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The Relationship Between Mental Health Literacy and Professional Help-Seeking Behavior among University Students in Digital Media Environments

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Abstract. University students increasingly understand psychological distress on social media, search engines, online forums and university portals but professional services are under-utilised. This study tested whether mental health literacy (MHL) influences professional help-seeking intention and past-year professional service contact, and whether self-stigma and conditions of digital information account for that influence. We did a cross-sectional study with a questionnaire survey of 428 university students. We included the Mental Health Literacy Scale, items about professional sources in the General Help-Seeking Questionnaire, past-year professional service contact, self-stigma, psychological distress, digital information credibility and information overload. Mental health literacy was positively associated with intention ($r = 0.501$) and contact ($r = 0.297$). In adjusted analyses, mental health literacy was associated with stronger intention (β 0.385, $p < 0.001$) and with a higher probability of contact (OR 1.63, 95% CI 1.22-2.19). Partial explaining variables of the MHL-intention association were self-stigma, while credible information increased intention and information overload reduced it. Intention independently predicted contact but the digital variables did not, predicting an intention–behaviour gap. Universities need to combine digital literacy, stigma-reduction and direct services navigation.

Keywords: mental health literacy, professional help-seeking, university students, digital media, self-stigma

1. Introduction

Common mental disorders are prevalent in university students, but many students with meaningful symptoms will not go for professional help [1]. This gap in treatment is not a problem of supply alone [2]. Students need to know when they are disturbed and need help, know which treatments and services are appropriate, find out who and where reliable sources are and consider to seek professional help. Competencies such as these are key mental health literacy (MHL), the knowledge and beliefs that protect people from distress, enable people to recognise and manage mental disorders, and promote mental health [3]. The Mental Health Literacy Scale (MHLS) assesses recognition, knowledge about risks and treatments, knowledge about information sources, and attitudes supportive of help seeking [4].

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Again, MHL should increase the probability of professional help-seeking, but help-seeking is a stage process rather than a product of knowledge. The General Help-Seeking Questionnaire distinguishes intention to approach a source from completing a service use [5]. For example, a student might correctly identify symptoms but forgo counseling because seeking help threatens one's self-image, autonomy, or perceived competence [6, 7]. The Self-Stigma of Seeking Help construct captures the anticipated loss of self-regard [8]. Psychological distress works in a double negative direction: greater perceived need might motivate care, whereas severe symptoms will likely tax the energy and executive capacity needed to engage services.

As digital media today influence each stage of this process. Search engines, social media feeds, online screening tools, apps, peer communities, universities' websites, for example, can make counseling normalising, give more privacy and point students towards appropriate service providers. They can also show users information about poorly verified claims, conflicting advice, algorithmic repetition, self-diagnosis. Reviews of university students' digital mental health use highlight credibility, confidentiality, and difficulty finding suitable services as common issues [9, 10]. Digital campaigns can increase literacy, awareness gains do not always lead to completed appointments [11].

Our model, therefore, deals with MHL as a cognitive resource and self-stigma as a psychosocial barrier; with help-seeking intention as the recent motivational stage; and digital credibility and overload as the information-environment conditions. We tested five hypotheses: H1, MHL is positively related to professional help-seeking intention; H2, MHL is positively related to past year professional contact; H3, self-stigma partially mediates the MHL–intention relationship; H4, perceived digital credibility is positively related to, and information overload negatively related to, intention; and H5, intention predicts completed contact once MHL, stigma, distress and demographics are controlled for. These hypotheses extend our recently obtained Egyptian and Chinese student findings by explicitly distinguishing intention from behaviour in a digital media environment.

2. Method

2.1. Design, sample, and transparency

Our study was based on a cross-sectional online questionnaire design. The analysis included 428 valid responses from university students. The questionnaire measured mental health literacy, intention to seek professional help and past-year contact with professional help, self-stigma, mental distress, trust in digital information, and information overload. The questionnaire data collected were applied to the evaluation of psychometric measures, description, correlation, regression and mediation analyses. The findings of this manuscript report are based on the questionnaire data collected in our participants.

Sample mean age was 20.45 years (SD 1.42); 242 people (56.5%) were women; 178 (41.6%) received some education regarding mental health; average daily hours spent using digital media were 4.92 (SD 1.63) and the student sample was most clearly connected; 116 respondents (27.1%) reported having had contact with a counsellor or psychologist, or psychiatrist, or GP about a mental health problem in the previous 12 months.

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2.2. Measures

Person's MH sensory literacy was measured by the 35-item MHLS (higher total score was indicative of stronger sensory literacy). Professional help seeking intention was the mean expected likelihood of contacting a counselor or psychologist, a psychiatrist or a general practitioner for personal-emotional problems on the following scale: 1 (extremely unlikely) to 7 (extremely likely); it was measured by the professional sources logic of the GHSQ [12, 13]. Actual professional help seeking was coded as 1 if at least one competent professional had been contacted during the past year and 0 otherwise. The 10-item self-stigma of seeking help scale measured anticipated loss of self-esteem. Psychological distress was measured by the four-item PHSQ (Patient Health Questionnaire for Depression and Anxiety): 0–12 [14].

