुनै पनिकामगर्न उत्साहितथिइन ।				
१७	म आफु योग्यव्यक्तिनभएको महशुस भयो ।				
१८	म बढि नै भावुकभएको महशुस भयो ।				
१९	शारिरिक क्रियाकलापविना नै मैले मेरो मुटुको धड्कन महशुस गरेको थिए–जस्तै छिटो छिटो धड्केको वाकहिलेकाहि धड्कन रोकिएको ।				
२०	मैले कुनै कारण विना नै डरको महशुस गरेको थिए ।				
२१	मलाई मेरो जीवनको सार्थकता नै छैनभन्ने अनुभवभएको थियो ।				

Appendix V

Study Setting

Setting of the study was not mentioned in the methodological section, because it is a sensitive topic and need to respect the right of the respondents. So the name of the public schools were revealed in this appendix section. Pseudo name A, B, C, D, E is given in the methodology section. The name of the school is given serially below

1. Bhabani Kalika secondary school ward no. 26, a reputed school established in 2011 BS and about 10 Km far from the centre of Kaski.
2. Laxmi secondary school, established in 2067 BS, it is in ward no 26 and about 14 Km far from the centre of the Kaski,
3. Laxmi Adhrash secondary school it was established in 2025BS, it is in ward no. 27 and about 18 Km far from the centre of Kaski,
4. Jana Prakash secondary school, established in 2015 BS, it is in ward no.29 and is about 21Km far from the centre of Kaski
5. Tribhuvan Shanti secondary school, established in 2015 BS. It is in ward no. 30. And about 25Km far from the centre of Kaski.

Appendix VI

Ethical Approval Letter

Regd. No. 47805/064/065 PAN No.: 302845752

गण्डकी मेडिकल कलेज
(टिचिङ हस्पिटल एण्ड रिसर्च सेन्टर प्रा.लि.)
GANDAKI MEDICAL COLLEGE
(Teaching Hospital & Research Centre Pvt. Ltd)

कर्मण्येवाधिकारस्ते
My right is to my work

Gandaki Medical College Institutional Review Committee

Registration No: 16/080/081 Date: 21/12/2023

Referral No:15 /080/081 - F

Subject : Approval of research proposal

Dear Ms. Muna Silwal

Department of Psychiatric Nursing

Thank you for submission of your research proposal entitled "**Factors associated with anxiety stress and depression among students in secondary school of Pokhara Metropolitan"** to the Institutional review Committee of Gandaki Medical College . we are pleased to inform you that the above mentioned proposal has been approved from ethical point view by GMC IRC on 20/12/2023.

Approval is given for one year from date of ethical approval. Study which have not been commenced or completed within a year of original approval must be re submitted to IRC for extension of the renewal. Any changes in the approved proposal has to be implemented only after prior approval from IRC. You are requested to follow the ethical principles for health and biomedical research by Nepal Health Research Council .

After completion of your study , you must submit a hard copy of final draft of your research to the GMC IRC.

Thanking you ,

Ms. Pramila Poudel
Member Secretary

Dr. Neelu Hirachan
Chairperson

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GMC Teaching Hospital
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+ 977-61-561718
Fax : +977-61-561768

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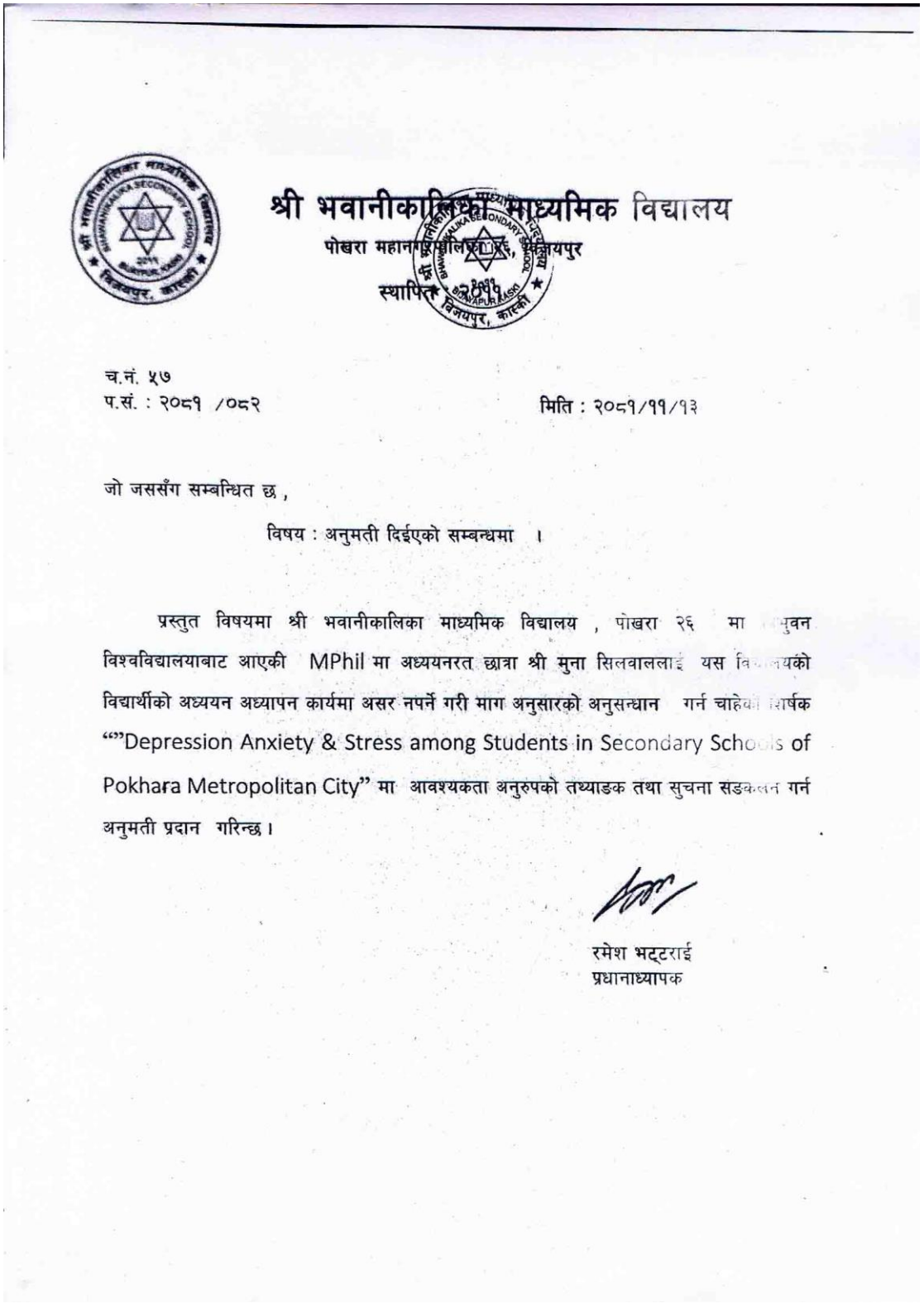
Appendix VII

Permission Letters for Data Collection



श्री भवानीकालिका माध्यमिक विद्यालय
पोखरा महानगरपालिका २६, बिजयपुर
स्थापित २०११
बिजयपुर, कास्की

च.नं. ५७
प.सं. : २०८१ /०८२ मिति : २०८१/११/१३

जो जससँग सम्बन्धित छ ,

विषय : अनुमती दिईएको सम्बन्धमा ।

प्रस्तुत विषयमा श्री भवानीकालिका माध्यमिक विद्यालय , पोखरा २६ मा [illegible]भुवन विश्वविद्यालयाबाट आएकी MPhil मा अध्ययनरत छात्रा श्री मुना सिलवाललाई यस वि[illegible]यकी विद्यार्थीको अध्ययन अध्यापन कार्यमा असर नपर्ने गरी माग अनुसारको अनुसन्धान गर्न चाहेको शीर्षक ""Depression Anxiety & Stress among Students in Secondary Schools of Pokhara Metropolitan City" मा आवश्यकता अनुरुपको तथ्याङक तथा सुचना सङ्कलन गर्न अनुमती प्रदान गरिन्छ ।

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विषय : तथ्याङ्क संकलन स्वीकृत सम्बन्धमा ।

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विषय : स्वीकृत प्रदान गरीएको बारे ।

जो जस संग सम्बन्धि छ

प्रस्तुत विषयका सम्बन्धमा गण्डकी मेडिकल कलेजका सह प्राध्यापक श्री मुना सिलवालाई M.Phil अध्यनका लागि "Depression, Anxiety and stress among students in Secondary Schools of Pokhara Metropolitan City" शीर्षकमा अनुसन्धान गर्न र आवश्यक तथ्याङ्क संकलन गर्न मिति २०८०।१।१४ देखि २०८०।१।१५ गते सम्म जम्मा दुई दिन अनुमति प्रदान गरिएको छ

प्रधानाध्यापक

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मिति : २०८०/१२/११

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विषय तथ्याङ्क संकलन स्वीकृत सम्बन्धमा ।