Two study-specific digital constructs were included. Perceived information credibility was measured by five items assessing whether online mental health information was evidence based, attributed to reliable sources, up-to-date, internally consistent and linked to suitable services. Information overload was measured by four items assessing contradictory information, hard to judge credibility, confusing and overwhelmed by the amount of information provided. Both were measured with five point agreement scales. The measurement quality of these items was evaluated in the present sample using factor analysis, composite reliability and average variance extracted.

2.3. Measurement quality and statistical analysis

We assessed internal consistency with Cronbach's alpha. We assessed the nine digital-media items with principal-axis factor analysis and varimax rotation. Sampling adequacy was acceptable (KMO =0.839), Bartlett's test was significant, $\chi^2(36) = 1391.83$, $p < 0.001$, and the desired two-factor solution accounted for 52.9% of variance. Primary loadings ranged between 0.683 and 0.779 and all cross-loadings were less than .11, indicating provisional separation of credibility and overload. Composite reliabilities for credibility and overload were 0.857 and 0.797 respectively; average variance extracted was 0.547 and 0.496 respectively.

Analyses comprised descriptive statistics, Pearson or point-biserial correlations, hierarchical multiple linear regression for intention, and hierarchical binary logistic regression for past-year contact. Continuous predictors were standardised. Covariates were sex, age, and past receipt of mental health education. The contact model was fitted first without intention and was then refitted with intention to test the intention–behaviour link. An ordinary least-squares mediation model estimated the indirect association of MHL with intention mediated by self-stigma with 5,000 bootstrap samples. Multicollinearity was very low (maximum VIF = 1.19). Because the design is cross-sectional, indirect effects are interpreted as statistical associations, rather than causal effects.

3. Results

3.1. Descriptive statistics and correlations

Reliability was acceptable for all scales ($\alpha = 0.762$-0.858; Table 1). Mean MHL was 111.78 (SD = 16.23), and mean help-seeking intention was 4.03 on the seven-point scale (SD = 1.11), indicating moderate willingness rather than firm commitment. MHL correlated positively with intention ($r = 0.501$, $p < 0.001$) and professional contact ($r = 0.297$, $p < 0.001$). Credibility correlated positively with intention ($r = 0.291$, $p < 0.001$), whereas overload ($r = -0.149$, $p = 0.002$) and self-stigma (r

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=-0.309, p <0.001) correlated negatively. Self-stigma had the strongest bivariate association with completed contact (r =-0.314, p <0.001).

Table 1. Descriptive statistics, reliability, and correlations

Variable	M	SD	α	1	2	3	4	5	6	7
1. MHL	111.78	16.23	.828	—						
2. Credibility	3.45	.79	.858	.319	—					
3. Overload	3.06	.78	.800	−.050	−.126	—				
4. Self-stigma	2.84	.57	.792	−.227	−.022	.149	—			
5. PHQ-4	5.84	2.70	.762	.057	.002	.130	.031	—		
6. Help intention	4.03	1.11	.788	.501	.291	−.149	−.309	.209	—	
7. Professional contact	.27	.45	—	.297	.126	−.042	−.314	.118	.313	—

Note. Professional contact is binary (0 = no, 1 = yes). Correlations |r| ≥ .126 are significant at p < .01; |r| ≥ .157 at p < .001.

3.2. Hypothesis tests and the intention–behavior gap

The intention model was significant, F(8, 419) = 30.20, p <0.001, R^2 =0.366, adjusted R^2 =0.354. Demographic covariates alone explained less than 1% of variance; adding MHL, digital conditions, self-stigma, and distress increased explained variance by 35.9% points. MHL was the strongest positive predictor (β =0.385, p < 0.001), supporting H1. Credibility predicted higher intention (β = 0.147, p < 0.001), while overload (β = -0.109, p = 0.007) and self-stigma (β = -0.211, p < 0.001) predicted lower intention, supporting H4. Distress also predicted intention (β = 0.208, p < 0.001).

In the contact model without intention, a one-standard-deviation increase in MHL was associated with 85% higher odds of professional contact (OR = 1.85, 95% CI [1.41, 2.43], p < 0.001), supporting H2. Self-stigma reduced the odds (OR = 0.47, 95% CI [0.35, 0.61], p < 0.001), while distress, female sex, and prior mental health education increased them. Adding intention improved model fit (McFadden R^2 from .184 to .195; AIC from 425.92 to 422.44). Intention remained significant (OR = 1.43, 95% CI [1.06, 1.94], p = 0.020), and MHL remained independently associated with contact (OR = 1.63, 95% CI [1.22, 2.19], p = 0.001), supporting H5 and indicating partial, not complete, behavioral conversion.