प्रस्तुत विषमा यहाँको विश्वविद्यालयबाट M Phil अध्ययन गर्नका लागि ' Depression, Anxiety and stress among students in Secondary schools of Pokhara Metropolitan City " भन्ने विषय मा यस विद्यालयबाट मिति २०८०/१२/१५ देखि १६ गते अभ्यास अनुसन्धानका लागि आवश्यक तथ्याङ्क लिन स्वीकृत प्रदान गरिएको व्यहोरा जानकारी यसै पत्रका साथ अनुरोध गरिन्छ ।

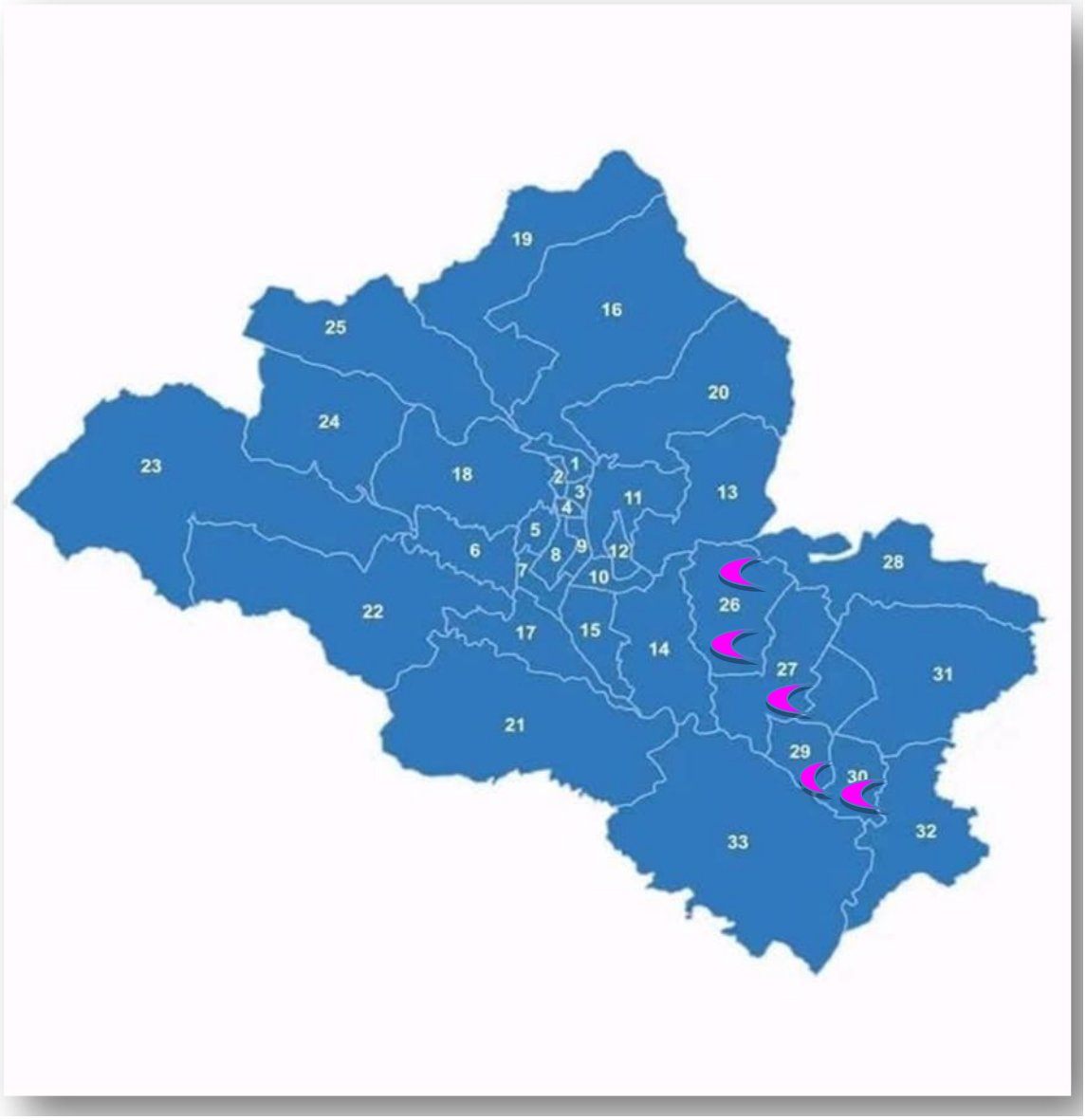
प्रधानाध्यापक
श्री सोमत कुमारी लामिछाने

श्री सोमत कुमारी लामिछाने
प्र.अ.

Appendix VIII

Map of Pokhara Metropolitan (33 wards)

Study Area ( )



Appendix VIII

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