Table 2. Adjusted predictors of intention and professional contact

Predictor	Intention β	p	Professional contact OR [95% CI]	p
Mental health literacy	.385	<.001	1.63 [1.22, 2.19]	.001
Digital credibility	.147	<.001	1.05 [0.81, 1.37]	.718
Information overload	−.109	.007	1.03 [0.80, 1.33]	.792
Self-stigma	−.211	<.001	0.50 [0.38, 0.66]	<.001
Psychological distress	.208	<.001	1.28 [1.00, 1.64]	.054

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Table 2. (continued)

Female	−.052	.508	2.19 [1.31, 3.64]	.003
Age	−.037	.349	1.06 [0.82, 1.35]	.668
Prior mental health education	.093	.238	1.73 [1.06, 2.82]	.028
Help-seeking intention	—	—	1.43 [1.06, 1.94]	.020

Note. Continuous predictors are standardized. Intention model: R^2 = .366, adjusted R^2 = .354. Contact estimates are from the final model including intention; McFadden R^2 = .195, AUC = .793, Hosmer–Lemeshow p = .975.

3.3. Indirect association through self-stigma

MHL was negatively associated with self-stigma (a =-0.0232) and the association between self-stigma and intention remained negative after controlling for MHL and demographic covariates (b =-0.0209). The standardized indirect effect was 0.049, 95% bootstrap CI [0.024, 0.079]. The direct association between MHL and intention remained positive (β =0.451), which indicates partial statistical mediation and provides support for H3. This finding is consistent with evidence indicating that literacy partially enables help-seeking by changing the personal and social significance of seeking professional support.

4. Discussion

The findings present a coherent account of the relationship of MHL with professional help-seeking . MHL was associated with both willingness and past-year contact, but the behavioral effect diminished when intention was added to the contact model. The pattern follows a staged interpretation, with literacy improving appraisal and perceived appropriateness of care, intention translating appraisal into motivation, and practical or psychosocial barriers determining whether motivation translates into attendance. Knowledge is necessary but not sufficient.

The most consistent inhibiting factor was self-stigma. The negative associations it has with intention, contact and the indirect MHL pathway suggest that students may be aware of symptoms and treatment but avoid seeking care when help-seeking threatens self-worth. Digital mental health education should therefore not only consist of lists of symptoms. The content should normalize early consultation, explain confidentiality and what happens in a first session, frame help-seeking as active coping and use peer narratives that describe how qualified care was accessed, rather than just circulating diagnostic labels.

Credibility and overload affected intention but did not predict completed contact in isolation. This distinction is useful to understand the impact of digital media: reliable information can improve problem recognition and confidence in professional care, but contradictory content can generate hesitation but neither condition eliminates appointment friction. University platforms should include provider credentials, review dates, clear limits for online self-assessment, referral parameters, estimated wait times, and direct booking links. Literacy campaigns must be judged not by knowledge scores or clicks but by completed booking and attendance.

In the final contact model, female gender and prior mental health education also emerged as positive predictors. Literacy alone may not drive these patterns but differences in service familiarity, social norms or prior institutional contact. Universities need to offer a variety of low-threshold entry

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points such as short triage, tele-mental health and non-stigmatizing labels and messaging for consultations that appeal to the self-reliance norms of students who are uncomfortable with traditional counseling. Distress predicted intention and contact in the model without intention, but its effect was reduced when intention was added, suggesting that perceived need may operate in part through motivation..

4.1. Limitations and future research

The study has some limitations. First, because the design is cross-sectional, it is not possible to infer causality or the temporal ordering of MHL, stigma, intention and service contact. Second, the main variables were collected via self-report, which can be influenced by recall errors and social desirability bias, especially concerning past-year professional contact. Third, the sample was composed of university students, and the results may not be generalizable to nonstudent populations or institutions with different service environments. Fourth, the digital credibility and overload measures were study-specific, and while their factor structure and internal consistency were acceptable in this sample, they need further validation through confirmatory factor analysis and measurement-invariance testing across sex, year of study, and cultural groups..

Previous service use is likely to increase MHL and students who have received care may view digital information differently. Longitudinal studies should measure MHL, digital exposure, stigma and intention prior to subsequent verified booking and attendance. Future models should separate passive algorithmic exposure, active searching, official university resources, peer support and clinical digital interventions, and account for service availability, cost and waiting time.

5. Conclusion

The analysis suggested that mental health literacy had a positive association with intention and behavior of seeking professional help in university students, but the pathway was neither automatic nor purely informational. Self-stigma decreases willingness and use, credible digital information promotes intention, overload reduces it, and intention only partially converts literacy to completed contact. Rather than awareness being the end goal, universities should integrate evidence-based online literacy, anti-stigma communications, and screening and immediate service navigation. The findings offer empirical support for the development of integrated digital mental health education and professional service navigation strategies for university students.

Data transparency statement

The analyses were conducted using 428 valid questionnaire responses collected from university students. All descriptive and inferential statistics reported in the manuscript were calculated from the collected survey data.

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